

**Independent Assessment Committee Report**  
**Constituted under Article 8.01 of the**  
**Collective Agreement**  
**between**  
**Kingston General Hospital**  
**and**  
**Ontario Nurses' Association**

**May 15, 2013**

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Ms. Lorie Daniels  
Ontario Nurses Association  
Professional Practice Specialist  
Labour Relations Officer  
Ontario Nurses' Association  
85 Grenville Street, Suite 400  
Toronto, Ontario, M5S 3A2

Ms. Eleanor Rivoire  
Vice President, Clinical Administration, Professional Practice and Chief Nurse Executive  
Kingston General Hospital  
76 Stuart St.  
Kingston, ON, K7L 2V7

Dear Ms. Daniels and Ms. Rivoire,

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 Kingston General Hospital and the Ontario Nurses Association.

This report contains the Independent Assessment Committee's findings and recommendations regarding Professional Workload Complaint submitted by Nurses from the Kidd 2 (K2) and Davies 4 (D4) units in the Critical Care Program at Kingston General Hospital.

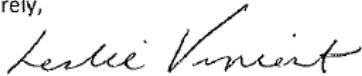
The process undertaken through an Independent Assessment Committee provides a unique opportunity for discussion and dialogue between all the parties regarding the complex issues and conditions that underlie a Professional Workload Complaint. The Committee has made fifty-six recommendations in twelve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

- Staffing
- Scheduling
- Retention
- Assignments
- Unit morale and staff engagement

- Culture and communication
- Leadership
- Education
- Model of care
- Patient flow and bed management
- CCIS data management
- Hospital Association Committee

The Committee hopes that the recommendations in this report will assist the Hospital and the Association to find mutually agreeable resolutions with regard to nursing workload issues on K2 and D4.


Sincerely,



Leslie Vincent RN MScA  
Chairperson



Cynthia Orlicki RN CNCC(C)  
Nominee for the Association



Ella Ferris RN MBA  
Nominee for the Hospital

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Appendix 1: Letter from the Association to the Hospital November 28, 2012.

Appendix 2: Letter from the Association to Chair of the IAC November 28, 2012.

Appendix 3: Letter from the Hospital to the Association November 29, 2012

Appendix 4: Information Request to Kingston General for IAC Submission

Appendix 5: Letter of March 25, 2013 from the IAC Chair to the Hospital and the Association

Appendix 6: Agenda of the IAC for Kingston General April 8-10, 2013.

Appendix 7: Revised appendix to Letter of March 25, 2013.

Appendix 8: List of Attendees from Kingston General Hospital and the Ontario Nurses Association.

# **1 Introduction**

## **1.1 Organization of the Independent Assessment Committee Report**

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

### **1. Introduction**

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

### **2. Presentation of the Professional Responsibility Workload Complaint**

Presents the context of practice relating to the professional workload complaint in the Critical Care Program at Kingston General Hospital; summarizes the relevant history leading to the referral of the professional workload complaint to the IAC; and reviews the presentations by the Ontario Nurses' Association ('the Association'), Kingston General Hospital ('the Hospital') at the Hearing.

### **3. Discussion, Analysis and Recommendations**

### **4. Summary and Conclusions.**

### **5. References and Appendices**

The submissions and exhibits of the Ontario Nurses' Association and Kingston General Hospital are on file with both parties.

## **1.2 Referral to the Independent Assessment Committee**

This Report addresses the professional workload complaints of Registered Nurses from the Critical Care Program at Kingston General Hospital. The Association stated the following in their pre-hearing submission:

*"ONA submits this Professional Responsibility Complaint as a result of the employer, (Kingston General Hospital) assigning a number of patients and a workload to an individual RN, and a group of RNs*

*working in the Kidd 2 (East and West) ICU, the Davies 4 ICU and RNs belonging to the Intensive Care Combined Nurse (ICCN) Virtual Unit for Critical Care Units, such that they have cause to believe that they are being asked to perform more work than is consistent with proper patient care.*

*For the purpose of the brief, the issues identified in the Davies 4 Intensive Care Unit will not be the primary focus, as many of the issues have resolved. However they have existed during the process of this professional responsibility complaint and have impacted the workload concerns identified. The workload issues on the Davies 4 ICU have been raised less frequently, however none have reached written conclusions attached to the Professional Responsibility Workload Responsibility Forms (PRWRFs) and therefore are not considered resolved, according to the Collective Agreement.”<sup>1</sup>*

### **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 Kingston General Hospital.

Article 8.01 states:<sup>2</sup>

- 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 IAC's jurisdiction thus relates to whether registered nurses are being requested and/or required to assume more work than is consistent with the provision of proper patient care. Workload is influenced by both direct factors (e.g. nurse-patient ratio, patient acuity/complexity of care requirements, patient volume) and indirect factors (e.g. roles and responsibilities of other care providers, physical environment of practice, standards of practice, and systems of care). The IAC is responsible for examining factors impacting workload, and for making recommendations to address workload issues. Concerns outside of workload are beyond the jurisdiction of the IAC.

In the matter of arbitration between Brantford General Hospital and the Ontario Nurses Association both parties acknowledged that while according to the collective agreement the IAC's report is not binding upon the parties, "the parties stressed to the board that the association and the participating hospitals all feel bound by the findings of such committees."<sup>3</sup>

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

The members were:

**For the Association:**

Cynthia Orlicki

**For the Hospital:**

Ella Ferris

**Chairperson**

Leslie Vincent

## **1.4 Proceedings of the Independent Assessment Committee**

### **1.4.1 Pre-Hearing**

On November 28, 2012 the Association notified the Hospital and the IAC Chair in letter sent 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. (Appendix 1)

On November, 28, 2012 the Association sent a letter via email to Ms. Leslie Vincent, confirming that she would be the Chairperson of the IAC to investigate the workload complaint at Kingston General Hospital. (Appendix 2)

On November 29, 2012 the Hospital sent a letter via email to the Association, confirming their nominee to the IAC. (Appendix 3)

On November 29, 2012 the Chair of the IAC contacted the Association and Hospital nominees to set the first meeting of the committee.

The IAC met by teleconference on December 7, 2012 and discussed the following issues:

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

On December 18, 2012 the IAC chair provided proposed hearing dates to the Hospital and the Association in March and April 2013. On January 14, 2013 the IAC hearing date of April 8-10, 2013 was confirmed and communicated to the Hospital and the Association by the IAC chair. Subsequently it was agreed to convene the hearing at the Sheraton Four Points in Kingston, Ontario.

On January 29, 2013 the IAC chair communicated by email with the Hospital and the Association with regard to the following matters:

- A request that the IAC receive the pre-hearing submissions by March 6, 2013 in order to allow the panel sufficient time to review the briefs and prepare for the hearing.
- A request of information to be included in the Hospital submission (Appendix 4)
- A request that the submissions and organizational information when provided to all parties, only be shared with those parties who are going to be in attendance at the hearing and that the information is treated as confidential.

- The Hospital and the Association were also informed in this email that the committee might include some information in the final report if it is germane to the discussion and recommendations.

At the request of the Association, the date for receipt of the pre-hearing submissions was extended to March 11, 2013.

On March 25, 2013 the IAC met in person to discuss the following matters:

- Review of submissions from ONA and the Hospital:
  - a. Discussion regarding issues arising from submission information
  - b. Any additional information requests
- Set the agenda for the hearing and rules of conduct during the hearing.

On March 25, 2012 the IAC sent a letter via email to the Hospital and the Association to thank both parties for their comprehensive submissions; and to request meetings prior to the hospital tour with the Medical Director of the Critical Care Program; and the Clinical Educators in the Critical Care Program. (Appendix 5). The letter also included some additional information requests from the Hospital. The Agenda for the hearing was also attached to the email. (Appendix 6)

On March 25, the IAC sent a revision to the aforementioned letter to request two additional information items. (Appendix 7.)

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

### **1.4.2 Hearing**

#### **Monday April 8, 2013**

The IAC met at the Hospital at 0745 Hours on April 8, 2013 and were greeted by representatives of the Hospital. The IAC then met privately with the Clinical Educators in the critical care program; followed by a private meeting with Dr. Drover, the Medical Director of the Critical Care Program.

Following the meetings, the IAC was provided with an extensive tour of the Kidd 2 (K2) and Davies 4 (D4) Critical Care Units. The tour served to familiarize the IAC with the work environment and physical layout of the units. Ms. Donna Leybourne, Charge Nurse, facilitated the tour.

The following individuals from the Association were on the tour:

- Leslie Buller-Hayes, Staff Nurse;
- Marci Almeida, Staff Nurse;
- Lorrie Daniels, Professional Practice Specialist, Ontario Nurses Association.

The following individuals from the Hospital were on the tour:

- Nicole McCormack, Manager of K2;
- Christina Panopoulos-Rowe, Manager of D4;
- Jason Green, legal counsel for the Hospital.

The Hearing convened at 1300 hours at the Sheraton Four Points in Kingston, Ontario as per the agenda (Appendix 6). Participants and Observers on the respective hearing dates are listed in Appendix 8.

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

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

Ms. Lorrie Daniels, Professional Practice Specialist (PPS), presented on behalf of the Association. The Association's presentation was based on their written Pre-hearing submission and supporting exhibits as well as a summary of the Professional Responsibility Workload Report Forms (PRWRFs) submitted by the Registered Nurses of K2 and D4 between 2009 and 2012.

During the presentation the Association stated that the following themes consistent with the issues identified in the PRWRFs have been increasing the workload of nurses in the critical care program:

- Insufficient RN staffing levels resulting in the inability to staff for the acuity of the patient population; the inability of staff to provide adequate support and assistance to new and novice practitioners; and to meet the daily shift needs and allow or adjust for changes in acuity and activity;
- Multiple and increasing numbers of vacant shifts on the posted schedule and increasing inability to replace vacant RN shifts including call-ins for acuity, and sick calls, due to inadequate base full time and part-time RN staffing resulting in high amounts of overtime, and the denial of requests for vacation and statutory holiday and lieu days;
- Inability to take or complete rest breaks; additional non nursing duties; lack of adequate support staff including Unit Clerks, and Patient Care Assistants.

The Association recommendations for resolution were in the areas of:

- Leadership;
- Professional practice;
- Culture and communication; and
- Fluctuating workload.

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

Ms. Eleanor Rivoire and Ms. Mae Squires presented on behalf of the Hospital. The content of the Hospital's presentation was based on their written pre-hearing submission. Ms. Rivoire also stated that the Hospital viewed the IAC as an opportunity to have external experts objectively hear the perspectives of each party, and an opportunity to work together to achieve the shared goals of patient care and professional practice. The presentation also provided a summary of recent events in the history of the Hospital including a period of investigation and supervision and the commitment to a significant financial recovery without impact to patient care and staff well being. The Hospital embarked on a new Strategic Plan in 2010 – "Strategy for Achieving Outstanding Care".<sup>4</sup> Significant change has occurred since 2010 including changes in people, construction projects and carpet removal. All the changes have had significant impact on the critical care program. The presentation provided the Hospital's view on four issues of importance from their perspective:

- The Hospital Association Committee
- Changes in the ICU
- Staffing issues; and
- Professional Development.

The Hospital provided a detailed chronology of the construction over the last two years, and the frequent moves of patients and staff between units that were undertaken to facilitate the construction of the new critical care unit. The Hospital acknowledged that over the past four years, there have been significant changes in the critical care program in terms of physical plant, technology and in the care team. During and following the presentation, the Hospital responded to questions of clarification from both the Association and the IAC.

The IAC Chair adjourned the Hearing at 1830 hours. Following adjournment of Day one of the hearing, the IAC met to review and synthesize the information provided, and to identify key issues requiring additional clarification and discussion on the second day of the hearing.

### **Tuesday April 9, 2013**

The IAC met on Tuesday morning prior to the start of day two of the hearing. The IAC Chair resumed the Hearing at 1000 hours. The ground rules for the Hearing were reviewed and all participants were introduced. Ms. Rivoire, Ms. Squires, Ms. McCormick and Ms. Panopoulos-Rowe provided the Hospital's response to the Association's submission. Members of the Hospital participated in the subsequent discussion. Ms. Lorrie Daniels, Professional Practice Specialist, Labour Relations Officer, with the

Association, provided the Association's response to the Hospital's submission. Other members of the Association also participated in the subsequent discussion.

The IAC Chair adjourned the Hearing at approximately 1730 hours. Following adjournment of the Hearing, the IAC met during the evening of April 9, 2013 to review and synthesize the information provided, and to identify key issues requiring additional clarification and their respective questions for the final day of the hearing.

### **Wednesday, April 10, 2013.**

The IAC Chair resumed the Hearing at 0900 hours. The ground rules were reviewed and all participants were introduced.

Members of the IAC asked further questions in order to understand a range of issues in more detail and gaining further clarity of the issues arising from both parties' presentations.

The IAC Chair concluded the hearing by thanking Ms. Cynthia Orlicki, Association Nominee and Ms. Ella Ferris, 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 IAC anticipated providing the final report within 45 days. The IAC Chair closed the Hearing at approximately 1330 hours.

### **1.4.3 Post Closure of Hearing**

The IAC met privately with the Clinical Educators at their request following the closure of the hearing.

The IAC met on Sunday April 21, 2013. At this meeting, the IAC had extensive discussion and reviewed draft recommendations and analysis. In the interim between April 21 and the next planned meeting, all IAC members contributed to the next version of the report and recommendations. The IAC met by teleconference on Tuesday, April 30, 2013 to discuss the draft report. In the interim between the April 30, 2013 and the finalization of the report, the members of the IAC all contributed to the final version of the report. The report was finalized on May 15, 2013.

## **2 PRESENTATION OF THE PROFESSIONAL RESPONSIBILITY WORKLOAD COMPLAINT**

### **2.1 Information on Kingston General Hospital and the Intensive Care Unit**

#### **2.1.1 Kingston General Hospital**

Kingston General Hospital is located in Kingston, Ontario and has 24 satellite locations and affiliate sites throughout south eastern Ontario. The hospital services almost 500,000 residents who live in a 20,000-square-kilometre predominantly rural area, as well as some communities on James Bay in Ontario's north. In addition to their regional role, the hospital also serves as a community hospital, caring for the less acute needs of the residents of Greater Kingston. The Hospital is affiliated with Queen's University and has important roles in education and research in addition to the care of patients. The Hospital has approximately 2,400 students per year from 34 universities and colleges across Canada. Hospital services include cancer; cardiac; critical care; emergency medicine; endocrinology and metabolism; gastroenterology; imaging; infectious disease; internal medicine; medical genetics; mental health; nephrology and dialysis; neurology; obstetrics and gynecology; pathology and molecular medicine; paediatrics; pharmacy; respirology; rheumatology; sexual assault and domestic violence; and surgical perioperative and anaesthesiology.<sup>5</sup>

The Kingston General Hospital Strategy is entitled "Strategy for achieving Outstanding Care, Always." The strategy presents their vision of KGH as a patient-centred, dynamic research Hospital and leader in inter-professional practice and education. The Hospital's guiding principles are respect, engagement, accountability, transparency and value for money.<sup>4</sup>

#### **2.1.2 Kidd 2 and Davies 4 Intensive Care Units**

The Intensive Care Unit is located on the Kidd 2 (K2) and Davies 4 (D4) units. There are currently 47 beds open on the two units. The Intensive Care Unit has recently been redeveloped in order to increase the critical care capacity on K2 by 12 beds from 21 to 33 beds. K2ICU is now a 33 bed unit, but only 27 beds are currently open on this unit. Two additional open beds that are part of the K2 complement are currently on D4. The Hospital anticipates that by August 31, 2013 that the two K2 beds on D4 will move back to K2, and that four additional beds will be opened on K2. The primarily single patient rooms on K2 are split between two co-located pods. Each pod has its own support spaces (i.e. supply room, medication room, etc.). It was noted that some equipment/supplies are only in one supply room and therefore not as easily accessed by staff. (eg. CRRT machines, stand alone patient lifts). The family waiting area is between the two pods. K2 currently operates under a closed medical model.

D4 is on a different floor from K2 and in a different wing. All 20 beds on D4 (18 D4 beds and 2 K2beds) are in one pod. The D4 unit currently operates under an open medical model.

## **2.2 Patient Activity Profile for Kidd 2 and Davies 4**

The number of ICU admissions per quarter over the period of Q4 2009-2010 to Q3 2012-2013 has varied from 152 patients to 316 patients. The Hospital noted during their presentation that there were some inaccuracies in the data for Q4 of 2011-2012. Admissions have steadily increased over this time as would be expected with the opening of additional beds.<sup>6</sup>

The average length of stay of patients in ICU is currently 8.10 days. Between Q1 of 2010-2011 and Q3 of 2012-2013, the average length of stay has varied from 5.92 days to 9.73 days. Average length of stay has steadily increased since the end of the fiscal year 2011-2012.<sup>7</sup>

The average Multiple Organ Dysfunction Scores between Q1 2010-2011 and Q2 2012-2013 have ranged between 4.23 to 5.16.<sup>8</sup>

The Nine Equivalent of Nursing Manpower Use Score (NEMS) average has varied between 31.09 and 27.33. Over the period of Q1 2010-2011 to Q2 2012-2013, the average score trend has been trending downward.<sup>9</sup>

## **2.3 Context of Staffing on Kidd 2 and Davies 4**

The K2 and D4 Intensive Care Units have recently undergone a complete renovation that took over three years to complete. The purpose of the renovation was to increase critical care capacity at Kingston General Hospital and to modernize the critical care environment. As a result, the units now function in a much larger footprint with primarily single patient rooms. The Hospital received Post Construction Operating Plan (PCOP) funding to open an additional 12 beds, thereby increasing the level 3 critical care capacity on K2 from 21 to 33 beds. The opening of the new beds on K2 has been staggered:<sup>10</sup>

- May 2010 – 2 beds
- December 6, 2011 – 1 bed
- January 2012 – 1 beds
- February 2012 – 2 beds
- March 2012 – 2 beds
- Planned for September 2013 – 4 beds

During the period of construction, the beds and staff from both K2 and D4 were moved on a regular basis from one area to another in order to allow for construction in the different zones of the critical care units. In addition, new staff were being recruited and oriented in order to support the opening of the new beds. The Hospital did not close beds at any time during the construction period due to patient care demands in the region. The opening of beds was delayed numerous times due to issues of recruitment.



Planned staffing levels were increased as beds were opened. Based on the information provided in the Hospital submission an historical summary of the bed movements and openings on K2 and D4, planned staffing levels and resultant staffing ratios was compiled.<sup>10</sup> (Tables 1 and 2).

Prior to the opening of beds to a twenty-nine bed total; there was a change to the closed medical model of care in the K2 ICU. Just prior to the opening of the additional beds, the intensivists determined that they did not have the capacity to cover the additional beds and as result an open medical model was established for the new beds.<sup>11</sup> This resulted in K2 becoming a mixed open/closed model of care unit. This mixed model change was very contentious and from the Hospital's perspective created additional workload for the K2ICU staff.<sup>11</sup> To resolve the issue, all open medical model beds were then subsequently relocated to D4; and K2 is now currently operating under a closed medical model.<sup>11</sup>

On K2 there is a mix of patients requiring either 1:1 care or 1:2 care. The bed to nurse ratio on K2 (based on planned not actual staffing and assuming 100% occupancy) ranged from 1.09 in October 2006, to a high of 1.23 in May 2010, and is currently 1.17.

**Table 1: Chronology of Bed Moves and Openings from October 2006-January 30, 2012.**

Date	Jan 30 2012	Jan 16 2012	Dec 13 2011	Dec 6 2011	May- 10	May- 09	Oct- 08	Oct- 06
PCOP Bed Openings	1 PCOP			1 PCOP	2 PCOP			
<b>K2</b>								
K2 Beds	25	24	17	17	16	14	21	21
Other beds on K2	8	8						4
Occupancy	86	86	92	91	92	84	86	
Charge Nurse	2	2	1	1	1	1	1	1
RN Staffing on K2	22	21	14	14	13	12	19	23
K2 Staff on D4			7	7	7	7		
D4 Staff on K2	4	4						
Ratio Bed to Nurse	1.14	1.14	1.21	1.21	1.23	1.17	1.11	1.09
Ratio Nurse to Bed	0.88	0.88	0.82	0.82	0.81	0.86	0.90	
Hospital Calculated Bed to Nurse Ratio	1.14	1.2	1.2	1.14	1.15	1.11	1.11	1.04
<b>D4</b>								
Beds	10	10	18	18	18	18	21	18
Occupancy	95	95	92	92	95	91	89	
<b>Total Beds D4</b>	<b>10</b>	<b>10</b>	<b>18</b>	<b>18</b>	<b>18</b>	<b>18</b>	<b>21</b>	<b>18</b>
K2 beds	33	32	17	17	16	14	21	25
D4 beds	10	10	18	18	18	18	21	18
<b>Total Beds</b>	<b>43</b>	<b>42</b>	<b>35</b>	<b>35</b>	<b>34</b>	<b>32</b>	<b>42</b>	<b>43</b>

**Table 2: Chronology of Bed Moves and Openings from February 2012 to September 2013.**

Date	Sep-13	At Time of IAC	Sep- 12	Jul- 12	March 30 12	Mar 12 12	Feb 20 2012	Feb 13 2012
PCOP Bed Openings	4 PCOP Beds				2 PCOP Beds		2 PCOP beds	
<b>K2</b>								
K2 Beds	33	27	27	26	29	27	27	25
Other beds on K2				CSU 7		4	6	6
Occupancy	100		91	81	95		92	
Charge Nurse	2	2	2	2	2	2	2	2
RN Staffing on K2	27	23	23	22	24	23	23	22
K2 Staff on D4				2				
D4 Staff on K2						2	3	3
Ratio Bed to Nurse	1.22	1.17	1.17	1.18	1.21	1.17	1.17	1.14
Ratio Nurse to Bed	0.82	0.85	0.85	0.85	0.83	0.85	0.85	0.88
Hospital Calculated Bed to Nurse Ratio			1.17	1.18	1.21	1.17	1.17	1.14
<b>D4</b>								
Beds			20	21	18	14	12	12
Occ			97	98	99		88	
<b>Total Beds D4</b>								
K2 beds			27	26	29	31	33	31
D4 beds			20	21	18	14	12	12
<b>Total Beds</b>			<b>47</b>	<b>47</b>	<b>47</b>	<b>45</b>	<b>45</b>	<b>43</b>

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

According to the Association, four Professional Responsibility Workload Responsibility Forms (PRWRFs) were submitted by nurses from the K2 during 2010-2011; and ten from the D4 during 2009-2011.

Between January 2012 and March 2013, one hundred and six (106) PRWRFs were submitted. According to the Association, these forms were completed by seventy-three RNs from K2 or D4. The Hospital provided documentation on 99 PRWRFs between January 2012 and November 2012; and one in January 2013.<sup>12</sup>

The issues identified on the PRWRFs from the Association's perspective include:<sup>13</sup>

- Insufficient RN staffing levels resulting in the inability to staff for the acuity of the patient population; the inability of staff to provide adequate support and assistance to new and novice practitioners; and to meet the daily shift needs and allow or adjust for changes in acuity and activity;
- Multiple and increasing numbers of vacant shifts on the posted schedule and increasing inability to replace vacant RN shifts including call-ins for acuity, and sick calls, due to inadequate base full time and part-time RN staffing resulting in high amounts of overtime, and the denial of requests for vacation and statutory holiday lieu days;
- Inability to take or complete rest breaks; additional non nursing duties; lack of adequate support staff including Unit Clerks, and Patient Care Assistants;

The issues identified in the PRWRFs from the Hospital's perspective include:<sup>14</sup>

- Concerns regarding doubled assignments (77 of 99 reports; and doubled assignments with highly acute critical care patients (29 of 99 reports);
- Issues regarding the usual unpredictable care needs in an ICU (70 reports) such as: the location of Room 18; isolation; break coverage; equipment issues; shortage of a unit clerk or PCA; and busy individual assignments.

In 2010 a subcommittee of HAC was formed for the purpose of reviewing PRWRFs and to bring information on identified trends to the HAC. There was issue in the formation and functioning of the subcommittee and according to the Association submission by June 2010 there was a backlog of PRWRFs extending back to 2009 that had not been discussed or resolved by the HAC.<sup>15</sup>

In August 2010, the PPS became involved at the Hospital. During 2010, a difference of opinion occurred between the Association and the Hospital with regard to whether or not nurses who had completed PRWRFs should attend the HAC meetings. The Association felt the nurses should attend, and the Hospital did not, stating that the appropriate time for nurses to discuss their issue is with the team, supervisor or manager in the first stages of the process. It was noted in the Association submission that

the Hospital has not prevented Association members from the HAC-PRC meeting with the ONA PPS. However, the issue appeared to still be a point of contention at the time of the hearing.

On October 12, 2010, a Hospital Association Committee – Professional Responsibility Committee (HAC-PRC) occurred. On December 8, 2010 a HAC-PRC for review of ICU PRWRFs took place. Several meetings between the Hospital and the Association took place during 2011 to discuss workload and practice concerns.

Following numerous meetings and development of action plans, a Memorandum of Agreement was signed on December 13, 2011 with regard to the K2 ICU. Resolutions were reached in the following areas:<sup>16</sup>

- Staffing;
- Charge Nurse Support;
- Orientation and Ongoing Education; and
- Retention Strategies;

At the request of the Hospital, a meeting with the Association to discuss the PRWRFs from the ICU occurred on February 9, 2012.

At the March 2012 HAC meeting, the Association presented a new action plan with recommendations<sup>17</sup>.

Numerous meetings and discussions continued during 2012. On June 12, 2012 a HAC-PRC meeting was held. The Hospital and the Association met again on August 15, 2012; September 20, 2012 and October 17, 2012.

In October 2012 the Association notified the Hospital that outstanding issues were being referred to the IAC.

In the Association submission it was noted that:

“For the purpose of this brief, the issues identified on D4 Intensive Care Unit will not be the primary focus, as many of the issues have been resolved.”<sup>18</sup> During the Hearing, the main focus of discussion was issues related to K2.

### **3 Discussion, Analysis and Recommendations**

#### **3.1 Staffing**

Effective nursing human resource planning and execution strategies are essential in workforce planning and to ensure adequate nurse staffing on a day to day basis in health service organizations.<sup>19</sup> Strategies include the consistent use of needs based human resource planning tools and appropriate data to assist in decision making. Organizations must also address short and long term planning.<sup>19</sup> Forecasting models in nursing human resources provide a predictive model to determine staffing requirements for the future. One such model is the toolkit published by HealthForceOntario - Building Capacity for Nursing Human Resource Planning: A Best Practice Resource for Nursing Managers.<sup>19</sup>

“There is a growing body of literature supporting the conclusion that nurse staffing and workload affect nurse satisfaction, nurse turnover, and patient outcomes”.<sup>20</sup> Understaffing and the increased complexity of work were identified in a study by Duxbury and colleagues as contributors to work overload. Work overload was also identified as a contributing factor to fatigue.<sup>21</sup>

During the IAC hearing, it was evident that the concerns regarding staffing levels were focused on K2.

##### **Current state on K2**

The number of beds on K2 is currently 27. There are two K2 beds that are currently being managed on D4. The Hospital has made the following assumptions in planning the current staffing levels on K2:

- 80% ventilator rate;
- 100% occupancy of average acuity;
- 19 patients are generally 1:1 and 8 patients are 1:2 ratio.

The current plan is to open the final 4 additional beds on K2 in September 2013 for a total of 33 beds. The Hospital has made the following assumptions in planning the staffing levels for K2 for September 2013:

- 80% ventilator rate;
- 90% occupancy;
- Planned staffing of 2 Charge Nurses and 27 Nurses;
- 21 patients will be 1:1 and 12 patients will be 1:2;
- Increase staffing at the time as required due to volume and acuity of patients.

The IAC calculates that when the final 4 beds are opened, assuming 100% occupancy and the planned staffing levels, that the ratio of patients to nurses will be 1.22.

Over the last two years the Hospital has hired a total of 82 nurses of which 25 were new graduates, 32 had previous ICU experience and 25 were experienced nurses but not in critical care. Unfortunately there has also been considerable turnover of staff during the same time period. Table 3 summarizes the turnover and internal churn of staff that was provided to the IAC by the Hospital during the IAC hearing.

**Table 3: Analysis of Turnover**

Time Period	Number of RNs who left K2	Average Number of Employees per Month in K2	Percentage of Churn or Turnover
April 4 2012 to March 26, 2013	15 – Internal Churn	113	13.27 %
	12 – Turnover	113	10.62 %
April 1 2011 to March 31, 2012	19 – Internal Churn	123	15.45%
	7 – Turnover	123	5.69%

Internal churn was defined as all people who moved from K2 to other positions in the Hospital or Critical Care Program. Turnover was defined as those who left the hospital. The IAC understands that the Association calculation for turnover was higher than the hospital; however, it was additive of internal churn and turnover. Nevertheless, the IAC viewed the turnover as much higher than desired.

The combination of increasing bed capacity, recruiting staff due to turnover and internal churn has resulted in almost continuous hiring and orientation of new staff. The Clinical Educators reported that orientation has taken place almost every month of the year.

During the Hearing, the Association provided extensive analysis on the gap between planned and actual staffing in the posted schedules and demonstrated that schedules were being regularly posted with holes. The Hospital stated during their presentation that there have been many challenges and difficulties in staffing and that they were not always able to achieve baseline staffing requirements.

Review of the Hospital data on Registered Nurse hours per patient day (HPPD) showed that the HPPD between December 2011 and February 2013 varied from month to month from a low of 17.66 (January 2013) to a high of 27.7 (December 2012).<sup>22</sup> The Hospital stated the average HPPD for peer hospitals (Source: HIT Data) was 22.40 in the fiscal year 2011-2012; 22.90 in fiscal year 2012-2013; and 23.40 in Quarter 3 of fiscal year 2012-2013. The Hospital stated that they would expect the HPPD to be approximately 22.5. Data from the Hospital Information Tool (HIT) data base showed that the HPPD on average has improved over the past two years.

However, despite the considerable efforts of the Hospital to recruit and orient staff, schedules have frequently been posted with holes and the Hospital has been unable to consistently staff the unit at the planned levels. This situation was compounded by other factors including the lengthy and disruptive unit construction and frequent bed moves; and the disruption caused by the use of a mixed open/closed model of care on K2. It is unclear to the IAC whether the Hospital has established an adequate number of full and part time positions to be able to staff on a regular basis to the planned levels and also ensure adequate coverage for replacement needs.

A further analysis of the staffing data was done. Also, according to the total paid hours for 2012-2013 (to Q3), the total paid hours for RNs on K2 it projected to be equivalent to 121.31 FTEs.<sup>23</sup> It is also assumed that some portion of the 9.52 FTEs in the ICCN (Intensive Care Combined Nursing) paid hours were worked in K2. Table 5 is a summary of the total paid hours and FTEs for K2 and ICCN for the fiscal year 2012-2013.

**Table 5: Total Paid Hours and FTEs for K2 and ICCN 2012-2013.**

	Total Paid Hours to Q3	Projection to Year End	Converted to FTEs
K2 Full Time RNs	138,788	185,050	94.90
K2 Part Time RNs	24,722	32,962	16.90
K2 Casual RNs	4,654	6,205	3.18
K2 Charge Nurses	9,247	12,329	6.32
Total for K2		236,548	121.31
ICCN	13,916	18,554	9.52
Total K2 and ICCN			130.83

Overtime is currently projected to be 10,814 hours or 5.55 FTEs or 4% of budgeted FTEs.<sup>24</sup> The sick time for Charge Nurses and RNs on K2 is projected to be 12,168 hours by year end or 6.24 FTEs or 4% of budgeted FTEs.<sup>24</sup> Some opportunity exists to reduce both sick time and overtime in order to achieve savings.

The Hospital can also make better use of the New Graduate Guarantee in the critical care program, thereby achieving additional revenue to support the orientation of staff and hopefully achieve funds that can be reinvested in staff development for more senior staff.



Through the use of a staffing budget worksheet (Figure 1) which calculates staffing FTEs based on the current planned number of staff per shift (2 charge nurses and 27 RNs) and estimated replacement requirements for 12 statutory holidays, 20 vacation days and 7 sick days, the K2 ICU would minimally require 130.41 RN FTEs and 9.66 Charge Nurse FTEs for a total of 140.07 FTES in order to staff the unit and replace staff for statutory holiday, vacation and sick time.

STAFFING PATTERN							Total Regular shifts [A]		
Staffing Mon-Fri	0730-1130	1130-1530	1530-1930	1930-2330	2330-0330	0330-0730			
RN	27	27	27	27	27	27	405		
Charge Nurse	2	2	2	2	2	2	30		
STAFFING PATTERN							Sat-Sun		
Staffing Sat-Sun	0730-1130	1130-1530	1530-1930	1930-2330	2330-0330	0330-0730	Total Regular Shifts [B]	A+B	Regular Shifts in FTEs [C]
RN	27	27	27	27	27	27	162	567	113.4
Charge Nurse	2	2	2	2	2	2	12	42	8.4
Regular FTEs					Total Relief Shifts	Total Relief FTEs	Total FTEs		
		Stat Holidays [cx12]	Vacation [Cx20]	Sick Time [Cx7]					
	[C]	[D]	[E]	[F]	[G]				
RN	113.4	1360.8	2268	793.8	4422.6	17.01	130.41		
Charge Nurse	8.4	100.8	168	58.8	327.6	1.26	9.66		
Total	121.8	1461.6	2436	852.6	4750.2	18.27	140.07		

Using the same worksheet, and assuming 95% occupancy and staffing with 2 Charge Nurses and 28 RNs, the minimum required FTEs would be 144.9. (Figure 2)

**Figure 2: Staffing Budget Worksheet for 2 Charge Nurses and 28 RNs on K2**

STAFFING PATTERN		Monday to Friday								
Personnel		0730-1130	1130-1530	1530-1930	1930-2330	2330-0330	0330-0730	Total # of Regular shifts [A]		
RN		28	28	28	28	28	28	420		
Charge Nurse		2	2	2	2	2	2	30		

		Saturday to Sunday								
		0730-1130	1130-1530	1530-1930	1930-2330	2330-0330	0330-0730	Total Number of Regular Shifts [B]	A+B	Regular Shifts in FTEs [C]
RN		28	28	28	28	28	28	168	588	117.6
Charge Nurse		2	2	2	2	2	2	12	42	8.4

	Regular FTEs	Relief Required			Total Relief Shifts	Total Relief FTEs	Total FTEs
		Stat Holidays [Cx12]	Vacation [Cx20]	Sick Time [Cx7]			
	[C]	[D]	[E]	[F]		[G]	
RN	117.6	1411.2	2352	823.2	4586.4	17.64	135.24
Charge Nurse	8.4	100.8	168	58.8	327.6	1.26	9.66
<b>Total</b>	<b>126</b>	<b>1512</b>	<b>2520</b>	<b>882</b>	<b>4914</b>	<b>18.90</b>	144.90

Using the same worksheet, and assuming 100% occupancy and staffing with 2 Charge Nurses and 29 RNs, the minimum required FTEs are 149.73. (Figure 3)

**Figure 3: Staffing Budget Worksheet for 2 Charge Nurses and 29 RNs on K2**

STAFFING PATTERN	Monday to Friday								
Personnel	0730-1130	1130-1530	1530-1930	1930-2330	2330-0330	0330-0730	Total # of Regular shifts [A]		
RN	29	29	29	29	29	29	435		
Charge Nurse	2	2	2	2	2	2	30		

	Saturday to Sunday								
	0730-1130	1130-1530	1530-1930	1930-2330	2330-0330	0330-0730	Total Number of Regular Shifts [B]	A+B	Regular Shifts in FTEs [C]
RN	29	29	29	29	29	29	174	609	121.8
Charge Nurse	2	2	2	2	2	2	12	42	8.4

	Regular FTEs	Relief Required			Total Relief Shifts	Total Relief FTEs	Total FTEs
	[C]	Stat Holidays [cx12] [D]	Vacation [Cx20] [E]	Sick Time [Cx7] [F]		[G]	
RN	121.8	1461.6	2436	852.6	4750.2	18.27	140.07
Charge Nurse	8.4	100.8	168	58.8	327.6	1.26	9.66
<b>Total</b>	<b>130.2</b>	<b>1562.4</b>	<b>2604</b>	<b>911.4</b>	<b>5077.8</b>	<b>19.53</b>	149.73

The staffing budget worksheet calculation does not include education and orientation hours. Table 6 shows a comparison of required FTEs at different occupancy levels.

**Table 6: Comparison of Staffing Requirements at Different Occupancy Levels**

Beds on K2	Occupancy	Charge Nurses	RNs	Required FTEs for CNs	Required FTEs for RNs	Total Required FTEs	Budget for 2013 - 2014
33	90%	2	27	9.66	130.41	140.07	8.44 FTEs for Charge Nurses
33	95%	2	28	9.66	135.24	144.90	125.5 RNs for K2 plus approximately 18 FTEs from PCOP funding for a total of 143.5 FTEs
33	100%	2	29	9.66	140.87	149.73	

Given an assumed budget of 143.5 FTEs for Fiscal Year 2013-2014 (which does not include the FTEs from the ICCN that will be utilized on K2) the IAC is of the opinion that the Hospital has some budget flexibility for 2013-2014 to staff to a higher than initially planned level for a period of time in order to stabilize the unit staffing and assess workload.

The Hospital plan for the September 2013 bed openings is based on an operating assumption of 90% occupancy. If volume and/or acuity increases, the Hospital plans to increase staffing at the time. Given the historical problems with staffing, the IAC suggests that this is a high-risk plan and the Hospital may wish to take a more conservative approach to staffing as the beds open, to allow for stabilization and a period of assessment to determine if the operating assumptions hold true. One option is to consider staffing at a slightly higher level than planned; using an assumption of 95% occupancy which would require scheduling 2 Charge Nurses and 28 Registered Nurses.

The ICU team is comprised of Registered Nurses, Physicians, Registered Respiratory Therapists, Pharmacists, Registered Dietician, Physiotherapy, Primary Care Assistants (PCA), Environmental Assistants (EA), and Unit Communication Clerks (UCC). In order for each discipline to function optimally, all disciplines must be present as scheduled. Strategies must be in place for replacement of support staff (UCC, PCA and EA) for illness, vacation, and lieu time. The schedule of support staff must be constructed to support the planned baseline staffing numbers per shift. For example, the Primary Care Assistant schedule is a 2D/2N (two day, two night) schedule, however, the current number of PCA positions cannot support the necessary 9 lines of a 2D/2N master that would result in the desired staffing levels per shift. Therefore the schedule needs to be improved to provide base staffing by changing to a different master such as a 2/3 (two days on, 2 off, 3 on, 2 off, 2 on, 3 off) schedule or hybrid of the two.

**Recommendations:**

1. The Hospital should continue to benchmark staffing to comparable critical care units to support decision making regarding nurse to patient ratio and hours per patient day for D4 and K2.
2. The Hospitals should implement the RNAO Healthy Work Environment Best Practice Guideline on Developing and Sustaining Effective Staffing and Workload Practice.<sup>26</sup>
3. The Hospital should evaluate the adequacy of the number of full and part time registered nurses to meet established staffing levels and replacement requirements on a regular basis (minimum twice a year) utilizing the forecasting tool published in the Building Capacity in Nursing Human Resource Planning: A Best Practice Resource for Nursing Managers.<sup>19</sup>
4. The Hospital must ensure that an adequate staffing complement of full and part time registered nurses are hired to meet the established staffing levels of the unit including predictable replacement requirements such as vacation, statutory holidays, maternity leaves, and sick time.
5. The Hospital must ensure that K2 is staffed to planned levels on a consistent basis in order to stabilize staffing on this unit and to support improved staff retention and morale; and to ensure proper work assignments.
6. The Hospital should establish a mechanism to identify future staffing gaps; and establish an objective measure of staffing gaps by regularly monitoring the actual gap between desired and actual staffing.
7. The Hospital should staff K2 at 95% occupancy levels for a minimum period of 3 months after the opening of the final 4 PCOP beds in September 2013. The recommended staffing for 95% occupancy is 2 Charge Nurses and 28 RNs. If during this period, occupancy and acuity for a shift(s) is lower than expected, the unit can staff down as necessary. Evaluate the cost effectiveness of this approach including use of overtime and sick time.
8. The Hospital should monitor the staffing resources, occupancy, ventilator rate, avoidable day rate and other measures as appropriate on a monthly basis to determine if and/how staffing can be adjusted.
9. The Hospital should monitor the ability to increase staffing when required.
10. The Hospital should ensure that an adequate number of support staff is scheduled and present for each shift. Improve the schedule for Patient Care Assistants to ensure consistent staffing across all shifts and days by considering a different master such as a 2/3 schedule or hybrid of the two.

### **3.2 Scheduling**

Scheduling has been a challenge due to increased demand for staff during a time of unit renovation and increase in number of patients due to opening of newly funded beds. Despite many efforts on the part of management to adequately cover staffing needs, the nurses felt that the RN vacancy rate resulted in high patient to nurse ratios and increased workload. Both the Hospital and the Association agree that safe, quality patient care is the priority at all times.

#### **Recommendations:**

1. The Hospital must ensure that staff schedules are posted without holes. If this cannot be done at time of posting every effort should be made to fill in any gaps at least one week before the shift.
2. The Hospital should review if there is a more effective schedule that could be developed for the K2 and D4 in order to create more balance across shifts and days of the week in order to support full staffing on every shift.
  - a. Schedule should be done respecting the rights of the nurses to take their vacation within the terms and conditions of the Collective Agreement.
  - b. Schedule should be reviewed and appropriate changes made as necessary by the Hospital to ensure that there is an appropriate range of skill mix from novice to expert on each line while not resulting in increased expenditures.
  - c. If the 2D2N schedule creates gaps that cannot be met by part-time or casual staff, the Hospital should determine how many traditional schedules (2/3) would be required to minimize the plus and minus days in the current master schedule. The traditional schedule should then be offered to new hires and the 2D2N offered only when there is a vacant line.
3. The Charge nurse should be given the autonomy to make staffing decisions on a shift by shift basis to ensure safe, quality patient care. The Charge Nurse should be able to increase staff as needed and decrease staff by not replacing sick-time or offering a vacation day or a leave of absence if all staff is not needed. The Charge Nurse should consult with the Manager or the Administrative Coordinator as required by Hospital policy.

### **3.3 Retention**

The Hospital stated that the organization has recruitment challenges due to geography and location and have increased the range and intensity of recruitment efforts through social media, job fairs and other avenues. The Hospital has recruited many novice nurses to work in the critical care units.

Retention issues identified during the IAC hearing included workload, perceived quality and safety of care, quality of work life and non-nursing activities. Nurse workload and stress can be exacerbated by low staffing and poor organizational support.<sup>27</sup>

The Hospital statistics on turnover were presented in Table 3. The Hospital and the Association both agreed that turnover is higher than desired and needs to improve.

The Association presented their analysis of the March 31, 2012 seniority list on K2 during the hearing. The Association's findings were that:

- 35% of full time staff has less than 2 years seniority;
- 61% of part time staff has less than 2 years seniority

An analysis of the data provided by the Hospital in their Submission documents showed the following:<sup>28</sup>

- 20 Staff on K2 has less than 2 years seniority;
- 20 Staff on K2 have between 2-5 years of seniority;
- About 12 staff on K2 have between 5-10 years of seniority;
- About 63 Staff on K2 have more than 10 years of seniority.

The IAC concluded that while there are significant numbers of staff with less than 2 years of seniority; there are also significant numbers of staff with a minimum of 5 years of seniority.

The IAC noted the following strengths in support of recruitment and retention:

- Creation of the ICCN (Intensive Care Combined Nursing) virtual unit ;
- Creation of additional full time positions on the ICCN and on D4 to have adequate staffing to cover maternity leave of absence (MLOA);
- Innovative scheduling: 2D2N schedule, traditional 2/3 schedule, weekend worker schedule, and job shares.

The IAC noted that the following issues may be negatively impacting retention:

- Inconsistent staffing on a day to day basis due to recruitment, retention and turnover issues;
- Restrictions in ability to grant vacation requests due to staffing levels;

With a large number of new staff mainly comprised of novice nurses and new graduate nurses entering critical care, successful integration of these new staff members is key to the retention of both existing staff and new hires.

The Preceptorship program offered at Queen's University and St. Lawrence College for preceptoring of nursing students is shared with preceptors only on request.

While the focus of education during orientation has been on the new hires, the existing staff would also benefit from education on the mentoring of new graduate nurse and novice nurses. Preparing the mentors to be better able to help develop critical thinking skills in new hires will enable greater growth

and skill development during the orientation process. As well, it would help with the relationship between the existing staff and new hires, and potentially result in improved retention of staff.

**Recommendations:**

1. The Critical Care nursing leadership and the unit staff nurses should collaborate to develop a unit specific plan to address staff retention.
2. Continue to utilize a variety of innovative scheduling practices in order to meet both patient care requirements and to support staff retention.
3. The Hospital needs to review the vacation quota calculation and revise as necessary to ensure that an accurate vacation quota is established to allow for vacation entitlements as per the collective agreement.
4. The Hospital should implement a mentorship education and development program for nursing staff who act as mentors to support the orientation and integration of new staff. Include educational material in the program on providing constructive feedback, role modeling, and information on developing critical thinking skills in novice critical care nurses.

### **3.4 Assignments**

The Association identified concerns regarding nursing patient care assignments such as:

- Challenges in effective mentoring of new staff if doubled or working short;
- Geographical layout of unit creates difficulty in managing some doubled assignments and also during break coverage; Room 18 is a particular challenge because of its isolated location in the unit;
- Nurses performing additional non nursing duties when support staff is not available or replaced;
- Concern regarding the number of doubled assignments;

The hospital provided the committee with a copy of the guidelines for alternative assignments in K2ICU and D4ICU dated December 2012.<sup>29</sup> These guidelines speak to the underlying principles, processes, and considerations for expanded assignments (more than one patient), collaborative nursing assignments (patients being cared for by team of health care providers); and guidelines for preparing double/triple assignments in the ICU. The document provided does not have any information about considerations for assigning nurses who are mentoring new staff on orientation. When new staff are near the beginning of their orientation, more time will be required by the mentor to explain and demonstrate. During the period of time when the new nurse is familiarizing with the procedures, processes, routines, and geography of the unit this time will decrease, it would be prudent to avoid assigning a mentor a doubled patient assignment as the mentor may feel that they cannot provide the support and time to explain items when trying to complete care for her/his own patients.



The three factor framework in the College of Nurse of Ontario practice guideline on RN and RPN Practice: The Client, the Nurse and the Environment<sup>26</sup> is a good reference tool that can be used to help nurses, employers and others make effective decisions about the utilization of individual nurses in the provision of safe and ethical care; and in matching the appropriately skilled nurse to meet the client's needs. Applying the three factors (the client, the nurse, and the environment) to the ICU setting, provides a framework for analysis of the practice context for nurses

The client factor considers complexity, predictability, and risk of negative outcomes.<sup>26</sup> The nurse factors that affect the nurse's ability to provide safe and ethical care to a client include leadership, decision-making, and critical thinking skills.<sup>26</sup> Other factors include the application of knowledge, knowing when and how to apply knowledge, and having the resources available to consult as needed.<sup>26</sup> Consultation is described as seeking advice or information from a more experienced or knowledgeable nurse or other health care professional.<sup>26</sup> An important aspect of efficient consultation is providing nurses with the time and resources needed to consult as often as is necessary to meet client needs.<sup>26</sup> In a unit with a high number of novice critical care nurses, the resources available to consult need to be available at all times in order to support efficient consultation.

Environment factors include practice supports, consultation resources, and the stability/predictability of the environment.<sup>26</sup> The ICU environment on K2 is a less stable environment because of the high proportion of novice nurses and unstable patients, therefore increasing the need for RN collaboration.

An example of the utilization of the principles in the three factor framework is when the Hospital made the decision to bring in a Resource Nurse, temporarily, when a significant number of new graduates were hired in the spring/summer of 2012.

### **Recommendations:**

1. Staffing of the unit must take into consideration the coverage needed to safely and appropriately provide for breaks. This may require the decision to staff above base in order to provide sufficient consultative support to mentoring of new staff and novice critical care nurses who are no longer on orientation.
2. Review the criteria for double assignments and include considerations for patient assignments of staff who are mentoring new hires on orientation and support consistent implementation by the Charge Nurse group.
3. Room 18 should not be utilized for critically ill patients. It is most appropriate for patients who require palliative care or are being discharged from the unit and do not require frequent interventions or close visual monitoring.

### **3.5 Unit Morale and Staff Engagement**

The Report from the Supervisor, Kingston General Hospital “Setting a New Standard” from December 15, 2009 stated that: “A major challenge impacting on the task was the need to address the issue of low staff morale that was pervasive throughout the organization.”<sup>31</sup> The report also addresses the need for “cultural change in the organization with respect to management and staff working together to establish modern clinical utilization processes and achieve greater accountability in reporting and accountability structures.”<sup>31</sup>

The IAC asked for further information on the nature of the low morale referred to in the Supervisor’s report. The Hospital stated that this was related to low levels of staff engagement, perceptions of a lack of respect from Hospital leadership, and a lack of transparency in decision making such that staff felt they had no part in decisions being made that impacted on them. The Hospital further stated that the results of the Worklife Pulse survey done in 2011 which measures staff perceptions of quality of work life were poor. The Hospital stated that the Worklife Pulse survey showed that there was a disconnection between staff and senior leadership, and that staff perceived they were not always supported by management. The Hospital stated that the results of the Worklife Pulse survey approximately a year later were better but that there was still considerable room for improvement. The Hospital is about to implement an organization-wide staff engagement survey for the first time. This survey will allow for benchmarking with other organizations and will also provide both organizational and unit based engagement results. The Hospital expressed their ongoing commitment to continued improvement in staff engagement through improved communication, leadership development, improved change management strategies, and effective mentorship and support of new staff.

Further discussion of morale at the IAC hearing provided a deeper understanding of the particular issues within K2. It was evident that there are issues of low morale within the K2 unit that are related to the quality of the relationship between management and staff.

In discussion with the staff nurses at the IAC hearing, suggestions for improvement in morale included:

- Improved support and mentorship for new staff;
- Improved communication through face to face communication with management; and through email so that they feel “more in the know”;
- More information on Hospital decisions and on issues that impact on K2;
- More staff support for the unit managers to assist with correspondence and other transactional work;
- The suggestion to continue with Hospital recognition of Nurses’ week;
- Increase the staff autonomy with respect to issues of scheduling; and
- Consistent staffing.

The span of control for both managers in the critical care program is large. Research on span of control in nursing has demonstrated that higher spans of control decrease the positive effects of transformational and transactional leadership styles on job satisfaction and patient satisfaction, and increased the negative effects of management.<sup>32</sup> Overcoming issues related to span of control is a significant management challenge.

Unfortunately the Unit Council is no longer active on K2. One of the reasons is that the agenda was becoming more like a staff meeting and also a forum for other disciplines to engage with nursing; but this had the impact of derailing the planned agenda of the unit council. The Hospital has initiated staff meetings every two months in the last year which is a positive step. Staff commented that the staff meeting has started to discuss issues that are better suited to a Unit Council.

### **Recommendations:**

1. Continue with regular staff meetings and post minutes electronically and in hard copy to increase access to staff.
2. Re-establish the unit council with staff nurse leadership.
  - a. Provide leadership support to the staff nurse leaders in their new roles.
  - b. Consider establishing representative membership from the unit staff to council rather than it being open to all staff.
  - c. Encourage the council to take on only a few key initiatives in their first year.
  - d. Provide remuneration to staff who are members of the unit council for time spent in unit council meetings.
3. Establish other methods to improve the relationship between staff and management.
  - a. Establish a town hall type meeting 3-4 times a year in the ICU for all staff and invite senior management (Director and VP/CNE) to attend and provide an update from a Hospital leadership perspective and to engage in active dialogue with unit staff. These meetings can be used to communicate corporate messages about external pressures, government priorities, budget etc and should be used for staff to bring forward their concerns and together management and staff should determine win-win solutions.
  - b. Establish unit manager rounding on staff to support staff engagement, relationship building, and to model approachability.<sup>33</sup>
4. Make a commitment to review the staff engagement survey results and to create corrective action plans to address gaps as identified by staff.

### 3.6 Culture and Communication

The many changes related to construction, the opening new critical care beds, staff shortages, new management and modifications in the medical model of care modifications has resulted in a breakdown of trust and communication between management and the nurses, nurses and physicians and in some cases nurse to nurse. Concerns regarding the quality of inter-professional collaboration between medical staff, nursing leadership, and nursing staff were identified during the IAC, particularly with regard to how decisions were made about instituting the open medical model. During the course of the IAC meetings, it was acknowledged by the Hospital that combining both the closed medical model (CMM) and an open medical model (OMM) in the K2 ICU was highly problematic and was eventually deemed unsuitable for the K2 ICU. Currently K2 is functioning as a closed medical model; and D4 is an open model.

“Magnet Hospitals” are known for attracting nurses to their organization; and report high levels of nurse autonomy, control over practice, and collaboration with physicians.<sup>34</sup> Having adequate staffing, good administrative support, and good relationships between doctors and nurses result in high satisfaction of care by nurses and significantly lower burnout.<sup>35</sup>

Healthy work environments have been described as “a practice setting that maximizes the health and well-being of nurses, quality patient outcomes and system performance”.<sup>36</sup> The Registered Nurses Association of Ontario (RNAO) identified six areas that are foundational to creating a healthy work environment: leadership, collaborative practice, workload and staffing, embracing diversity and workplace health, safety, and well-being.<sup>36</sup>

The issues of trust, teamwork, and collaboration require rebuilding between management and staff nurses, within the staff nurse team itself, and between the nursing group and the physician group in the K2 ICU. Trust needs to be re-established and this is essential to maximize individual personal and professional contribution to the hospitals mission and strategy. “Strategy for Achieving Outstanding Care Always” will not be achieved unless trust at all levels can be rebuilt. A high trust environment will lead to healthy work culture with improved relationships which will result in improved quality of work life for management, nursing and medical staff. This will result in higher productivity, higher staff morale, better staff engagement and retention which will lead to improved patient satisfaction, improved clinical outcomes and a more cost efficient and effectively managed unit.

Implementation of one or more of the Registered Nurses’ Association of Ontario (RNAO) Best Practice Healthy Work Environment Guidelines including developing an implementation strategy with commitment to time-lines and evaluation metrics would support the development of a healthy work environment. The Healthy Work Environments best practice guidelines while developed by the RNAO with a focus on nurses can be extended to the inter-professional ICU team and meet KGH’s strategic direction of the Inter-collaborative Practice Model (ICPM). It was noted during the hearing that the Hospital has supported 42 staff to attend the RNAO workshop on implementation of best practice

guidelines; and is in discussion to become a best practice “spotlight organization” which is commended by the IAC.

The best practice guideline on Collaborative Practice among Nursing Teams<sup>36</sup> focuses on how nursing staff and leadership can benefit from improving the nursing team at a unit level. The guideline also provides recommendations for leadership on organizational decisions and system characteristics to support and enable effective nursing teamwork.

Effective and consistent communication methods support effective teamwork and a healthy work environment. Standardized methods of communication in health care are being implemented in most organizations. The use of SBAR (Situation-Background-Assessment-Recommendation) promotes patient safety because it helps individuals communicate with each other with a shared set of expectations; as well as improving efficiency and accuracy. Utilizing a consistent method of communication with a shared set of expectations will promote teamwork, respect, and value of the contributions of each individual of the team within the ICU.

Consistent orientation practices for all team members will support effective teamwork and common expectations among team members. An orientation could include, but is not limited to, the following:

- Expectations of communication as an ICU team member and use of Vocera use at KGH;
- Roles of the Nurse Manager and Charge Nurse; Introduction to ICU Team members: Pharmacists, Dietician, Physiotherapists, Respiratory Therapists and their roles within the ICU team
- Hospital policies that are deemed relevant for medical staff;
- IPAC information about Hand Hygiene policy and personal protective equipment;
- The current use of bundles for VAP prevention and Central Line Infection Blood Stream Infection prevention;
- Pre-printed order sets and protocols used in the K2 ICU;

#### **Recommendations:**

1. Implement the RNAO Best Practice Guideline on Collaborative Practice Among Nursing Teams.<sup>36</sup> Timelines for implementation and evaluation metrics must also be established.
2. The unit management and nursing staff in the critical care program (K2, D4 and ICCN) should review the Hospital “Get Real” program to determine relevance and implementation strategies at a local level in critical care. This strategy must address code of conduct and behavior expectations to support professionalism and mutual respect.
3. Publicly post indicators of a healthy work environment – reduced absenteeism, reduced turnover, improved staff satisfaction. Post safety and patient satisfaction outcomes.

4. Unit management and nursing staff should both commit to improving formal and informal two-way communication.
  - a. Informal face to face communication should be used daily by management, charge nurses and nurses to build relationships. All parties should commit to active listening skills, be aware of good non-verbal communication techniques, and take responsibility for what is said and how it is said.
  - b. Nurses should bring their questions and concerns directly to management to be addressed and for resolution.
5. The Hospital should help employees understand the Hospital's overall business strategy and communicate to the staff how their work contributes to the unit and overall Hospital success.
6. Unit management should commit to responding to staff e-mails and/or voice-mails within 72 hours unless away from the hospital.
7. If not already in use, implement a standardized method of communication by all staff in the ICU like SBAR (Situation-Background-Assessment-Recommendation).
8. The Hospital should ensure that the use of Vocera is consistent among all team members working in the ICUs in order to support timely access to team members and resources. Provide formal education/review of Vocera communication system to all staff that is expected to use Vocera with scenarios of when it would be useful to use the communication device. Ensure that all medical learners receive Vocera training as part of their orientation to the ICU; and expectation of its use at KGH.

*Scenario examples: RN calling PCA to assist with patient boost in bed; RN to Pharmacy regarding missing medication; RN to PT to plan getting patient up in chair; RN to RT for assist with desaturation of patient after a turn or new STAT order for ABG or planned bronchoscopy; UCC to RN to inquire about visitor; UCC to RN to inquire about picking up a shift the next day; MD to RN to inform about new orders written.*

9. In order to support effective and efficient teamwork, all medical and other professional learners must attend a K2 ICU orientation session. This session should be led by the Nurse Manager outlining expectations of medical and other health professional learners in the K2 ICU.

### **3.7 Leadership**

Both Hospital management and the association members will need to demonstrate leadership competencies if the unit is to recover from this place of unrest and low staff morale. It was evident to the IAC that there is willingness from both parties to move forward to a new space of mutual respect. The unit will be poised for success with a goal of mutual respect and a common commitment to creating a healthy work environment where staff can feel satisfied and patients and families will receive safe, quality care.

The Hospital has been very focused on managing the operational changes related to the unit expansion and meeting the Ministry of Health requirements to open additional ICU beds.

Best practices for transformational leadership practices result in healthy outcomes for nurses, patients, organizations, and systems.<sup>37</sup>

#### **Recommendations:**

1. The Hospital should also focus their leadership on enhancing teamwork so that nurses see their unit leadership as part of the team. Working together management can assist all staff to reach their full potential and achieve common personal, professional, unit and Hospital goals.
2. Unit staff must be open to working with unit leadership to move forward, and align their skills and knowledge to meet the needs of the unit and the hospital, while also meeting their personal and professional goals.
3. The Hospital should determine the leadership development needs of the Managers, Charge Nurses, Clinical Educators and Nurses on K2, D4 and ICCN. Job descriptions should be current and relevant to the practice environment. The RNAO best practice guideline on Developing and Sustaining Nursing Leadership can be used as a resource.<sup>37</sup>

### 3.8 Education

#### Orientation

New hires can be new graduate nurses, novice nurses with less than 2 years' experience, experienced nurses who are novice to critical care, and critical care experienced nurses. The current orientation program in the ICU can be challenged by nurses with experience and the program can be extended for novice nurses who express that they require more time on orientation. The Critical Care Orientation program has been run monthly for the last 2 years except for one month of the summer and December.

Currently the critical care orientation program for all new hires is 300 hours. The classroom curriculum is a systems-based modular program that takes place over thirteen days. It is a comprehensive program including theory and simulation lab time. Following the classroom based program, all new hires, with varying levels of skills and years of experience, are typically scheduled for eighteen tours of 11.25 hours of orientation with a staff mentor. Additional time on orientation can be provided upon request by the orientee.

Revisions to the program and schedule are continually done to improve the program. An example of such a modification is when there were a large number of new graduate nurses hired in the spring/summer of 2012. A period of "grounding" took place for the new hires on D4 with 12 buddied tours on D4 followed by 6 months of independent nursing practice on D4. This group was then subsequently orientated to the K2 ICU. They were all scheduled for 6 buddied tours on K2 with a mentor prior to working independently on K2.

Introduced in *October 2012*, the "Nursing Self-Appraisal" document is used by new hires to record a self-assessment of competency for various skills and abilities during the orientation period. This document is to be used by the new hire in setting goals while on orientation and to create a learning plan to follow when orientation is completed.

Competence is based on knowledge, skills, attitudes, critical analysis and decision-making, which are enhanced throughout an individual's professional career by experience and education.<sup>26</sup> Novice nursing staff competence in general nursing skills and advanced critical care skills is lower due to reduced time within the field of nursing. Novice nurses experience a higher degree of mental workload in that they will encounter many new experiences and stimuli which will require a greater amount of processing and more mental effort.<sup>20</sup> An opportunity for reinforcement of the content taught during the orientation classroom sessions is at the change of shift during handover and the transfer of accountability (TOA). Following the systems-based approach taught during orientation, a handover/TOA process to support orientees could include a review of the patient's condition and plan of care as well as provide an opportunity to identify and reinforce adherence to Hospital policies (example: IV tubing and solution changes) and required practices (VAP bundles, CVL-BSI).



The Ministry of Health and Long Term Care (MOHLTC) New Graduate Guarantee (NGG) provides government funded bridge positions to support the hiring and orientation for new nurses for up to six months. The new graduate position enables the novice nurse time to build a strong base of skills required to perform in a critical care setting. It is also a good recruitment strategy for the organization as the program enables a relationship to build between the new graduate nurse, the unit, and the organization. It can also lead to a permanent position which supports recruitment. The MOHLTC New Graduate Guarantee has been used for the Critical Care program since February 2013. Currently, there are 2 RNs participating in the NGG.

### **Ongoing Education**

The KGH “Strategy for Achieving Outstanding Care” document<sup>4</sup> stated that: “staff members said we should make continuing education and learning a priority so that they can stay at the forefront of their fields and access knowledge in ways that enable them to bring research results and best practices into the clinical setting faster”.

The Critical Care Standards Nursing Standards<sup>38</sup> competency statement under “Client and Nurse Safety/Risk Prevention” states that the health care facility provides opportunities for the critical care nurse to maintain the knowledge and skills necessary to deliver safe and knowledgeable care through the provision of continuing education and communication on the following: advanced skills or skills that are used infrequently (e.g. IABP and CRRT), the use of personal protective equipment, new or revised policies and procedures.

However, current education efforts in the ICUs are primarily focused on the orientation of new staff. Ongoing professional development and education after orientation is limited. Annual education days for critical care staff to maintain competence in core skills and to support acquisition of new knowledge and/or best practices do not currently exist. A skills fair for nursing staff is currently being developed by the educators which is commended by the IAC.

### **Education Resources:**

There are currently the equivalent of 3.5 clinical educators dedicated to the K2, ICCN and D4 ICU. The IAC noted the dedication and passion that the educators have for their role and nursing education. The clinical educators play a very important role for the critical care program and the IAC commends the Hospital for their investment in this role.

One of the Clinical Educators is designated on a daily basis to be a Circulating Clinical Educator (Monday to Friday). The role of the Circulating Educator is to be available to provide practical assistance and be a consultative resource for new hires and the assigned mentor. As discussed during the hearing, the role of the circulating Educator is a very necessary but does not seem to be well understood and /or utilized by nursing staff.

The ongoing professional development of both nursing staff and educators is essential. A program such as the RNAO 5-day course on “Developing and Delivering Effective Education Programs” might be a course that the Hospital would consider an opportunity to support Clinical Educators or the ICU. The program can be provided on-site by request to the RNAO and could be open to other professional educators within KGH. With an intra-collaborative practice model (ICPM) in mind, the course can be open to anyone within the organization that prepares educational presentations and may reduce costs to an individual clinical program.

**Recommendations:**

1. Orientation should be not be scheduled more than every two months to allow time for clinical educators to follow-up and evaluate new hires; provide some time for new staff to integrate with the ICU Team; and for mentors to have a break between mentoring new staff.
2. In line with best practices in other organizations with critical care programs, new graduate nurses should be hired to the ICU under the New Graduate Guarantee.
3. Consistently utilize the “Nursing Self-Appraisal” tool with all new hires.
4. Augment the transfer of accountability process at shift handover by ensuring that novice nurses consistently utilize the systems based approach taught during orientation.
5. Establish an annual education day for all critical care nursing staff with financial support for attendance.
6. Redefine the Circulating Clinical Educator (CE) role and expectations within the ICU. Ensure that all staff understands the role and how the circulating clinical educator can be effectively utilized.
7. The Hospital should support the ongoing professional development of the Clinical Educators.

### **3.9 Model of Care**

During the course of the IAC meetings, it was acknowledged by the Hospital that combining both the closed medical model (CMM) and an open medical model (OMM) in the K2 ICU was highly problematic and was eventually deemed unsuitable for the K2 ICU. Currently K2 is functioning as a closed medical model; and D4 is an open model.

#### **Recommendation:**

1. Maintain the closed medical model on K2.

### **3.10 Patient Flow and Bed Management**

The Hospital stated that the current rate of avoidable ICU days is greater than 9%. This is very high for a critical care unit and means that patients are waiting for hours/days to be transferred out of critical care to a more appropriate care level. This has resulted in a higher than desired level of occupancy in the critical care units and a higher than desired rate of night time discharge. The Hospital has implemented new protocols and guidelines for patient flow although this issue was not explored in depth at the IAC hearing. A decrease in avoidable days should have a significant impact on occupancy and patient flow in critical care. This could also positively impact the number of double assignments and staffing demand.

Every morning the Charge Nurses from K2, D4 and PACU and ER meet to discuss patient flow and have started to do a walk around of the four units during the meeting. The Charge Nurses also collaborate on the night shift as well.

#### **Recommendations:**

1. Continue with current corporate efforts to improve patient flow and to decrease the avoidable days in critical care.
2. Extend the daily Charge Nurse meeting to include the Nurse Managers of the Critical Care units on a consistent basis.
3. Establish a mechanism for collaboration between the critical care program and other programs with regard to patient flow. This will help to inform Critical Care Charge Nurses to anticipate bed flow in and out of the K2 and D4 ICU.

### 3.11 CCIS Data Management

*The Critical Care Information System (CCIS) is the most comprehensive source of province-wide information on access to critical care, quality of care and outcomes for critically ill patients. As part of the Ministry of Health and Long-Term Care's Critical Care Strategy, the CCIS has been developed to provide real time data on every patient admitted to Level 3 and Level 2 critical care units in Ontario's acute care hospitals. It is intended to provide the ministry, Local Health Integration Networks (LHINs) and hospitals with information on bed availability, critical care service utilization and patient outcomes.*<sup>39</sup>

*The CCIS has been implemented in 201 adult and paediatric Level 3 and Level 2 critical care units. The system provides an important medium for monitoring and managing the province's critical care resources more effectively, as well as highlighting opportunities for implementing quality improvement initiatives at individual hospitals and across the LHINs. CCIS data supports the Ventilator Associated Pneumonia and Central Line Infection data collection under the ministry's Patient Safety Initiative. The data captured in CCIS is also used to develop quarterly reports to inform health care system improvements.*<sup>39</sup>

The critical care program at KGH submits data on a daily basis as is done in all critical care units. Data is entered by a clerical staff member. The process for data collection and verification prior to entry can be improved. As described to the IAC, the clerical staff asks the nurses for information on their patients, and then enters the data in the system. There does not appear to be any review of the quality of the data prior to entry. Best practices would indicate that Registered Nurses in critical care are entering the CCIS data.

The Advanced Practice Nurse (APN) does review the draft reports on results that are sent by the Ministry on a quarterly basis and adjustments are made as necessary through CCIS. There are no concurrent audits of the Hospital CCIS data. The IAC was made aware that CCIS is developing new quality audit tools for use in hospitals.

Given that the CCIS data is used to support publicly reported data, it is essential that the data is accurate, valid and reliable. The Hospital also makes use of this data to support decision making and to support quality improvement efforts. The nursing staff should also be aware of how this data is utilized and how it is being interpreted.

#### **Recommendations:**

1. The Charge Nurses on K2 and D4 should collect and enter the CCIS data; or at a minimum review the CCIS data prior to entry by a clerical staff member.
2. To ensure the highest quality of CCIS data, implement an audit system when the new audit tools are available from CCIS.

3. Include a review of CCIS data results in staff meetings/town halls on a regular basis so that staff is aware and informed on the data, the interpretation by the Hospital and how it is being used to support decision making.

### **3.12 Hospital Association Committee**

During the course of the hearing, both the Hospital and the Association acknowledged that the functioning of the Hospital Association Committee and supporting processes for PRWRFs would benefit from review and improvement.

The Hospital recommended that improvements in process and functioning would include:

- Respectful exchange;
- Rules of engagement;
- Fact based discussion;
- Clarity regarding lines of communication; and
- Systems for completion, submission and tracking of PRWRFs.

The Hospital stated their view that there is tremendous benefit of a well-functioning HAC and HAC-PRC process.

The Association also acknowledged that the structures and processes to support PRWRFs could be improved.

The Association recommended:

- Develop and provide concise education for Clinical Managers regarding workload reporting; and
- Revision to the HAC meeting process including addressing membership, chair, management of the agenda, minute taking and distribution.

#### **Recommendations:**

1. The Hospital and the Association should jointly Review the articles and language in the Central and Local Collective Agreements with regard to the Hospital Association Committee and revise the Kingston General Hospital Association Committee Terms of Reference as necessary.
2. The Association and the Hospital should jointly develop rules of conduct for joint meetings that address issues such as respectful engagement; processes for inviting guests to the HAC; determining for each party who is the designated contact person if there is a request for information;
3. The Hospital and the Association should develop a template for agendas and minutes that both parties utilize on a consistent basis to support effective meeting preparation and management.

4. The Association and the Hospital should on an annual basis develop and agree to the annual schedule of HAC meetings.
5. The Hospital should offer education to all Clinical Managers as necessary on the processes for effective management of PRWRFs and management response.
6. The Hospital and the Association should jointly develop a system for tracking PRWRFs.

## **Part 4 SUMMARY and CONCLUSIONS**

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 Committee has made fifty-six recommendations in twelve areas regarding issues that directly or indirectly impact the workload of Registered Nurses:

- Staffing
- Scheduling
- Retention
- Assignments
- Unit morale and staff engagement
- Culture and communication
- Leadership
- Education
- Model of care
- Patient flow and bed management
- CCIS data management
- Hospital Association Committee

The members of the Independent Assessment Committee unanimously support all recommendations in this report. The Independent Assessment Committee hopes that the recommendations in this report will assist the Hospital and the Association to find mutually agreeable resolutions with regard to nursing workload issues on Kidd 2 and Davies 4 in the Critical Care Program.

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**Appendix 1: Letter from the Association to the Hospital November 28, 2012.**



**Ontario Nurses' Association**

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November 28, 2012

Eleanor Rivoire  
Chief Nursing Executive  
Kingston General Hospital,  
76 Stuart St.  
Kingston, Ontario,  
K7L 2V7

***Via Email***

Dear Eleanor,

**Re: Advancing Professional Responsibility Issues in the Intensive Care Units (K2 and D4) to an Independent Assessment Committee (IAC) – ONA Gel File # 201005718 and 201005764**

This letter is in follow up to previous discussions at the PRC/Hospital Association meetings and earlier communication advancing the professional practice and workload issues in the Intensive Care Unit (ICU) and Critical Care Program at Kingston General Hospital (KGH) to the Independent Assessment Committee and is in accordance with Article 8.01(a) v) of the Hospital/Ontario Nurses' Association (ONA) collective agreement.

As previously stated, the Registered Nurses (RNs) working in the Critical Care Program and especially the Kidd 2 ICU, at Kingston General Hospital have consistently identified serious practice and workload concerns, and have documented that the current practice, patient care and workload environment does not allow them to meet College of Nurses of Ontario (CNO) standards; and they believe they are being asked to perform more work than is consistent with proper patient care. Effective supports have not been provided to respond to patient acuity and volumes, fluctuating workloads, fluctuating staffing and professional practice issues.

Please be advised that in accordance with the Hospital/Ontario Nurses' Association (ONA) collective agreement, Letter of Understanding dated April 10, 2012, Leslie Vincent has accepted the nomination to Chair the Independent Assessment Committee (IAC). This has occurred in consultation with Mr. Stephen Green, Director, Employee Relations Services, Ontario Hospital Association (OHA).

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E-mail: [leslievincent@sympatico.ca](mailto:leslievincent@sympatico.ca)

Provincial Office: Toronto

Regional Offices: Ottawa • Hamilton • Kingston • London

Orillia • Sudbury • Thunder Bay • Timmins • Windsor



Re: Advancing Professional Responsibility Issues in the Critical Care Program  
(K2ICU and D4ICU) to an Independent Assessment Committee (IAC)  
– ONA Gel File # 201005718 and 201005764

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Please be advised the Ontario Nurses Association nominee to the Independent Assessment Committee is:

Cynthia Orlicki RN BSc  
27 Colquhoun Crescent  
Hamilton, Ontario  
L9C 4W7  
Phone: 905-318-6862  
E-mail: corlicki@shaw.ca

You are requested to please provide the name and contact information for your nominee to the Chairperson, Leslie Vincent and copy the Association, in accordance with the timeframes as set out in the Collective Agreement and the referral letter of October 15, 2012.

Yours truly,

**ONTARIO NURSES' ASSOCIATION**

  
Lorrie Daniels  
Professional Practice Specialist

ld/al

- C: Linda Haslam Stroud President, Ontario Nurses Association, by email  
Cathryn Hoy, Local Coordinator and Bargaining Unit President, ONA Local 99, by email  
Ellen Mulville, Bargaining Unit Professional Practice Representative, by email  
Doug Anderson, Manager, Provincial Services Team, by email  
Mark Miller, Labour Relations Officer, ONA, by email  
Leslie Vincent, IAC Chairperson, by email  
Cynthia Orlicki, ONA Nominee, by email  
Leslee J. Thompson, President and CEO, KGH, by email  
Colleen Cross, Human Resources Advisor, KGH, by email  
Mae Squires, Program Operational Director, Mental Health and Critical Care Program, by email  
Nicole McCormack, Program Manager, Intensive Care Unit, by email  
Christina Panopoulos-Rowe, Program Manager, D4ICU, by email  
Tom Buchanan, Chair, KGH Board of Directors, by email  
Annette Bergeron, KGH Board of Directors, by email  
Scott Carson, Vice-Chair, KGH Board of Directors, by email  
Wendy Forsythe, KGH Board of Directors  
Timo Hytonen, KGH Board of Directors  
Donna Janiec, KGH Board of Directors, by email

Re: Advancing Professional Responsibility Issues in the Critical Care Program  
(K2ICU and D4ICU) to an Independent Assessment Committee (IAC)  
– ONA Gel File # 201005718 and 201005764

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Geoffrey Quirt, KGH Board of Directors  
Gordon MacDougall, KGH Board of Directors  
Susan Lounsbury, KGH Board of Directors  
Donna Segal, KGH Board of Directors  
George Thomson, KGH Board of Directors  
David Yake, KGH Board of Directors  
Dr David Zelt, Chief Of Staff and VP Medical Administration, KGH Board of Directors, by email  
Paul Huras, Chief Executive Officer, South East LHIN, by email  
Andreas von Cramon, Acting Chair, Board of Directors, South East LHIN, by email  
Stephen Green, Director, Employee Relation Services, Ontario Hospital Association, by email

**Appendix 2: Letter from the Association to Chair of the IAC November 28, 2012.**



**Ontario Nurses' Association**

85 Grenville Street, Suite 400, Toronto, Ontario M5S 3A2

TEL: (416) 964-8833 • FAX: (416) 964-8864

November 28, 2012

Ms Leslie Vincent  
716 Windermere Ave.  
Toronto, Ontario, M6S 3M1

*Via Email*

Dear Leslie,

**RE: Kingston General Hospital and Ontario Nurses' Association: Professional Responsibility Complaint – Critical Care Program (Kidd 2 and Davies 4 Intensive Care Units): – Independent Assessment Committee – ONA File (s) #201005718 and 201005764**

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Thank you for accepting the nomination to chair an Independent Assessment Committee (IAC) investigating a complaint at Kingston General Hospital. I have consulted with Mr. Stephen Green, Director Employee Relations Services at the Ontario Hospital Association and both parties have agreed to you chairing this IAC.

I have previously provided the Guidelines for the Chairperson of the IAC. I believe that you have previously received a copy of the current Central Hospital Collective Agreement. If you require any other documents, please do not hesitate to let me know and I will forward them to you.

The attached letter provides the Association's nominee - name and contact information, and requests that the employer provides you with their nominee information within the timeframes as set out in the Collective Agreement. Please set up dates with nominees, who will confirm with their respective parties.

Yours truly,

**ONTARIO NURSES' ASSOCIATION**

  
Lorrie Daniels  
Professional Practice Specialist

C: Cathryn Hoy, Local Coordinator/Bargaining Unit President, by email  
Ellen Mulville, Bargaining Unit Professional Practice Representative, by email  
Mark Miller, Labour Relations Officer, ONA, by email  
Cynthia Orlicki, ONA Nominee, by email  
Eleanor Rivoire, Chief Nursing Executive, Kingston General Hospital, by email  
Stephen Green, Director, Ontario Hospital Association, by email

Encl.

Provincial Office: Toronto

Regional Offices: Ottawa • Hamilton • Kingston • London

Orillia • Sudbury • Thunder Bay • Timmins • Windsor



### Appendix 3: Letter from the Hospital to the Association November 29, 2012



76 STUART STREET  
KINGSTON, ONTARIO  
K7L 2V7  
TEL: 613-548-3232

November 29, 2012

Lorrie Daniels  
Professional Practice Specialist  
Ontario Nurses' Association  
85 Grenville Street, Suite 400  
Toronto, Ontario  
M5S 3A2

*Sent Via Email*

Dear Lorrie,

**Re: Independent Assessment Committee (IAC) – ONA Gel File #201005718 and 201005764**

I am writing you in response to your letter received October 18, 2012, regarding "Advancing Professional Responsibility issues in the Intensive Care Units (K2 and D4)" and referral to an Independent Assessment Committee (IAC).

Kingston General Hospital is committed to providing and maintaining excellent, safe, and quality patient and family centered care that meets or exceeds professional standards. The Hospital takes concerns raised by the Registered Nursing staff in the Critical Care Unit seriously, and we have responded appropriately to date by, but not limited to, participation in joint meetings, issue discussions, providing relevant information, review and proposal of resolution options and implementing resolutions where operationally feasible.

The Hospital has offered to continue to discuss action toward resolutions as we have since April 2011, prior to the IAC review should the Ontario Nurses Association (ONA) be prepared to continue such discussions. Given that ONA believes that such actions have not impacted workload, patient safety and standards of care, we welcome the opportunity and process to review our Critical Care program in relation to professional responsibility and workload as outlined in Article 8.01 of the collective agreement. Further to this, our nominee is:

Ella Ferris, Executive Vice President, Programs & Chief Nursing Executive  
St. Michael's Hospital  
30 Bond St.  
Toronto, ON  
M5B 1W8  
416-864-5487  
[ferris@smh.ca](mailto:ferris@smh.ca)

By copy, this letter has been sent to Leslie Vincent, who will be the chair of this committee.

Sincerely,

A handwritten signature in dark ink, appearing to read 'Eleanor Rivoire'.

Eleanor Rivoire,  
Vice President,  
Clinical Administration & Professional Practice, CNE



## **Appendix 4: Information Request to Kingston General for IAC Submission**

Independent Assessment Committee for Kingston General Hospital

January 29, 2013

1

### **Information Request to Kingston General for IAC Brief**

- 1. Patient Information (for past 3 fiscal years)**
  - a. Number of admissions to unit
  - b. Average length of stay
  - c. Average APACHE score of patients
  - d. Nine Equivalents of Nursing Manpower Scores NEMS (CCIS – Critical Care Information System)
  - e. Care Paths used for patients care
- 2. Budget (for last 3 years)**
  - a. Total planned and actual budget for ICU – labour, supplies etc.
  - b. Any planned unit growth or change;
- 3. Unit Organization**
  - a. Organizational chart of nursing in ICU
    - i. Role descriptions for Team Leader/Charge Nurse or other formal nursing leadership roles below level of Manager
    - ii. Role description for Manager
  - b. Description of how ICU is organized; areas and functions.
  - c. Number of beds in unit (physical capacity); number of beds in operation and staffed;
  - d. Master Schedule; copy of last two posted schedules; copy of a daily assignment sheet
  - e. Copy of typical chart format for ICU; and Charting guidelines and /or policies for ICU
  - f. Clinical policy regarding actions to be taken if volumes/admissions exceeds capacity; including any procedures/policies regarding calling in additional staff because of high volumes/admissions
  - g. List of medical directives
  - h. Program quality minutes or program minutes related to staffing and change process
  - i. Reports on indicators being utilized to evaluate efficiency and effectiveness of the ICU (example - monthly reports on: Ventilator Associated Pneumonia Rates, Central Line Infection Rates, Infection Control Rates of VRE, MRSA, C-Diff)
  - j. RACE or CCRT Team Utilization-Staffing
  - k. Any equipment sourcing issues – availability of IV infusion pumps, feeding pumps, pressure bags, transducer cables – is there sufficient for each patient room
- 4. Professional Practice**
  - a. Orientation program for new nursing staff in the ICU (length and outline of content)
    - i. Is education in any skills deferred for new hires until more experience is obtained in the unit (example: continuous renal replacement therapy, pulmonary artery catheters, intracranial pressure monitoring etc.)
  - b. Description of preceptorship and/or mentorship program in ICU for nursing staff
- 5. Staffing data ( for 2012-13 and 13/14 as indicated)**
  - a. Budgeted FTEs for all staff categories in the ICU for 2012/13 and 2013/14.



- b. Active full time, part time, casual, agency FTEs for each staff category (total paid hours in FTEs for each category YTD);
  - c. Number of FT, PT, Casual positions (i.e. head count) by each staff category;
  - d. Number and type of positions posted in the current fiscal year;
  - e. Sick time, overtime in FTEs for all staff categories (YTD); and a comparison for the last 3 years
  - f. Current vacancies for all staff categories;
  - g. Turnover rate;
  - h. Retirement projections to end of 2013;
  - i. Future LOAs e.g. MLOA in 2013;
  - j. Confirmed internal or external recruitment;
  - k. LOAs returning in 2013;
  - l. Job posting information or requirements
  - m. Average age overall of staff and the number of staff over 60 if possible;
  - n. Experience profile - Average years of experience in organization and in ER; number of junior staff (less than 2 years' experience )
  - o. Number of nursing staff on modified work; or have permanent accommodations
  - p. Allied Health by discipline (including FTE allocation) and advanced practice nursing staff
  - q. Support Staff – housekeeping etc.
    - i. Daily hours for weekdays and weekends of housekeeping coverage for unit
  - r. Physicians
    - i. Physician coverage by hour of day
    - ii. Physician assistants by hour of day
  - s. Organizational float pool: size in FTEs and types of staff
6. **Other**
- a. Copy of local collective agreement;

## Appendix 5: Letter of March 25, 2013 from the IAC Chair to the Hospital and the Association

Leslie Vincent RN MScA

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

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March 25, 2013

Via Email

Colleen Cross  
Human Resources Advisor, People Services and Organizational Effectiveness  
Kingston General Hospital  
76 Stuart St., Kingston, ON, K7L 2V7

Lorie Daniels  
Ontario Nurses Association, Professional Practice Specialist, Labour Relations Officer  
Ontario Nurses' Association  
85 Grenville Street, Suite 400, Toronto, Ontario M5S 3A2

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

Dear Ms. Cross, Ms. Daniels and Mr. Green,

The IAC Panel members met today in preparation for the Kingston General IAC Hearing scheduled for April 8-10, 2013. We wish to thank you for the comprehensive briefs which we have received from both parties.

The finalized agenda is appended to this letter. Following our discussion today, we have made changes to the agenda.

1. We request a meet with the Clinical Educators on Monday morning, preferably at 0800.
2. We would like to start the tour at 0900 and visit both K2 and D4.
3. We request a meeting with Dr. Drover who we understand to be the Medical Director for Critical Care.

In addition we have a few additional information requests from the hospital. Please see Appendix A. This data can be provided to us at the start of the hearing. We do not require it in advance.

Sincerely,

Leslie Vincent RN MScA

c.c.

Cindy Orlicki  
Ella Ferris  
Eleanor Rivoire

**Leslie Vincent RN MScA**

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

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## **Appendix A**

### **Additional Data Requests**

1. A new copy of the Corpus Sanchez report under Tab 20 – we received only the even pages.
2. Corporate bed management policy
3. Safe Doubling guidelines for Intensive Care
4. ICU data for the last calendar on the following indicators:
  - a. Hand hygiene audits
  - b. Falls
  - c. Prevalence and incidence of wounds
  - d. Urinary tract infections
  - e. Medication errors
5. Critical Care Program scorecard
6. Nursing HPPD for the ICU by month from December 2011 to present.
7. Budgeted RN FTEs in the ICCN. (We were not clear if these FTEs were included in the FTEs for K2 and D4.

**Appendix 6: Agenda of the IAC for Kingston General April 8-10, 2013.**

**Independent Assessment Committee Hearing  
Ontario Nurses' Association and Kingston General Hospital**

**Agenda**

**Monday April 8, 2013**

**Four Points Sheraton  
285 King Street West, Kingston  
Gibraltar Room**

<b>Time</b>	<b>Item</b>	<b>Participants</b>
08:00 — 09:00	Meeting with Clinical Educators Meeting with Dr. Drover	IAC
09:00 — 12:00	Tour of ICUs – K2 and D4	IAC, KG and ONA
12:00 — 13:00	Lunch	IAC
13:00 — 13:15	Introduction and Review of Proceedings by Chairperson	IAC Chair
13:15 — 14:45	Ontario Nurses' Association Submission Presentation Response to questions of clarification from: <ul style="list-style-type: none"><li>• Independent Assessment Committee</li><li>• Kingston General Hospital</li></ul>	IAC, KG and ONA
14:45 — 15:00	Break	All
15:00 — 16:30	Kingston General Hospital Submission Presentation Response to questions of clarification from: <ul style="list-style-type: none"><li>• Independent Assessment Committee</li><li>• Ontario Nurses' Association</li></ul>	IAC, KG and ONA
16:30	Review of Process for Tuesday, April 9, 2013. Adjournment of Hearing	IAC Chair

**Independent Assessment Committee Hearing  
Ontario Nurses' Association and Kingston General Hospital**

**Agenda**

**Tuesday, April 9, 2013**

**Four Points Sheraton  
285 King Street West, Kingston  
Gibraltar Room**

<b>Time</b>	<b>Item</b>	<b>Participants</b>
10:00 — 13:00	Kingston General Hospital Response to Ontario Nurses' Association Submission  Response to questions from <ul style="list-style-type: none"><li>• Independent Assessment Committee</li><li>• Ontario Nurses' Association</li><li>• Discussion</li></ul>	IAC, KG and ONA
13:00 — 14:00	Break	All
14:00 — 17:00	Ontario Nurses' Association Response to Kingston General Hospital  Response to questions from <ul style="list-style-type: none"><li>• Independent Assessment Committee</li><li>• Kingston General Hospital</li><li>• Discussion</li></ul>	IAC Chair
17:00— 17:15	Review of Process for Wednesday, April 10, 2013	IAC Chair
17:15	Adjournment of Hearing	IAC Chair
17:15 onwards	Independent Assessment Committee Meeting	IAC

**Independent Assessment Committee Hearing  
Ontario Nurses' Association and Kingston General Hospital**

**Agenda**

**Wednesday, April 10, 2013**

**Four Points Sheraton  
285 King Street West, Kingston  
Gibraltar Room**

<b>Time</b>	<b>Item</b>	<b>Participants</b>
09:00 — 12:00	Questions to both Parties by Independent Assessment Committee	IAC, KG and ONA
12:00 — 12:30	Closing Remarks and Identification of Next Steps by Chairperson	IAC Chair
12:30	Closure of Hearing	All
12:30 — 14:30	Independent Assessment Committee Meeting	IAC

**Appendix 7: Revised appendix to Letter of March 25, 2013.**

**Leslie Vincent RN MScA**

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

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**Appendix A**

**Additional Data Requests**

1. A new copy of the Corpus Sanchez report under Tab 20 – we received only the even pages.
2. Corporate bed management policy
3. Safe Doubling guidelines for Intensive Care
4. ICU data for the last calendar on the following indicators:
  - a. Hand hygiene audits
  - b. Falls
  - c. Prevalence and incidence of wounds
  - d. Urinary tract infections
  - e. Medication errors
5. Critical Care Program scorecard
6. Nursing HPPD for the ICU by month from December 2011 to present.
7. Budgeted RN FTEs in the ICCN. (We were not clear if these FTEs were included in the FTEs for K2 and D4.
8. Copies of all schedules since June 2012; both at initial posting; as well as copy of schedule at the end of the period with changes made.
9. The number of full and part time RNs who have transferred out of the ICU in the last calendar year.

## **Appendix 8: List of Attendees from Kingston General Hospital and the Ontario Nurses Association.**

### **Kingston General Hospital**

1. Mae Squires, Program Operational Director, Critical Care Program
2. Nicole McCormack, Program Operational Manager, Kidd 2 ICU
3. Christina Panopoulos-Rowe, Program Operational Manager, Davies 4 and ICCN
4. Eleanor Rivoire, VP, Clinical Administration, Professional Practice and CNE
5. Tom Hart, Program Operational Manager, Staffing Centre and Resource Pool
6. Carol Kolga, Director, Professional Practice – Nursing
7. Andrea Kellar, Administrative Coordinator
8. Micki Mulima, Director, People Service and Organizational Effectiveness
9. Jason Green, Hicks Morley
10. Colleen Cross, HR Advisor

### **Ontario Nurses Association**

1. Lorrie Daniels, ONA Professional Practice Specialist
2. Rozanna Haynes, ONA, Professional Practice Specialist
3. Mark Miller, ONA Labour Relations Officer
4. Cathryn Hoy, Local 99 KGH Bargaining Unit President/Local Coordinator
5. Ellen Mulville, Local 99 KGH Vice President
6. Marci Almeida, RN Kidd 2 ICU
7. Rhonda Beare, RN ICCN
8. Leslie Buller-Hayes, RN Kidd 2 ICU
9. Lauri Burgess, RN Kidd 2 ICU
10. Aveleigh Kyle, RN Kidd 2 ICU
11. Shelley Sterling, RN Kidd 2 ICU

### **ONA Observers**

#### **April 8, 2013 – Afternoon**

1. Jackie Bird
2. Beth Reed
3. Autumn Randall
4. Tracy Gavel
5. Adrian Stephens
6. Jenn Bird
7. Vanessa Yanagawa, ONA, Professional Practice Specialist
8. Marilyn Dee, ONA Labour Relations Officer

#### **April 9, 2013 – Morning**



1. Laurie Mack
2. Jenn Bird
3. Amanda Aird
4. Dave Warfe
5. Aideen Collin
6. Mini Hewett
7. Marie Beseau,
8. Adrian Stephens
9. Vanessa Yanagawa, ONA, Professional Practice Specialist
10. Erik Vogel
11. Marilyn Dee, ONA Labour Relations Officer

#### April 9, 2013 Afternoon

1. Tracy Murphy
2. Jenn Bird
3. Karen Bourgault
4. Amanda Aird
5. Laura Thomson
6. Adrian Stephens
7. Vanessa Yanagawa, ONA, Professional Practice Specialist
8. Marilyn Dee, ONA Labour Relations Officer

#### April 10, 2013 - Morning

1. Nicole Taylor
2. Amanda Aird
3. Shelley La Rush
4. Jenn Bird
5. Denise Elliott
6. Vanessa Yanagawa, ONA, Professional Practice Specialist
7. Marilyn Dee, ONA Labour Relations Officer

#### Additions

1. Erin Wales
2. Wendy Spofford
3. Jen McDonald
4. Kim Lawrence