Independent Assessment Committee Report

Constituted under Article 8.01 of the Collective Agreement between

Lakeridge Health Corporation, Oshawa Campus, 7G and

Ontario Nurses’ Association

June 2011
Independent Assessment Committee

Gordon Fitzgerald  
Joint Director Labour Relations  
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85 Grenville Street, Suite 400  
Toronto, ON M5S 3A2

May 2011

Dear Mariana and Gord

The members of the Independent Assessment Committee respectfully submit the attached Report with findings and recommendations concerning the Professional Workload Complaint presented by registered nurses working on unit 7G, Oshawa Campus, Lakeridge Health Corporation.

The Complaint was presented to the Independent Assessment Committee in accordance with Article 8.01 of the Collective Agreement (expiry March 2011) between the Lakeridge Health Corporation and the Ontario Nurses' Association.

The members of the Independent Assessment Committee recognize and appreciate the efforts taken by representatives of the Hospital and the Association and the registered nurses of the 7G, to prepare and present information and respond to our questions prior to and during the three day hearing.

The attached Report includes a number of unanimously submitted recommendations which we hope will assist all parties to continue to work together, in good faith, to provide optimal care to patients receiving care on unit 7G.

Respectfully submitted

June Duesbury-Porter RN, MScN, MBA

Leslie Vincent, RN, MSc (A)

Trudy Molke, RN, BScN

Independent Assessment Committee's report  
Lakeridge Health Corporation, Oshawa Campus, 7G and Ontario Nurses Association  
May 2011
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PART I

INTRODUCTION

1.1 Organization of the Independent Assessment Committee Report

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

- **Part I** Outlines the referral of the Professional Workload Complaint to the IAC, reviews the IAC’s jurisdiction as outlined in the Collective Agreement, and presents the Pre-Hearing, Hearing and Post-Hearing processes.
- **Part II** Presents the context of practice relating to the professional workload complaint in the 7G, summarizes the relevant history leading to the referral of the professional workload complaint to the IAC, and reviews the presentations by the Ontario Nurses’ Association (‘the Association’) and Lakeridge Health Corporation, Oshawa Campus, 7G (‘the Hospital’) at the Hearing.
- **Part III** Presents the IACs’ discussion, analysis and recommendations.
- **Part IV** Summary and Conclusions
- **Part V** Contains Appendices referenced in the Report.

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

1.2 Referral to the Independent Assessment Committee

This Report addresses the professional workload complaints of Registered Nurses from unit 7G, Oshawa Campus, Lakeridge Health Corporation.

The Association Local 051 outlines in their pre-hearing submission that the:

*Workload issues on 7G have been known to the Hospital since January of 2006. Communication between the Hospital and Association (Local 051) to address workload complaints relating to professional responsibility have been discussed at the Hospital Association Committee (HAC) meeting, unit Staff Meetings on 7G and at supplementary HAC-OPRC (Professional Responsibility Concern) meetings. Professional workload complaints have been addressed on a regular basis at Hospital Association Committee (HAC) meetings. However, by September 7th 2010, the Association did not feel that sufficient progress was being achieved, and on November 4th 2010 the Association notified the Hospital of its intent to move to an IAC (Appendix 1).*

Throughout 2007-2010, efforts were made on both sides to resolve the outstanding issues. In addition to regularly scheduled HAC meetings, there was correspondence between the Association and the Hospital to address workload issues outside of the HAC process however, the Association did not feel that sufficient resolution was achieved, and the IAC Hearing proceeded from April 5th-7th 2011.

1.3 Jurisdiction of the Independent Assessment Committee

The IAC is convened under the authority of Article 8.01 of the Central Hospital Agreement between the Ontario Hospital Association/Lakeridge Health Corporation and the Ontario Nurses Association. Article 8.01 relates to Professional Responsibility and identifies the process to be followed in the event of a concern regarding the provision of proper patient care.
8.01
The parties agree that patient care is enhanced if concerns relating to professional practice, patient acuity, fluctuating workloads and fluctuating staffing are resolved in a timely and effective manner in the event that the Hospital assigns a number of patients or a workload to an individual nurse or group of nurses such that they have cause to believe that they are being asked to perform more work than is consistent with proper patient care, they shall:

(a) i) at the time the workload issue occurs, discuss the issue within the unit/program to develop strategies to meet patient care needs using current resources.
   ii) if necessary, using established lines of communication, seek immediate assistance from an individual(s) identified by the Hospital (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, 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. The manager will provide a written response to the complainant(s), with a copy to the Bargaining Unit President.
   iv) Complain in writing to the Hospital-Association Committee within twenty (20) calendar days of the alleged improper assignment. 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 complaint. The Committee shall hear and attempt to resolve the complaint to the satisfaction of both parties and report the outcome to them parties.
   v) Prior to the complaint being forwarded to the Independent Assessment Committee, the Union may forward a written report outlining the complaint and recommendations to the Chief Nursing Executive.
   vi) Any settlement arrived at under 8.01(a) iv) or v) shall be signed by the parties. The creation of an IAC is referenced in Article 8.01 (a) vii) and Article 8.01 (a) viii)

8.01 (a)

vii) Failing resolution of the complaint within fifteen (15) calendar days of the meeting of the Hospital-Association Committee the complaint 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.

viii) The Assessment Committee shall set a date to conduct a hearing into the complaint 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 report its findings, in writing, to the parties within thirty (30) calendar days following completion of its hearing.

ix) 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.

x) Any complaint 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.

(b) 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.
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 of the list of Chairs who has not been previously assigned. 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.

1. 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.

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

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

For the Association:
Trudy Molke

For the Hospital:
Leslie Vincent

Chairperson
June Duesbury-Porter
1.4 Proceedings of the Independent Assessment Committee

1.4.1 Pre-Hearing

The Association in a letter dated November 4th 2010 notified the Hospital that in accordance with Article 8.01 of the Central Hospital Agreement between the parties, ONA was forwarding this Professional Responsibility Complaint to the Independent Assessment Committee (IAC). Within a letter dated November 4th 2011 the Association advised the Hospital that the Associations’ nominee to the IAC was Trudy Molke. Subsequently, on December 20th 2010, the Hospital advised the Association that the Hospital’s nominee was Leslie Vincent.

The IAC Chairperson received notification of the Association and Hospital IAC Nominees on November 4th 2010. The IAC Nominees discussed potential dates for the Hearing with their respective parties over the following weeks. On January 26th 2011 the dates of April 5th, 6th and 7th 2011 were confirmed. The IAC held its first meeting at 200 Front Street, Tuesday March 22nd 2011. The IAC discussed logistics associated with the Hearing, reviewed a draft Agenda for the Hearing, and discussed submission and distribution of the Pre-Hearing Briefs. The IAC, the Hospital and the Association agreed that the Hearing would be held at the Hilton Garden Inn, Ajax on April 5th,7th 2011.

The IAC Chairperson wrote to the Association and the Hospital on March 23rd 2011 confirming the date and location of the Hearing. The IAC requested the Hospital and the Association to forward the Hearing Submission and associated exhibits to the Chairperson by March 4th 2011 in order to support the principle of full disclosure and to streamline the process of the Hearing by enabling the IAC to become familiar with the issues in advance. The IAC Chairperson received the Hospital and Association Submission Briefs and associated exhibits on March 4th 2011 as requested, and distributed the Briefs and exhibits by courier to all parties on March 6th 2011. The Hospital further to this provided additional material in support of their pre-hearing submission on March 7th 2011 and it was shared with all parties on the same day. The Association and the Hospital provided additional information to supplement their Submission Brief by email on March 11th.

The IAC held a Pre-Hearing Meeting in Toronto on Tuesday March 22nd 2011. The IAC during this meeting:

- Reviewed the anticipated process of the Hearing;
- Discussed the submissions and exhibits provided by both the Hospital and the Association;
- Determined the requirement for additional information in selected areas;
- Constructed a draft agenda;
- Identified the key issues for exploration at the Hearing.

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

- Confirming the plans for the Tour of 7G;
- Providing the Hearing Agenda;
- Requesting the Hospital to provide selected additional information by the close of the Hearing.

The Hospital and Association provided the IAC Chair with the list of tour participants on March 28th 2011 (Appendices 3 and 4). On the morning of April 5th 2011, the IAC were greeted in the lobby by Leslie Motz, Program Director Surgery, Endoscopy and Sterile Processing Department who escorted us to a meeting room for our use while at the Hospital. Prior to the pre-meeting Lisa Shiozake, Vice President Patient Services and Chief Nurse Executive introduced herself and indicated that she would be joining us in the afternoon. The IAC then took the opportunity to confirm the questions/issues for focus on the Site Tour.

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The IAC meet with Dr. Murray Treloar, Chief of Staff as it was unfortunate that the new Chief of Surgery was away on vacation. This meeting served to confirm that the Hospital has a zero tolerance approach with respect to workplace bulling which was reinforced throughout the hearing which had been of some concern to the IAC given references made on Professional Responsibility Workload Report Forms (PRWRFs).

The IAC toured 7G, Oshawa Campus, Lakeridge Health Corporation from 10:00 — 12:00 hours on Tuesday April 5th 2011. The Site Tour was conducted by the following representatives:

On behalf of the Association:
  • Irene Ellwood, RN 7G Main Surgery Unit
  • Ruth Wittveen, RN 7G Main Surgery Unit
  • Shelley Flack, RN, Local 051- Workload Chair
  • Mariana Markovic, Professional Practice Specialist, Labour Relations Officer, ONA

On the tour was:
  • Leslie Motz, Program Director Surgery, Endoscopy and Sterile Processing Department
  • Jaime Miller, Patient Care Manager 7G Inpatient Surgery
  • Sherida Chambers, Director Inter Professional Practice
  • Gordon Fitzgerald, Joint Director Labour Relations/Legal Counsel

1.4.2 Hearing

The Hearing convened at 1300 hours in Canadian Hall A of the Hilton Garden Inn, Ajax. In concordance with the Agenda (Appendix 5), the Hearing was held over three days:

April 5th 2011: 1300 — 1700 hours
April 6th 2011: 1000 — 1600 hours
April 7th 2011: 0845 — 1245 hours

Participants and Observers on the respective hearing dates are listed in Appendix 6.

April 5th 2011

The IAC Chairperson opened the Hearing at 1300 hours. Following introduction of the IAC Committee members and round-table introductions of the Association and Hospital participants, the IAC Chairperson reviewed:
  • The jurisdictional scope of the IAC, including the purpose of the IAC.
  • The scope of its recommendations, and the processes agreed to by the Hospital and the Association as outlined in Section 8.01 of the Collective Agreement.
  • The ‘ground rules’ for the Hearing procedure including confirmation that all participants understood and agreed.

Mariana Markovic, Professional Practice Specialist presented on behalf of the Association. The content of the Association’s presentation was based on their written Pre-hearing submission and exhibits of supporting / explanatory information, as well as a summary of the PRWRFs submitted by the 7G Unit RNs between April 4th 2006 and January 21st 2011. Following the presentation, the Association responded to clarification questions posted by the Hospital and IAC.

Gordon Fitzgerald, Joint Director Labour Relations/Legal Counsel for Lakeridge Health Corporation, presented the submission on behalf of the Hospital. The content of the Hospital’s presentation was based on their written Pre-hearing submission and Brief and exhibits of supporting / explanatory information, PRWRFs submitted by the 7G RNs between May 20th 2010 and January 21st 2011.
Following the presentation, the Hospital responded to clarification questions posted by the IAC and the Association.

The IAC Chairperson adjourned the Hearing at 1700 hours.

April 6th 2011

The IAC Chairperson opened the Hearing at 1000 hours. The ground rules for the Hearing were reviewed and new participants at the Hearing were introduced.

Gordon Fitzgerald Joint Director Labour Relations/Legal Counsel for the Hospital provided the Hospital’s response to the Association’s submission.

Members of the Hospital team participated in the discussion following as appropriate.

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

The IAC Chairperson adjourned the Hearing at 1600 hours.

Following adjournment of the Hearing, the IAC met during the evening of April 6th 2011 to review and synthesize the information provided, and to identify key issues requiring additional clarification and discussion.

During the second day of proceedings the IAC realized that there was not a common understanding between the Hospital and the Association of staffing levels pre and post ‘Regeneration’. Therefore, the IAC chair led both sides in the development of the Tables 1-4 for the purpose of identifying the underlying reasons for the discrepancies. The following tables outline the staffing levels for the time period leading up to the IAC, and they identify the underlying reasons the staff of 7G perceive the loss of one RN FTE and an increase in the nurse patient ratio on the day and evening shifts.

| Table 1: Pre-Regeneration, Oct 2009 Staffing Monday – Friday for 40 Beds |
|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|
| Shift | RNs | Scheduled unbudgeted RN/RPN FTE | PCF no patient assignment | RPNs | Total FTEs | Nurse/Patient Ratio |
| D | 6 | 1 | 1 | 2 | 10 | 1:4.4 |
| E | 6 | 0 | 1 | 2 | 9 | 1:5 |
| N | 5 | 0 | 0 | 5 | 1:8 |

| Table 2: Pre-Regeneration, Oct 2009-June 2010 Staffing Monday - Friday for 36 beds |
|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|
| Shift | RNs | Scheduled unbudgeted RN/RPN FTE | PCF no patient assignment | RPNs | Total FTEs | Nurse/Patient Ratio |
| D | 6 | 1 | 1 | 2 | 10 | 1:4 |
| E | 6 | 0 | 1 | 2 | 9 | 1:4.5 |
| N | 6 | 0 | 0 | 6 | 1:6 |

It became apparent that 7G’s schedule had an unbudgeted RN or RPN position on days from October 2009 – June 2010, which improved the nurse to patient ratio on days and on nights. However, without this unbudgeted position, the nurse patient ratio would have been higher on the day shift (1:5 for 40 beds and 1:4.5 for 36 beds).
The Hospital in the pre-hearing submission had stated:

“The Hospital understands that part of ONA’s current concern stems from the elimination of the Patient Care Facilitator (PCF) position from the unit which was itself a byproduct of Regeneration. Although the PCFs were eliminated from the unit, the Hospital maintained the same number of RNs on days and evenings as before their elimination (the former daytime PCF-RN became a non-PCF-RN and the former temporary evening PCF-RN became a non-PCF-RN) and actually added another RN on nights”

*The Charge Nurse patient assignment of 1-2 patients in Tables 3-7 are as stated in the Hospital’s pre-hearing submission.

Table 3:  Post Regeneration, June 2010 Monday-Friday Staffing for 36 beds

<table>
<thead>
<tr>
<th>Shift</th>
<th>RNs</th>
<th>Charge Nurse</th>
<th>RPNs</th>
<th>Total</th>
<th>Nurse/Patient Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>D</td>
<td>6</td>
<td>1*</td>
<td>2</td>
<td>9</td>
<td>1:4.37</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>E</td>
<td>6</td>
<td>1</td>
<td>4</td>
<td>8</td>
<td>1:4</td>
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<tr>
<td>N</td>
<td>5</td>
<td>1</td>
<td>6</td>
<td>6</td>
<td>1:6</td>
</tr>
</tbody>
</table>

Table 4:  Post Regeneration, June 2010 Weekend Staffing for 24 beds

<table>
<thead>
<tr>
<th>Shift</th>
<th>RNs</th>
<th>Charge Nurse</th>
<th>RPNs</th>
<th>Total</th>
<th>Nurse/Patient Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>D</td>
<td>3</td>
<td>1*</td>
<td>2</td>
<td>6</td>
<td>1:4.6</td>
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<td></td>
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<td>6</td>
<td>4</td>
<td>1:6</td>
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</table>

Since June 2010 and the introduction of the Charge Nurse role the nurse patient ratio has marginally increased on both days and evenings, in both the 36 and 24 bed scenarios. The nurse patient ratio on nights has remained the same over the same period of time. While since June 2010 the Hospital has strived to achieve a 1:4 nurse-to-patient ratio on days when the unit is at 100% occupancy, this is exceeded. The ratio was calculated by dividing the total number of beds on the unit minus the Charge Nurse’s assignment, by the number of other nurses for the shift.

During the hearing the Hospital indicated that they were increasing the weekend staffing as outlined below (Tables 6-7) given the inability to reach and or maintain occupancy levels of 24 beds on Saturday afternoons. With the additional staff, the nurse patient ratio on weekends will be marginally less than 1:4 if the census of 24 beds is achieved/maintained. Given the Hospital’s inability to reach and or maintain an occupancy level of 24 beds by 1500 hours on Saturdays the additional staffing will create ‘limited’ additional bed capacity. The IAC saw this as a positive step and believes it is consistent with the staffing required due to higher than planned weekend occupancy. The IAC also recognizes that the Hospital is opening two (2) more additional critical care beds in the near future.
Table 5: Post Regeneration - April 2nd 2001 Monday-Friday Staffing for 36 beds

<table>
<thead>
<tr>
<th>Shift</th>
<th>RNs</th>
<th>Charge Nurse</th>
<th>RPNs</th>
<th>Total</th>
<th>Nurse/Patient Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>D</td>
<td>6</td>
<td>1</td>
<td>2</td>
<td>9</td>
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</tr>
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<tr>
<td>E</td>
<td>6</td>
<td>1</td>
<td>4</td>
<td>8</td>
<td>1:4.5</td>
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<tr>
<td></td>
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<td>2*</td>
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<td></td>
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<tr>
<td>N</td>
<td>5</td>
<td>1</td>
<td>6</td>
<td>6</td>
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</tr>
</tbody>
</table>

Table 6: Staffing announced during hearing - April 2nd 2011 Saturday Staffing for 24 beds

<table>
<thead>
<tr>
<th>Shift</th>
<th>RNs</th>
<th>Charge Nurse</th>
<th>RPNs</th>
<th>Total</th>
<th>Nurse/Patient Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>D</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>6</td>
<td>1:4.6</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1*</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>E</td>
<td>4</td>
<td>1</td>
<td>4</td>
<td>7</td>
<td>1:3.3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>4</td>
<td>1</td>
<td>6</td>
<td>6</td>
<td>1:4.8</td>
</tr>
</tbody>
</table>

Table 7: Staffing announced during hearing - April 2nd 2011 Sunday Staffing for 24 beds

<table>
<thead>
<tr>
<th>Shift</th>
<th>RNs</th>
<th>Charge Nurse</th>
<th>RPNs</th>
<th>Total</th>
<th>Nurse/Patient Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>D</td>
<td>4</td>
<td>1</td>
<td>2</td>
<td>7</td>
<td>1:3.8</td>
</tr>
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<td></td>
<td>1*</td>
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</tr>
<tr>
<td>E</td>
<td>4</td>
<td>1</td>
<td>4</td>
<td>7</td>
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<td>4</td>
<td>1</td>
<td>6</td>
<td>5</td>
<td>1:4.5</td>
</tr>
</tbody>
</table>

The IAC also noted the effective use of internal data regarding occupancy in the review of staffing and subsequent decision to increase staffing on weekends. The IAC saw this acknowledgement as an important and positive step and strongly recommend that data continue to underpin the rationale for future decision making. This will serve to ensure transparency with all stakeholders in addition to enabling the adoption of learn and adjust approach to decision making utilizing data trends. An example of where external data mining may improve is in respect to the Hospitals reference to “a review of some peer community Hospitals” (Table 3 ‘Nurse/Patient Ratio and RN/RPN Industry Report’) ‘staffing comparator data’. A number of the Hospital’s listed in the pre-hearing submission ‘staffing comparator data’ given size and case mix characteristics etc. known to the IAC were not considered aligned with the MOHLTC’s comparator organizations for Lakeridge. This was confirmed by Lakeridge Health Corporation.

April 7th 2011

The IAC Chairperson opened the Hearing at 0900 hours, reviewed the ground rules and asked the Hospital and Association to introduce any new participants.

The IAC took the opportunity to review in more detail issues requiring further clarification arising from both parties’ presentation and ensuing discussion with both the Hospital and the Association in an open Question and Answer session. All Hearing participants actively participated.

The IAC Chairperson thanked the participants for their commitment to the Hearing process and for their active and open discussion during the Hearing. She noted the IACs’ recognition of the challenges,
for both parties, associated with open and honest dialogue, and reiterated the IACs' hope that the opportunity for discussion during the Hearing would enable both parties to move forward. She reaffirmed that the IACs' Report and associated recommendations are intended to provide all concerned (Registered Nurses, the Association and the Hospital) with an independent external perspective to aid in the resolution of outstanding issues, and are not binding. She confirmed that the IACs' Report would be distributed by courier after the Victoria Day long weekend.

The IAC Chairperson closed the Hearing at 1245 hours.

1.4.3 Post Hearing

The IAC met briefly immediately following the Hearing on April 7th 2011 to reflect on the issues identified.

Between the close of the Hearing on and submission of the PDF Report on June 3rd by e-mail, followed by a hard copy being couriered to both the Hospital and Association the IAC undertook the following in the development of this report:

- A full-day meeting on May 2nd 2011 to draft the outline of the Report and to discuss the findings and proposed recommendations in depth;
- Independent review of the first draft;
- A teleconference on May 20th 2011 to further discuss the findings and proposed recommendations in depth for the purpose of refining the report further;
- The 2nd draft was circulated on May 23rd 2011 for comments;
- Independent review of the second draft during the week of May 23rd 2011;
- Comments and recommended revisions were received by Friday May 27th 2011;
- Further comments and recommendation revisions were received on Sunday May 29th 2011;
- A third draft reflecting additional input was circulated for further final review and comment on May 29th 2011;
- A fourth draft reflecting additional input was circulated for further final review and comment on May 30th 2011;
- A fifth draft reflecting additional input was circulated for further final review and comment on May 31st 2011;
- Final agreement of the IAC report was on June 2nd 2011;
- The Final Report was submitted to the Association and the Hospital by courier on June 3rd 2011.
PART II

PRESENTATION OF THE PROFESSIONAL RESPONSIBILITY WORKLOAD COMPLAINT

2.1 Context of Practice

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

“In October, 2009 the Hospital embarked on an ambitious plan to revamp the manner in which it delivered its services known as “Regeneration”. The objectives were as follows:

- Create standardized inpatient units
  - Processes centered around patient experience
  - Each unit to have appropriate the Hospital structure and accountability for flow
- Other expected benefits include:
  - Sick time and overtime, supply the Hospital etc
  - Improve the quality of work life (appropriate scheduling and management support)

Regeneration of Patient Care – Inpatient Principles and Enablers

- All inpatient units ‘right-sized’ (24-30 beds)
- Cluster Specialized Care: (like needs e.g. stroke, oncology)
- Units to have capacity for isolation and variation in demand
- Every patient unit will have 2 management positions:
  - Patient Care Manager (accountable to manage and support staff)
  - Patient Care Specialists (primarily accountable for staff development)
- Nurses will fulfill full scope of practice (RNs and RPNs working at full scope, and clerical staff)
- Centralized staffing/scheduling for coordination of replacements”

Further to their submission the Hospital specifically stated that:

“All RPNs are now working to the full scope to their practice as defined by the College of Nurses of Ontario whereas previously RNs were managing many of the nursing tasks for the patients assigned to the RPN.”

Letter dated September 7th 2010; the Hospital stated “In response to the question regarding the all RN staff, as discussed in our meeting dated Friday July 9th 2010, in keeping with our regeneration model, a short stay unit is planned for approximately July 2011. At this time 7G is planned to decrease in size to 24 beds with an all RN staffing pattern.”

2.1.1 Structure of 7G Surgical Unit

The 7G Surgical Unit is located on the seventh floor of the Oshawa Campus of the Lakeridge Health Corporation. The design is that of a ‘race track’ with a central core of service area serving both the staff and patient care rooms. The unit appeared cluttered, somewhat disorganized and crowded to the IAC members, however, is consistent with units of its vintage and design. For example, storage/locker room for students at the end of the unit had an eclectic selection of haphazardly stored equipment and supplies which included, patient lift slings, Ostomy supplies, upright scales, mobility aids and heavy housekeeping supplies. The introduction of computerized charts has led to several workstations being placed in the hallways due to space limitations in the core space. Patient rooms are very small and cannot accommodate computers or additional patient care equipment. The IAC recognizes that the age of the physical design of 7G places limitations on how effectively space and equipment can be managed.
The unit has a bed capacity of 40 beds, although it currently functions as a 36 bed unit from 0700 hours on Monday through 1500 hours on Saturday when at which time it becomes a 24 bed unit for the balance of the weekend.

To accommodate the design limitations of the unit the Hospital has implemented the EZ call system in 2005 with ongoing improvements to identifying priority calls and response times (supplies the care areas with a porter for transportation requirements), reorganized storage/supply space and a centralized equipment management process for access to patient related equipment.

The current medication cart system is not easily accommodated as the unit was not designed to accommodate carts of this nature. While the unit waits for the Hospital’s implementation of a medication unit dose system, a vacant patient room has been converted into a dedicated medication room (which also houses a computer on wheels (COW) for charting purposes).

2.1.2 Patient Population

The Hospital pre-hearing submission states the patient population of the unit consists of the following surgical specialties and associated case mix:

- General Surgery:
  - Appendectomy
  - Bowel Resection/colectomy
  - Cholecystectomy
- Urology:
  - TURP
  - Prostatectomy
- Gynecology:
  - Hysterectomy
  - Burch Sling Procedure
- Thoracics:
  - Thoracoscopy
  - Post ICU Lung Resection

It is noteworthy that following the Hospital’s designation as a Regional Surgical Thoracic Centre in the fall of 2010 has resulted in increased volumes given the appointment of an additional two Thoracic Surgeons.

2.1.3 7G Unit Staffing

The unit is currently staff with RNs, RPNs and a Unit Clerk and is supported by leadership from both the Patient Care Manager (PCM) and Patient Care Specialist (IPCS) both of which are full-time and have regularly scheduled hours of 0800-1600 hours Monday – Friday.

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

**Patient Care Manager:** The PCM is responsible for resource managements, work processes, performance improvement initiatives, human resource management and patient/staff safety for the unit.

**Patient Care Specialist:** The PCS’s primary role is to be responsible for improving the patient experience through unit orientation< staff education and staff development as well as provide leadership through human resource education and staff development as well as provide leadership though human resource management.
The unit also benefits from a number of professionals in patient care planning and includes:

- Social Worker;
- Physiotherapist;
- Registered Dietician;
- Enterostomal Therapist/Wound Care Specialist; and
- Pharmacist.

All of above attend patient care rapid rounds on a daily basis.

The Hospital also noted that there are Service Associates which provide coverage from 0700-1900 hours Monday – Friday (two FT and 1 Float) and 0700-1500 on weekends to ensure the unit’s cleanliness is maintained.

**Staffing Data**

Unit 7G is staffed with RNs, and RPNs. The staffing data – base budget for 2010 as provided by the Hospital by means of the IACs’ additional request for information is indicated in Table 8 and 9.

<table>
<thead>
<tr>
<th>Designations</th>
<th># of FTE</th>
<th># of PTE (includes Casual Hours)</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>RN</td>
<td>18.00</td>
<td>10.15</td>
<td>28.15</td>
</tr>
<tr>
<td>RPN</td>
<td>5.00</td>
<td>2.92</td>
<td>7.92</td>
</tr>
<tr>
<td>Total</td>
<td>23.00</td>
<td>13.07</td>
<td>36.07</td>
</tr>
</tbody>
</table>

**Table 9:** Allied Health Staffing Data (Oshawa Campus)

<table>
<thead>
<tr>
<th>Designations</th>
<th># of FTE</th>
<th>RPT</th>
<th># Assigned 7G (FTE)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physiotherapy</td>
<td>7.5</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Rehab Assistant</td>
<td>3.8</td>
<td>0</td>
<td>.02</td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>4.1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Social Work</td>
<td>8.52</td>
<td>0</td>
<td>0.25</td>
</tr>
<tr>
<td>Clinical Nutrition</td>
<td>8</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Pharmacists</td>
<td>11.4</td>
<td>0</td>
<td>0.6</td>
</tr>
<tr>
<td>Educators</td>
<td>3</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Enterostomal Therapy</td>
<td>1*</td>
<td>0</td>
<td>0.5</td>
</tr>
<tr>
<td>(Wound Care)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PSWs</td>
<td>3.0</td>
<td>8.0</td>
<td>As required</td>
</tr>
</tbody>
</table>

* Currently, pre-op markings and post discharge follow-up provided by external professional agency
Retention

As outlined by the Hospital in the pre-hearing submission:

Over the last 18 months a total of six (6) full-time (FT) and six (6) part-time (PT) have left 7G. One of the five retired which the other five (5) of the six (6) full time staff chose to pursue opportunities in specialty areas such as Emergency Department, Maternal Child and Day Surgery within the Hospital. Of the six (6) PT, one retired, two transferred to other community Hospitals, one relocated out of province, and the remaining two accepted FT positions on other units within the Hospital’s surgical program. The association does not agree with these numbers but suggests 24 nurses full and part-time have left the unit. This discrepancy in perception was not resolved by the IAC panel.

PART III
DISCUSSION, ANALYSIS AND RECOMMENDATIONS

3.1 Introduction

The IAC believes that it has obtained a comprehensive understanding of the professional responsibility concerns relating to the 7G Surgical Unit, Oshawa Campus, of the Lakeridge Health Corporation. This was achieved through review and analysis of the written submissions and exhibits, the oral presentations and discussion, and the thoughtful comments made by the Hearing participants in response to questions posed by the IAC.

The IAC has based its comments and advice on the perspective that ‘nursing workload’ is impacted by and must be understood within the context of the practice environment. The practice environment includes both direct factors, such as role responsibilities, patient acuity/care needs and staffing resources, and indirect factors, such as leadership, communication, opportunities for development, staff mix and processes and systems of care. A practice environment that supports and respects the professional practice of nurses will result in the provision of safe and efficient care of patients and retention of health care staff.

In making its recommendations, the IAC would just like to reference that medical and surgical nurses form the largest single group of nursing professionals in health care and therefore in any acute care facility. The Canadian Association of Medical Surgical Nurses has worked with the Canadian Nurses Association to develop a national certification exam in medical-surgical nursing.

Medical and Surgical nurses provide nursing care to adults experiencing complex variations in health. They utilize diverse clinical knowledge and skills to care for multiple acutely ill adults and their families. They are leaders at organizing, prioritizing and coordinating care as well as working with interdisciplinary teams. The practice of medical-surgical nursing requires application of evidence based knowledge and best practice standards to provide quality, safe and ethical care to clients across the continuum of care. The Canadian Association of Medical and Surgical nurses advocates, supports and promotes the integral role of medical and surgical nurses to the health care system.¹

The IAC believes that the key issues influencing the professional practice environment on 7G relate to change management, communication, staffing, professional development support and evaluation and measurement.

¹ The Canadian Association of Medical and Surgical Nursing, http://www.medsurgnurse.ca
Recommendation 1: 
Leverage the Kotter Model Change Management Model to enable ‘Regeneration’.

The Hospital stated during the hearing that it has adopted the “Kotter” model of change as illustrated in Figure 1.

Figure 1: Kotter’s phases

The Kotter model (1995) is used widely in both private and public sector organizations. The philosophy behind the Kotter theory in managing change is:

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

It became apparent to the IAC during the hearing that the potential of the Kotter model had not been fully leveraged.

In the Hospital’s conclusion of the pre-hearing submission they acknowledged

“That there have been concerns from the nurses on 7G that addressing those concerns has been somewhat complicated by the Hospital’s Regeneration plan. However it submits that as a result of the initiatives completed within the past two years and those to which the Hospital has committed itself, the unit currently provides for a workload consistent with proper patient care and that as Regeneration really takes hold things will only continue to improve in terms of both the patient and workplace experience."

During the hearing the Hospital reaffirmed its commitment to Regeneration. The IAC is of the opinion that the lack of a comprehensive visible/transparent change management strategy embraced by the staff of 7G likely contributed to the ‘complications’ identified by the Hospital above.

The Hospital leadership needs to leverage the Kotter model in a change management strategy particularly in the areas of implementing and sustaining change.

The Hospital notes in their pre hearing submission that while a Warren Schepell – “Coping in time of Change” workshop was offered, it was cancelled due to lack of participants. While workshops of this
nature can always be helpful as part of comprehensive mitigation strategy it needs to complement other change management efforts.

**Recommendation 2:** Implement Frequent and Consistent Patterns of Communication with the Staff.

From the Hospital’s pre-hearing submission and discussion during the hearing the IAC learned that there was limited unit communication with staff. Some unit meetings had been withdrawn and cancelled because of controversy and conflict. Meetings with staff were primarily limited to huddles, rather than a more formalized meeting with an agenda and minutes. In the fall of 2010 the staff on 7G had time limited participation on the Regeneration task force. Therefore, it became apparent to the IAC that the Hospital needs to implement frequent and consistent patterns of communication with the staff on 7G in support of implementing the changes associated with “Regeneration” as well as updates and progress in addition to other corporate and program related information.

The Hospital release of their new Mission, Vision, and Core Values in May 2011 is viewed by the IAC as a new opportunity to develop communication with the staff of 7G regarding the mission/vision/values. It is important that there is a consistent, transparent forum on 7G for dialogue between the staff and the hospital. This also provides the staff with a regular forum to discuss issues, and raise any issues in a productive manner with the hospital. There is also an opportunity for the Hospital to both align the new corporate vision and further to this enable the staff to see how their day to day activities contribute to achieving both the change and new Hospital vision.

As part of Kotter’s model communication of the change vision is also key as part of an overall change management strategy (see Recommendation 1).

*Kotter (1996) contends that the most effective vision can be described in five minutes or less; therefore, any employee can describe and grasp the vision. Without this level of interest and understanding from the employees, there could be trouble*.

**Recommendation 3:**

a. Establish an Interprofessional Unit Council to engage staff by September 2011.

b. Begin planning with staff immediately.

c. The IAC also recommends that there be a robust process established inclusive of the following to facilitate communication:
   - Charter (terms of reference including ground rules)
   - Agenda (pre-circulated for items)
   - Minutes
   - Processes for effective dissemination of information

In the Hospital’s pre-hearing submission a letter from Lorraine Sunstrum-Mann, the previous VP Patient Services and CNE stated that in “September 2010 a Unit Based Council met for three (3) sessions – dissolved in October 2009 due to efforts required to prepare for regeneration changes. Several staff have inquired regarding the need to implement again.”

During the hearing the Hospital indicated its intention to establish an Interprofessional Unit Council in September 2011.
In establishing Interprofessional Unit Council, it may be useful for the Program Director to be in attendance during the initial meetings to provide support to the Patient Care Manager and Patient Care Specialist.

**Recommendation 4:** Expand the Regeneration Dashboard to include Indicators of Staff Efficiency and Effectiveness.

During the hearing the Hospital shared the Regeneration Dashboard and upon review the IAC strongly recommends it be expanded to be inclusive of indicators of staffing efficiency and effectiveness. Strengthening organizational performance measures and focusing on process indicators of change can ensure the celebration of early wins, create opportunities to learn and adjust and ensure continuous support for change.

**Recommendation 5:** Develop a 7G Unit Specific Regeneration Dashboard.

The Hospital needs to use a balanced set of measures for the dashboard which are updated quarterly and are likely to include:

1. Recruitment and retention (see Recommendation 8).
2. Occupancy rates for both Monday-Friday and Weekends (to identify trends early on for the purpose of learning and adjusting in a timely manner).
3. Restraint use (see Recommendation 15).
4. RNs who have successfully completed Charge Nurse education (see Recommendation 16)
5. Patient Satisfaction results.

The white board currently labelled “7G Performance Board – know how we are doing” on the 7G by the nurses’ station will be utilized to convey the direction of key metrics.

The IAC takes this opportunity to reinforce the importance of achieving short-term “wins” when looking to achieve sustained change in the long term on 7G, Measuring progress, seeking feedback, and continuing to adjust and improve are all important for following through on Regeneration.

**Recommendations 6:** Ensure adequate staffing on 7G for the near term as continued planning occurs regarding the number and service mix on surgical units in the Hospital. Increase the base staffing complement on 7G within budget through the addition of 2.47 FTEs in new full and/or part time positions.

Until decisions regarding Post Construction Operating Plan (PCOP) funding (see Appendix 7) and unit/service mix are made and implemented, it is recommended that the RN ratio on this unit be increased temporarily (i.e. Replace one RPN with an RN on all shifts that have 2 RPNs currently scheduled) to address patient care needs.

The 7G unit has undergone significant change since October 2009 when the Regeneration Project was initiated. Any amount of significant change in a unit or organization will naturally result in both challenges and opportunities.

It was evident in many of the professional responsibility complaints that the unit staffing was not sufficient to meet the needs of the unit. This was evident as the 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. While the organization has a new central staffing pool, it is also not consistent in its ability to respond to staffing requirements on 7G as it is meeting the staffing needs of the entire organization. Based on the information provided by the Hospital and the Association, 7G seems to be a very busy and acute surgical unit. It is reasonable to assume that staff works at a high level of productivity on a regular basis. On any unit, there will be fluctuating acuity levels. The Hospital’s position that high levels of patient acuity can be construed as “unforeseen circumstances” does not
Seem reasonable, especially when it is occurring on a regular basis. Staffing resources to respond to fluctuating acuity need to be in place in the organization.

The introduction of planned weekend closure of 12 beds implemented in the fall of 2010 has been very challenging and has not been consistently achieved resulting in inadequate staffing on the unit on many weekends. The panel recognizes that the Hospital is increasing staffing on the weekends starting with the March 2011 schedule. However, this is being done after several months where it has been clearly evident that the closure was being achieved erratically and subsequently the unit was frequently short staffed.

It is very important that the Hospital consistently staff this unit to meet the patient care requirements over the near term as future planning occurs regarding the PCOP funding. The erratic staffing of the unit has eroded staff trust and confidence in the Hospital and this must be rebuilt for the future. The Hospital’s data reflects a turnover rate of 22% which is very high and a focus on retention is critical. The association stated that they believe that a larger number of staff left the unit. Consistent staffing will build trust and confidence in the Hospital and reduce the stress on the staff; and hopefully reduce the turnover of staff.

To the degree that 7G can increase the base number of positions within budget, it would serve to stabilize the staffing and the ability of the unit to meet the staffing requirements. This recommendation should be implemented irrespective of the decisions regarding the PCOP funding. As the Hospital intends to grow volume over the near future it can be assumed that more staff will be required to meet the patient care needs associated with the volume increase. The addition of a few new positions within this unit can be absorbed into future growth in the near term.

Forecasting models in nursing human resources provide a predictive model to determine staffing requirements for the future. One such model is the one published in the recently published toolkit - Building Capacity for Nursing Human Resource Planning: A Best Practice Resource for Nursing Managers. Table 9 shows the results for 7G based on data provided by the Hospital.
Table 9: Nursing Forecasting Model 7G

<table>
<thead>
<tr>
<th>Nursing Forecasting Model</th>
<th>Lakeridge 7G</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Current Staffing Profile</strong></td>
<td>RN</td>
</tr>
<tr>
<td>Budgeted FTE</td>
<td>28.15</td>
</tr>
<tr>
<td><strong>Available Staffing</strong></td>
<td></td>
</tr>
<tr>
<td>Active Full time FTE</td>
<td>19</td>
</tr>
<tr>
<td>Active Part time FTE</td>
<td>5.4</td>
</tr>
<tr>
<td><strong>Current Vacancies</strong></td>
<td>3.75</td>
</tr>
</tbody>
</table>

- A Total Unit UPP RN and RPN Only
- B Active Nursing FTEs - excluding temp. leaves
- C Active Nursing FTEs - excluding temp. leaves
- D=A-B-C Difference (calculation)

**Vacancy Management**

- Casual | 0.97 FTE |
- Overtime | 1.06 FTE |
- Agency | 0.27 FTE |

- E Hours converted to FTE
- F Hours converted to FTE
- G Hours converted to FTE

- 2.3

**Staffing to March 2011**

- Budgeted FTE | 28.15 | 7.92 | 36.07 |
- Current Staffing | 24.4 | 6.2 | 30.6 |
- Current Vacancies | 3.75 | 1.72 | 5.47 |

- H=B+C
- I=A-H

**Plus Projected FTEs**

- Projected Terminations | 5.37 | 5.37 | 22% |
- Retirements | 1 FTE |
- Future Leaves of Absence | 1 FTE |

- J=H*% Turnover percentage for 2009/10
- K Projected Retirements to March 31, 2012
- L MLOA, Education, LTD, Secondment in FTEs

- Subtotal | 5.368 | 0 | 7.37 FTE |

- M=J+K+L

**Less Projected FTEs**

- Confirmed External Recruitment | 0 | 0 |
- Future LOA Returning | 2 |

- N Actual Confirmed Recruits
- O Estimate returning MLOA/other leaves in FTEs

- Subtotal | 0 | 0 | 2 |

- P=N+O

**Sub-Total** | 9.12 | 10.84 |

- Q=J-M-P

**Plus Service Growth**

- R Estimate FTEs for Service Growth

**Less Protected FTE**

- S Estimate FTEs for overtime, agency, casual

**Less Budget Reduction**

- T Estimate FTEs if planning reduction in service

**Total Recruitment Target** | 0 | 9.84 |

- U=Q+R+S-T

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Independent Assessment Committee's report
Lakeridge Health Corporation, Oshawa Campus, 7G and Ontario Nurses Association
May 2011
Underlying Rationale

The current budgeted staffing for 7G is 36.07 FTEs. The unit currently has 25 FT staff (20 RNs, 5 RPNs) and 11 PT staff (9 RNs, 2 RPNs). Based on an estimate of .6 FTE for each PT staff member, this equates to 6.6 FTEs. This leaves a difference of 4.4 FTEs between the budgeted FTEs and actual FTEs based on head count. Based on data provided by the Hospital which was annualized to a full year, 7G utilized 2.3 FTEs in staffing from the staffing office, in overtime, or from agencies.

- 0.97 FTE in staff from the staffing office
- 1.06 FTE in overtime
- 0.27 FTE in agency staff

Turnover in the last year was 22%. There is four (4) staff that is eligible to retire in the coming year. A low estimate of 1 FTE in retirement is utilized in this modeling. There is one staff member going on MLOA, and there are 2 currently on MLOA, which are assumed to return in the model. One FTE is allocated for agency, casual and overtime.

The model, based on the information and assumptions stated, predicts that 7G will need to recruit approximately 9.84 FTEs in staff in the coming year. This is based primarily on a high turnover rate in this unit and assuming that not all eligible staff will retire. Changes in these assumptions would change the model prediction.

If the 7.37 FTEs in predicted turnover replacement are deducted from the total recruitment target, there is difference of 2.47 FTEs. The 2.47 FTEs could be allocated to additional FT and/or PT lines in the unit.

Recommendation 7:

1. **Utilize an enhanced evidence based model to determine the future skill mix on 7G.**

2. **Engage the nursing staff of 7G in the planning and change process for the future of the unit in terms of number of beds, service mix and staff mix.**

3. **Established regular staff meetings regarding the unit future that include all staff, the Patient Care Manager, the Patient Care Specialist and the Director of Surgery.**

The pre hearing submission from the Hospital stated the intent to implement an all RN staffing model on 7G based on the Hospital’s assessment of patient acuity and nursing workload; and assuming that 7G would be converted to a 24 bed unit as part of a larger reorganization in which the current inpatient bed complement for surgery will be divided into 3 separate 24 bed units.

During the hearing, the Hospital stated that due to recently received PCOP (Post Construction Operating Plan) funding, the Hospital is re-evaluating the number of beds required to service the planned additional volumes. As a consequence the number and size of the patient care units as well as service mix is also being evaluated. Therefore it can be anticipated that a decision regarding the number of beds and service mix on 7G will be made in the near future. It can also be assumed that the patient complexity will not likely decrease with additional volumes of patients.

It has been well demonstrated in the literature that both RN/RPN skill mix and hours of nursing care per patient are both directly related to patient outcomes. In 2005 the College of Nurses on Ontario published a practice standard on the utilization of RNs and RPNs based on the evaluation of factors related to the client, the clinical environment and the characteristics of the nurse. The Hospital used this model as a basis for making decisions regarding skill mix. In May 2010, Blasterah et al published a toolkit for staff mix decision making based on the College of Nurses Practice standard for utilization...
of RNs and RPNS. This recently published toolkit on determining RN/RPN skill mix that was completed as a nursing demonstration project for the Nursing Secretariat of Ontario’s Ministry of Health and Long Term Care provides an evidence based approach based on the 3 factor model to determine the skill mix on 7G. This model was validated in both academic and community Hospitals and is applicable to Lakeridge Health Corporation.

Integral to the continuing change process, the nursing staff of 7G should be engaged in the process and kept informed on a regular basis of the rationale for decisions being made by the Hospital; and consulted regularly and appropriately for input and feedback. Regularly planned staff meetings that include the Patient Care Manager, Patient Care Specialist and the Director of Surgery where there is discussion of the future of the unit would provide a structure and forum for dialogue. These meetings may be part of the interprofessional council on the unit. (Refer back to Recommendation 3)

**Recommendation 8: Focus on Lowering the Turnover Rate on 7G Through Improved Retention Strategies.**

Turnover on 7G was 22% in the last year. This is a combination of staff choosing to pursue opportunities in other specialty areas, and a retirement. It would appear that staff is choosing to stay within the organization which is a positive sign. However, a turnover rate of 22% is very high and must be addressed in order to stabilize staffing and ensure the best patient care. It would be informative for a neutral 3rd party to interview staff who have left to understand the factors in their decision. Staff would need to be assured of confidentiality in the interview. There is also four (4) staff that is eligible to retire this year. This is a significant number. The Hospital needs to anticipate for this factor, and plan accordingly. It may be beneficial to establish additional new graduate positions on this unit under the New Graduate Initiative given the historical turnover and to strengthen retention.

**Recommendation 9: Identify the Activity Patterns for Conscious Sedation, Epidurals, PCAs for the Purpose of Establishing Appropriate Thresholds which can be Safely Managed within Staffing Levels.**

Nursing staff frequently referred to increased workload and patient care needs due to the number of patients requiring conscious sedation or who had epidurals or PCAs for pain the Hospital. It is recommended that the nursing staff work with medical leadership on the unit to determine appropriate thresholds; scheduling of procedures requiring conscious sedation; and timely discontinuation of epidural/PCA sedation to ensure that patient care is safely managed within the staffing levels for the unit.

**Recommendation 10: Fill all Shifts when the Schedule is posted every six weeks. Centralized Staffing Office effectively coordinates replacements for sick calls and, reasonable last minute personal/vacation requests.**

It is important when implementing change that the staffs’ new work structures/processes are aligned with the ‘inpatient principles and enablers of regeneration (as cited in Recommendation 1).

During the hearing the IAC heard from the staff of 7G that the schedule was regularly posted with ‘holes/unfilled shifts’. These unfilled shifts remained as such and were often of concern when for weekend shifts when staffing was already reduced in the anticipation of realizing the 24 bed census on Saturday at 1500 hours. In addition to these shifts arising from sick calls and or last minute needs for vacation or personal days by staff were not always filled.

**Recommendation 11: Provide Education to Patient Care Managers (PCMs) and Patient Care Specialists related to Leadership, Decision Making, Coaching and Conflict Resolution.**
Lisa Shiozake Vice President Patient Services and Chief Nurse Executive stated the organization has identified the need for managerial development and participation of the PCMs and PCSs to empower unit level decision making. Continued leadership development for management staff is strongly supported by the IAC. The unrelenting nature of change in the health care sector places considerable expectation on all staff, but particularly formal leaders to be effective change agents. Professional development of the nursing staff as well as leadership will serve to support the implementation and imbedding the regeneration model of care into day to day practice; and continue to develop effective collaborative relationships between the staff and leadership.

**Recommendation 12: Focus the role of The Patient Care Specialist (PCS) Primarily (80% of their Available Working Hours) on Staff Development.**

Although the intent of the role of the PCS was to be “primarily accountable for staff development” as per the “Regeneration of Patient Care – Inpatient Principles and Enablers”, the Hospital stated during the hearing the PCS for the past year had been focused on utilization and patient flow issues. The Hospital further stated that it was their intention to return to their primary accountability for staff development. The IAC supports and recognizes the immediate need for this as it will serve to resolve the inconsistent messaging of what the role was to be and what the actual experience of the staff has been over the last year.

The IAC is of the opinion that had the PCS been primarily accountable for staff development from the onset the staff as per the ‘Regeneration of Patient Care – Inpatient Principles and Enablers’ the staff would have been better supported during the transition to the new unit the Hospital structure.

**Recommendation 13: Conduct Learning Needs Survey of RNs including Elements of Professional Practice such as Analysis, Critical Thinking, Decision Making and Leadership.**

The Hospital during the hearing admitted that there had been no formal or informal educational sessions in support of the changing roles of RNs including; analysis, critical thinking, decision making and leadership which are required to achieve the organizational goal of RNs working to their full scope of practice.

Increased knowledge would serve complement the organization's goal of having their Registered Nurses working to their full scope of practice and be supportive of them embracing their role in the new unit structure.

**Recommendation 14: Implement Education based on the Assessment of Learning Needs.**

All staff nurses need to receive formal education to ensure that there is a common understanding regarding the expectations of their role and other roles within the model of care post regeneration. Specifically, they need to understand how the introduction of the new Charge Nurse role supports and assists them in the delivery patient care on a day to day basis in the absence of the Patient Care Facilitator.

**Recommendation 15:**

1. **Develop a clear role description for the Charge Nurse consistent with the staffing model implemented with Regeneration.**

2. **Provide additional leadership training for RNs who function in the Charge Nurse role to enable them to work effectively within the new model.**
3. All RN staff who assume the role of Charge Nurse to complete the leadership training within 3 months to facilitate functioning within their full scope of practice with respect to competencies such as leadership, resource the Hospital, coaching, critical thinking, conflict.

4. An annual refresher should be developed and attending by all RN staff who assumes the role of Change Nurse.

5. Limit the Charge Nurse’s assignment to no more than one patient.

With the implementation of the Regeneration Project, the Patient Care Facilitator role was eliminated. RNs and Charge Nurse are expected to work within a new model of care. The Charge Nurse role appeared to receive minimal attention with regard to role implementation. It is recommended that additional support and education be provided to charge nurses to ensure they can work effectively within the new model of care. The nurses of 7G need to commit to work with the Hospital in development of the new Charge Nurse model.

The orientation material for the Charge Nurse role provided to the IAC in the Hospital’s pre-hearing submission reflected a very task driven approach to the role and did not appear to be aligned with regeneration goal of the RNs functioning at their full scope of practice i.e. inclusive of critical thinking, decision making, and leadership. RNs who do not assume charge nurse role were not offered any education related to their new role.


Education be provided relating to Assessment and prevention of confusion and delirium in the elderly after surgery and to identify strategies other than restraints to manage the confusion.

Restraints

The Registered Nurses Association’s Best Practice Guidelines “Care giving Strategies for Older Adults with Delirium Dementia and Depression” and “Screening for Delirium, Dementia and Depression in Older Adults” are a useful resource and also offer e-learning modules.

Several of the PRWLFS submitted by staff mentioned the use of restraints on confused patients. During the tour, 7G nursing staff mentioned “that there was always someone in restraints” on the unit. Wrist, ankle and even five point restraints were not uncommon according to the nursing staff. Although the Patient Care Manager mentioned that alternatives to restraints were used first, and that the Hospital had a least restraint policy, it was still a concern of the committee that restraint use was so common, and in particular the use of 5 point restraints which one would only normally see in a mental health unit or an emergency department.

Confusion and delirium is a common occurrence among the elderly after surgery. The causes are varied and each patient needs to be individually assessed to determine possible causes and possible approaches. It is the IACs’ understanding that restraint use is not recommended for confused patients after surgery because of the risk of increasing the confusion and because of the many other complications that can result.

Restraints increase the workload of staff because of the need for frequent monitoring and repositioning of the patient.

Recommendation 17: Move as quickly as possible to a unit dose medication system and explore the feasibility of advancing 7G on the implementation timetable.
Although the Hospital has provided a dedicated medication room on 7G for the nurses to pour medication in a quiet area with no interruptions the current medication administration system is a mixture of the several systems. Medication drawers labeled with each patient's name contain labeled medication containers. The nurse finds the drawer and the appropriate medication and pours the medication from the MAR (medication administration record) sheet which is delivered from pharmacy every morning and corrected during the day by unit staff. The medication is poured into a medication cup and then taken to the patient. At times the whole cart is taken to the patient. Only two carts contain narcotics so sometimes a nurse needs to access a different cart.

However, there remains an additional small medication room in the central core, which disrupts efficient workflow. The Hospital admits that the system is not the best and that Lakeridge Health Corporation is changing the medication system however the medication system on 7G will not be changing until the patients and staff moves to the new tower. Current literature suggests that medications kept locked in the patients' room facilitates safe administration.

**Recommendation 18: Continue to improve the physical design and resources on 7G to improve workflow.**

The physical environment on 7G is inadequate by current design standards for the current patient needs and level of computerization that is required in today’s health care environment. The IAC appreciates that the Hospital has implemented a number of physical and workflow design changes in the Hospital and on 7G to improve workflow for nursing staff. The new medication room was established. It would be more efficient for the nurses if all medication resources were consolidated in one workspace. The EZ call system for supplies seems to be working well and staff did not raise issues regarding this new system. The Hospital has also tried to ensure that there are an adequate number of pieces of small equipment to support patient care (e.g., Pulse oximeters).

**PART III**

**SUMMARY and CONCLUSIONS**

The IAC was requested to specifically address the issue that the workload complaint arising from the Hospital “assigning a number of patients and a workload to an individual RN and group of RNs working on the Inpatient Surgery Unit -7G Main such that they have cause to believe that they are being asked to perform more work than is consistent with proper patient care”.

The IAC has made 18 Recommendations following a comprehensive process involving review of written and oral submissions, focused discussion and clarification during the three (3) day hearing and extensive Committee analysis and discussion following the Hearing.

The 18 Recommendations address change management, communication, staffing, professional development support and evaluation and measurement, a number of which are interdependent and are therefore referenced accordingly.

The IAC strongly believes that the Hospital and Association have a tremendous opportunity for a “fresh start”. The IAC also strongly believes that the process of implementing these recommendations will have a very positive impact on the relationship between the Hospital and the RN staff of 7G which will have a cascading effect of improving the quality of the patient care, nursing workload, the RN staff working environment, and the implementation of “Regeneration”.

The IAC encourages the Hospital and the Association to work together to achieve these recommendations, and to make effective use data to evaluate their progress and leverage the ability to learn and adjust as appropriate along the way.
Appendices
November 4, 2010

June Duesbury-Porter
390 Swanson Court
Burlington, ON L7R 4G8

Dear Ms. Duesbury-Porter,

Re: Lakeridge Health Corporation (LHC) - 7G Surgery Unit, Professional Responsibility Complaint – Proceeding to an Independent Assessment Committee – Ontario Nurses’ Association (ONA) FILE # 200900029

In accordance with Article 8.01 of the Central Hospital Agreement set out between Ontario Nurses’ Association (ONA) and Lakeridge Health Corporation (LHC) the Labour Management Committee (LMC) has met on a number of occasions and exchanged letters of communication several times in attempt to resolve workload issues causing RNs on 7G Surgery Unit to believe that they are being asked to perform more work than is consistent with proper patient care.

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

As a result, it is difficult for RNs working on 7G Surgery Unit of the LHC to provide safe quality patient care and practice safely in accordance with the professional standards set out by the CNO for RNs. The effect of the workload situation on RNs covered under the Regulated Health Professions Act (RHPA) relates to professional practice, patient acuity, fluctuating workloads and fluctuating staffing.

Failing resolution of workload issues at the LMC with the Employer and receiving a response from the Chief Nursing Executive that is inadequate in nature of the concerns presented and to the recommendations put forward by the Association, the Association has no other recourse but to forward this matter to a hearing at the Independent Assessment Committee.

ONA respectfully submits this Professional Responsibility Complaint to the IAC along with a letter naming ONA’s nominees to the committee and contact information.

It is our expectation that the Employer will forward the name of their nominee along with their contact information to the IAC chair. When the IAC meets and a date for the
hearing is agreed upon both, the Employer and ONA will be advised by the chair of the date by which to make their submissions to the IAC.

We thank you for your assistance in this matter.

Sincerely,
ONTARIO NURSES’ ASSOCIATION

Mariana Markovic
Professional Practice Specialist

C: Lorraine Sunstrom-Mann, Chief Nursing Executive, LHC
Lisa Shiozaki, VP Patient Services, LHC
Leslie Mota, Surgical Program Director, LHC
John Hemm, Manager Labour Relations, LHC
Shelley Flack, Professional Practice Chair, ONA
Lynda Rath, Bargaining Unit President, ONA
Paul Marshall, Labour Relations Officer, ONA
November 4, 2010

John Harris
Manager Human Resources
Lakeridge Health Corporation
1 Hospital Court
Oshawa, Ontario
P1B 6J4

Dear Mr. Harris,

Re: Professional Responsibility Complaint - Proceeding to an Independent Assessment Committee

Thank you for the communication dated Sept 7, 2010, to state the Employer’s position on the workload concerns of RNs working at Lakeridge Health Corporation - 7G Surgery Unit. To this time the Ontario Nurses’ Association (ONA) finds the Employer has not sufficiently addressed measures to resolve the RN workload issues relating professional responsibility concerns.

In accordance, with Article 8.01 of the Central Hospital Agreement between the parties, ONA is forwarding this complaint to the Independent Assessment Committee.

Timely resolution of the RNs being assigned more work than what is consistent with proper patient care is important in the accountability RNs have under the College of Nurses of Ontario regulation for professional responsibility and in accordance with the Regulated Health Professions Act (RHPA) to ensure safe, quality care for patients placed in their care.

Accordingly, please be advised that the Ontario Nurses’ Association nominee to the Independent Committee is:

Trudy Molko
Trudy Molko Practice Consulting
48 Overbank Crescent
Toronto, ON M3A 1W2
Telephone: 416-447-7738
Email: trudy.molko@symantec.ca

Please provide written confirmation concerning the name, mailing address, home and office phone numbers and e-mail address of your nominee. The IAC chairperson next on
the list of the Hospital Agreement is June Duesbury-Porter who will additionally need to have the nominee information.

Yours truly,
ONTARIO NURSES’ ASSOCIATION

[Signature]

Mariana Markovic
Professional Practice Specialist

C: Lorraine Sunstrum-Mann, Chief Nursing Executive, LHC
Lisa Shiozaki, VP Patient Services, LHC
Lesley Mott, Surgical Program Director, LHC
Shelley Flack, Professional Practice Chair, ONA Local
Lynda Rath, Bargaining Unit President, ONA Local
Paul Marshall, Labour Relations Officer, ONA
June Duesbury-Porter, IAC Chair
APPENDIX 2

Pre-Hearing Meeting was held in Toronto on Tuesday March 22nd 2011
The IAC reviewed the anticipated process of the Hearing and included an agreed request for additional information in selected areas from the employer

Request for additional information from the Employer includes:

Staffing data

**Base Staffing (Budgeted for 2010)**

<table>
<thead>
<tr>
<th>RNs</th>
<th># of FT</th>
<th># of PT</th>
</tr>
</thead>
<tbody>
<tr>
<td>RPNs</td>
<td># of FT</td>
<td># of PT</td>
</tr>
<tr>
<td>Casual Staff available hours</td>
<td># of Casual RNs</td>
<td># of Casual RPNs</td>
</tr>
<tr>
<td>PSW</td>
<td># of FT</td>
<td># of PT</td>
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Allied Health (including FTE allocation of Physiotherapy, Occupational Therapy, Social Work, Clinical Nutrition, Enterostomal Therapy, Pharmacists, Educators, APN etc)

<table>
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<tr>
<th># of FT</th>
<th># of PT</th>
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</thead>
</table>

Vacancy Information

<table>
<thead>
<tr>
<th># of vacant RN and their respective FTE</th>
<th># of vacant RPN and their respective FTE</th>
</tr>
</thead>
</table>

Allotted Support Staff – housekeeping etc. for 7G

<table>
<thead>
<tr>
<th>Daily hours for weekdays and weekends of housekeeping coverage for unit</th>
<th># of FT</th>
<th># of Temp FT</th>
<th># of PT</th>
<th># of Temp PT</th>
</tr>
</thead>
</table>
**Actual Staffing (Headcount currently in place)**

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

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

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

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

**Allied Health (including allocation)**
- # of FT
- # of Temp FT
- # of PT
- # of Temp PT

**Support Staff – housekeeping hours allotted to 7G**
- # of FT
- # of Temp FT
- # of PT
- # of Temp PT

**Staff Scheduling**
- Who does the schedule for the unit?
- Who has accountability for ‘filling’ the holes on the posted scheduled?
- Who has accountability for calling in replacement staff for 7G (include both inside and outside of Scheduling Office hours)

**Vacancy Information**
- # of vacant RN and their respective FTE
- # of vacant RPN and their respective FTE

**Vacation Allocations for RNs and RPNs (peak and off peak times)**
- # of RNs allowed off during peak and off peak vacation times
- # of RPNs allowed off during peak and off peak vacation times
Human Resource Indicators and Information

- Number of RNs, RPNs with 1-3 and greater than 3 years experience
- Sick time: sick rate/FTE for nursing within the Lakeridge Health System, within the Surgical Program, Oshawa Site, and within 7G
- Sick time for 7G as a cumulative FTE for budget YTD
- Overtime: OT rate/FTE for nursing within the Lakeridge Health System, within the Surgical Program, Oshawa Site and for 7G
- OT for 7G as a cumulative FTE for budget YTD
- Turnover: RN rate/FTE for nursing within the Lakeridge Health System, within the Surgical Program, Oshawa Site and for 7G
- Casual Nurse utilization for 7G as a cumulative FTE for budget YTD
- Float Nurse utilization for 7G as a cumulative FTE for budget YTD
- Agency Nurse utilization for 7G as a cumulative FTE budget YTD
- Is there an annual performance review process?
- Number of RNs and RPNs on 7G currently on any kind of leave (e.g. MLOA, personal, education); those expected back to work in the next year (please specify FT or PT)
- Number of RNs and RPNs expected to go on a leave in the next year, (please specify if FT or PT)
- Number of RNs and RPNs on 7G expected to retire in the next year

Non-nursing duties

- A list of identified ‘non-nursing’ duties

Other Staffing Items

- Charge Nurse job description
- Guidance for the assignment of patients for Float and/or Agency Staff

Equipment

- # of IV pumps for 7G
- # PCAs and PCEAs
- # of Automatic Digital Blood Pressure Devices

Patient Profiles

- # ALC days
- # of patients over age 65

Patient Flow Data

- Daily bed census for last 6 months
- % occupancy for last 6 months illustrating the difference between M-F and w/e bed levels
- ALOS for 7G
- Number of admissions and discharges by day of week for 7G for last 6 months
- Times of admissions and discharges by day of week for 7G for last 6 months
- OR block times by day of week (designating if ½ or full days) for all specialties which admit to 7G for last 6 months
- More information regarding ‘blue’ list

Professional Development

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

**Surgical Program**
- Leadership structure
- Last annual Surgical Program report to the Board and MAC

**Patient Satisfaction**
- Patient satisfaction data relating to Lakeridge Health System, within the Surgical Program, Oshawa Site, and within 7G

**Staff Satisfaction**
- Staff satisfaction/quality of worklife data to Lakeridge Health System, within the Surgical Program, Oshawa Site, and within 7G

**Administrative Information**
- Organizational chart for Lakeridge Health as a whole, and for the Oshawa Campus.
  - Lines of accountability for operations and for professional nursing practice.
  - Medical leadership, site and program
- 7G Manager span of control
- 7G documentation forms, including transfers
- Restraint Policy
- Conscious sedation policy
- PCA/PCEA policy including any caps for all inpatient areas for workload
- Role and operational hours of Scheduling Office

**Medical Leadership**
- The IAC would find it beneficial to meet and speak with the members of the medical staff which admit patients to 7G, especially the unit, site and surgical chief.

**Medication Administration**
- Medication administration policy (including independent double check)
- TPN - prepared prior to arrival on inpatient unit
- Are MARs preprinted on 7G?
- Schedule of pharmacy deliveries
- Process for locating/replacing lost/missing medication

**Quality and Patient Safety**
- Adverse and critical incidents in last 12 months
- Medication incidents and information regarding near-miss events, adverse events, and critical incidents
- # Isolations for last 6 months
- Infection Control rates for last 6 months
- Description of Quality/Continuous Improvement projects over the past two years relating to nurses and/or nursing practice for 7G.

The IAC recognizes that some of the above information will be readily available and other information may take time to access. We request that as much information as possible be provided to the IAC and ONA by the conclusion of the Hearing on Thursday April 7th 2011 and that the remainder be provided at the latest by Tuesday April 12th 2011.
March 28, 2011

Sent via E-Mail juneduesburyporter@cogeco.ca

June Duesbury-Porter
390 Swanson Court
Burlington, ON
L7R 4G6

Re: Re: Independent Assessment Committee (IAC) Lakeridge Health Corporation (LHC) – 7G Surgery Unit, Professional Responsibility Complaint Ontario Nurses’ Association (ONA) FILE# 200900829

Dear Ms. Duesbury-Porter

I am writing with respect to your correspondence dated March 23, 2011. This will confirm that the following persons will be in attendance at the hearing on behalf of Lakeridge Health:

Lisa Shiozaki, VP Patient Services and CNE
Leslie Motz, Program Director Surgery, Endoscopy and Sterile Processing Department
Jaime Miller, Patient Care Manager 7G Inpatient Surgery
Sherida Chambers, Director Inter Professional Practice
Linda Calhoun (or delegate), Director Critical Care and Emergency Department
John Harris, Manager Labour Relations
Gord Fitzgerald, Joint Director Labour Relations/Legal Counsel

Lakeridge will not require a laptop or LCD projector.

With respect to the availability of nurses from 7G to attend the hearing, there will be four RNs from 7G in attendance which accords with the request made of the Hospital by ONA.

With respect to physicians, the Hospital’s only paid physician is the Chief of Surgery and Medical Director. He is on vacation from March 30 through April 10, inclusive. The Hospital will endeavour to arrange for you to speak with other members of the medical staff which admit patients to 7G but as I am sure you can appreciate this may prove difficult given both the short time notice and the understandable reluctance of most physicians to make time available during their busy clinical hours.

With respect to the additional information requested by the panel, Lakeridge will endeavour to obtain as much of the information as possible and in as timely a fashion as possible but notes that there is a large amount of information requested and a very short time in which to pull it together.
Yours Truly,

Gordon Fitzgerald
Joint Director Labour Relations and Legal Counsel, Lakeridge Health

cc: L. Motz
J. Harris
November 4, 2010

June Duesbury-Porter
390 Swanson Court
Burlington, ON L7R 4G6

By Email only

Re: Lakeridge Health Corporation (LHC) - 7G Surgery Unit, Professional Responsibility Complaint – Proceeding to an Independent Assessment Committee – Ontario Nurses’ Association (ONA) FILE # 200900829

In accordance with Article 8.01 of the Central Hospital Agreement set out between Ontario Nurses’ Association (ONA) and Lakeridge Health Corporation (LHC) the Labour Management Committee (LAC) has met on a number of occasions and exchanged letters of communication several times in an effort to resolve workload issues causing RNs on 7G Surgery Unit to believe that they are being asked to perform more work than is consistent with proper patient care.

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

As a result, it is difficult for RNs working on 7G Surgery Unit of the LHC to provide safe quality patient care and practice safely in accordance with the professional standards set out by the CNO for RNs. The effect of the workload situation on RNs covered under the Regulated Health Professions Act (RHPA) relates to professional practice, patient acuity, fluctuating workloads and fluctuating staffing.

Failing resolution of workload issues at the HAC with the Employer and receiving a response from the Chief Nursing Executive that is inadequate in nature of the concerns presented and to the recommendations put forward by the Association, the Association has no other recourse but to forward this matter to a hearing at the Independent Assessment Committee.

ONA respectfully submits this Professional Responsibility Complaint to the IAC along with a letter naming ONAs nominee to the committee and contact information.

It is our expectation that the Employer will forward the name of their nominee along with their contact information to the IAC chair. When the IAC meets and a date for the
Re: LHC - 7G Surgery Unit, PRC - Proceeding to an IAC – ONA FILE # 200903829
Letter dated November 4, 2010

haring is agreed upon both, the Employer and ONA will be advised by the chair of the
date by which to make their submissions to the IAC.

We thank you for your assistance in this matter.

Sincerely,
ONTARIO NURSES’ ASSOCIATION

Marina Markovic
Professional Practice Specialist

C:
Lorraine Sunstrum-Mann, Chief Nursing Executive, LHC
Lisa Shiozaki, VP Patient Services, LHC
Leslie Mota, Surgical Program Director, LHC
John Harris, Manager Labour Relations, LHC
Shelley Flack, Professional Practice Chair, ONA
Lynda Rath, Bargaining Unit President, ONA
Paul Marshall, Labour Relations Officer, ONA

Independent Assessment Committee’s report
Lakeridge Health Corporation, Oshawa Campus, 7G and Ontario Nurses Association
May 2011
## APPENDIX 5

**Independent Assessment Committee Hearing**

*Ontario Nurses’ Association and Lakeridge Health Corporation—Oshawa Campus*

**Agenda**

Tuesday April 5th 2011

Canadian Hall A, Hilton Garden Inn, Ajax

<table>
<thead>
<tr>
<th>Time</th>
<th>Item</th>
<th>Participants</th>
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<tbody>
<tr>
<td>08:00 — 09:00</td>
<td>Pre-Meeting</td>
<td>IAC</td>
</tr>
<tr>
<td>10:00 — 12:00</td>
<td>Tour of 7G</td>
<td>IAC, LS and ONA</td>
</tr>
<tr>
<td>12:00 — 13:00</td>
<td>Lunch at Hilton Garden</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>
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</tbody>
</table>
| 13:00 — 14:30 | Ontario Nurses’ Association Submission Presentation Response to questions of clarification from:  
     • Independent Assessment Committee  
     • Lakeridge Health Corporation—Oshawa Campus | IAC, LS and ONA                    |
| 14:30 — 14:45 | Break                                                                | All                               |
| 15:15 — 16:45 | Lakeridge Health Corporation—Oshawa Campus Submission Presentation  
     Response to questions of clarification from  
     • Independent Assessment Committee  
     • Ontario Nurses’ Association | IAC, LS and ONA                    |
| 16:45 — 17:00 | Review of Process for Wednesday April 6th 2011                      | IAC Chair                         |
| 17:00         | Adjournment of Hearing                                                | IAC Chair                         |
**Independent Assessment Committee Hearing**

**Ontario Nurses’ Association and Lakeridge Health Corporation— Oshawa Campus**

**Agenda**

Wednesday April 6th 2011

Canadian Hall A, Hilton Garden Inn, Ajax

<table>
<thead>
<tr>
<th>Time</th>
<th>Item</th>
<th>Participants</th>
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<tbody>
<tr>
<td>10:00 — 13:00</td>
<td>Lakeridge Health Corporation— Oshawa Campus Response to Ontario Nurses’ Association Submission Response to questions from • Independent Assessment Committee • Ontario Nurses’ Association • Discussion</td>
<td>IAC, LS and ONA</td>
</tr>
<tr>
<td>13:00 — 14:00</td>
<td>Break</td>
<td>All</td>
</tr>
<tr>
<td>14:00 — 17:00</td>
<td>Ontario Nurses’ Association Response to Lakeridge Health Corporation— Oshawa Campus Submission Response to questions from • Independent Assessment Committee • Lakeridge Health Corporation— Oshawa Campus • Discussion</td>
<td>IAC Chair</td>
</tr>
<tr>
<td>17:00— 17:15</td>
<td>Review of Process for Wednesday April 6th 2011</td>
<td>IAC Chair</td>
</tr>
<tr>
<td>17:15</td>
<td>Adjournment of Hearing</td>
<td>IAC Chair</td>
</tr>
<tr>
<td>17:15 onwards</td>
<td>Independent Assessment Committee Meeting</td>
<td>IAC</td>
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## Independent Assessment Committee Hearing

**Ontario Nurses' Association and Lakeridge Health Corporation—Oshawa Campus**

### Agenda

**Thursday April 7th 2011**

Canadian Hall A, Hilton Garden Inn, Ajax

<table>
<thead>
<tr>
<th>Time</th>
<th>Item</th>
<th>Participants</th>
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</thead>
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<tr>
<td>09:00 — 12:00</td>
<td>Questions to both Parties by Independent Assessment Committee</td>
<td>IAC, LS and ONA</td>
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<tr>
<td>12:00 — 12:30</td>
<td>Closing Remarks and Identification of Next Steps by Chairperson</td>
<td>IAC Chair</td>
</tr>
<tr>
<td>12:30</td>
<td>Closure of Hearing</td>
<td>All</td>
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<tr>
<td>12:30 — 14:30</td>
<td>Independent Assessment Committee Meeting</td>
<td>IAC</td>
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### APPENDIX 6

Participants and Observers on Hearing Date: TUESDAY APRIL 5th 2011

#### ASSOCIATION

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paul Marshall</td>
<td>LRO, ONA</td>
</tr>
<tr>
<td>Michael Levey</td>
<td>RN Float Pool / Grievance Chair</td>
</tr>
<tr>
<td>Shelley Flack, RN</td>
<td>Oshawa Site Rep – Workload Chair</td>
</tr>
<tr>
<td>Lynda Rath, RN</td>
<td>ONA Bargaining Unit, President</td>
</tr>
<tr>
<td>Mariana Markovic</td>
<td>PPS, Labour Relations Officer, ONA</td>
</tr>
<tr>
<td>Marie Carter, RN</td>
<td>7G, Full-time</td>
</tr>
<tr>
<td>Irene Ellwood, RN</td>
<td>7G, Full-time</td>
</tr>
<tr>
<td>Christine Anderson, RN</td>
<td>7G, Full-time</td>
</tr>
<tr>
<td>Ruth Wittveen, RN</td>
<td>7G, Full-time</td>
</tr>
<tr>
<td>Lorrie Daniels, RN</td>
<td>PPS, ONA</td>
</tr>
</tbody>
</table>

#### HOSPITAL

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gordon Fitzgerald</td>
<td>Director Labour Relations</td>
</tr>
<tr>
<td>Leslie Motz</td>
<td>Director Surgery, LHC</td>
</tr>
<tr>
<td>Jamie Miller</td>
<td>Patient Care Manager 7G, Inpatient Surgery</td>
</tr>
<tr>
<td>Sherida Chambers</td>
<td>Director, Inter Professional Practice</td>
</tr>
<tr>
<td>John Harris</td>
<td>Manager, Labour Relations</td>
</tr>
<tr>
<td>Lisa Shiozaki</td>
<td>Executive Vice President and Chief Nursing Executive</td>
</tr>
<tr>
<td>Sue McKinnon</td>
<td>PCM ER, ER / Critical Care</td>
</tr>
</tbody>
</table>
Participants and Observers on Hearing Date: WEDNESDAY APRIL 6th 2011

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
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</thead>
<tbody>
<tr>
<td>Gordon Fitzgerald</td>
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<tr>
<td>Jamie Miller</td>
<td>Patient Care Manager 7G, Inpatient Surgery</td>
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<td>Director, Inter Professional Practice</td>
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**Participants and Observers on Hearing Date: THURSDAY APRIL 7th 2011**

### ASSOCIATION

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### HOSPITAL

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<tr>
<td>Jamie Miller</td>
<td>Patient Care Manager 7G, Inpatient Surgery</td>
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<tr>
<td>Leslie Motz</td>
<td>Director Surgery, LHC</td>
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APPENDIX 7

Q1. What is Post Construction Operating Plan funding (PCOP)?

A: The PCOP is a Hospital’s plan for the operations of its facility following completion of an approved capital project. The plan identifies the space and service expansions expected and the additional money the Hospital will need to operate the new or expanded facility. PCOP funding provides operating dollars to cover the costs of the new or expanded programs and services as well as the additional space and equipment amortization. The Ministry has a separate unit within its Capital Planning Branch that deals with all PCOP issues directly with affected Hospitals. LHINs are not directly involved in the discussions.

Q2. Is this an annual funding?

A: Yes, this is an annual funding. The additional operating funding is added to each Hospital’s base funding, which they receive on an annual basis.

Q3. How is funding determined by the Ministry?

A: The funding is based on the agreed service expansion volumes before the project is started. The funding is for a unit of service (i.e. emergency room visit, ICU bed, rehabilitation patient day) and the methodology for funding is the same for all Hospitals. Funding is also for the facility cost of additional space, including cleaning, maintenance, plant operations and security, as well as for the amortization of equipment purchased for the redevelopment project. The methodology to calculate this funding is also consistent across the province.

Q4. What is the basis of funding?

A: The basis of funding is Hospital’s requirement for incremental operating funding associated with an approved MOH Capital Investment/Expansion

Q5. What is the time lag between commissioning of service and funding?

A: Generally, funding is provided as soon as the Hospital commissions services. If funding is delayed, Hospitals set up receivables for the amount on their balance sheet. There is no impact on the Hospital’s bottom line but tends to put cash-flow pressure.

Q6. How do Hospitals account for the difference between assumed costs and actual costs?

A: There is a settlement process as part of the on-going validation of assumptions when the funding was provided. The Ministry recovers funding for volumes not delivered. It is seldom that the Hospital would deliver more volumes; if that is the case; discussions with Ministry are held to revised PCOP volumes. The allocation is based on the Hospital’s request to the Ministry. Should the Hospital find the assumed volumes are incorrect and it needs additional operating funding, the Ministry normally works with the Hospital to rectify the assumptions. In some cases, the Ministry does assist the Hospital for factors beyond Hospital control. There are instances where Hospital may have to absorb the shortfall.

Reprinted from Ministry of Health and Long Term Care website.