Independent Assessment Committee Report

Constituted under Article 8.01 of the

Collective Agreement

between

Lakeridge Health Corporation

and

Ontario Nurses’ Association

April 30, 2013
April 30, 2013

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

Ms. Lisa Shiozaki
Executive Vice President and Chief Nursing Executive
Lakeridge Health Corporation
1 Hospital Court,
Oshawa, ON, L1G 2B9

Dear Ms. Markovic and Ms. Shiozaki,

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 Lakeridge Health Corporation 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 Emergency Department at Lakeridge Health.

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 68 recommendations in the following areas:

- Human Resource Planning and Nurse Staffing;
- Registered Nurse and Registered Practical Nurse Practice in the Emergency Department
- Professional Practice;
- Emergency Department Care Model; and
- Unit Culture, Morale and Communication.

The members of the Independent Assessment Committee unanimously support all recommendations in this report. 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 in the Emergency Department.
Sincerely,

Leslie Vincent RN MScA
Chairperson

Cindy Gabrielli RN(EC) BSN MSN
Nominee for the Association

Susan Woollard RN MAED CHE ENC(CC)
Nominee for the Hospital
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PART I INTRODUCTION

1.1 Organization of the Independent Assessment Committee Report

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

- **Part 1** Outlines the referral of the Professional Workload Complaint to the IAC, reviews the IAC’s jurisdiction as outlined in the Collective Agreement, and presents the Pre-Hearing, Hearing and Post-Hearing processes; as well as extensive communication between parties prior to the hearing regarding matters relevant to the hearing.

- **Part 2** Presents the context of practice relating to the professional workload complaint in the Emergency Department, Lakeridge Health Oshawa; 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’), Lakeridge Health Corporation (‘the Hospital’) at the Hearing.

- **Part 3** Discussion, Analysis and Recommendations;

- **Part 4** Summary and Conclusions;

- **Part 5** Contains Appendices referenced in the Report.

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

1.2 Referral to the Independent Assessment Committee

This Report addresses the professional workload complaints of Registered Nurses from the Emergency Department at Oshawa site of the Lakeridge Health Corporation. The Association stated the following in the pre-hearing brief:

“ONA submits this Professional Responsibility Complaint as a result of the employer, Lakeridge Health Oshawa assigning a number of patients and a workload to an individual RN, and a group of RNs working in the Emergency Department, such that they have cause to believe that they are being asked to perform more work than is consistent with proper patient care.

Notwithstanding, recent statistical improvements in patient flow and patient wait times; serious endemic concerns related to patient care, professional practice, and patient and staff safety have remained unresolved as demonstrated by the ongoing documentation on the PRWRFs. It is imperative for both nurses and especially patients that these issues be addressed and resolved in a timely and effective manner.” 1
1.3 Jurisdiction of the Independent Assessment Committee

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

Article 8.01 states:

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

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

(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 1986 arbitration between Brantford General Hospital and the Ontario Nurses Association, it was acknowledged that while IAC’s report is not binding upon the parties, the report carries considerable weight and is accepted by the parties as a method of obtaining a final dispute resolution in these difficult areas.²

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

For the Association:
Cindy Gabreili

For the Hospital:
Susan Woollard

Chairperson
Leslie Vincent

1.4 Proceedings of the Independent Assessment Committee

1.4.1 Pre-Hearing

On September 17, 2013 the Association notified the Hospital and the IAC Chair via email that the Association was forwarding the Professional Responsibility Complaint to an IAC. The Ontario Nurses Association also requested that a date for the hearing be set; and also provided the name of the nominee for the Ontario Nurses Association (Appendix 1).
In a letter dated September 27, 2012 the Association notified the hospital that in accordance with Article 8.01 of the Central Hospital Agreement between the parties, that the Association was forwarding this Professional Responsibility Complaint to an IAC (Appendix 2).

On November 15, 2012 Mr. John Harris provided the name of the hospital nominee to the Association and the Chair of the IAC (Appendix 3).

In the same email of November 15, 2012, the Hospital attached two letters:
1. An undated letter from ONA to the hospital regarding matters related to workload complaints and resolution processes (Appendix 4.)
2. A letter dated November 8, 2012 from Linda Calhoun, Senior Director Clinical Services, to Shelley Flack, President of ONA Local 51 (Appendix 5).

In the letter of November 8, 2012 (Appendix 5) the hospital stated the following:

“I believe we have addressed not only the three (3) main concerns identified in your recent letter, but those concerns previously identified. We are continuing to meet to discuss ongoing issues and I look forward to those continued discussions to ensure we are sharing ideas for improvement, learning from each other, and always implementing systems to increase the quality of health care we deliver to our patients. Given all this information, the Employer is once again, respectfully requesting that consideration be given to not proceeding with the IAC.”

In the email of November 15, 2012 (Appendix 3), the Hospital stated:

“Subsequent to that letter, the Employer was advised by the ONA local that the use of RPN’s in the Emergency Department was the remaining outstanding issue, thus narrowing the scope of the IAC. To this end, the Employer wishes to inform you of our intent to invite participation from our CUPE bargaining unit (who represent the RPN’s here at Lakeridge) and from representatives of the RPNAO at the IAC.”

In an email on November 14, 2012 to the IAC Chair and the ONA Nominee, ONA stated that the employer intent to have representation from CUPE (Canadian Union of Public Employees) or the RPNAO (Registered Practical Nurses Association of Ontario) was an unusual request.

On November 19, 2012 the IAC Chair discussed the issue of representation of CUPE and/or RPNAO with Ms. Mariana Markovic, Professional Practice Specialist at the Ontario Nurses Association, the IAC Chair in order to understand the perspective and views of ONA.

On November 20, 2012 the IAC Chair discussed the issue of representation of CUPE and/or RPNAO with Hospital representatives of Lakeridge Health (Mr. John Harris, Manager, Labour Relations; Lisa Shoziaki, Executive Vice President and Chief Nursing Executive; Darrell Sewell, Vice President, Human Resources and Hospitality Services; Linda Calhoun, Senior Director, Clinical Services; and Sue McKinnon, Manager) in order to understand the perspective and views of the Hospital.
On November 26, 2012, the IAC met by teleconference. The IAC discussed potential dates for the hearing during the teleconference of November 26, 2013. Proposed hearing dates in February 2013 were provided to the Hospital and the Association. Following discussion with both parties of their availability for a hearing, the IAC Chair notified the Hospital and the Association via email on December 6, 2012 that the hearing would be held on March 18-20, 2013. In the email of December 6, 2012, Ms. Vincent also requested the pre-hearing briefs and exhibits be submitted to the panel no later than February 15, 2013 in order to inform the committee of the issues and to allow the committee members adequate time to prepare for the hearing. Following further communication with both parties, it was agreed that the hearing would be held at the Hilton Garden Inn in Ajax, Ontario.

On November 27, 2012 ONA sent a letter via email to the IAC Chair regarding their concerns of the Hospital’s intent to have invite representation by CUPE and/or RPNAO at the IAC hearing (Appendix 6).

During the November 26, 2012 teleconference the IAC also discussed the issue of representation by RPNAO and/or CUPE at the IAC hearing.

On January 14, 2013, the IAC chair advised the hospital and ONA by email (Appendix 7) of the IAC’s decision regarding the hospital’s intent to invite participation from representatives of CUPE and from RPNAO. The IAC decided that representation at the hearing would be restricted to representatives from the Ontario Nurses’ Association and Lakeridge Health. This decision by the IAC was unanimous. The decision was based on the following considerations:

- An IAC panel is constituted under the collective agreement between the Hospital and the Association. Neither CUPE nor RPNAO are parties to this collective agreement.
- The IAC panel has responsibility for the conduct of the hearing; and is empowered to investigate as is necessary and appropriate to the circumstances.
- The mandate of the panel is to review and examine if registered nurses in the emergency department at Lakeridge Health are being asked to perform more work than is consistent with proper patient care.
- The issues of Registered Nurse work are only in relation to the Emergency Department at Lakeridge Health, and to that end, we wish to hear the perspectives of the nurses in the ED and the leadership staff of Lakeridge Health.

The IAC also advised the hospital in the same communication that if there was written documentation that is publicly available from such organizations as the College of Nurses of Ontario or RPNAO on Registered Nurses and/or Registered Practical Nurses that they felt was germane to the review, that it could be included in their brief.
In an email communication on January 14, 2013 the IAC Chair informed the Hospital of the information the IAC would like to have included with the submission brief from Lakeridge Health (Appendix 8).

On January 29, 2013 via email, the IAC Chair informed the hospital that the submission date for briefs would be extended to February 18, 2013 because of a request for extension by the Association. In an email communication on February 13, 2013 the IAC chair requested both parties to courier the briefs directly to each party. All parties had confirmed their mailing addresses prior to this email communication.

The parties who received briefs were:
- Leslie Vincent, Chair, IAC
- Susan Woollard, Hospital Nominee
- Cindy Gabrielli, ONA Nominee
- John Harris, Lakeridge Health
- Mariana Markovic, ONA

On February 15, 2013 the Hospital sent a letter via email to the IAC Chair (Appendix 9). In the letter of February 15, 2013, the Hospital requested that the IAC confirm that it will not make any findings or recommendations relating to a) the appropriateness of the work being performed by RPN staff as it relates to the scope of practice and abilities of RPN staff, and b) the staffing levels and roles of RPNs within the Emergency Department. The letter also stated that the hospital had reviewed the list of documents requested by the IAC and were of the opinion that a number of the documents did not appear to be relevant to the issue that ONA had put forward to the IAC, did not exist and/or were confidential. The letter also stated that the hospital was prepared to reconsider its assessment of any of the items upon the IAC providing the rationale as to why the information was required and how the information was relevant.

In this letter the hospital also indicated that they would be unable to provide copies of the briefs by February 18, 2013 due to materials being put into electronic format. The hospital apologized for any inconvenience. The IAC Chair subsequently requested that all parties receive their briefs by February 22, 2013. The hospital provided a PDF copy of their brief by email on February 22, 2013. The hospital’s attachments were provided on a USB key that was sent by courier to all parties. All parties confirmed receipt of briefs and attachments on or shortly after February 22, 2013.

The IAC discussed the letter of February 15, 2013 from the Hospital and on February 20, 2013, the IAC chair responded on behalf of all the members of the IAC (Appendix 10).
The following is an excerpt from the letter of February 15, 2013 from the IAC Chair to the Hospital:

“The mandate of the IAC panel is to review and examine if registered nurses in the Emergency Department at Lakeridge Health are being asked to perform more work than is consistent with proper patient care. Nursing workload is a complex issue and influenced by numerous factors including patient volume/acuity and nursing care demand; resource and organizational factors; interprofessional and support team membership and structure; leadership; policies and procedures; environment; and so forth.

The purpose of the briefs to be submitted by ONA and Lakeridge Health is for each party to provide information and perspective on the relevant issues impacting on the workload of Registered Nurses in the Emergency Department. Your letter, in part, focuses on the issue of RPNs working in the Emergency Department and the statement that is the focus of the workload issue. We have not yet received the briefs from either party, and therefore, the panel cannot know what all the relevant issues may be with regard to workload in this unit.

Therefore, we encourage the representatives of Lakeridge Health to provide in your brief and during the hearing, whatever information and perspectives on the workload of RNs in the ED, including the role of RPNs which you believe to be relevant. However, as per our earlier communication of January 14, 2013, the representation cannot be from a 3rd party such as CUPE or RPNAO.

The IAC panel has the responsibility to investigate as necessary and appropriate to the circumstances; and to provide a report on our findings and recommendations. We will not make any commitment to either party on what may be included or excluded from our report.

We are happy to provide further rationale with regard to the list of documents that was requested from the hospital. We were unclear however, on what items you are “not agreeable” to providing or “do not exist” and/or are “confidential”. The original request was based on the information that we believe is necessary in understanding the work context of RNs in the ED. As stated previously, there are many factors which impact on workload in an Emergency Department. In our estimation, all the information requested is relevant to context of nursing work in the ED and nursing workload”.

The IAC reviewed the comments regarding the information requests of January 14, 2013 and provided extensive explanations for the requested information (Appendix 10).

On February 22, 2013, the Hospital responded to the letter of February 20, 2013 (Appendix 11). The hospital stated in the letter:
“As previously stated, the Hospital’s understanding is that the sole matter before the IAC is the utilization being made by the hospital of RPN staff within the Emergency Department at the Oshawa site. The hospital has been clear about this, including writing to ONA to confirm this point. ONA did not respond to the hospital to indicate otherwise. As such, the hospital is proceeding on this basis. This means that the hospital’s brief will focus on this issue and it also means that other materials it provides will need to be relevant to this issue.”

The letter of February 22, 2013 also stated that the hospital was considering the rationale provided by the panel for various documents.


“In your February 22nd letter to the IAC chair you state the Hospital understands is that matter before the IAC is the utilization by the Hospital of RPN staff, in particular that "ONA did not respond to the Hospital to indicate otherwise. To establish there was communication as you state I request you provide the date of this communication, the format in which this communication was exchanged, and the name and address to whose attention the communication was sent to."

In a communication by email on February 28, 2013 the Association provided documentation of an email from Ms. Shelley Flack to Ms. Linda Calhoun (Appendix 13) in response to a letter dated February 7, 2013 from Ms. Linda Calhoun, Senior Director Clinical Services. The letter of February 2, 2013 to Shelley Flack, Bargaining Unit President of Local 51 stated: “It is our understanding that the issue ONA is placing before the IAC is the utilization/usage being made of RPN staff in the Oshawa Emergency Department. It is my understanding that the other workload concerns raised by ONA involving the Emergency Department have been resolved.” The letter also asked that Ms. Flack respond by the end of February 11, 2013 if Ms. Calhoun’s understanding was correct and if not, what matters ONA believes are being put before the IAC. The email response on February 19, 2013 (Appendix 13) referred these matters of professional practice workload issues in the ER at Lakeridge Health to ONA Central.

On March 7, 2013 the IAC met for pre-hearing planning session: The IAC during this meeting:

- Reviewed the process of the Hearing;
- Discussed the themes arising from the pre-hearing submissions and exhibits provided by both the Hospital and the Association;
- Determined the additional information requirements in selected areas;
- Developed an agenda for the hearing;
- Identified the key issues for in depth clarification and exploration at the Hearing.
On March 7, 2013 the IAC Chair wrote a letter to the Hospital (Appendix 14) requesting additional information from the hospital. A modified list of information requirements from the original request in January 2013 was provided in the letter (Appendix 15).

On March 11, 2013 the IAC chair wrote the Association and the Hospital for the purpose of:

- Providing the Hearing Agenda;
- Providing context for the purpose of the tour of the Emergency Department, Oshawa site, Lakeridge Health.

During the morning of March 18th 2013, the IAC were provided with an extensive tour of the Emergency Department.

On behalf of the Association on the tour was:

- Cindy Tarbett RN, Staff Nurse, Emergency Department, Lakeridge Health
- Ian Anderson RN, Staff Nurse, Emergency Department, Lakeridge Health
- Mariana Markovic, Professional Practice Specialist, LRO, ONA

On behalf of the Hospital on the site tour was:

- Mary Derks, Patient Care Manager, Emergency Department, Lakeridge Health
- Linda Calhoun, Senior Director, Clinical Services
- Shannon Keddy, Patient Care Specialist.

1.4.2 Hearing

The Hearing convened at 1300 hours at the Hilton Garden Inn, Ajax, Ontario as per the agenda (Appendix 16), the Hearing was held over three days:

Monday March 18th 2013: 0800 — 1645 hours
Tuesday March 19th 2013: 1000 — 1715 hours
Wednesday March 20th 2013: 0800 — 1230 hours*

*the agenda was adjusted on March 19, 2013 to start one hour earlier than originally planned.

Participants and Observers on the respective hearing dates are listed in Appendix 17.
Monday March 18, 2013

The IAC arrived at Lakeridge Health at 0745 and were met by both Hospital and Association representatives prior to proceeding with a tour. Ms. Shannon Keddy, Patient Care Specialist, facilitated the tour on behalf of the Hospital. The tour included an orientation to the Hub and Spoke model of care utilized in the emergency department and the following areas within the department:

- Triage area
- Patient and Family Waiting Areas
- Zone 1: Trauma/Resuscitation
- Zone 2: Corridor
- Zone 3: Acute Care
- Zone 4: Medical Observation
- Zone 5: Initial Assessment
- Zone 6: Assessment

The tour facilitated a greater understanding of the model of care and related patient flow in the Emergency Department.

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

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

Ms. Mariana Markovic, Professional Practice Specialist presented on behalf of the Association. The Association’s presentation was based on their written Pre-hearing submission and supporting exhibits as well as a summary of the Professional Responsibility Workload Report Forms (PRWRFs) submitted by the Registered Nurses of the Emergency Department between 2010 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 Emergency Department:

- Staffing
- Nurse patient ratio
- Equipment
- Security
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 clarification questions posted by both the Hospital and IAC.

Mr. Shane Smith, Legal Counsel for the Hospital presented the submission on behalf of the Hospital. The content of the Hospital’s presentation was based on their written pre-hearing submission. The Hospital reaffirmed their position that an IAC is not an appropriate forum for addressing workload concerns around the utilization of Registered Practical Nurses (RPN) staff or the appropriateness of workload assignments to the RPN staff. The hospital also stated in their brief that the utilization of RPN staff in the ED has not and is not resulting in an increase to RN workload leading to RN staff being asked to perform more work than is consistent with proper patient care. During and following the presentation, the Hospital responded to clarification questions posted by the Association and IAC.

The IAC Chair adjourned the Hearing at 1730 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 March 19, 2013

The IAC also met on Tuesday morning prior to the start of day two of the hearing. The IAC Chair resumed the Hearing at 1000 hours. Members in attendance introduced themselves. The ground rules for the Hearing were reviewed and new participants at the Hearing were introduced. Mr. Shane Smith, Legal Counsel for the Hospital provided the Hospital’s response to the Association’s submission and reaffirmed the Hospital’s position. Members of the Hospital participated in the subsequent discussion. Mariana Markovic, Professional Practice Specialist, Labour Relations Officer, with the Association, provided the Association’s response to the Hospital’s submission. Other members of the Association also participated in the subsequent discussion.

The IAC Chair adjourned the Hearing at approximately 1730 hours.
Following adjournment of the Hearing, the IAC met on the evening of March 19, 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, March 20, 2013.**

**Hearing**

The IAC Chair resumed the Hearing at 0800 hours, reviewed the ground rules and asked the Hospital and Association to introduce any new participants.

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

The IAC Chair concluded the hearing by thanking Cindy Gabrielli, Association Nominee and Susan Woollard, 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 immediately following the hearing on Wednesday, March 20th, 2013.

The IAC met on Saturday, April 6, 2013. At this meeting, the IAC had extensive discussion and started to draft the recommendations and the analysis. In the interim between April 6 and the next planned meeting, all IAC members contributed to the next version of the report.

The IAC met on Friday, April 19, 2013 to discuss the draft report. In the interim between April 19, 2013 and April 27, 2012 all IAC members contributed to the next version of the report.

The IAC met on Saturday, April 27, 2013 to review and revise the draft report. The Report of the Independent Assessment Committee was finalized on April 30, 2013.
PART 2 PRESENTATION OF THE PROFESSIONAL RESPONSIBILITY WORKLOAD COMPLAINT

2.1 Information on Lakeridge Health and the Emergency Department

Lakeridge Health, formed in 1999 by an amalgamation of five hospital corporations, provides a wide range of health care services in the eastern greater Toronto area. The hospital has 4 sites: Whitby, Oshawa, Port Perry and Bowmanville. There are three Emergency Departments within the 4 sites of Lakeridge Health. The services provided by Lakeridge Health are divided across 8 clinical programs: Emergency and Critical Care, Maternal Child, Medicine, Addictions and Mental Health, Post-Acute Specialty Services, Regional Cancer Services, Regional Nephrology System/Durham Region Diabetes Network, and Surgery.4

2.2 Patient Population and Performance Data

The Emergency Department at Lakeridge Health Oshawa is currently serving over 94,000 patients per year. Volumes are predicted to continue to increase. Table 1 provides the ER volumes from 2009/10 to 2012/13 (to Q3 only).

Table: 1 Health Oshawa Emergency Department Visits by Fiscal Year53

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<tr>
<th>Fiscal Year</th>
<th>Emergency Department Volumes Lakeridge Health Oshawa</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009-2010</td>
<td>88,670</td>
</tr>
<tr>
<td>2010-2011</td>
<td>85,842</td>
</tr>
<tr>
<td>2011-2012</td>
<td>92,542</td>
</tr>
<tr>
<td>2012-2013 (to Q3)</td>
<td>70,303</td>
</tr>
</tbody>
</table>

The Hospital also provided data on patient distribution by CTAS level; volume of visits by arrival mode and average ambulance offload times. The CTAS distribution shows a stable pattern over the last 4 years as shown in Table 2.
Table 2 Distribution by CTAS Levels by Fiscal Year

<table>
<thead>
<tr>
<th>Year</th>
<th>CTAS 1</th>
<th>CTAS 2</th>
<th>CTAS 3</th>
<th>CTAS 4</th>
<th>CTAS 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009-2010</td>
<td>1%</td>
<td>15%</td>
<td>48%</td>
<td>30%</td>
<td>6%</td>
</tr>
<tr>
<td>2010-2011</td>
<td>1%</td>
<td>15%</td>
<td>48%</td>
<td>31%</td>
<td>5%</td>
</tr>
<tr>
<td>2011-2012</td>
<td>1%</td>
<td>16%</td>
<td>48%</td>
<td>30%</td>
<td>5%</td>
</tr>
<tr>
<td>2012-2013 (to Q3)</td>
<td>1%</td>
<td>16%</td>
<td>49%</td>
<td>29%</td>
<td>5%</td>
</tr>
</tbody>
</table>

2.3. Hub and Spoke Model of Care Overview

In October 2012, the Hospital changed the model of inter-professional care in the ED and moved to the “Hub and Spoke” patient flow model based on LEAN principles. The Guideline for Patient Allocation in the Lakeridge Health Oshawa Emergency Department utilizing the Hub and Spoke Model from November 2012 describes the Hub and Spoke model of care. The following is a summary from the Guideline supplemented by additional information from the Hospital brief submission.

1. The Hub and Spoke model was adapted from Airline Companies as a means to better organize services and decrease delays. The principle behind the model is to pull patients in to see a physician in one central area, establish the care needs and plan for the patient and transfer the patient to various treatment areas throughout the department. This improves efficiency and provides standard work for physicians, clerks and nurses, thereby decreasing the time a patient waits to see the physician.

2. Prior to patient allocation, each patient is triaged by a triage RN according to the Canadian Triage and Acuity Scale (CTAS) Guidelines.

3. The department is divided into care zones, each with a specific purpose.
   a. Zone 1: Trauma/Resuscitation
      i. appropriate for CTAS 1 patients, trauma, cardiac arrest, STEMI etc. or any patient requiring 1:1 nursing care
      ii. 2 RNs work collaboratively in Zone 1 with 1 registered respiratory therapist
   b. Zone 2: Corridor
      i. Provides 4 ambulance offload spaces staffed by an EMS offload nurse.
   c. Zone 3: Acute Care
i. 12 bed cardiac monitored curtained zone. Suitable for patients requiring a higher level of nursing assessment and care at a CTAS 2 or 3 levels. This may include cardiac monitoring.

ii. Patients are cared for in this zone by a team of RNs with skill and knowledge in cardiac monitoring, interpretation and defibrillation.

iii. Acute care has the capacity to take one to two patients over census for a short term.

iv. Decisions regarding patient allocation are made by the Triage and /or Charge nurse using CTAS guidelines, critical thinking and prioritization taking into consideration the environment of the entire ER.

d. Zone 4: Medical Observation

i. 12 negative flow cubicles appropriate for patients who require droplet or contact isolation, 2 short term seclusion rooms and one negative pressure isolation room. The 12 cubicles contain cardiac monitoring capability and most rooms have ceiling lifts.

ii. All patients transferred to Zone 4 are to have a physician and/or nurse assessment and an established plan of care.

iii. Zone 4 provides care to stable patients and/or patients who have been admitted to the hospital when there are not any inpatient beds. All patients in Zone 4 have in a place a physician and/or RN assessment and an established plan of care.

iv. The zone is staffed by 2 RNs and 1 RPN.

e. Zone 5: Initial Assessment

i. Hub of the emergency department; patients are triaged and pulled into the zone to be assessed by the ER physician and RN. The waiting room nurse prioritizes the patients waiting to see the physician.

ii. The goal of the zone is to decrease the amount of time a patient waits to see a physician.

iii. Following physician assessment, the RN makes decisions regarding the needs of patients and where the patient can be cared for and by whom.

iv. Patients requiring a treatment of less than 10 minutes are to be treated and discharged from the zone; otherwise patients are to be transferred to the appropriate zone. Transfer of care is to occur at this time from caregiver to caregiver.

v. The Assessment zone is staffed by a team of RNs, physicians and a unit clerk.

f. Zone 6: Treatment

i. Designed for stable patients who have been assessed by a physician and require treatments and care that cannot be met within 10 minutes. It is not suitable for patients requiring constant observation, four point restraints (unless accompanied by security) or cardiac monitoring; or admitted patients.
ii. Two RNs and 1 RPN collaborate in a team model for care of patients

iii. Zone 6 provides care to stable patients who have been assessed by a triage RN, a waiting room RN (if necessary), a physician and have an established plan of care prior to transferring to Zone 6. The majority of patients in Zone 6 are treated and discharged home. Within Zone 6 the frequency of reassessment of patients by the nursing staff is based on the patient’s condition, history, chief complaint, or as directed by the physician in the established plan of care.9

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

Beginning in December 2010, the Association began to identify concerns regarding the Emergency Department (ED) and nursing workload. During 2011 and 2012 140 Professional Responsibility Workload Report Forms (PRWRFs) were completed according to the Association. A summary of the forms as well as a copy of each form was provided in the Association submission.

At the December 14, 2010 HAC meeting, 14 PRWRFs from the month of November were presented. The themes in these reports according to the Association submission were:

1. Increase in overtime, sick time, agency use, number of admits, lack of inpatient beds;
2. RN staff feeling they are putting their license at risk;
3. RN staff expressed feeling stressed and burnt out.

At the February 15, 2011 HAC meeting 11 PRWRFs for the month of December 2010 were discussed. Issues were related to admitted patients.

At the March 15, 2011 HAC meeting, 13 PRWRFs from January 2011 and 5 from February 2011 were discussed. Issues identified by the Association in these forms included number of admitted patients in the ED; lack of beds/stretchers available for patients; and a shortage of monitors.

At the May 17, 2011 HAC meeting 6 PRWRFs from March 2011 and 6 from April 2011 were discussed. Workload concerns included volume of admits; of acuity; number of ambulance offloads.

At the June 2011 HAC meeting, 3 PRWRFs from May 2011 were presented. Workload concerns admits in the ED; volume of patients presenting to the ED; number of ambulance offloads coming to the ED.

At the August 16, 2011 HAC meeting 13 PRWRFs for June 2011 and 17 for July 2011 were presented. Workload concerns included: number of admits in the ED, high volume and acuity, lack of specialty beds, staffing issues.
At the September 20, 2011 19 PRWRFs were presented. Workload concerns included: staffing; volumes; admitted patients in the ED; lack of CCU and mental health beds; security issues and Charge RN issue.

At the October 17, 2011 a PRC Sub-HAC meeting took place. Issues presented by the Association at this meeting included concerns related to:
1. Staffing
2. Nurse patient ratio
3. Equipment
4. EMS offload
5. Charge Nurse
6. Triage
7. Security Issue
8. RN and RPN role in the ED

The Association submission contained a copy of hand written notes for the October 17, 2011 meeting. There were no approved minutes of this meeting provided to the IAC.

At the November 15, 2011 HAC meeting 22 PRWRFs from September 2011 and 15 PRWRFs from October 2011 were presented. Workload concerns included: patient and volume acuity, EMS offloads, admitted patients, transfers to other hospitals, RPNs caring for CTAS level 2 patients; staffing shortage, caring for ICU patients in the ER, no PICU beds, CT transfer to LHB.

On January 6, 2012 the Association made a request by email to the Hospital for a second meeting to resolve the PRWRFs.

On January 24, 2012 a HAC-subcommittee meeting took place. The Association exhibits contained a copy of hand written notes for the January 24, 2012 meeting. There were no approved minutes of this meeting provided to the IAC.

Workload concerns and recommendations for resolution identified at this meeting by the Association included:
1. EMS offload
2. Charge Nurse
3. Triage
4. RPN role in the ED

There was not sufficient time at the meeting to discuss 4 additional workload concerns: staffing, nurse patient ratio, equipment and security.

On January 25, 2012 and February 21, 2012, the Association emailed the Hospital to request the scheduling of an ED HAC-subcommittee in follow-up to the January 24, 2012 meeting.
At the February 21, 2012 HAC meeting, 1 PRWRFs from November and 1 from December 2011; and 4 from January 2012 were submitted.

On February 24, 2012 communication was sent from the Hospital to the Association to confirm March 26, 2012 as the next ED HAC subcommittee meeting. On March 19, 2012 the Association sent a proposal for resolution of workload issues including recommendations on the following issues: 13
1. Staffing
2. Triage
3. Charge nurse
4. EMS
5. RPNs in the Emergency Department
6. Security
7. Nurse patient ratio
8. Equipment
9. Cultural audit (noted as a new item)

At the March 20, 2012 HAC meeting one PRWRF was noted regarding acuity.

On March 23, 2012 the Hospital sent a Summary of the Workload Action Plans by email to the Association. 14 This action plan included issues and planned actions for the following issues:
1. EMS Issues affecting RN Workload
2. RN and RPN
3. Charge Nurse
4. Triage

At the March 26, 2012 HAC-Subcommittee the action plans were discussed. Four other issues were also discussed: staffing, nurse patient ratio, equipment and security.

On April 10, April 18, May 11 and May 23, 2012 the Association requests by email that a HAC subcommittee be scheduled. 11

At the May 15, 2012 HAC meeting 5 PRWRFs from March 2012 and 6 PRWRFs from April 2012 were submitted. Workload issues identified in these forms include: volume and acuity of patients, lack of in hospital beds; lots of holes and unfilled positions.

At the June 19, 2012 HAC meeting 7 late PRWRFs from March and April were submitted; and 10 from May 2012 were submitted. Workload concerns identified in these forms include: acuity, staffing, lack of inpatient beds and RAZ.

On June 29, 2012 the Association requested that a sub-HAC committee be scheduled. 11
On July 26, 2012 the Local Coordinator and Bargaining Unit President, Ms. Shelley Flack, met with Ms. Lisa Shiozaki, Executive Vice President and Chief Nursing Executive.

On July 30, 2012 the ED Manager announced additional permanent RN positions in the ER which were a conversion from the temporary funded positions from the Pay for Performance (P4R) funding. In an email on July 31, 2012 to the Hospital, the Association states that the IAC process has been initiated and the next scheduled chair contacted.

On August 8, 2012 the Hospital responds to the July 31 email and states that referral to an IAC is premature given the recent work done by the ER RNs and Managers with the local bargaining unit. During the hearing, it was confirmed that such meetings did occur, but there were no approved minutes of the meetings. The email also confirmed that 10 full time and 5 part time nursing positions will be added to the Emergency Department Oshawa. The hospital also stated that there were ongoing meetings and the input of staff, and a number of initiatives implemented including, but not limited to, development of a policy for TOA and assignments to ensure appropriate patient assignments within Acute, and a full review of RAZ with a Kaizen event scheduled for late August.

At the August 14, 2012 HAC meeting, 11 PRWRFs from June, and 4 from July were submitted. At this meeting, the Hospital announces that surge beds are being established throughout the hospital to relieve the issues of patient flow including admitted patients in the ED. Issues identified in the HAC minutes include acuity, volume, lack of beds, transfers, RAZ not working well, lack of crisis staff for patient assessment.

On September 7, 2012 the Hospital provided copies of the following by email to the Association:
1. Emergency Department Transfer of Care and Accountability Policy and Procedures;
2. Ambulatory Care RPN Role; and
3. Daily RN assignment and RN schedule.

On September 17, 2012 the Hospital emails the Association and asks if a meeting can be schedule for October.

On September 27, 2012 the Association notifies the hospital by email of their intent to advance the Professional Workload Complaint of RNs in the ED of Lakeridge Health Oshawa to an investigation and a hearing before the IAC.
An undated letter that is assumed to have been written before November 14, 2012 documents a discussion between Ms. Linda Calhoun and Ms. Shelley Flack regarding a joint commitment to resolving workload issues of the RNs in the ED before going before an IAC. (Appendix 4)

In a letter dated November 8, 2012 from Ms. Linda Calhoun to Ms. Shelley Flack, the Hospital provided documentation on their efforts to resolve issues and requesting the consideration be given to not proceeding with the IAC. (Appendix 5)

At the December 18, 2012 HAC meeting PRWRFs for the following months were reported:
- August 2012: 5
- September 2012: 3
- October 2012: 1
- November 2012: 3

Workload concerns identified by the Association were due to acuity, volume, lack of beds and triaging.

The Hospital provided several updated Emergency Department ONA Action Plans to the IAC in their submission attachments:
- Emergency Department Workload ONA Action Plan – Charge Nurse. Updated January 2013
- Emergency Department Workload ONA Action Plan – Triage Updated January 2013
- Emergency Department Workload ONA Action Plan – EMS Offload Updated January 2013
- Emergency Department Workload ONA Action Plan – Equipment Updated February 2013
- Emergency Department Workload ONA Action Plan – RPNs Updated January 2013

These documents are comprehensive and have specific action plans, but were apparently never formally discussed with the Association. However these plans may form the basis for continuing discussion between the parties to reach mutually agreeable resolutions.
Part 3 DISCUSSION, ANALYSIS AND RECOMMENDATIONS

Part III of the IAC report is the analysis and discussion of workload and related issues that are impacting workload in the ED at Lakeridge Health Oshawa. The recommendations of the IAC are in the following areas:

- Human Resource Planning and Nurse Staffing;
- Registered Nurse and Registered Practical Nurse Practice in the Emergency Department Professional Practice;
- Emergency Department Care Model;
- Unit Culture, Morale and Communication.

3.1 Human Resource Planning and Nurse 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. 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. 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.

The Lakeridge Health Oshawa ED is a large modern department organized into discreet physical areas and functional zones aligned with the Hub and Spoke model of care. The daily staffing assignment is also aligned with the Hub and Spoke model of care zones. Patient volumes at the Emergency Department Oshawa site are predicted to exceed 94,000 visits in the fiscal year 2012-13. This is an increase from the previous fiscal year of approximately 2,000 visits. The review of data provided by the hospital of patient volumes and length of stay by day of week and patient volumes demonstrates that volumes are evenly spread across the days of the week. It can be safely assumed that the nursing staff is working at a high level of productivity in the ED. Therefore consistent staffing at desired levels is imperative on all shifts and days of the week in order to facilitate flexible staffing across zones and to meet patient care requirements.

The hospital has tried to respond to workload concerns of staff and increased patient volumes by increasing the planned nurse staffing starting in the fiscal year 2009-2010. According to the Hospital the planned staffing levels were planned to increase as follows:

For the 2009-2010 fiscal year patient volumes in the Emergency Department increased by 5,872 and the Hospital increased Registered Nurse planned staffing levels by 24 hours as follows:
- 0700-1100, increased staffing from 13 to 14
- 1100-1500, increased staffing from 16 to 17
- 1500-1900, increased staffing from 16 to 17
- 1900-2300, increased staffing from 16 to 17
- 2300-0700, increased staffing from 13 to 14

For the 2010-2011 fiscal year patient volumes in the Emergency Department increased by 6,700 and the Hospital increased Registered Nurse Staffing planned staffing levels by 40 hours.\textsuperscript{19, 20}

- 0700-1100, increased staffing from 14 to 16
- 1100-1500, increased staffing from 17 to 19
- 1500-1900, increased staffing from 17 to 19
- 1900-2300, increased staffing from 17 to 19
- 300-0700, increased staffing from 14 to 15

**Registered Practical Nurses**

Registered Practical Nurse staffing planned levels were increased as follows: \textsuperscript{19}

- In November 2009, a 1 day shift and 1 night shifts of Registered Practical Nurses was added;
- In July 2011, Registered Practical Nurse planned staffing was increased to 2 on days and 2 on nights.
Current Daily Staffing the Emergency Department

The current daily assignment in the ED is provided in Table 3. This information was provided by the Hospital.

Table 3: Daily Nurse Staffing and Assignments

<table>
<thead>
<tr>
<th>Assignment</th>
<th>Days 0700-1900</th>
<th>Nights 1900-0700</th>
</tr>
</thead>
<tbody>
<tr>
<td>Charge RN</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Triage RN</td>
<td>07-13</td>
<td>13-19</td>
</tr>
<tr>
<td>Assessment RN</td>
<td></td>
<td>19-01</td>
</tr>
<tr>
<td>Assessment RN</td>
<td></td>
<td>01-17</td>
</tr>
<tr>
<td>Trauma RN</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trauma RN</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute 1-4 RN</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute 5-8 RN</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute 9-12 RN</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute Float RN</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Observation 1-6 RPN</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Observation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Health/Isolation RN</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Observation 7-12 RN</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Treatment RPN</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Treatment RN</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Treatment RN</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Waiting Room RN</td>
<td></td>
<td></td>
</tr>
<tr>
<td>EMS Triage</td>
<td></td>
<td>(no EMS Triage on Nights)</td>
</tr>
<tr>
<td>Respiratory Therapist</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Evenings 1100-2330</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Offload RN</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Triage RN</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assessment RN</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
In addition there are:

- Respiratory Therapist
- Geriatric Emergency Nurses
- Unit clerk support 24/7
- ECG Tech 12 hours per day
- CCAC staff seven days per week
- Registration staff 24/7
- Admitting clerk seven days a week on days; and evenings on Sat/Sun
- Service Assistants 24/7
- Porter on days Monday to Friday
- Two Social Workers from Monday to Friday with combined coverage from 0800-1900; and every 3rd weekend
- Crisis Monday to Friday on days
- DV/SACC 7 days a week
- Lab tech 24/7
- IPAC staff Monday to Friday on days
- Child Youth Worker 24/7
- Physiotherapist 8 hours /day; 6 days per week

The hospital further responded in July 2012 by establishing ten (10) full time and five (5) part time additional permanent RN positions in the ER which were a conversion from the temporary funded positions from the P4R funding.

The Hospital stated during the IAC that they have benchmarked ED staffing with like comparators in terms of patient volumes and acuity. It was unclear what other human resource planning and forecasting methods were used by the Hospital.

However, although the Hospital had decided to increase staffing levels, the ED has subsequently not been consistently staffed to planned levels. In review of the documentation provided by both the Association and the Hospital, and through discussion at the IAC, it was evident that the hospital has been unable to consistently staff the ED to the planned levels resulting in fluctuating nurse staffing levels. In fact, due to a change in management, the Hospital was unable to state exactly when the 2012 increases in staffing were actually implemented on the schedule.
The staffing schedule has been historically posted with holes in it, and the unit is not able to consistently replace sick calls and other short term staffing requirements or to increase staffing because of volume/acuity issues through the use of emergency department staff or the central relief pool.

The hospital stated that charge nurses can decide to increase staffing due to patient acuity or volume; and charge nurses did acknowledge that they were aware of this; but it is not clear that all charge nurses are comfortable to enact this authority when required or did it in a consistent manner; and/or are actually able to find staff to work due to the chronic staffing issues in the department.

In addition, the Hospital implemented a new model and organization of care in the fall of 2012 which required a reorganization of how staff was allocated in the department.

The inconsistent staffing of the unit over a considerable period of time has resulted in a lack of staff trust and confidence in management which must be rebuilt for the future.

**Analysis of Staffing and Budget Data**

The Hospital provided the budgeted FTES for RNs and RPNs the ED for the fiscal year 2012-2013 as well as an updated staffing assignment form. A staffing budget worksheet (Figure 1), was utilized to calculate the annual required FTEs for the ED based on the planned number of staff per shift and estimated replacement requirements of twelve (12) statutory holidays, twenty (20) vacation days and seven (7) sick days. Based on this calculation the ED would minimally require 81.11 RN FTEs and 9.66 RPN FTEs for a total of 92.22 FTES in annual staffing.
Figure 1: Staffing Budget Worksheet

Unit: Emergency Department Lakeridge Health

<table>
<thead>
<tr>
<th>STAFFING PATTERN</th>
<th>Monday to Friday</th>
<th>Total # of Regular shifts [A]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personnel</td>
<td>0730-1130</td>
<td>1130-1530</td>
</tr>
<tr>
<td>RN</td>
<td>16</td>
<td>19</td>
</tr>
<tr>
<td>RPN</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Saturday to Sunday</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personnel</td>
<td>0730-1130</td>
</tr>
<tr>
<td>RN</td>
<td>16</td>
</tr>
<tr>
<td>RPN</td>
<td>2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>RN</td>
<td>71.4</td>
<td>856.8</td>
<td>1428</td>
<td>82.11</td>
</tr>
<tr>
<td>RPN</td>
<td>8.4</td>
<td>100.8</td>
<td>168</td>
<td>9.66</td>
</tr>
<tr>
<td>Total</td>
<td>79.8</td>
<td>957.6</td>
<td>1596</td>
<td>91.77</td>
</tr>
</tbody>
</table>
The ED is currently staffed with:

- 70 Full time Registered Nurses
- 20 Part Time Registered Nurses
- 7 Full Time Registered Practical Nurses
- 4 Part Time Registered Practical Nurses

At the time of the IAC hearing, it was stated by the Hospital that there were 5 regular part time job vacancies.

Assuming that every part time staff works a .6 FTE on average, the equivalent number of current full and part time FTEs is 91.40 (Table 4), which is in alignment with the 92.22 required FTEs from the staffing budget worksheet. Table 5 provides a comparison of Budgeted FTEs and Calculated FTEs using a staffing budget worksheet.

**Table 4: Number of Positions and Equivalent FTEs**

<table>
<thead>
<tr>
<th>Type of Staff</th>
<th>Number of Positions</th>
<th>Equivalent FTEs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full time Registered Nurse</td>
<td>70</td>
<td>70</td>
</tr>
<tr>
<td>Part Time Registered Nurse</td>
<td>20</td>
<td>12</td>
</tr>
<tr>
<td>Full Time Registered Practical Nurse</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>Part Time Registered Practical Nurse</td>
<td>4</td>
<td>2.4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>101</strong></td>
<td><strong>91.40</strong></td>
</tr>
</tbody>
</table>

**Table 5: Summary of Budgeted FTEs and Calculated FTEs using a Staffing Budget Worksheet**

<table>
<thead>
<tr>
<th>Type of Staff</th>
<th>Budgeted FTES 2012-2013</th>
<th>Staffing Budget Worksheet Calculation for Staffing FTEs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registered Nurses</td>
<td>71.73</td>
<td>82.11</td>
</tr>
<tr>
<td>Registered Practical Nurses</td>
<td>9.94</td>
<td>9.66</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>81.67</strong></td>
<td><strong>91.77</strong></td>
</tr>
</tbody>
</table>

The hospital also stated that they desire to provide 2 paid days per staff for education on an annual basis. Assuming that 2 days are budgeted for 101 full and part time staff, an additional .78 FTEs would be required (based on two 7.5 hour days for 101 staff). It was also stated during the IAC by the hospital that not all part time staff consistently meet their committed hours of work and number of required weekends. The float pool is being utilized to fill “holes” in the schedule in addition filling shifts due to unexpected absences.
In addition, if predictable replacement requirements are greater than the assumed parameters of 20 vacation days, 12 statutory holidays and 7 sick days, then additional FTEs would be required.

Given that the addition of FTES for education, and if the actual sick time or vacation entitlements exceed the calculation in the staffing budget worksheet, the required FTEs to staff the ED would exceed 91.77 FTEs.

Therefore, the IAC is concerned that the current complement of full and part time nurses (91.40 FTEs) is not adequate to consistently meet a calculated minimum staffing requirement of 91.77 FTES (i.e. in order to meet the current daily planned staffing levels).

It was unclear to the IAC what systematic methods the Hospital utilizes to determine the optimal number of positions in the ER to meet staffing requirements.

The use of needs based human resource planning tools will assist the Hospital leadership to assess both short and longer term staffing requirements. The tools in the Building Capacity in Nursing Human Resource Planning: A Best Practice Resource for Nursing Managers can be utilized for this purpose utilizing specific data relevant to the ED.

Although requested by the IAC, the hospital did not provide staffing information on sick time, overtime, and total paid hours for full and part time registered nurses in 2012/13 and therefore further analysis of the adequacy of the staffing was not possible.

Recommendations:

1. The Hospital should employ a more systematic human resource planning methodology and evaluate on a regular basis (minimum of twice a year) the adequacy of the number of full and part time registered nurses and registered practical nurses in the ED to meet the regularly planned staffing levels utilizing the forecasting tool published in the Building Capacity in Nursing Human Resource Planning: A Best Practice Resource for Nursing Managers.

2. The Hospital must ensure that there are adequate staffing complement of full and part time registered nurses in the ED to meet the established staffing levels of the unit including predictable replacement requirements such as vacation, statutory holidays, maternity leaves, and sick time.

3. The Hospital must ensure the ED is staffed to the planned levels (i.e. as stated on the daily staffing sheet) on a consistent basis.
4. The Hospital and the Association must ensure that part time staff in the ED is meeting their part time commitment in terms of hours per week and number of weekends.

5. The Hospital must ensure that all shifts in the ED are filled when the schedules are posted.

6. The Hospital should establish a mechanism to identify future staffing gaps in the ED; and establish an objective measure of staffing gaps by regularly monitoring the actual gap between desired and actual staffing.

7. The Hospital should utilize the float pool for unplanned staffing needs and absences rather than filling vacant lines in the ED schedule.

8. The Hospital must monitor the ability to increase staffing when required.

9. The Hospital must ensure it has sufficient staffing to be able to respond to requirements to increase staff at short notice due to volume and/or acuity issues. A written guideline for charge nurses to guide decision making for increasing and/or decreasing staff due to patient volume and/or acuity should be developed, implemented and evaluated. This guideline may include specific triggers to assist in decision making. The guideline should be developed with the input of management and ED nursing staff.

3.2 Registered Nurse and Registered Practical Nurse Practice in the Emergency Department

The College of Nurses practice guidelines are intended to help nurses to understand their responsibilities and legal obligations to enable them to make safe and ethical decisions when practicing. They provide an outline of professional accountabilities and relevant legislation.

The purpose of the practice guideline on RN and RPN Practice: The Client, the Nurse and the Environment is to:

- help nurses and employers to make effective decisions about the utilization of individual nurses;
- highlight the differences and similarities of foundational knowledge and impact on autonomous practice;
- understand nurses’ accountabilities when collaborating with one another;
- identify the attributes of practice environments that facilitate nursing assignments; enhance collaboration and lead to improved client outcomes and public protection.

Key Principles in the guideline include:

- The goal of professional practice is to obtain the best outcomes for clients;
• Although RNs and RPNs study from the same body of knowledge, RNs do so for a greater period of time allowing for greater foundational knowledge; decision making, critical thinking, leadership, research utilization and resource management. Therefore the level of autonomous practice differs for RNs.
• The complexity of the client’s condition influences the nursing knowledge required and the level of care.
• A more complex client and less stable environment create an increased need for consultation and/or the need for an RN to provide the full range of care requirements. 

Nursing Accountability

The Practice guideline states that nurses are expected to consult with others when any situation is beyond their competence. Every nurse is accountable for their own actions and decisions; understanding the roles and responsibilities of other team members; collaborating and consulting with clients and with each other for the benefit of the client.  

The designated nursing authority (which is the nurse with the highest level of authority for nursing in the practice environment) is accountable for ensuring that mechanisms are in place such as policies, procedures, guidelines and other resources to support utilization decisions, nurse collaboration and consultation; clear role descriptions; etc. 

Three Factor Framework

The practice guideline on RN and RPN Practice focuses on three factors: the client, the nurse and then environment. The three factors impact on decisions related to care-provider assignment (RN or RPN) to match client needs as well as consultation and collaboration among providers. The 3 factors – the client, the nurse and the environment are of equal importance. 

Client factors include complexity, predictability and risk of negative outcomes. 

Nurse factors include decision making and critical thinking skills. Nurses must also be aware of the limits of their own competence. 

Environmental factors include practice supports, consultation resources and stability/predictability of the environment. The less stable these factors, the greater the need for RN staffing. The environment continuum ranges from more stable to less stable. The less stable the factors, the greater the need for RN staffing. 

Use of RNs and RPNs in the Emergency Department at Lakeridge Health

Registered Nurses (RN) and Registered Practical Nurses (RPN) are both employed in the ED. Registered Practical Nurses have worked in the Emergency Department at the Oshawa site since September 2009. There are 2 RPNs on every shift.
Prior to the implementation of the Hub and Spoke Model RPNs worked in the RAZ zone and Medical Observation. RPNs currently work in a collaborative model with RNs in Zone 4 Medical Observation and also work in Zone 6 Treatment. All other nursing roles in the ED are staffed by Registered Nurses. The Hospital asserts that the proper application of the CNO’s Three-Factor Framework confirms the suitability of RPNs within the Oshawa ED.23 The Hospital further stated in their brief that:

1. “Nursing staff within the ED are very experienced and knowledgeable about the appropriate application of the Three-Factor Framework within the ED environment.”
2. “Within the ED, it is a regular part of the daily activities that the RPN and RN staff discusses and consult regarding care of patients and deal with transfer of care matters.”
3. “The Hospital is aware that circumstances can arise where patients who have been assigned to an RPN member of the ED staff may not in fact be appropriate for an RPN, or may become inappropriate for an RPN.”

The hospital stated in their submission:

“The works assigned to and being performed by RPNs in Zone 4 and 6 is well within the abilities of the scope of the Hospitals’ RPN staff as outlined by the legislation and College of Nurses standards and guidelines. Further the resources and supports available to RPN staff with Zone 4, 6, and more broadly with the ED, ensure that RPN staff can consult as needed with other health care professionals and transfer care to an RN member of staff if necessary.”

The Hospital further described in their brief the use of the Transfer of Accountability policy in dealing with situations where transfer of care may be required; and the application of the College of Nurses Three -factor Framework.

The Hospital states that at RPN staff is assigned to autonomously care for patients who have been identified as less complex, more predictable and at low risk of negative outcomes. The more complex the care requirements, the greater the need for consultation with an RN.

**Lakeridge Health Environment Analysis**

The Emergency Department at Lakeridge is typical of a high volume and acute emergency department. By definition, an ED has high turnover of patients. The Ministry of Health and Long Term Care Pay for Performance (P4R) funding for emergency departments is based on improving the length of stay of patients in EDs, improving Physician Initial Assessment (PIA) times and other factors to improve both the quality and efficiency of patient care. Lakeridge Health has made significant progress in improving their performance metrics including their ability to meet
Physician Initial Assessment (PIA) times. There is significant pressure and incentive to achieve timely, efficient, and high quality care; and appropriate and safe disposition.

A less stable environment requires strong processes to support care such as role descriptions, policies, guidelines, consultation resources, care pathways and so forth. The ED at Lakeridge is characterized by several factors which make it a less stable environment including:

- High turnover of clients; potential for fluctuation in patient stability;
- The majority of patients are CTAS 3 or higher (urgent to resuscitation) which minimally is defined as having conditions that could potentially progress to a serious problem requiring emergency intervention.
- The plan of care may vary from very clear to unclear;
- Medical directives are out of date;
- A history of unstable staffing levels;
- Consultation resources from nursing management and education are concentrated on Mon-Fri during the day;
- The role description for a RPN in the treatment zone is not comprehensive and is primarily a list of tasks that they can complete. The role clarity document is essentially a list of tasks as well.

**Lakeridge Health Client Factors Analysis**

The majority of patients who arrive in the ED are not known to the ED. Until a primary assessment is done, the complexity of the patient cannot be defined. In the hub and spoke model of care, patients are sent to assessment and seen by the physician, followed by nursing assessment. It is following this primary assessment where a determination of complexity would be determined. This type of assessment can only be done by a RN, which is the case at Lakeridge Health.

The client factors which impact on decisions about the utilization of an RPN or an RN are: complexity, predictability and risk of negative outcomes. Factors in determining the level of complexity in an ED include: are the care needs well defined, does the patient have multiple conditions and co-morbidities; does the patient require frequent monitoring or reassessment; and is there a risk of negative outcomes.

Decisions on unit staffing models are in part made based on analysis of the consistent level of acuity and care requirements of the patients in a unit that can be cared for by a specific type of care provider. While there are individual patients in an ED that can be safely cared for by an RPN, the rapid turnover of patients and movement across the department from one zone to another, creates challenges to consistently assign RPNs to appropriate patients. This is also compounded by the reality that patients are often assigned to an available chair/bed/stretcher in a zone prior to transfer and any discussion/collaboration regarding their care needs and the
appropriate provider. This results in additional time being spent in consultation between the RN and the RPN. It was evident while the model of care is designed to cohort patients with similar levels of complexity and potential for negative outcomes, the reality of where patients may receive care because of volume/stretcher availability and other factors may vary considerably from this model.

**Lakeridge Nurse Factors Analysis**

Nurse factors include level of individual competence, knowledge, the expectation to consult with one another when the situation is beyond their level of competence; and having the appropriate resources available to consult.

Approximately 20% of RNs in the ED have less than 2 years of experience in the ED at Lakeridge (although some have experience at other EDs). The implementation of the Three Factor framework in the ED with regard to nurse education on the model and the integration with necessary policies and procedures to support practice does not appear to have been strong. There does not seem to have been any consistent monitoring and/or evaluation of how effectively, consistently and appropriately nurse consultation and collaboration is done by RNs and RPNs in the ED. Nursing staff did not seem to be aware of the new Emergency Program Transfer of Care and Accountability Policy and Procedures that was approved in January 2013.

The fact that the model of nursing care is built on optimizing autonomous practice of RNs and RPNs creates additional challenges when a collaborative model may be better suited to client needs in this environment. Nurses stated that having the time for appropriate and necessary consultation between nurses was of concern; ensuring that patients were being consistently assigned to an appropriate care provider; and that fragmentation was occurring because when both an RN and RPN were providing care to a patient.

The hospital has developed an Emergency Program Transfer of Care and Accountability Policy and Procedures which was approved in January 2013. However, nursing staff did not seem to be consistently aware of this new policy, although all were familiar with the principles of consultation and collaboration within the 3 Factor Framework.

**Recommendations:**

1. The Hospital must do a thorough re-evaluation of the appropriateness of the role of the RPN in the ED using an evidence based approach. The RPN/RN Utilization Toolkit developed as part of the 2009 Ministry of Health and Long Term Care Nursing Secretariat Health Human Resources Project is recommended.
2. The Hospital should provide additional education to RNs and RPNs on the application of the Three Factor Framework in the ED; with particular focus on effective consultation and collaboration in practice.

3. The Hospital should implement and re-educate all nursing staff on the Emergency Program Transfer of Care and Accountability Policy and Procedures that was approved in January 2013. The Hospital should develop methods to monitor the quality of the consultation and collaboration between nurses and the appropriate assignment of patients to RPNs.

4. Registered Nurses should only replace Registered Nurses on the posted or daily schedule. If an RPN cannot be replaced with an RPN, an RN should be utilized.

5. The Hospital should not utilize RPNS in areas other than Treatment and Medical Observation.

6. The hospital should consider the use of an all RN model in the Treatment area. This would allow for more staffing flexibility between the Treatment and the Assessment areas. If RPNs are maintained in Treatment, a collaborative care model is seen as more appropriate with the RPN working as a care partner with an RN and therefore in a less autonomous role.

7. Continue with the use of one (1) RPN per shift in the Medical Observation area where there are more stable patients.

3.3 Professional Practice

3.3.1 Shared Governance in the Emergency Department

Porter-O’Grady says that shared governance, as a dynamic, is a way of conceptualizing "empowerment and building structures to support it" and embodies four principles: partnership, accountability, equity, and ownership. Unit-based systems are governance models specifically tailored to an individual nursing unit.

Shared Governance empowers front line nursing staff to actively participate and have a voice in providing input to decision making that benefits their work environment and patient outcomes. The IAC observed that there was a group of nurses who were very engaged in Process Improvement activities and thus the potential and foundation is there to develop a Shared Governance council in the ED. The Emergency Department Improvement Team (EDIT) had accomplished a great deal of momentum in improving processes throughout the department.

The implementation of a successful Shared Governance Model requires planning, leadership, and education, mentorship, providing tools for success and importantly celebrating
accomplishments. The ED leadership will need to support Shared Governance by assisting with organization and planning, providing time away from the bedside, guiding those resistant to change, aligning the work with identified needs of the department. The IAC noted that there was a lack of consistency in both front line staff and ED leadership to attend Emergency Department Improvement Team (EDIT) meetings. A Shared Governance Model would require commitment, and structure including but not limited to: regularly scheduled meetings, monitoring attendance, developed agenda’s, minutes from the meetings for staff distribution, a reporting structure to the Program Governance Council.

This unit based council should be co-chaired by a front line staff nurse (consider a charge nurse as a leadership development opportunity) and a leadership team member (i.e. manager, patient care specialist or ED Clinical Supervisor). As co-chairs they should develop a regularly scheduled planning meeting prior to council meetings to develop the agenda and flow to the meeting that is inclusive all members. As a starting point, Terms of Reference should be drafted with:

1. Clear goals or purpose statement
2. Membership
3. Frequency of meetings
4. Roles, responsibilities and accountabilities
5. Reporting structure

The Terms of Reference should be formally approved by the council as an agreed upon document. The meetings should be open to all nursing staff to attend. The council is an ideal forum to discuss operational, practice issues, best practice guidelines, opportunities for future education, continuous quality improvement planning for the ED, opportunities to recognize achievements of staff members and social events.

**Recommendations:**

1. Implement a Unit Based Shared Governance Council that is co-chaired by a front line nurse and member of the leadership team by the fall of 2013.

2. Develop terms of reference for the Unit Council which include a reporting structure to the Emergency Department Program Council.

3. Evaluate the effectiveness of the Unit Based Shared Governance Council annually (attendance, participation, resolution of issues, outcome measurements).

4. The Hospital should facilitate attendance of staff at the council meetings and provide remuneration for time at unit council meetings.
3.3.2 Medical Directives Development and Utilization

Lakeridge Health, Oshawa has Medical Directives (MD) for the ED which are utilized to support quality patient care and flow within the department. However the majority are outdated. The hospital is in the process of updating the medical directives utilizing the Ontario Hospital Association Emergency Department (ED) Medical Directives Implementation Kit. This will consolidate a number of the current medical directives.

Patient flow in the ED may be impacted when MDs are outdated and therefore not being consistently utilized by staff. Renewing of MDs ensures they remain current. The IAC does understand that the process of moving forward involves several steps and final approval at the MAC. Both completed and updated MD lead to efficient patient flow and care.

The method of education for nurses on MDs in time has been varied, including orientation, reading package, and/or an education session. This is a concern to the committee as this does not provide for any form of evaluation of the knowledge/competence of the RN’s initiation of directives. With a more formal education process there would be a standardized approach to the utilization of medical directives. There would also be a record of those nurses who attended/completed the required education surrounding the MD. This would ensure all RN’s are educated on new and updated documents. Continued involvement of the RN’s would be beneficial in the development and the evaluation of the directives as they are the providers who work with them on a daily basis. With input from the manager/staff and educator an evaluation tool would be an asset. The unit council may be an appropriate avenue for the development of an evaluation and be linked to a quality improvement initiative.

The MD’s presently are initiated in the Waiting Room by the Waiting Room nurse if appropriate for safe quality care. The IAC also supports initiation of the directive in any of the ED zones as required. The RN’s in the department play an important role in providing that care. Initiating MD improves the flow of patients through the department as well as empowering the RN to determine what is in the best interest of patient care.

Recommendations:

1. The Hospital must complete the updating of all medical directives by end of June, 2013 and approval by the Medical Advisory Committee by September 2013.

2. The education and implementation of the revised Medical Directives should include a formal education session for all nurses.
3. The Hospital should develop an appropriate method to evaluate the appropriate use of medical directives.

4. The Registered Nurses in the ED should utilize medical directives in all of the ED zones as appropriate and as required to support patient care.

3.3.3 Education

The Professional Standards for Nursing in Ontario require that every nurse maintains and continually improves their competence.\(^{33}\) This is done by participating in the Quality Assurance Program set out by the College of Nurses of Ontario, assuming responsibility for their own professional development, and engaging in a learning process to enhance practice.\(^{33}\)

The CNO practice guideline on Supporting Learners outlines the accountabilities of nurses who support learners.\(^{34}\) Educators who support learners develop, implement and facilitate learning activities which helps nurses to enhance their practice.\(^{35}\) The Hospital is fortunate to have a full time educator for the Emergency Department at the Oshawa site. The role description the Patient Care Specialist (PCS) includes reference to facilitating patient flow management and also providing coverage when the manager is away. The efforts and time of the PCS must be focused on the education and development of nurses in the emergency department. In addition to the formal education activities of the PCS, a consistent visible presence in the department is important to support immediate resolution to practice issues and real-time bedside teaching.

The hospital has increased the number of courses required and offered to the ED staff. The nurses through the hearing acknowledged the importance of education and learning to their practice but appeared unaware at hearing about some of the sessions being offered. Nurses stated that is was challenging to schedule the time away from work to attend education sessions. This does make it more difficult for nurses to meet some of their professional standards outlined by the CNO or NENA. The IAC does encourage the hospital to continue in offering sessions. Advanced planned and posting would support scheduling for staff and management. Both the nurses and the employer agreed at the hearing this would be worth exploring. This would both facilitate staff attendance and consolidate learning.

Regular assessment of staff learning needs is essential. This forms the basis for working with staff and leadership to determine and plan for educational programs and learning opportunities.

Preceptors have a valued role within the orientation program. They are responsible for providing a positive learning experience. It was documented in the ONA Submission and the Hospital Association Committee meeting on October 17, 2011 (item 13) that on occasion learners and preceptors are being taken off orientation and either being given a patient assignment or being reassigned to another shift because of staffing issues. This is not conducive to an effective orientation and learning.
The Preceptor facilitates learning, provides coaching, evaluates and provides feedback to the learner/manager/educator as appropriate. This is difficult to attain if not available to support and guide the learner. The college also identifies the role of the manager in supporting both the learner and the preceptor. The College guidelines states the following: “The nurse in the administrator role will assess the workload of all nurses whose clients are cared for by learners and make ongoing workload adjustments so that nurses are available to support and communicate with learners.”

**Recommendations:**

1. The PCS role must focus on education and be relieved of other duties such as patient flow responsibilities and management coverage.

2. Create an annual education plan. Communicate and post the plan for staff.

3. Develop and implement a learning needs assessment for nursing staff in the ED. Conduct the needs assessment a minimum of every two years.

4. The hospital should continue to offer 2 paid education days for the nurses per the Collective Agreement. It is important for the hospital to endeavor to provide the time required for the nurses to attend. The Hospital and the Association should collaborate on mechanisms to support nurses to attend education and professional development opportunities.

5. Nurses who are preceptors should be supported to attend a preceptor workshop.

6. Ensure that nurses on orientation have the opportunity to complete their hospital and unit orientation as planned without interruption. The orientation needs to be consistently supported through consultation between the orientee, mentor and PCS.

7. Nurses on orientation should complete their full orientation prior to receiving an independent patient assignment.

8. The Hospital should assess the workload of all nurses whose clients are cared for by learners and make ongoing workload adjustments so that nurses are available to support and communicate with learners.
3.3.4 Collaborative Practice within the Inter-Professional Team

Collaborative and effective working relationships are a hallmark of an effective ED team. The standards of the professional colleges for nurses and physicians in Ontario also describe the clear expectation for nurses and physicians to engage in productive, collaborative relationships in order to effectively meet the needs of patients.

Effective structures to support inter-professional practice are essential. The ED does have an established Emergency Department Improvement Team (EDIT) and meetings were scheduled on a regular basis during 2012. However, a review of the minutes of the EDIT shows that attendance of members is erratic and that a sufficient quorum is not consistently achieved.

During the hearing nursing staff described instances of inappropriate physician behavior in the workplace with regard to issues around patient flow and the implementation of medical directives that is negatively impacting the effectiveness of nurses and the team. The Hospital was clear in IAC hearing that they are aware of this issue and that it is currently being addressed by senior hospital and physician leadership; and further stated their commitment to resolving any issues related to inappropriate workplace behavior.

Recommendations:

1. Any disruptive behavior of physicians in the Emergency Department must be effectively addressed by physician and hospital leadership. The College of Physicians and Surgeons of Ontario publication on Managing Disruptive Physician Behavior is an excellent resource for hospitals.

2. Continue to schedule regular EDIT meetings and facilitate the attendance of committee members.

3.4 Emergency Department Model of Care

3.4.1 Model of Care

The hospital implemented a new model of care called the “Hub and Spoke” model in the fall of 2012. There has been no formal evaluation of this new model since the implementation. Sustainability of any model of care requires rigorous and regular evaluation of process and outcomes indicators; as well as analysis of work flow and related processes. It was evident that the Hospital and some members of the nursing staff have considerable expertise the use of LEAN methodologies of quality improvement which is commended. An inter-professional Kaizen event led to the implementation of the new model of care.
The CNO Three-Factor Framework is used by the Hospital as the basis for determining the most appropriate care provider for patient. The hospital has also developed transfer of accountability policy and framework based on the Three Factor Framework. It was not clear how the TOA policy was implemented, what education the staff received, and the consistency of application in practice. There is a shared responsibility between management and staff to understand and effectively implement approved policies for patient care.

Recommendations:

1. Evaluate the effectiveness of the new Hub and Spoke model of care and determine next steps in improving and sustaining this model of care.

2. Engage the ED staff in the evaluation process through the EDIT and staff meetings.

3. Utilize a variety of outcome measures in evaluating the model of care including measures of quality and efficiency, patient satisfaction and staff satisfaction.

4. Educate all staff on the transfer of accountability policy and monitor the consistent use of the policy within the ED.

5. In keeping with the Transfer of Care and Accountability Policy and Procedures, the transferring and receiving RNs and/or RPNs should consistently consult regarding the needs of the patient for an RN or RPN at the time of transfer.

3.4.2 Triage and Emergency Medical Services (EMS) Offload

Emergency Department (ED) overcrowding and long waits makes triage one of the most challenging and high pressure areas in the ED. The current triage system at the Hospital has patients entering ambulatory through the main ED doors (82% of ED volume) or via a separate ambulance entrance (18% of ED volume).

The Triage Nurses presently work in private rooms that face a triage waiting area with good sight lines (there is protective glass for enhanced protection). The nurses did have input into the design of the area and subsequent redesign efforts (including the addition of panic buttons, protective glass, back door escape and a window between triage rooms), and the triage rooms have been redesigned based on staff input.

In recognition of the risks associated with long wait times and to enhance patient safety, the IAC supports full RN coverage of the triage area and waiting room. Staffing at triage is as follows:
1 RN x 24 hours and a second RN 1100 – 2300 hours. It was noted that during the IAC tour that the 1100 nurse is often pulled to other areas of the department when short staffed or relieves other roles for breaks. This puts significant pressure on the remaining nurse to both assess and sort patients on arrival to the ED. As triage is the gatekeeper to the ED it is important that there is consistent coverage across 24 hours. Considering the volumes, there should be a process to identify who will support triage in times of higher volumes or acuity. Options for consideration could include: the float nurse would assist with break coverage if necessary, waiting room nurse or an alternative use of the EMS triage nurse (as described below).

According to NACRS data, the CTAS (Canadian Triage Acuity Scale) profile of the patients seen in the hospital from 2009 through to 2013 has remained fairly stable (Table 2 and 3 in section 2.2).

Consistent triage staffing has numerous quality and safety benefits including but not limited to:
   i. The triage nurses will be more aware of patients on arrival.
   ii. The ability to meet CTAS guidelines for contact with a Triage RN within 10 minutes of arrival will be greatly improved.
   iii. Patient comfort and satisfaction will improve as they will be seen a timely manner and able to sit down in the waiting room sooner.\(^\text{36}\)

Quality assurance initiatives at triage is imperative at to ensure an accurate ED profile is determined and maintained. Currently audits are done by the ED- Patient Care Specialist (PCS) and should be continued. This process could be considered as a learning opportunity for front line nursing staff and done in partnership with the PCS. Engaging front line nurses in quality assurance activities embraces ongoing leadership, engagement and educational development.

The hospital has a documented role description\(^\text{37}\) and policy\(^\text{38}\) for the triage area which is based on the Ontario Hospital Association Toolkit on Triage\(^\text{39}\). It was noted at the IAC that changes to CTAS guidelines (modifiers) were not effectively rolled out to all triage nurses. This is an area that must be improved upon. It is also imperative that the designation of new triage nurses is done regularly to ensure adequate coverage for this area on an ongoing basis.

The role of the EMS Offload nurse is new and has the responsibility to ensure safe and timely Transfer of Accountability from paramedics to hospital nursing staff.\(^\text{40}\) This role is to ensure paramedic crews are released from the hospitals and available for their next patient call. The hospital has been allocated financial resources for twelve (12) hours of EMS offload coverage per day. This nurse is used on the day shift and exclusively for monitoring ambulance patients. There is also a hospital resource nurse that is assigned EMS triage. The IAC is of the opinion that the role of EMS Offload could incorporate both triage and offload, thereby freeing up additional nursing time to be reallocated to other patient care needs.
The hospital does employ a waiting room nurse and the IAC supports continuation of this position 24 hrs per day. Patients are sent to this waiting room following triage, or they may be sent back from inside the department awaiting test results and may require some treatments. The visualization of this waiting room would be improved with the replacement of wooden slats to a clear material. The current Spoke and Hub Model of Care does facilitate patient flow with a pull system to support reducing number of patients waiting in the outer waiting room.

**Recommendations:**

1. Ensure consistent coverage at triage as per the schedule in the unit assignment.

2. The nursing staff and management should collaborate in determining what volume and acuity factors and associated trigger points should be utilized to determine when staffing should be increased at triage.

3. The EMS Offload Nurse role should also include triage of EMS patients which would relieve the present role of the EMS Triage Nurse. The hours currently allocated to the EMS Triage Nurse must be reallocated to another Zone in the ED.

4. Triage education must be ongoing and rolled out effectively in relation to changes in triage guidelines (modifiers). To ensure adequate triage coverage, identification of new triage nurses should be done regularly.

5. Optimize visualization of the waiting room by removing the wooden slats and replacing with a clear material.

**3.4.3 Patient Flow and Bed Management**

The Ministry of Health, Long Term Care has emphasized the importance of reducing Emergency Department wait times. Among other components, the strategy includes ED targets, reducing Alternate Level of Care (ALC) days in hospitals and public reporting of indicators related to patient flow and satisfaction. Hospitals have been working towards achieving established targets that reflect improved patient flow in the ED and to in-patient units. This strategy is known as ED Pay for Performance. Indicators have been established and hospitals are using innovative approaches to achieve the desired results.41

The Hospital is working to improve all the Pay for Performance (P4R) indicators. Most notably there has been a reduction from 63.1 hours in 2009 to currently 38.2 hours for the *ED Length of Stay at the 90% for Admitted Patients*. Of note, also over the past three years, the admission rate has remained stable at 9 – 10 %, with an ED volume growth rate of 7%. The Emergency
Department Improvement Team (EDIT) has the opportunity to remain engaged with activities that target improvements related to the internal operations of the P4R indicators.

Effective and efficient functioning in the ED is heavily dependent on patient flow, utilization, length of stays and occupancy rates on the in-patient units. Patient flow and bed management is a complex ED, hospital and system issue. It requires a multi-pronged comprehensive corporate plan to address internal issues and pressures along with external barriers. The commitment to patient flow and bed management needs to be embedded in the culture of the organization and daily working processes as a priority. It should be viewed as a hospital wide responsibility and shift away from an ED overcrowding problem. It requires support on all levels of management. The Hospital has demonstrated their commitment to timely effective and accessible patient centered care as outlined in their Quality Improvement Plan: “These objectives and associated change ideas all align with our aims to improve flow, reduce unnecessary lengths of stay and support patient self-management. Examples of our change ideas include process improvements to optimize early morning pull and coordinated assignment of beds for patients, …transition planning tools”.

While many of the causes of ED overcrowding are external to the ED, the effects are primarily manifested within the ED. These effects include backlogs of admitted patient compromising the capacity of the ED, long wait times, and risk of poor outcomes, patient dissatisfaction, ambulance offload delays, and highly stressful working conditions for the staff and physicians. Facilitating flow to the in-patient units and effective bed readiness needs to be addressed through a variety of innovative initiatives. Common bottlenecks and barriers often result from inadequate planning for discharges, lack of team coordination, housekeeping/portering issues, delays in accessing medical imaging, isolation beds, physician and nursing practices. These were not the focus of this review however the impact of admitted patients in ED was addressed. The corporate structure for patient flow, initiatives and processes were discussed during the tour of the ED and in the IAC meeting time and it was evident that front line ED nursing staff were unaware of the many corporate projects that were being done to support patient flow.

Hospital policies can have significant impacts on wait times and patient flow. The Hospital has an outdated policy that does not reflect the current bed management structure, volumes and acuity of ED, nor does it reflect the new Hub and Spoke Model of Care. This policy addresses Bed Crisis but lacks the day to day bed placement protocols. The morning pull to the inpatient units is an example of a current practice that is not documented in the policy. The goal is to achieve 4 – 8 patients assigned to the right in-patient care area every morning. It was identified that there is a new policy in draft to be approved and rolled out shortly that includes corporate bed management.

During the tour of the ED, the IAC team was introduced to the corporate Operations Supervisor who manages corporate bed flow. It was clear that the effectiveness of this role was person
dependent rather than position dependent. Standard work had been created with the implementation of this role however it was identified that the Charge Nurse was not always aware of bed placement plans for each shift. There is also a new role specific to the ED (ER Clinical Supervisor) that supports patient flow within the ED and works in tandem with the corporate role.

Bed Rounds should be reviewed with a goal to improve their effectiveness. There did not appear to be a clear trigger for afternoon Bed Rounds and this should be established for consistency in practice. It is important that daily decisions are made and priorities are determined related to admissions, discharges and transfers at these meetings. Regular attendance should be considered mandatory for Patient Care Managers and other key support personnel (e.g. representatives of Environmental Services, Diagnostic Imaging and Infection Control). Program Directors should attend as needed, particularly in overcrowded situations. This is a key meeting for effective day to day patient flow and bed management. It also supports the culture of a corporate perspective to patient flow.

The hospital recognizes the need to accommodate a 7 day a week approach to patient flow and bed management. Weekend bed meetings currently do not occur however there is consideration to implementing this in the future. Weekend discharges play a key role in smoothing patient flow across the organization. This can dramatically improve holding admits in the ED early in the week.

There was a lack in consistency for staffing the admitted patients in the ED. Some nurses stated that they did not feel supported when additional staff were called in to accommodate the needs of the department. Charge nurses stated their practice in managing surge was not documented as a standard practice and it was clear that this was an area that required improvement and consistency. The development of a decision tree that provides triggers and actions could be undertaken by EDIT. This was discussed as an important issue with the ED nurses and thus should be addressed in a bed management guideline.

The hospital uses a daily dashboard known as DART which is one day retrospective. It is posted in the ED and sent to a variety of key stakeholders throughout the organization. There is great benefit from this tool having real time information and distributed more frequently than daily. This information also supports the corporate responsibility to responding to all patient flow needs across the organization. This tool can also include some ED Pay for Performance Indicators such as Length of Stay for an in-patient bed which supports the organization in achieving their targets.

Alternative Level of Care patients (ALC) are patients who are awaiting post hospitalization services and beds. They pose real challenges to patient flow. ALC is a well-known system wide issue. The IAC team heard of the bed pressures that were directly related to the high number of
ALC patients and how they pose considerable stress on the organization. The Executive Team is actively engaged in system wide discussions.

**Recommendations:**

1. A communication strategy should be developed to raise the awareness for front line staff of the initiatives to support patient flow and improve wait times.

2. Update the policy on Bed Level Crisis Response (2003) to reflect the current work, targets and activities that the Hospital has undertaken. The policy should address the corporate needs that include their Regional repatriation agreements for stroke, cardiac and cancer patients etc. Completion of the Hospital Bed Management Policy (which is currently in draft) will supplement the Bed Level Crisis Response. These policies will both require education to all levels of management and front line staff to ensure awareness and understanding. An effective roll out plan should be established to ensure defined thresholds are followed, monitored and evaluated. They must be vetted through key stakeholder groups and supported by all levels of Management.

3. A dashboard (DART) with real time information should be communicated broadly a minimum of three times a day to all relevant departments, physician leaders, senior leadership, directors and managers. This information will guide the organization to follow the new bed management policy which is currently being finalized by the Hospital.

4. There should be clear expectations for all programs and services in their role to facilitate patient flow. Programs and services need to be held accountable to adhere to the organization’s bed management and policies.

5. Bed meetings should be held 7 days a week at least once per day with a trigger to identify a need for a second bed meeting. Daily plans from the bed meeting need to reach the ED charge nurse consistency to allow improved ED patient placement and flow.

6. Executive team continues to work with external agencies, LHIN and MOHLTC to advocate for resources to support a system approach to improving ALC beds. It is recognized that this a very complex issue that takes changes in legislation, innovative approaches, reallocation of resources and other solutions that take time and political will.
3.4.4 Security

In addition to triage and waiting room coverage, it would be remiss not to mention the need for consistent security to support these areas. Violence in the workplace has been defined under the Occupational Health and Safety Act, 2009, Bill 168 as:

1. The exercise of physical force by a person against a worker, in a workplace that causes or could cause physical injury to the worker
2. An attempt to exercise physical force against a worker,
3. A statement or behavior that is reasonable for a worker to interpret as a threat to exercise physical force against the worker

Employers under the act have an obligation to protect workers from violence. When there is an aggressive, violent patient personal safety becomes the prime concern. The ED has a unique feature of a diverse patient population that may involve highly emotionally charged situations or individuals have been involved with the police which may put staff, patients and visitors at risk of harm.

The current model of security coverage in the ED has two different levels of security officers; and there are security cameras throughout the department. As described during the IAC process and on tour of the ED, the High Risk Security Officer (HRO) has additional training to deal with escalated behaviors in patients. The second level of Security Officer in the department is more of a sitter role who is not trained to use physical contact if needed, but to monitor mental health and confused patients. They communicate concerns to both nursing and security staff. It was agreed by both parties that staff and patient safety is of utmost importance. All security personnel are contracted from a third party provider security service which results in some inconsistency in the staff who is assigned to Lakeridge Health.

The IAC also heard that the incident reporting system, known as the Better System had some inherent functional problems that delayed the ED Manager from responding to reported security concerns (i.e. the Manager did not always see the reports depending on the reporting algorithm in the Better system). Staff indicated that when security issues had been reported that they did not receive a timely response and this has led to them feeling very discouraged. The Hospital did respond that staff security is of utmost importance and they are looking at a more robust system.

Recommendations:

1. A High Risk Security Officer should be visible at triage and in the waiting room seven (7) days a week, twenty four (24) hours per day. A permanent desk to support security presence at the entrance to the main ED doors would heighten the protection for staff, patients and visitors.
2. The Security Officers who are in the triage area, waiting room and internal area of the main ED should all be High Risk Security Officers who can respond to the heightened needs of any concerning behaviors. The lower level of security officers should be minimized and utilized for the constant observation role.

3. Implement consistent personnel in the HRO position in order to support improved communication, relationships, expectations and a team approach to security management and crisis management.

4. Review policies on annual basis as related to workplace violence and harassment. Consider having an ED nurse being a member of the Corporate Joint Health and Safety Committee.

5. All security alarm systems should be tested on a weekly basis (Triage nurses should be aware this is being done in their area as an added safety measure).

6. The ED Leadership team responds to security issues in a timely manner. The organization review the current Better System reporting algorithm to ensure information does get to the Manager for review and a response to the staff involved.

7. Ensure that access to the department from either outside or within the hospital is restricted.

8. Utilize the RNAO Best Practice Guideline, Preventing and Managing Violence in the Workplace. 47

3.4.5 Role of the Charge Nurse in the Emergency Department

The role of the Charge Nurse is a central and critical role in the efficient and effective management of and ED. There need to be a sufficient number of nurses in the ED who are able to fulfill the role of Charge Nurse. The role requires strong analytic, organizational and communication skills. Charge Nurses benefit from ongoing professional and leadership development. Formal leadership and skill development in the charge nurse role can be improved. The Hospital has recently implemented a new Charge Nurse workshop to support ongoing development. However, not all the charge nurses in the ED have had the opportunity to attend. Charge Nurses who have attended the workshop suggested that the course content could be improved by the addition of more ED specific scenarios.

The new Manager of the ED has established daily huddles for all staff including the Charge Nurse to discuss staffing and patient flow issues. The new Operations Supervisor, who works Monday to Friday, is now regularly updating the ED Charge Nurse on patient flow which is seen as an improvement by staff.
Recommendations:

1. The assignment of staff nurses to Charge Nurse role should rotate through a group of qualified nurses and be seen as a professional development opportunity.

2. All nurses who act as Charge Nurses should be scheduled to attend a Charge Nurse Workshop and have access to other leadership development opportunities.

3. Establish a schedule of regular meetings (3-4 times a year) between the Charge Nurses, Operations and the Clinical Manager by the fall of 2013 to support team development as well as role development of charge Nurses, and discussion of relevant issues such as patient flow, decision making, and surge staffing.

3.4.6 Equipment

Several PRWRFs stated that equipment issues were a factor in workload. The Hospital has responded by installing additional equipment throughout the ED. This includes lifts in appropriate patient care areas except where this was not possible due to construction. There have also been additional monitors and ECG machines made available.

Considerable attention has been given to improving the organization and accessibility of supplies and linens. Supported by the management team, the nursing staff has taken considerable time and effort to ensure the standardization of supply carts. The Hospital has implemented supply stocking position. Standardization of all supplies has been a positive experience for both the staff and the hospital. The IAC encourages this to continue. The Hospital has recently converted to utilizing an offsite supplier for disposable supplies. The carts are scanned and restocked by the supplier. It is important especially in an emergency that there are sufficient and appropriate supplies available when needed.

Nursing staff who work in the resuscitation area recommended that functioning in the zone would be improved by adding a second trauma cart in order to have easy access to supplies at all times.

As is common in any hospital, especially the ED, equipment can be misplaced due to patient transfers out of the ED. Nurses noted that this is common with infusion pumps.

Recommendations:

1. Continue the work on standardization of supply and laundry carts throughout the ED. Continue to engage the staff in the ongoing evaluation of stocking processes and frequency.
2. Establish a second trauma zone standardized supply cart.

3. The hospital to ensure the ED has sufficient number of infusion pumps.

4. **Unit Culture, Morale and Communication**

A healthy work environment will promote the health and well-being of the nurses. The RNAO Best Practice Guideline; Health, Safety and well-being of the Nurse\(^48\), has determined there are many factors which contribute to the overall health of the nurse. Some of these factors include the culture of the environment relating to communication, relationships, support and learning. Other factors involve workload, schedules and personal safety.\(^48\) Heathfield describes employee morale as the overall outlook, attitude, satisfaction and confidence that employees feel at work.\(^49\)

It was evident throughout the hearing that unit culture, morale and team functioning in the ED is a major concern. The concerns of nurses at the hearing included staffing and workload, ongoing expectation to improve flow and the perception that their concerns are not being heard or appreciated. It was also evident that nursing staff have concerns about speaking frankly and raising their concerns to management.

Team building is an important aspect of getting back on track. Mutual trust is critical in building partnerships between the staff and management.

Communication amongst all care providers and the management team is pivotal to quality nursing care and a healthy work environment. The IAC is aware there has been a change in the management team in the fall 2012; this would be an opportunity to move forward to improve communication. The IAC encourages the continued practice of the daily huddles between management and staff. Management also needs to respond in a consistent and timely manner to staff with regard to their concerns and other issues such as their work schedule.

Information is disseminated through various means. It is a continuing challenge in most units to remain abreast of all current information and communications. All staff has the responsibility to ensure that they keep up to date with information.

**Recommendations:**

1. The Hospital and nursing staff in the ED should review the following RNAO best practice guidelines and implement the appropriate recommendations within the guidelines for the express purpose of improving unit morale, communication, conflict resolution and unit culture.
- RNAO Best Practice Guideline Healthy Work Environment; Workplace Health, Safety and Well-being of the Nurse; Collative Practice Among Nursing Teams; Professionalism in Nursing.

2. The management and staff of the ED should work together to review the methods and avenues of communication including but not limited to:
   a. Reinstating regular staff meetings.
   b. Establishing a “what you need to know board”.

3. The Hospital needs to acknowledge and respond in a timely and consistent manner to staff. As maximum of two weeks is reasonable unless the issue is of a more urgent nature. While the IAC appreciates some issues are confidential, a response of acknowledgement of the communication to the nurse is necessary.

4. The Hospital should support a retreat for all ED staff with a clear purpose and expected outcomes in order to support team building and mutual goal setting. It is recommended that a facilitator who is external to the department be utilized for the retreat. Nursing staff who attend the retreat should be remunerated for their time.
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 68 recommendations in the following areas:

- Human Resource Planning and Nurse Staffing;
- Registered Nurse and Registered Practical Nurse Practice in the Emergency Department;
- Professional Practice;
- Emergency Department Care Model; and
- Unit Culture, Morale and Communication.

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 in the Emergency Department.
References


10. Ontario Nurses Association Exhibits Book One, Tab 13

11. Ontario Nurses Association Exhibits Book One, Tab 14

12. Ontario Nurses Association Exhibits Book One, Tab 15

13. Ontario Nurses Association Exhibits Book One, Tab 16

14. Ontario Nurses Association Exhibits Book One, Tab 17

15. Ontario Nurses Association Exhibits Book One, Tab 3


18. Lakeridge Health, 2013, Emergency Department LOS by Day of Week, Submission Document 6


33. The College of Nurses of Ontario, Professional Standards, Revised 2002

34. The College of Nurses of Ontario, Practice Guideline on Supporting Learners, 2009


39. OHA The Canadian Triage and Acuity Scale: Combined Adult/Pediatric Educational Program 2010.


42. (Lakeridge Health Organization, Quality Improvement Plan 2012 -13) Retrieved from: http://www.lakeridgehealth.on.ca/en/document/document.aspx?param=0THAqUlfHu1PIUsPIUsTWfPIUsOT5IA5HpAeQuAleQuAI


Appendix 1: Email from Ontario Nurses Association to L Vincent, September 17, 2012.

From: Mariana Markovic [MARIANAM@ona.org]
Sent: September-17-12 2:51 PM
To: Leslie Vincent
Cc: cgabrielli@cogeco.ca; Daryl Sewell; John Harris; Linda Calhoun; Lisa Shiozaki; Shelly Flack; SGreen@oha.com; Shelley Flack; Paul Marshall
Subject: Re: IAC Date and Nominee for Lakeridge Health Oshawa ER Program
Importance: High

Hi Leslie,

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

ONA has made every effort in working with the Senior Administrative team at Lakeridge Health Oshawa over the past two years to address RN workload issues presenting professional practice concerns and quality of patient care delivery in the Emergency Room Department at the Oshawa site.

Without progress or commitment from the Employer for resolve of workload issues that make nursing practice unsafe and patient care delivery unsafe, ONA has no alternative but to advance this complaint before an IAC for an investigation and a hearing.

The RNs working at Lakeridge Health Oshawa have been submitting workload forms since fall of 2009 to the present. To this time ONA has been attempting to set up meetings with the Employer and work towards a resolution on issues of short staffing RN hours in the ER and utilization of RPNs in an area of practice that is beyond the scope of the RPN as defined by the CNO. To date attempts in resolving this with the Employer continues to be met with resistance and Employer refusing to meet with us.

In order to move forward on resolving workload issues ONA is requesting a date to be set for an IAC investigation and hearing. ONA remains committed to working with the employer to such time a date is set for the IAC. Please find attached the information for our nominee on the IAC panel.
A copy of this email is being sent to the Employer for the purpose they will do the same.

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

Please feel free to contact our nominee for dates directly in proceeding. Furthermore should you have any additional questions please do not hesitate to contact me at the information provided in my signature.

Kind Regards,
Mariana

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

marianam@ona.org
Tel: 416-964-8833, ext. 2413
1-800-387-5580
Fax: 416-964-8864
Appendix 2: Letter for September 27, 2012 from ONA to Hospital

September 27, 2012

Ma. Lisa Shiozaki
Chief Operating Officer
Lakeridge Health Oshawa
1 Hospital Court
Oshawa, ON L1C 2B9

Dear Ms. Shiozaki,

Re: Professional Responsibility Complaint Emergency Department – ONA Gel File Number 201106409

The Registered Nurses of the Emergency Department, Lakeridge Health Oshawa (LHO) have identified ongoing practice and workload concerns as evidenced by the data consistently submitted on numerous Professional Responsibility Workload Report Forms.

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

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

Cynthia Gabrielli
6205 McMicking Street
Niagara Falls, Ontario
L2J 1W7
Tel: 905-357-6276 (home)
Tel: 905-329-3597 (cell)
Email: cgabrielli@codeco.ca

Please provide written confirmation concerning the name, mailing address, home or cell and office phone numbers and e-mail address of your nominee. The name of the next Chairperson

"
on the list in Appendix 2. Leslie Vincent, will also need to have the nominee information.

Sincerely,

ONTARIO NURSES’ ASSOCIATION

Mariana Markovic

Mariana Markovic
Professional Practice Specialist

/mm/ml

C:  Cynthia Gabrielli, ONA nominee
    John Harris, LHO Manager Labour Relations
    Daryl Sewell, LHO Vice President Human Resources
    Linda Calhoun, LHO Director Emergency Services
    Kevin Empey, LHO Chief Executive Officer
    Thorste Koseck, LHO Board of Directors, Chair
    Bonnie St. George, LHO 1st Vice Chair
    Doug Allingham, LHO Board of Directors, Past Chair
    Shelley Flack, ONA Local Coordinator
    Paul Marshall, ONA Labour Relations Officer
    Doug Anderson, ONA Manager Provincial Services Team
    Linda Haslam-Stroud, ONA President
    Leslie Vincent, Chair IAC
    Stephen Green, OHA, Director Employee Relations
Appendix 3: Email from Hospital to IAC Chair November 15, 2012

From: Harris, John [mailto:jharris@lakeridgehealth.on.ca]
Sent: November-15-12 8:20 AM
To: Leslie Vincent (leslvincent@sympatico.ca)
Subject: IAC Nominee - Lakeridge Health

Hi Leslie here it is

John

John Harris
Manager, Labour Relations, Lakeridge Health
Tel: 905-576-8711 ext3604 | Fax: 905-721-3455
jharris@lakeridgehealth.on.ca

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Hi Leslie, further to Mariana’s e-mail of September 19th, the contact information for our nominee is as follows;

Susan Woollard
18 Bowater Drive
Toronto, Ontario
M1T 1T2

647-408-3549
Susan.Wolllard@nygh.on.ca

I have also taken the liberty of enclosing two recent letters, the first undated from ONA identifying three (3) main areas of concern and the second, the Employer’s response dated November 8, 2012.

Subsequent to that letter, the Employer was advised by the ONA local that the use of RPN’s in the Emergency Department was the remaining outstanding issue, thus narrowing the scope of
the IAC. To this end, the Employer wishes to inform you of our intent to invite participation from our CUPE bargaining unit (who represent the RPN's here at Lakeridge) and from representatives of the RPNAO at the IAC.

Should you have any questions, feel free to give me a call.

John Harris
Manager, Labour Relations, Lakeridge Health
Tel: 905-576-8711 ext3604 | Fax: 905-721-3455
jharris@lakeridgehealth.on.ca

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Appendix 4: Undated Letter from Ontario Nurses Association to the Hospital

Dear Linda,

Thank you for taking the time to speak with me about a joint commitment in resolving workload issues of the RNs, working in the ER Department of the LHO, complaint going to a hearing in front of the IAC.

Timely resolution of workload issues does require both parties to be committed to working together to achieve mutually agreeable solutions to the ER ONA/Hospital Professional Practice responsibility. Workload Concerns. Your proposal of weekly meetings to reach solutions is commendable. However, time and acuity of the situation is a crucial factor that must be considered. ONA central has elevated this Professional Practice Concern to the OHA and Leslie Vincent, the next IAC Chair, and as such, the date of November 14th is the date by which the Employer’s required to name their nominee and advise on the next IAC Chair, or not, but that a date is set for the IAC hearing. I am copying John Harris in on this so if you should you have any questions on the Collective Agreement Language around this he will be able to assist.

As stated earlier this complaint is at the level of ONA central, and as I have made clear at our meeting, ONA remains committed to resolving the workload issues. This is evident by the “proposed letter of understanding” dated March 14, 2012 sent to Employer’s attention and attached here for your reference. If we are to work together on timely resolutions to workload issues at the local level it requires there to be immediate action by you, the Employer’s side, to make a commitment to the ‘proposed letter of understanding’ by:

1) filling in all posted vacancies, ensuring no holes in posted schedule, staff sick calls are replaced on all shifts, consistently (item 1, proposed LOU).
2) An additional RN is scheduled 24 hours a day, 7 days a week, to each RN working issue have been appropriately addressed and evaluated (item 2 and 7, proposed LOU); and
3) the role of the RNs is limited to TRAS 4 and 5 patients only with immediate removal of the RNs from the Rapid Assessment Zone (item 5).

Employer commitment to the ‘proposed letter of understanding’ to resolve workload issues for RNs working in the ER may be seen as evident in the implementation of the aforementioned three items before November 14th.

The Employer and ONA working toward resolving the acuity of the presenting Professional Practice Workload Complaint to the satisfaction of both parties is only possible at this time through the LOU (Letter of Understanding) prior to the IAC hearing date being set. In that the Employer and ONA may come to an agreement through the Letter of Understanding on the resolve of the workload issues in a timely manner I am prepared to work with you week to week on the proposed resolutions in the LOU. I await your response.

Sincerely,

Shelley
Appendix 5: Letter From Hospital to ONA Bargaining Unit President November 8, 2012

Linda Calhoun Senior Director Clinical Services
Lakeridge Health
Tel: 905-576-8711 ext. 4535
Email: lcalhoun@lakeridgehealth.on.ca

Shelley Flack
President
ONA Local 51

November 8, 2012

Dear Shelley,

Thank you for your recent letter in response to our conversations concerning the pending IAC for the Emergency Department at Lakeridge Health Oshawa.

In your letter, you have indicated that “ONA remains committed to resolving the workload issues”, and have identified three (3) main areas of concern. I would like to take this opportunity to address those areas you have identified.

1. Currently the schedules are posted with no holes and concerted efforts are made to replace sick calls, subject of course to the availability of staff. Additionally, all full-time positions are currently filled.

2. Significant changes have been made to increase staffing levels in the Oshawa Emergency Department. As you are aware in September 2012, we added nine Permanent Full-Time RN positions as a result of the conversion of temporary wait-time funding positions to the Emergency Department complement. Additionally, next month we will be adding one (1) Temporary Full-Time RN position as a result of additional Pay for Results funding.

3. As you are aware, the Emergency Department has implemented a new “Hub and Spoke” model of care and the Rapid Assessment Zone (RAZ) no longer exists. In keeping with the College of Nurses of Ontario Three Factor Framework, RPN’s are caring autonomously for CTAS 4 and 5 patients and in collaboration with the RN’s for CTAS 3 patients who have a clear plan of care and diagnosis. Our nursing staff were involved in the new model of care design from the beginning and report improvements in their workload, in their satisfaction, and our patients are receiving the highest quality health care.

In light of the above, I believe we have addressed not only the three (3) areas of main concern identified in your recent letter, but those concerns previously identified. We are continuing to meet to discuss ongoing issues and I look forward to those continued discussions to ensure we are sharing ideas for improvement, learning from each other, and always implementing systems to increase the quality of health care we deliver to our patients. Given all of this information, the Employer is once again, respectfully requesting that consideration be given to not proceeding with the IAC.

I look forward to your response.

Sincerely,

Linda
Appendix 6: Letter of November 27, 2012 from ONA to IAC Chair regarding Representation

November 27, 2012

Ms. Leslie Vincent
Independent Assessment Committee (IAC) Chair
716 Windermere Ave.
Toronto, Ontario, M6S 3M1

Dear Ms. Vincent:

Re: Upcoming IAC – Lakeridge Health Corporation, Oshawa (LHC) and The Ontario Nurses’ Association (ONA)

It has come to our attention that the Hospital has invited Canadian Union of Public Employees (CUPE) and the Registered Practical Nurses Association of Ontario (RPNAO) to participate in the IAC hearing that is yet to be scheduled. As ONA has previously indicated, we oppose the participation of anyone other than the parties to the collective agreement.

As you are aware, the IAC Committee is appointed under Article 8 of the collective agreement between ONA and Lakeridge Health Corporation. Neither CUPE or RPNAO are parties to that agreement. As the IAC Committee is a creature of the collective agreement, ONA submits that the Board would be exceeding its jurisdiction if it were to permit non-parties to participate in the process.

It is important to note that the IAC Committee does not produce a binding decision but rather its role is to provide recommendations to the parties. Principles of administrative law and natural justice dictate that a third party is only entitled to participate in legal proceeding (under a collective agreement or otherwise) if the outcome of the proceeding could have a significant impact on that party. This principle has been upheld by the Ontario Court of Appeal and affirmed by the Supreme Court of Canada in the decision CUPE v. CBC. Since the IAC Committee does not produce a binding outcome, there is no impact on either CUPE or the RPNAO. Nevertheless, if the IAC Committee could make binding recommendations then RPNAO would still have no standing to participate in the process as they would not be directly impacted by the outcome.

1 CUPE v. Canadian Broadcasting Corp. (1996) 70 D.L.R. (4th) 175 (Ont. CA) affd

Ontario Nurses’ Association
85 Greene Street, Suite 400, Toronto, Ontario M5S 1L2
ph 416/964-3833 fax 416/964-3834

Independent Assessment Committee Report
Emergency Department, Oshawa Site, Lakeridge Health Corporation and Ontario Nurses Association
Moreover, if either third party were granted status to participate it would substantially delay the process as these parties could arguably be provided the right to request adjournments, present evidence or make submissions.

In light of these considerations we request that you decline any request from CUPE, the RPNAO or any other third party to participate in the upcoming IAC process. Thank you for your attention and cooperation.

Yours truly,

ONTARIO NURSES’ ASSOCIATION

Mariana Markovic

Mariana Markovic RN, BScN, MN, MHSc
Professional Practice Specialist

C: Cindy Gabrielli, ONA Nominee for IAC by email
   Susan Woollard, Employer Nominee for IAC by email
   Paul Marshall, Labour Relations Officer, ONA by email
   Shelley Flack, Bargaining Unit President by email
Appendix 7: Email of January 14, 2013 regarding IAC Hearing Parties

From: Leslie Vincent [leslvincent@sympatico.ca]
Sent: January-14-13 3:14 PM
To: 'Harris, John'
Cc: 'Mariana Markovic'; 'Susan Woollard'; cgabrielli@cogeco.ca; 'Leslie Vincent'
Subject: Lakeridge Health IAC Hearing Parties

Dear John,

The IAC panel members have discussed the issue related to Lakeridge Health's intent to invite participation from representatives of CUPE and from the Registered Practical Nurses' Association of Ontario (RPNAO). The panel members have decided that representation to the panel will only be from the Ontario Nurses' Association (ONA) and Lakeridge Health. Our decision is unanimous. This decision is based on the following considerations:

- An IAC panel is constituted under the collective agreement between the hospital and ONA. Neither CUPE nor RPNAO are parties to this collective agreement.
- The IAC panel has responsibility for the conduct of the hearing; and is empowered to investigate as is necessary and appropriate to the circumstances.
- The mandate of the panel is to review and examine if registered nurses in the emergency department at Lakeridge Health are being asked to perform more work than is consistent with proper patient care.
- The issues of Registered Nurse work are only in relation to the Emergency Department at Lakeridge Health, and to that end, we wish to hear the perspectives of the nurses in the ER and the leadership staff of Lakeridge Health.

If there is written documentation that is publicly available from such organizations as the College of Nurses of Ontario or RPNAO on Registered Nurses and/or Registered Practical Nurses that you feel is germane to the review, you may wish to include this in your brief.

If you have any questions, please feel free to contact me.

Sincerely,

Leslie

Leslie Vincent RN MScA
Consultant
716 Windermere Ave., Toronto, ON, M6S 3M1
leslvincent@sympatico.ca
Mobile: 647-295-8983
Office: 416-767-8773
(Ross W. Paterson Consulting Inc.)

1. Emergency Department
   a. Patient Information (for past 3 fiscal years)
      i. Volumes
      ii. Distribution by CTAS level
      iii. Admissions by CTAS level (including admission rate)
      iv. Ambulance volumes and offload times
      v. Performance indicators (including Pay for Results)
      vi. ED LOS by day of week
      vii. Reports on any other indicators being utilized to evaluate efficiency and effectiveness of the ER.
   b. Department Organization
      i. Organizational chart of nursing in emergency department
      ii. Role descriptions for Team Leader/Charge Nurse and Triage Nurse
      iii. Description of how ER is organized; zones and functions.
   c. Copy of typical chart format for Emergency Department;
   d. Charting guidelines and/or policies for ER
   e. 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
   f. List of medical directives
   g. Results of triage audits
   h. Program quality minutes or program minutes related to staffing and change process

2. Staffing data (for 2012-13 and 13/14 as specified)
   a. Budgeted FTEs for all staff categories in the ER 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. Average age overall of staff and the number of staff over 60 if possible;
   m. Experience profile - Average years of experience in organization and in ER; number of junior staff (less than 2 years experience)
   n. Number of nursing staff on modified work; or have permanent accommodations
   o. Any planned service growth or change;
   p. Copy of local collective agreement;
q. Master Schedule; copy of last two posted schedules; copy of a daily assignment sheet
r. Allied Health by discipline (including FTE allocation of Physiotherapy, Occupational Therapy, Social Work, Clinical Nutrition, Enterostomal Therapy, Pharmacists, Educators, APN et
s. Support Staff – housekeeping etc.
   i. Daily hours for weekdays and weekends of housekeeping coverage for unit
t. Physicians
   i. Physician coverage by hour of day
   ii. Physician assistants by hour of day
u. Organizational float pool: size in FTEs and types of staff

3. **Budget (for last 3 years)**
   a. Total Budget for ER – labour, supplies etc.

4. **Professional Practice**
   a. Orientation program for new nursing staff in the emergency department (length and outline of content)
   b. Description of preceptorship and/or mentorship program in emergency department for nursing staff
   c. Description of content and dates of education or in-services on the role of RPN
February 15, 2013

Via E-Mail

Ms. Leslie Vincent, Chair
Independent Assessment Committee
716 Windermere Ave.
Toronto, ON M6S 3M1

Dear Ms. Vincent:

RE: ONA and Lakeridge Health IAC Hearing

I am legal counsel to Lakeridge Health in respect of the above referenced matter.

I am writing to address a number of issues relating to the upcoming IAC hearing scheduled for March 18 through 20, 2013.

First, it is the Hospital’s understanding that the issue advanced by ONA before the IAC is the utilization/usage being made of RPN staff in the Oshawa Emergency Department.

Since the issue being pursued by ONA before the IAC directly concerns RPNs, the Hospital sought to invite representatives from CUPE and the RNNAO to participate in the IAC hearing. The IAC denied this request for the reasons outlined in its e-mail of January 14th.

In light of the issue before the IAC and given the IAC’s decision to not allow RPN involvement, the Hospital is requesting that the IAC confirm that it will not make any findings or recommendations relating to a) the appropriateness of the work being performed by RPN staff as it relates to the scope of practice and abilities of RPN staff, and b) the staffing levels and roles of RPNs within the Emergency Department.

To be clear, and with respect to the panel, it is the Hospital’s position that the IAC has no mandate or jurisdiction to make findings or recommendations around the utilization and work being performed by RPN staff. This is particularly the case where there is no participatory opportunity granted to RPN staff and where ONA is already actively challenging the Hospital’s use of RPN staff in the Emergency Department through the grievance procedure.

Second, the Hospital has reviewed the list of documents requested by the IAC. A number of the requested items either do not appear to be relevant to the issue that ONA has put before the IAC, do not exist and/or are confidential. I have set out below the items on the list that the Hospital is not agreeable or is unable to produce:
1 - (a)(vii) and (f)  
2 - (b), (d), (e), (h), (i), (j), (k), (l), (n), (o), (r), (s), and (t)  
3 - (a)  

Please be advised that the Hospital is prepared to reconsider its assessment of any of these items upon the IAC providing the rationale as to why the information is required and how the information is relevant.  

The materials that are being produced by the Hospital are being put into electronic format for ease of access and distribution. This is taking more time than anticipated and will delay the Hospital being able to provide the materials to the IAC until mid to late next week. These materials will be produced in conjunction with the Hospital’s brief. The Hospital apologizes for any inconvenience.  

Third, the Hospital feels it is necessary to place some parameters around the number of persons participating in the tour on the first day of the IAC.  

Given that this is a busy, functioning Emergency Department, it is important to keep the number of person participating in the tour to a minimum to reduce the disruption to patients and staff as much as possible. To that end, the Hospital is proposing that in addition to the members of the IAC that there be a maximum of three representatives from ONA and the Hospital participating in this tour.  

Further, please be advised that anyone participating in the tour who is external to the Hospital – which would include the members of the IAC and non-Lakeridge ONA representatives - will be required to sign a confidentiality agreement.  

Lastly, for the information of the IAC and ONA I have set out a list of persons who will be attending at the hearing on behalf of the Hospital. The Hospital requests that ONA be directed to distribute a similar list.  

1. Lisa Shiozaki (Executive Vice-President and Chief Nursing Executive)  
2. Linda Calhoun (Senior Director, Clinical Services)  
3. Mary Derks (Patient Care Manager, Lakeridge Health Oshawa Emergency Department/SACC/DV)  
4. Darrell Sewell (Vice-President, Human Resources and Hospitality Services)  
5. Wanda Leach (Senior Director, Human Resources and Workforce Strategy)  
6. John Harris (Manager, Labour Relations)  
7. Shane Smith (Legal Counsel)  
8. Stephen Green (Director Hospital Employee Relations Services, Ontario Hospital Association – March 19th only)  

I would be pleased to further discuss any of the matters raised in this letter with the IAC at your convenience.
Thank you.

Sincerely yours,

Shane Smith
(416) 364-3641, x.20

c: Susan Wocladl
Cindy Gabrielli
John Harrts, Lakeridge Health
Shelley Flack, ONA
Mariana Markovic, ONA
Appendix 10: Letter from IAC to Legal Counsel Lakeridge Health February 20, 2013.

February 20, 2013
Via E-mail

Mr. Shane Smith
24 Ryerson Ave., Suite 207
Toronto, Ontario, M5T 2P3

Dear Mr. Smith,

Thank you for your letter of February 15, 2013 regarding issues related to the Independent Assessment Committee (IAC) hearing regarding the Emergency Department (ED) at Lakeridge Health scheduled for March 18-20, 2013. The three IAC panel members met to discuss the issues and questions in your letter. This letter of response is written on behalf of all the panel members.

The mandate of the IAC panel is to review and examine if registered nurses in the Emergency Department at Lakeridge Health are being asked to perform more work than is consistent with proper patient care. Nursing workload is a complex issue and influenced by numerous factors including patient volume/acuteity and nursing care demand; resource and organizational factors; interprofessional and support team membership and structure; leadership; policies and procedures; environment; and so forth.

The purpose of the briefs to be submitted by ONA and Lakeridge Health is for each party to provide information and perspective on the relevant issues impacting on the workload of Registered Nurses in the Emergency Department. Your letter, in part, focuses on the issue of RPNs working in the Emergency Department and the statement that is the focus of the workload issue. We have not yet received the briefs from either party, and therefore, the panel cannot know what all the relevant issues may be with regard to workload in this unit.

Therefore, we encourage the representatives of Lakeridge Health to provide in your brief and during the hearing, whatever information and perspectives on the workload of RNs in the ED, including the role of RPNs which you believe to be relevant. However, as per our earlier communication of January 14, 2013, the representation cannot be from a 3rd party such as CUPE or RPNAO.
The IAC panel has the responsibility to investigate as necessary and appropriate to the circumstances; and to provide a report on our findings and recommendations. We will not make any commitment to either party on what may be included or excluded from our report.

We are happy to provide further rationale with regard to the list of documents that was requested from the hospital. We were unclear however, on what items you are “not agreeable” to providing or “do not exist” and/or are “confidential”. The original request was based on the information that we believe is necessary in understanding the work context of RNs in the ED. As stated previously, there are many factors which impact on workload in an Emergency Department. In our estimation, all the information requested is relevant to context of nursing work in the ED and nursing workload.

- Recent evidence has clearly demonstrated the link between nurse staffing and outcomes. This is the basis for asking for indicators that are being utilized by the hospital to evaluate efficiency and effectiveness in the ED.(1.a –vii)
- We requested the list of any medical directives for RNs in the ER because this has a direct impact on nursing workload. (1.f)
- The staffing data is requested so that we have a clear understanding of the resource allocation for RNs in the ED.(2.b)
- We requested the number of type of positions posted in the last year; if you would prefer, the turnover rate for RNs in the ED for the past year would be sufficient (2.d).
- Turnover, sick time and overtime are all key factors in nursing workforce management. The data on RNs in the ED is sufficient.(2.e)
- We requested expected retirement, MLOA information and confirmed recruitment in order to understand other factors which impact turnover and staff recruitment in order to have a fully staffed unit. This information on RNs only would be sufficient. (2.h,l,j,k)
- In order to understand some aspects of the demographics of RNs in the ED, we requested the average of age of RNs. (2.l)
- On further consideration, we do not require at this time the number of staff on modified work or who have permanent accommodation.(2.n)
- We requested information on planned service growth. Most if not all, Emergency Departments across the GTA have experienced some degree of growth in patient volumes on an annual basis. The hospital estimate of patient volume increases in 2013/14 would be sufficient. (2.O)
- RNs work with many other professionals in the delivery of care in an ED. We requested information on the professional and support team allocations so that we could understand the team that nurses work with on a daily basis. (2.r,s,t) We consider this to be highly relevant to nursing workload.
- We requested the budget for the ED in order to understand the total allocation of resources for this unit. We do not require detailed information on the budget.
We agree with your request to limit the number of persons on the tour to three representatives from ONA and three representatives from the hospital, in addition to the panel members. We would appreciate receiving a copy of the confidentiality agreement in advance of the hearing.

The preferred dates of the hospital for the IAC hearing were respected by the panel in our planning and the hospital agreed several weeks ago to the planned dates of March 18-20, 2013. The request for information was provided to the hospital on January 14, 2013 by email. We believe the hospital has had sufficient time to prepare a brief and we would appreciate no further delays. You stated in the letter of February 15, 2013 that the brief would be available by mid-end of this week. We would appreciate receiving your brief by Friday, February 22, 2013. As you can appreciate, the IAC panel members are all professionals with considerable work obligations and need sufficient preparation time before the panel.

I would be pleased to discuss any further issues with you if necessary.

Sincerely,

Leslie Vincent

C.c.
Susan Woollard
Cindy Gabrielli
John Harris
Lisa Shoziaki
Shelley Flack
Mariana Markovic
February 22, 2013

Via E-Mail

Ms. Leslie Vincent, Chair
Independent Assessment Committee
715 Windermere Ave.
Toronto, ON M6S 3M1

Dear Ms. Vincent:

RE: ONA and Lakeridge Health - IAC Hearing

Thank you for your letter of February 20, 2013.

In your letter you indicate that the panel cannot know what all the relevant issues may be with regard to workload in this unit until you receive the briefs of the parties. You also state that the purpose of the briefs to be submitted by ONA and the Hospital is for each party to provide information and perspective on the relevant issues impacting on workload of RNs in the Emergency Department.

With greatest respect, the issues before the IAC should be settled prior to the provision of briefs. The briefs are not an opportunity for either party to raise whatever issue they feel is appropriate before the IAC. The purpose of the briefs is for the parties to provide information and perspective only on those specific matters that are actually before the IAC.

I am concerned that the IAC made an extensive request for documentation and information from the Hospital without apparently knowing what issues were actually before the IAC. The hearing is not an opportunity for the IAC to engage in a general review or audit of a particular department.

As previously stated, the Hospital’s understanding is that the sole matter before the IAC is the utilization being made by the Hospital of RPN staff within the Emergency Department at its Oshawa site. The Hospital has been clear about this, including writing to ONA to confirm this point. ONA did not respond to the Hospital to indicate otherwise. As such, the Hospital is proceeding on this basis. This means that the Hospital’s brief will focus on this issue and it also means that the materials it provides will need to be relevant to this issue.

The Hospital is concerned that while the IAC has not permitted participation by RPN representatives, it is not able or willing to commit to not making findings or recommendations in respect of the appropriateness of work being performed by RPN staff as it relates to the scope of
practice and abilities or RPN staff or the staffing levels and roles of RPNs within the Emergency Department. It seems fundamentally unfair for any adjudicative body to deny participation to a group of individuals, but retain the jurisdiction to make findings about that group that could potentially negatively impact on that group. While the Hospital is committed to participating in the IAC process, it is doing so while maintaining an objection to the IAC reviewing the work assignment and abilities of RPN staff and to making any findings or recommendation relating to same.

I appreciate the panel has provided its rationale in respect of a number of requested documents. The Hospital will consider this information in assessing the requests made for these materials.

A copy of the confidentiality agreement will be provided to the IAC prior to the hearing as requested.

Lastly, I renew my request for a direction from the IAC for ONA to provide a list of the individuals who will be attending at the hearing.

Thank you.

Sincerely yours,

Shane Smith
(416) 364-3641, x.20

c: Susan Woolard
   Cindy Gabrielli
   John Harris, Lakeridge Health
   Shelley Flack, ONA
   Mariana Markovic, ONA
Appendix 12 : Email from Association to Hospital on February 27, 2013.

From: Mariana Markovic [MarianaM@ona.org]

Sent: February-27-13 9:45 AM

To: Shane Smith

Cc: John Harris; Shelley Flack; Susan.Woollard@nygh.on.ca; cgabrielli@cogeco.ca; leslvincent@sympatico.ca

Subject: Re: Lakeridge Health and ONA - IAC Hearing

Mr. Smith

I am the Professional Practice Specialist from ONA that is taking the professional practice complaint for RNs working in the ED of Lakeridge Health Oshawa before the IAC.

In your February 22nd letter to the IAC chair you state the, the Hospital's understanding is that matter before the IAC is the utilization by the Hospital of RPN staff, in particular that "ONA did not respond to the Hospital to indicate otherwise."

To establish there was communication as you state I request you provide the date of this communication, the format in which this communication was exchanged, and the name and address to whose attention the communication was sent to.

With thanks,

Mariana

Mariana Markovic RN, BScN, MN, MHSc

Professional Practice Specialist
Labour Relations Officer

Provincial Services Team
Ontario Nurses' Association
85 Grenville Street, Suite 400
Toronto, Ontario M5S 3A2

marianam@ona.org
Tel: 416-964-8833, ext. 2413
1-800-387-5580
Fax: 416-964-8864
Appendix 13: Email communication enclosed in Email from ONA to Hospital on February 28, 2013.

From: Flack, Shelley
Sent: Tuesday, February 19, 2013 8:58 AM
To: Calhoun, Linda
Subject: RE: Independent Assessment Committee

February 19, 2013

Dear Linda,

Thank you for your letter of expressed interest concerning the ongoing Professional Practice Workload issues in the ER department at Lakeridge Health Oshawa. I need to advise you the issue is currently at ONA Central and the IAC preparation is being handled by the Professional Practice Specialist, Mariana Markovic. You may contact Mariana Markovic at ONA Central for any communication about the IAC or the unresolved Practice issues.

Thank you,

Shelley

From: Veysey, Tiffany On Behalf Of Calhoun, Linda
Sent: Thursday, February 07, 2013 2:34 PM
To: Flack, Shelley
Cc: Harris, John
Subject: Independent Assessment Committee
Shelley Flack  
President  
ONA Local 51  
February 7, 2013

Dear Shelley,

As you are aware, the IAC hearing requested by ONA in respect of the Oshawa Emergency Department is scheduled to be held on March 18-20th.

In order to properly prepare for this process it is necessary for the Hospital to know the specific matter to be addressed by the IAC.

It is our understanding that the issue ONA is placing before the IAC is the utilization/usage being made of RPN staff in the Oshawa Emergency Department. It is my understanding that the other workload concerns raised by ONA involving the Emergency Department have been resolved.

Could you let me know by end of day Monday (February 11) if my understanding is correct or, if not, what matters ONA believes are being put before the IAC.

Thank you,

Linda

Linda Calhoun  
Senior Director – Clinical Services

Cc: John Harris, Labour Relations Manager
Appendix 14: Letter from IAC Chair to Hospital on March 7, 2013

March 7, 2013
Via E-mail

Mr. Shane Smith
24 Ryerson Ave., Suite 207
Toronto, Ontario, M5T 2P3

Dear Mr. Smith,

Thank you for the Lakeridge Health Emergency Department IAC submission brief and data. The three IAC panel members met today to prepare for the hearing and discuss the briefs we have received from Lakeridge Health and the Ontario Nurses Association. This letter is written on behalf of all the panel members.

The mandate of the IAC panel is to review and examine if registered nurses in the Emergency Department at Lakeridge Health are being asked to perform more work than is consistent with proper patient care. Nursing workload is a complex issue and influenced by numerous factors including patient volume/acuity and nursing care demand; resource and organizational factors; inter-professional and support team membership and structure; leadership; policies and procedures; environment; and so forth.

It is evident from the briefs that we have received that there are several issues related to workload which require review during the IAC review. The IAC panel has the responsibility to investigate as necessary and appropriate to the circumstances; and to provide a report on our findings and recommendations. To effectively meet our mandate, we require additional information and data from the hospital. Several of these items were previously requested on January 14, 2013. A modified list of data requirements is attached.

If there are any questions, please feel free to contact me.

Sincerely,

Leslie Vincent

C.c.
Susan Woollard
Cindy Gabrielli
John Harris
Lisa Shoziaki
Shelley Flack
Mariana Markovic
1. **Emergency Department**
   a. **Department Organization**
      i. Organizational chart of nursing in emergency department
      ii. Role descriptions for Team Leader/Charge Nurse and Triage Nurse
   b. 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

2. **Staffing data (for 2012-13 and 13/14 as specified)**
   a. Budgeted FTEs for all staff categories in the 2013/14.
   b. Active full time, part time, casual, agency FTEs for each staff category (summary of total paid hours in FTEs for each category YTD);
   c. Sick time, overtime in FTEs for all staff categories (YTD); and a comparison for the last 3 years
   d. Turnover rate;
   e. Retirement projections to end of 2013;
   f. Future LOAs e.g. MLOA in 2013;
   g. Confirmed internal or external recruitment;
   h. LOAs returning in 2013;
   i. Support Staff – housekeeping, porters, team attendants etc.
      i. Daily hours for weekdays and weekends of housekeeping coverage for unit
   j. Physicians
      i. Physician coverage by hour of day
      ii. Physician assistants by hour of day
   k. Organizational float pool: size in FTEs and types of staff

3. **Job Descriptions and Postings**
   a. Job description for Registered Nurse and Registered Practical Nurse at Lakeridge Health
   b. Role description or RN and RPNs in Emergency Department
   c. Copy of posting for RN and RPN roles in Emergency Department

4. **Professional Practice**
   a. Description of preceptorship and/or mentorship program in emergency department for nursing staff
## Appendix 16: Agenda for IAC Hearing for Lakeridge Health

### Agenda

**Monday March 18, 2013**

Canadian Hall C, Hilton Garden Inn, Ajax

<table>
<thead>
<tr>
<th>Time</th>
<th>Item</th>
<th>Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>08:00 — 08:30</td>
<td>IAC Panel Members Pre-Meeting at Hospital</td>
<td>IAC</td>
</tr>
<tr>
<td>08:30— 11:00</td>
<td>Tour of Emergency Department</td>
<td>IAC, LH and ONA</td>
</tr>
<tr>
<td>11:00 -13:00</td>
<td>IAC Panel Travel time to Hilton Garden Inn and Preparatory Meeting</td>
<td>IAC</td>
</tr>
<tr>
<td>13:00 — 13:15</td>
<td>Introduction and Review of Proceedings by Chairperson</td>
<td>IAC Chair</td>
</tr>
<tr>
<td>13:15 — 14:45</td>
<td><strong>Ontario Nurses’ Association Submission Presentation</strong></td>
<td>IAC, LH and ONA</td>
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<td></td>
<td>Response to questions of clarification from:</td>
<td></td>
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<tr>
<td></td>
<td>• Independent Assessment Committee</td>
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<tr>
<td></td>
<td>• Lakeridge Health Corporation</td>
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<tr>
<td>14:45 — 15:00</td>
<td>Break</td>
<td>All</td>
</tr>
<tr>
<td>15:00 — 16:30</td>
<td><strong>Lakeridge Health Submission Presentation</strong></td>
<td>IAC, LH and ONA</td>
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<tr>
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<td>Response to questions of clarification from:</td>
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<td></td>
<td>• Independent Assessment Committee</td>
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<td></td>
<td>• Ontario Nurses’ Association</td>
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</tr>
<tr>
<td>16:30 — 16:45</td>
<td>Review of Process for Tuesday, March 19, 2013.</td>
<td>IAC Chair</td>
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<tr>
<td>16:45</td>
<td>Adjournment of Hearing Day 1</td>
<td>IAC Chair</td>
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<td>16:45 Onwards</td>
<td>IAC Panel Meeting</td>
<td>IAC</td>
</tr>
<tr>
<td>Time</td>
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<tr>
<td>10:00 — 13:00</td>
<td><strong>Lakeridge Health Response to Ontario Nurses’ Association Submission</strong></td>
<td>IAC, LH and ONA</td>
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<tr>
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<td>Response to questions from</td>
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<td></td>
<td>• Independent Assessment Committee</td>
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<td>• Ontario Nurses’ Association</td>
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<td></td>
<td>• Discussion</td>
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<tr>
<td>13:00 — 14:00</td>
<td>Lunch</td>
<td>All</td>
</tr>
<tr>
<td>14:00 — 17:00</td>
<td><strong>Ontario Nurses’ Association Response to Lakeridge Health Submission</strong></td>
<td>IAC, LH and ONA</td>
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<td>Response to questions from</td>
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<td>• Independent Assessment Committee</td>
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<td>• Lakeridge Health Corporation— Oshawa Campus</td>
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<td></td>
<td>• Discussion</td>
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<tr>
<td>17:00— 17:15</td>
<td>Review of Process for Wednesday, March 20, 2013</td>
<td>IAC Chair</td>
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<td>17:15</td>
<td>Adjournment of Hearing</td>
<td>IAC Chair</td>
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<tr>
<td>17:15 onwards</td>
<td><strong>Independent Assessment Committee Meeting</strong></td>
<td>IAC</td>
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**Agenda**

**Wednesday, March 20, 2013**

**Canadian Hall C, Hilton Garden Inn, Ajax**

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<th>Time</th>
<th>Item</th>
<th>Participants</th>
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<tr>
<td>09:00 — 12:00</td>
<td>Questions to both Parties by the Independent Assessment Committee</td>
<td>IAC, LH and ONA</td>
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<tr>
<td>12:00 — 12:30</td>
<td>Closing Remarks and Identification of Next Steps by Chairperson</td>
<td>IAC Chair</td>
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<tr>
<td>12:30</td>
<td>Closure of Hearing</td>
<td>All</td>
</tr>
<tr>
<td>12:30 onwards</td>
<td>Independent Assessment Committee Meeting</td>
<td>IAC</td>
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Appendix 17: Attendees at the Hearing

Lakeridge Health:

1. Lisa Shiozaki, Executive Vice President and Chief Nursing Executive
2. Linda Calhoun, Senior Director, Clinical Services
3. Mary Derks, Patient Care Manager, Lakeridge Health, Oshawa Emergency Department
4. Darrell Sewell, Vice President, Human Resources and Hospitality Services
5. Wanda Leach, Senior Director, Human Resources and Workforce Strategy)
6. John Harris, Manager, Labour Relations
7. Shane Smith, Legal Counsel
8. Stephen Green, Director, Hospital Employee Relations Services, Ontario Hospital Association (March 19th, 2013 only).

For the Ontario Nurses Association:

Presenting at the Hearing

Mariana Markovic, Professional Practice Specialist, LRO, ONA
Janet Borowy, ONA Counsel (March 18th afternoon)
Jo Anne Shannon, Professional Practice Specialist, LRO, ONA
Shelley Flack, RN, Bargaining Unit President, Local Coordinator
Irene Ellewood, RN, Workload Chair, Local Executive
Marie Haase, LRO, ONA
Ian Anderson, RN, THE HOSPITAL ER
Bonnie Bradley, RN THE HOSPITAL ER
Diane Hutton, RN, THE HOSPITAL ER
Cindy Tarbett, RN, THE HOSPITAL ER
Vicki Wenzel, RN, THE HOSPITAL ER

Observers/Learners ONA staff
Robyn Hutton LRO, ONA
Savita Singh, LRO, ONA

Observors: Tuesday March 19, 2013
Adriana Covassi
Bonnie Bradley
Cindy Tarbett
Kelli Clark
Lisa Dunbar
Yvonne St. Pierre
Zoe Bergeron
Katie Snelgrove
Ian Anderson

Observers: Wednesday March 20, 2013
Sarah Hughes,
Michelle Moore
Vicki Wenzel
Melissa Tuer
Cindy Mitchell
Anna Vanderburggen
Patrick Rand
Katie Snelgrove
Zoe Bergeron
Yvonne St. Pierre
Adrianna Covassi
Bonnie Bradley
Tracey Johnston
Joanne Vilander
Diane Hatton
Ian Anderson
Crystal Kyte
Cathy Rehel
Michelle Sherwood
Jenn Savage
Christine Raper
Melody Baronet
Sandra Craig
Lisa Dunbar
Amanda Baxter
Mary Ann Dorris
Cindy Tarbett
Linda Haslam Stroud