

# **Independent Assessment Committee Report**

**Constituted under Article 8.01 of the  
Collective Agreement**

**between**

**Niagara Health System  
St Catharines General Site**

**and**

**Ontario Nurses' Association**

**March 2009**



# ***Independent Assessment Committee***

## ***Niagara Health System, St Catherines General Site and Ontario Nurses' Association***

March 13, 2009

Sue Matthews  
Chief Nurse Executive  
Anne Atkinson  
Vice President, Patient Services  
Niagara Health System  
142 Queenston Street  
St Catherines, Ontario  
L2R 7C6

Rozaana Haynes  
Professional Practice Specialist  
Ontario Nurses' Association  
85 Grenville Street  
Suite 400  
Toronto, Ontario  
M5S 3A9


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 in the Emergency Department at the St Catherines General Site of the Niagara Health System.

The Complaint was presented to the Independent Assessment Committee in accordance with Article 8.01 of the Collective Agreement (expiry March 2011) between the Niagara Health System 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 Emergency Department, to prepare and present information and respond to our questions. 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 in the Emergency Department.

Respectfully submitted

  
Joan Cardiff, RN, MScN

  
Winnie Doyle, RN, MN

  
Trudy Molke, RN, BScN



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# **PART 1**

## **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 Emergency Department, summarizes the 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 the Niagara Health System St Catharines General Site ('the Hospital') at the Hearing.
- **Part III** presents the IAC's discussion, analysis and recommendations.
- **Part IV** presents the conclusion and lists the IAC's recommendations.
- **Part V** contains Appendices referenced in the Report.

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

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

This Report addresses the professional workload complaints of registered nurses in the Emergency Department at the St Catharines Site of the Niagara Health System (NHS).

The Hospital and Local 26 of the Association have been working together to address professional workload issues relating to the Emergency Department since 2004. Professional workload complaints have been addressed on a regular basis at Hospital-Association Committee (HAC) meetings. However, by 2008, the registered nurses and the Association did not feel that sufficient progress was being achieved, and in June 2008 the Association notified the Hospital of its intent to move to an IAC.

Throughout the remainder of 2008, efforts were made on both sides to resolve the outstanding issues. In addition to regularly scheduled HAC meetings, the Association and the Hospital jointly attempted to address workload issues outside of the HAC process: a "Fireside Chat" with the Vice President Patient Services responsible for both the Emergency Program and the St Catharines General Site occurred in May, an "IAC Prevention Meeting" was held in July, and a mandatory facilitated focus group discussion, involving staff, management and the Association, was held in October. In follow-up, the Association wrote to the Interim Chief Nursing Executive, outlining unresolved issues within 20 areas of concern and proposing immediate, short and long-term solutions. The Hospital responded in writing in November, and the issues and proposed

resolutions were discussed at a special HAC meeting held in early December. However, the nurses and the Association did not feel that sufficient resolution was achieved, and the IAC Hearing proceeded in January 2009.

### 1.3 Jurisdiction of the Independent Assessment Committee

The IAC is convened under the authority of Article 8.01 of the Collective Agreement between the Ontario Hospital Association/Niagara Health System 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 the 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.*

The IAC's jurisdiction thus relates to whether registered nurses are being requested and/or required to assume more work than is consistent with the provision of proper patient care. Workload is influenced by both direct factors (e.g. nurse-patient ratio, patient acuity/complexity of care requirements, patient volume) and indirect factors (e.g. roles and responsibilities of other care providers, physical environment of practice, standards of practice, 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 IAC's jurisdiction ceases with submission of its written Report. The IAC's findings and recommendations are intended to provide an independent external perspective to assist the registered nurses, the Association and the Hospital to achieve mutually satisfactory resolutions. The IAC is not an adjudicative panel, and its recommendations are not binding.

In accordance with Professional Responsibility Article 8 of the Collective Agreement, the IAC was comprised of three registered nurses. The members were:

For the Association:

- Trudy Molke

For the Hospital:

- Winnie Doyle

Chairperson

- Joan Cardiff

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

### **1.4.1 Pre-Hearing**

The IAC Chairperson received notification of the Association and Hospital IAC Nominees on October 25, 2008 (Appendix 1). The IAC held its first meeting by teleconference on November 13, 2008. 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. Following the teleconference, the IAC Nominees discussed potential dates for the Hearing with their respective parties. The IAC, the Hospital and the Association agreed on November 27, 2008 that the Hearing would be held at the St Catharines General Site on January 26-28, 2009.

The IAC Chairperson wrote to the Association and the Hospital on November 28, 2008, confirming the date and location of the Hearing. 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 requested the Hospital and the Association to forward the Hearing Submission and associated exhibits to the Chairperson by January 9, 2009 (Appendix 2).

The IAC Chairperson received the Hospital and Association Submission Briefs and associated exhibits on January 9, 2009 as requested, and distributed the Briefs and exhibits by courier to all parties on January 10, 2009 (Appendix 3). Both the Association and the Hospital provided additional information to supplement their Submission Brief by email on January 16, 2009 and in hard copy on January 19, 2009; this information was distributed to all parties on January 20, 2009 (Appendix 4).

The IAC held a Pre-Hearing Meeting in Toronto on January 21, 2009. The IAC reviewed the anticipated process of the Hearing, discussed the Submissions and exhibits provided by the Hospital and the Association, determined the requirement for additional information in selected areas, and identified the key issues for exploration at the Hearing. Following this meeting, the IAC Chairperson wrote to the Association and the Hospital, confirming the plans for the Tour of the Emergency Department, providing the Hearing Agenda, and requesting the Hospital to provide selected additional information by the close of the Hearing (Appendix 5).

The IAC met briefly on the morning of January 26, 2009, to confirm the questions/issues for focus on the Site Tour.

The IAC toured the Emergency Department of the St Catharines General Site from 10:00 – 12:00 hours on Monday January 26, 2009. The Site Tour was conducted by the following representatives:

On behalf of the Association:

Vera Gerard, Clinical Resource Nurse, ER Department, SCG Site  
Penny Kyle, Permanent Charge Nurse, ER Department, SCG Site  
Sharon Phair, Vice President Local 26

On behalf of the Hospital:

Anne Atkinson, Vice President Patient Services, SCG Site  
Elaine Burr, Clinical Manager, ER Department SCG Site; Prompt Care OSS  
Christopher Cecchini, Director Labour Relations, NHS

#### 1.4.2 Hearing

The Hearing convened at 1300 hours in the Moore 1 Boardroom of the St Catharines General Site of the Niagara Health System. In concordance with the Agenda (Appendix 6), the Hearing was held over three days:

January 26, 2009:	1300 – 1700 hours
January 29, 2009:	0900 – 1600 hours
January 30, 2009	0845 – 1245 hours

Participants and Observers at the Hearing are listed in Appendix 7.

January 26, 2009:

- 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. She reviewed the 'ground rules' for the Hearing procedure, and confirmed that all participants understood and agreed.
- Rozanna Haynes, Professional Practice Specialist with the Association, and JoAnne Shannon, Labour Relations Officer with the Association, presented the submission on behalf of the Association, and responded to questions of clarification from the Hospital and the IAC.
- Brent Labord and Kathryn Meehan, Counsel for the Niagara Health System, presented the submission on behalf of the Hospital and responded to questions of clarification from the Association and the IAC.
- The IAC Chairperson adjourned the Hearing at 1700 hours.

January 27, 2009:

- The IAC Chairperson opened the Hearing at 0900 hours. She reviewed the ground rules for the Hearing and ensured that new participants at the Hearing were introduced.
- Brent Labord, Counsel for the Hospital, and Sue Matthews, Chief Nursing Executive of the NHS provided the Hospital's response to the Association's submission. All members of the Hospital team participated in the discussion following.
- Rozanna Haynes, Professional Practice Specialist with the Association, Vera Girard, Clinical Resource Nurse and Penny Kyle, Permanent Charge Nurse, provided the Association's response to the Hospital's submission. All members of the Association team participated in the discussion following.
- The IAC Chairperson adjourned the Hearing at 1600 hours.

Following adjournment of the Hearing, the IAC met during the evening of January 27, 2009 to review and synthesize the information provided, and to identify key issues requiring additional clarification and discussion.

January 28, 2009:

- The IAC Chairperson opened the Hearing at 0845 hours. The new participants at the Hearing were introduced.

- The IAC reviewed the issues requiring further clarification from and 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 IAC's recognition of the challenges, for both parties, associated with open and honest dialogue, and reiterated the IAC's hope that the opportunity for discussion during the Hearing would enable both parties to move forward. She reaffirmed that the IAC's 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 IAC's Report would be distributed by courier on March 13, 2009.
- The IAC Chairperson closed the Hearing at 1245 hours.

#### 1.4.3 Post Hearing

The IAC met briefly immediately following the Hearing on January 28, 2009 to reflect on the issues identified.

Between the close of the Hearing on January 28, 2009 and submission of the Report on March 13, 2009, the IAC held four teleconferences and one face-to-face meeting.

- The IAC reviewed the first draft of the Report by teleconference on February 10, 2009.
- The IAC held a full-day meeting on February 18, 2009 to review the second draft of the Report and to discuss the findings and proposed recommendations in depth.
- The IAC met by teleconference on March 5, 2009 to review the third draft of the Report.
- The IAC reviewed the fourth draft of the Report, and finalized the recommendations, by teleconference on March 10, 2009
- The IAC reviewed the final draft of the Report by teleconference on March 12, 2009.

The Final Report was submitted to the Association and the Hospital by courier on March 13, 2009.

## **PART II**

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

#### **2.1 Context of Practice**

##### **2.1.1 Structure of the Emergency Services Program**

The Niagara Health System is comprised of six hospital sites and an ambulatory care centre. It is the largest multi-site amalgamation in Ontario, and provides care for residents in 12 municipalities within the Regional Municipality of Niagara.

Five of the hospital sites have Emergency Departments functioning on a 24/7 basis:

- St Catharines General (SCG) Site,
- Douglas Memorial Hospital Site (located in Fort Erie),
- Greater Niagara General Site (located in Niagara Falls),
- Port Colborne General Site, and
- Welland Hospital Site

A Prompt Care Centre, located at the Ontario Street Site in St Catharines, (the former St Catharines Hotel Dieu Hospital), provides minor treatment and non life-or-limb threatening injuries from 0800 – 2200 hours daily.

The data provided to the IAC indicated that the St Catharines General Site Emergency Department has the highest volume and provides the most acute care of the five Emergency Departments within the NHS (Table 1), and receives 50% of all ambulance visits within the NHS. The closest comparator, the Greater Niagara General Site, opened a new 'state of the art' Emergency Department in January 2007.

**Table 1: Emergency Volume/Acuity by CTAS Level**

Site	07-08 Visits	CTAS 1-2 Patients		% CTAS 3 Patients		% CTAS 4-5 Patients	
St Catharines General	45,823	6,873	15%	26,120	57%	12,830	28%
Greater Niagara General	45,160	5,871	13%	20,774	46%	18,515	41%
Welland	27,686						
Port Colborne	22,860						
Douglas Memorial	19,450	973	5%	18,447			95%

The Hamilton Niagara Haldimand Brant LHIN made the decision on January 27, 2009 that the NHS is to close the Emergency Department at the Douglas Memorial Site and convert it to a 24/7 Urgent Care Centre as part of the NHS Hospital Improvement Plan. The impact that this decision

will have on the St Catharines General Emergency Department is unknown. However, given the distance between Fort Erie and St Catharines, it is likely that critical patients will continue to be taken to Erie County Medical Centre, or Greater Niagara General, rather than St Catharines.

### 2.1.2 Configuration of the St Catharines General Site Emergency Department

The Emergency Department (ER) is located on the first floor of the Hospital. The Department has undergone a number of renovations since the 1960s. Many hospital patients and visitors, particularly those who require wheelchair support to access Outpatient Clinics located behind the ER Department, appear to use the ER entrance as a 'main hospital entrance' resulting in a large amount of foot traffic in the triage and waiting room areas. The Department is laid out on a square, but feels like a maze of rooms and corridors. There is no 'command central' location providing visual access to treatment areas, or easy sight lines from one area to another.

The ER contains separate treatment areas:

- Cardiac-trauma room, with five stretchers (each with full monitor capability);
- Observation Unit, with 8 stretchers, including an isolation room and capacity for monitoring;
- Treatment Area, with 10 stretchers in three 'rooms' and a Clinical Decision Unit with 4 stretchers in a fourth 'room';
- Individual treatment rooms (2 paediatric, 1 gynecology, 2 suture, cast room, ENT) with a total of 6 stretchers; and
- Clinical System Investigation (CSI) area with 2 stretchers and 4 lounge chairs, and a small waiting room across the hall.

There are a number of staff areas:

- Triage room provides space for 2 triage nurses, each with desk, computer, phone and patient chair (stretcher for patients requiring ECGs is also located in this room);
- Nurses charting area, with four computers (one for Ward Clerk, 3 for nurses) and a small area with a computer for physician documentation and a PACS monitor;
- Staff lounge, with a computer for accessing email; and
- Storage room (also used as a classroom/meeting room).

The main ER waiting room is down a short corridor from the Triage desk. There is an ambulance off-load area adjacent to the Triage desk.

Although it was reported that a 'de-cluttering process' has occurred on several occasions, the Department appeared cluttered, disorganized and crowded to the IAC members. For example, the door to the CSI Waiting Room was propped open with a full and a half empty bag of computer paper, rather than an appropriate doorstop. When this was questioned, the response from both staff and management was nonchalant. The nurses charting area felt very crowded, with four computers, several fax machines, a small medication room, wall chart holder, multiple bulletin boards etc and multiple staff (Charge Nurse, Triage Nurse, RNs assigned to the Treatment area, physicians) continually entering and exiting<sup>1</sup>. In addition, at the time of the Site Tour, there was evidence of coffee cups, food etc in the area, which contributed to the sense of disorder.

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<sup>1</sup> The NHS has submitted a proposal to the Ministry of Health and Long Term Care to expand and improve the Nurses Charting area but has not yet received a response.

A significant successful effort has been made to clean up the equipment and supplies areas; location of equipment and supplies in the Clean Utility Room and Storage Room is clearly marked, equipment is put away etc. At the time of the Site Tour, the hallways were not being used for equipment storage.

The NHS has recently moved to an automatic drug dispensing system, and there are four AUDD (automatic unit drug dispensing) carts within the Department. The carts are large, and do not fit easily into the current space which was not designed for such equipment. Due to space limitations, the drawers do not extend fully, making it difficult to access drugs, especially those in the bottom drawer. The content of the carts differ depending on the location within the Department (for example, the cardiac-trauma room contains less antibiotics and more cardiac drugs than the cart in the Treatment area). The carts do not contain refrigerated medications, nor all narcotics, some of which must therefore continue to be double locked in a traditional narcotics cupboard.

#### 2.1.2.1 Clinical System Investigation (CSI)

A Clinical System Investigation (CSI) area has been created to enable more efficient movement of CTAS 3-4-5 patients through the Emergency Department. Renovations to create a CSI Area, with two stretchers and four lounge chairs and a dedicated waiting room, were completed in October 2008. To enable the nurses to begin diagnostic testing and/or treatment prior to the patient being seen by the physician, 23 Medical Directives<sup>2</sup> have been developed. Following identification by the Triage Nurse, patients move from the general ER waiting room to CSI for initial review and implementation of lab work etc; the patients wait in the CSI waiting room until test results are returned and/or until the next phase of care can proceed.

The RNs in the Emergency Department were actively involved in the development of the CSI, and are enthusiastic about its potential. However, it appeared to the IAC that the implementation process is still in the developmental stages.

- The CSI processes do not appear to be consistently followed by all nurses and physicians follow (for example, how the CSI patient chart is identified and where it is located).
- Staffing was not augmented when the CSI was opened, as the number of patients in the Department has not changed. The assignment has not been effectively reconfigured to accommodate the altered flow of patients. Responsibility for the CSI often defaults to the Charge Nurse and/or second Triage Nurse, both of whom have other responsibilities.
- Effective management of the CSI depends on consistent physician coverage; while there is double physician coverage in the Department between 1300 – 0100 hours, the IAC was not clear how CSI responsibilities are allocated within the physician team.

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<sup>2</sup> The 23 Medical Directives include the following:

- ECG, cardiac enzymes and troponin, possible acute coronary syndrome,
- febrile neutropenia,
- lab tests (group and screen, PT/PTT/INR, serum/urine BHCG, urinalysis, urine C&S, blood cultures, drug screen for possible overdose),
- ER abdomen, sepsis, management of renal colic, management of seizure, tetanus/diphtheria, ophthalmic anaesthetic drops for adults, acute respiratory distress in adults and children, oxygen administration for children, oral rehydration therapy for children.



### 2.1.2.2 Medical Holding Unit

The St Catharines General Site was one of 23 hospitals in Ontario to receive Pay for Results Initiative funding to improve Emergency Department wait time and process flow. The initial funding period was five months, October 1, 2008 to March 31, 2009. SCG received \$1.25M, which it allocated across a number of initiatives<sup>3</sup>, one of which was the creation of a 10-bed Medical Holding Unit (MHU). The MHU opened on December 3, 2008.

The MHU is located on the 3<sup>rd</sup> floor. Staffed by an RN and two RPNs, the MHU is open from 0800-1800 daily. The Charge Nurse and Bed Flow Coordinator review the “admit no bed” (ANB) patients in the ER at 0800, and move those who are expected to receive an inpatient bed that day to the MHU to wait until the inpatient bed becomes available. (The patient is returned to the ER at 1800 if the bed has not become available). Patients who have been discharged from an inpatient bed and are awaiting transportation are also moved to the MHU to improve inpatient bed availability.

Although quantitative data regarding the impact of the MHU on wait times in the ER was not available at the time of the Site Tour, anecdotal comments from both staff and management indicated that the MHU was decreasing both the number and length of stay of ANB patients in the ER. Subsequent data received from the Hospital showed that the ALOS of admitted patients in the ER decreased from 20.8 hours in November to 17.0 hours in December 2008, the lowest ALOS for admitted patients since January 2008.

### 2.1.3 Emergency Department Staffing

#### 2.1.3.1 Nursing Leadership

The Clinical Manager of the SCG Emergency Department is also responsible for the Prompt Care Centre at the Ontario Street Site. The NHS has a matrix reporting structure.

- For operational issues, the Clinical Manager reports to the Health Program Director for Emergency Services, who in turn reports to the Vice President Patient Services responsible for the Emergency Services and Critical Care Services Programs and the St Catharines and Ontario Street Sites.
- For professional practice issues, the Clinical Manager reports to the Regional Director for Emergency Services. Issues requiring further direction or support are discussed with the Chief Nursing Officer and Chief Nursing Executive.
- The Clinical Supervisor reports to the Clinical Manager, as do the Clinical Resource Nurse, Permanent Charge Nurses, RNs, RPNs and other staff (total approximately 150 direct reports).
- The Clinical Educator reports to the Regional Education Director. The Education Department is managed centrally.

#### 2.1.3.2 Staffing Status

The Emergency Department is staffed with RNs, RPNs, HCAs and Ward Clerks. The current status of these positions is indicated in Table 2.

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<sup>3</sup> Pay for Results Initiative Funding was allocated to the following: wireless communication system, ER porters, bed flow coordinator, portable ultrasound machine, increased CCAC coverage, Medical Holding Unit, electronic bed availability monitoring system, admissions nurse, peak hours patient transport management and discharge bed cleaners.



**Table 2: St Catharines General Site Emergency Department Staffing Status**

Position	# positions	Status of RN positions
RN: Charge Nurse	5 FTE positions	5 positions permanently filled with actively working Permanent Charge Nurses ♦5 FT and 1 PT RNs
RN: Full-time	48 FTE positions	29 positions permanently filled with RNs actively working ♦25 FT RNs ♦8 PT RNs who job-share 4 FT lines  11 positions permanently filled with RNs not actively working ♦2 RNs on Long-Term Disability ♦5 RNs on orientation ♦1 RN awaiting accommodation ♦3 RNs on Maternity Leave of Absence  8 positions vacant; temporarily filled with other health care professionals ♦4 positions filled with 1 year (July 2008-July 2009) temporary term positions ♦4 RPNs and 2 HCA*** ♦4 positions filled by RRTs hired permanently into NHS but temporarily into the ER ♦2 RRTs currently on orientation ♦1 RRT starting in March ♦1 RRT starting in June
RN: Part-time	4 FTE positions	4 positions permanently filled ♦1 PT A (works only at Prompt Care) ♦5 PT B (contract is for 45 hours in 2 week period)
RN: Casual	Flex positions to cover vacation, sick time, leaves of absence etc	♦20 multi-site nurses (RNs and RPNs) ♦Work at other ER Departments within NHS and pick up additional shifts as desired at SCG ♦14 casual RNs
RPN: Full-time	3 FTE positions	3 positions permanently filled with RPNs actively working
RPN: Part-time	1 FTE position	1 position permanently filled with RPN actively working
RPN: Casual		3 casual RPNs (***)plus 4 RPNs above)
HCA	2 FTE positions	2 positions permanently filled with FT HCAs actively working 2 positions permanently filled with PT HCAs actively working 4 casual HCAs (***)plus 2 HCAs above)
Ward Clerk		5 FT positions ♦4 positions permanently filled by FT WCs actively working 1 position temporarily filled by casual WC 1 position permanently filled by PT WC actively working 4 casual WCs

The staff complement for the SCG ER also covers the Prompt Care Centre at the OSS. Due to the small number of staff at the Prompt Care Centre, only senior experienced nurses can be assigned to Prompt Care, as the RNs must be able to triage<sup>4</sup>.

As noted in Table 2, only 60% of the full-time RN positions (29 of 48) are currently permanently filled by RNs who are actively working. 40% of the positions (19 of 48) are either permanently filled with RNs not currently working (11 positions), or are vacant (8 positions). Therefore, on a shift-by-shift basis, 40% of the RN 'lines' must be filled by part-time or casual RNs, agency nurses, or multi-site or full-time RNs working overtime; these nurses must also provide coverage for vacation, sick time, bereavement leave etc. As it is frequently not possible to cover all of the budgeted shifts, the Emergency Department is often short-staffed. The Hospital indicated that during the summer of 2008, the ER was routinely staffed with 6 or 7, rather than 10 RNs, but that this situation has improved over the course of the fall.

The Hospital has endeavoured to address the staffing shortage by "filling" the 8 vacant full-time RN positions with other health care providers:

- 4 RN positions have been filled on a 1-year temporary term basis (July 2008 – July 2009) with 4 RPNs and 2 HCAs;
- 4 RN positions are being filled by RRTs, who have been hired permanently into the NHS, but temporarily into the Emergency Department<sup>5</sup>.

Nine (9) staff are currently on orientation:

- 5 full-time RNs, who have been allocated permanent full-time positions and will complete orientation at the end of April;
- 2 full-time RNs who are part of the New Graduate Initiative; these RNs will assume permanent positions in June (will take 2 of the 4 positions currently filled by the RPN/HCA group)
- 2 full-time RRTs, who will complete orientation at the end of April.

By the end of June 2009, the staffing resources will shift.

- 38 of the 48 full-time RN positions will be filled by actively working staff:
  - The number of full-time RN positions permanently filled with RNs actively working will increase from 60% (29 of 48) to 75% (36 of 48), when the seven RNs currently on orientation will have completed orientation and be ready to assume a patient care assignment.
  - Two of the RRTs will also have completed orientation.

However, a significant proportion of the RNs (30 – 40%)<sup>6</sup> will be 'junior staff', i.e. those with less than two to three years of Emergency Department experience.

This will leave 10 full-time RN positions (21% of the full-time lines) which will have to be filled on a day-to-day shift-by-shift basis:

- 6 positions permanently filled by RNs currently unable to work (2 on LTD, 1 on accommodation and 3 on MLOA)
- 2 positions allocated to RRTs (one starting in March and one in June)

<sup>4</sup> Staffing at Prompt Care is as follows: 2 RNs 0745 – 1545 (1 RN is Charge Nurse Mon-Fri); 2 RNs 1545-2345; 1 RPN 1000-2200, 1 HCA 1700-2100, 1 Ward Clerk 0745-1545; 1 Ward Clerk 1545-2345.

<sup>5</sup> The Hospital stated that as RNs are recruited, these positions will reconvert to RN positions, and the RRTs will be placed elsewhere within the NHS.

<sup>6</sup> As of February 2008, 29% of SCG ER RNs had less than 2 years experience. This number will increase with the number of newly hired nurses over the past year.

- 2 positions vacated by the RPN/HCAs whose temporary term positions will expire in July 2009.

The Hospital will therefore need to continue to actively recruit for 6 RN positions:

- 4 positions filled by RRTs, and
- 2 positions vacated by RPNs/HCAs.

In the meantime, the Hospital has entered into contracts with three Nursing Agencies to provide staffing support. Originally intended as a short-term measure, the Emergency Department is now dependent on filling 1-3 positions per shift with agency nurses.

### 2.1.3.3 Staffing Schedule

The current Emergency Department is staffed on a daily basis with RNs, RPNs, HCAs (most of whom are trained as PSWs) and Ward Clerks.

The Department is budgeted for 10 RNs 24/7, including the Charge Nurse, as well as 3 float positions (Triage float 0900 – 1700, Evening Float 1500 – 2300 and Cardiac/Trauma float 1100 – 2300). In addition, the Department has been staffing an unbudgeted Treatment float position\* (1100 – 2300).

**Table 3: SCG Emergency Room Daily Assignment Schedule**

Position	Days 0700 - 1900	Evening/Float	Nights 1900 - 0700
RN: Charge Nurse	1 RN		1 RN
Triage Nurse	1 RN 1 RN (0900 – 1700)	1 RN (1500-2300)	1 RN
Treatment	4 RNs	1 RN (1100 – 2300)*	4 RNs
OBS Area	2 RNs		2 RNs
Cardiac/Trauma	2 RNs	1 RN (1100 – 2300)	2 RNs
RPN	1 RPN 1 RPN (Temp FT)***		1 RPN (Temp FT)***
HCA	1 HCA (0700-1500)	1 HCA (1500 – 2300)	1 HCA (Temp FT***)
Ward Clerk	1 WC 1 WC (0800 – 1600)**		1 WC

\* Treatment float RN (1100 – 2300) is an unbudgeted position

\*\* Second Ward Clerk works in the OBS Area

\*\*\* The temporary full-time positions (filled by 4 RPNs/2HCAs) are funded by 4 'vacant' RN positions

In addition to the staff identified above, the Hospital has augmented support to the Emergency Department staffing with resources obtained through specific initiatives.

- The Pay for Results Initiative funding, which exists from October 1, 2008 through March 31, 2009, has been used to support additional positions:
  - four (4) Porter positions (2 Porters each day, working 0700-1900 and 0900-2100) within the SCG ER, to transfer patients between the ER and diagnostic departments and inpatient units;
  - Bed Flow Coordinator, focused on transfer of ANB patients from the ER to inpatient beds;
  - Increased CCAC coverage (from 8 – 12 hours per day) in the ER;
  - Admissions Nurse,
  - an additional Housekeeper for the inpatient units, to speed discharge cleaning and facilitate transport of ANB patients out of the Emergency Department more quickly, and
  - Medical Holding Unit.
- The EMS Funding has been used to support an EMS Offload Nurse, who works 1000-1700 to provide care to patients who arrive by ambulance until care can be assumed by the Emergency Department staff<sup>7</sup>.

A 24/7 CSI 'slot' was added to the assignment sheet on October 1, 2009 but there is no position designated to CSI. When possible, an RN is pulled from another area; when this is not possible due to patient volume or acuity, CSI is covered by the second Triage Nurse and/or the Charge Nurse.

The four (4) temporary RPNs provide 24/7 coverage (one per shift). They are added to the assignment sheet each day; usually the RPN replaces one of the RNs in the OBS area (previously staffed by 2 RNs).

The Emergency Department has a dedicated CCAC Case Manager for eight hours daily (1200 – 2000 hours). The Department has successfully accessed funding from the LHIN for an additional four hours of dedicated coverage per day, but the additional part-time position has not yet been filled by the CCAC.

The Hospital is seeking funding through the Aging at Home Strategy for a Social Worker, Geriatric Mental Health Nurse and Pharmacist for the Emergency Department. At this time, other than RRTs, no allied health professionals are designated to the Emergency Department.

#### 2.1.3.4 Scheduling Process

The Emergency Department moved to a self-scheduling model approximately 18 months ago. The scheduling parameters are included in a Letter of Understanding included in the Local Collective Agreement. Originally, the nurses selected shifts across all 10 'lines' included on the daily rotation; due to staffing shortages, the full-time and regular part-time nurses now select shifts across 7 lines for each of the day and night shifts. Once the schedule selections have been made by the full-time and part-time RNs, a Scheduler, who is permanently assigned to work with the Emergency Department, calls nurses to cover the unfilled shifts in the remaining 3 lines. If the Scheduler is unable to cover the shifts with part-time and casual staff and agency nurses,

<sup>7</sup> This position was implemented the week of the IAC Hearing, and the IAC was unable to evaluate the impact of this position on the workload of the ER staff.

additional shifts are offered to the full-time staff. The maximum number of agency nurses booked per shift is three. Therefore, if there are seven ER nurses and three agency nurses scheduled and a nurse calls in sick, the replacement is an SCG RN (likely working overtime).

Monday through Friday overtime shifts are offered on the basis of seniority; overtime shifts on the weekend are offered on the basis of lowest cost, due to the Superior Condition in the Local Agreement<sup>8</sup>. If weekend shifts have not been filled by the previous Wednesday, the Scheduler calls full-time staff to offer the opportunity for a “3<sup>rd</sup> weekend” shift(s). Previously, such shifts were booked in advance, resulting in significant premium pay costs.

The Emergency Department nurses are not able to request stat holidays within the self-scheduling system (although this occurs on other Units within the SCG) due to staffing shortages. “Paying out” stats at the end of the year, due to the Hospital’s inability to grant them, has occurred.

In order to enhance communication between the Scheduler and the Charge Nurses, the night Charge Nurse and Scheduler speak each morning at 0600 to confirm the staffing for the day (i.e. confirm last minute changes due to sick calls etc). This enables the night Charge Nurse to develop the day shift patient care assignment on the basis of the number of nurses actually working (vs. the number listed on the master rotation). In addition, a fax machine dedicated to scheduling communication updates has been installed in the Nurses Charting area<sup>9</sup>.

#### 2.1.3.5 Sick Time

The data provided to the IAC indicated that

- within the NHS, the St Catharines General Site has the highest level of sick time (35% of the total NHS sick time), and
- within the St Catharines General Site, the Emergency Department has the highest level of sick time.

Sick time has increased comparatively between October 2007 and November 2008, as indicated in Table 4.

**Table 4: Sick Time**

	Provincial Community Hospitals (OHA)	NHS	St Catharines General Site	SCG Emergency Department
October 2007 YTD: Sick days / FTE	10.65	10.4	12.1	12.67
November 2008 YTD : Sick days / FTE	10.33	12.2	14.1	16.91

<sup>8</sup> Article 14.01: *When a nurse works on her day or days off, such nurse will be compensated at the rate of time and one-half and shall be scheduled for another day or days off with pay.*

Article F: Scheduling F-2 (b) *A nurse will receive premium pay, as defined in Article 14.03 for all hours worked on a third consecutive and subsequent weekend, save and except where.....* The regular schedule includes working every second weekend. Therefore an RN working on an “off” (3<sup>rd</sup>) weekend will receive premium pay for that weekend, and all subsequent weekends worked until the RN has two weekends off in a row.

<sup>9</sup> However, due to a glitch in the scheduling software, some scheduling information continues to be sent on the ‘regular’ Emergency Department fax, requiring the Charge Nurse to access information in two locations.

The YTD level of 16.91 sick days / FTE in the SCG ER is 64% above the provincial average of 10.33 sick days / FTE in community hospitals across Ontario. This level of sick time leads to a 'Catch-22' cycle: as the number of sick calls increase, the ability to cover all sick call shifts decreases, which leads to increased overtime and enhanced stress for the nurses working, which leads to further increased sick time.

#### 2.1.3.6 Overtime

The data provided to the IAC indicated that

- within the NHS, the St Catharines General Site had the highest overtime percentage of YTD worked hours, and
- within the St Catharines General Site, the Emergency Department has the second highest overtime percentage of YTD worked hours.

Overtime has increased only very slightly comparatively between November 2007 and November 2008, as indicated in Table 5, but is substantially (360%) higher than elsewhere within the SCG or NHS.

As noted above in Section 2.1.3.4, "overtime" relates to the payment of premium pay. Due to the superior condition in the SCG Local Agreement, RNs may be paid premium pay for regularly scheduled shifts. Therefore, the level of "overtime" relates to percentage of shifts paid at a premium rate, which may not be the same as the percentage of shifts actually worked above regularly scheduled hours. Data regarding the actual percentage of shifts above regularly scheduled hours was not available to the IAC.

Table 5: Overtime

	NHS	St Catharines General Site	SCG Emergency Department
November 2007 YTD: Overtime Hours as % of Total Worked Hours	3.92	5.3	20.2
November 2008 YTD: Overtime Hours as % of Total Worked Hours	3.89	5.5	20.3

#### 2.1.3.7 Turnover

Data provided to the IAC indicated that, over the past year (January 1, 2008 to January 27, 2009), the number of staff who left the SCG ER was approximately equal to the number who joined the Department, as indicated in Table 6.

**Table 6: Turnover in the SCG Emergency Department**

Turnover out of SCG ER			Turnover Into SCG ER		
	#	%		#	%
Resigned from NHS	7	9%	New hire into NHS	8	10%
Transferred out of ER to elsewhere in NHS	<u>10</u> 17	<u>13%</u> 22%	Transfer into ER from elsewhere in NHS	<u>10</u> 18	<u>13%</u> 23
Total # of RN staff in ER	78		Total # of RN staff in ER	78	

However, although the balance was equal, the number of staff moving was significant: 45% of the staff (35 people) moved either into or out of the Department over this 13 month period. This was higher than in any of the other Emergency Departments within the NHS, both in terms of percentage and volume (number of actual staff moving). The second highest rate of turnover was at the Welland Site ER; although the percentages of staff in/out was close to that of the SCG (19% in / 23% out), the numbers of actual staff involved was much smaller (total of 13 vs 35 at SCG), likely making the 'felt impact' much less.

#### 2.1.4 Patient Safety

Data provided to the IAC indicated that during the eight month period April to December 2008, the following incidents/adverse events were reported:

- 33 medication incidents, including one serious and one moderately serious incident
  - 13 'omission'
  - 4 'dosage too much'
  - 2 'strength/concentration'
  - 2 'time'
  - 2 'type of medication'
  - 1 'solution type'
  - 9 'other'
- 24 falls, including one serious, one moderate and seven slight degree of injury
- 41 treatment/test procedure variances, including 3 with moderate impact

The IAC is aware that there is no comparative data regarding incidents within Ontario, and so cannot comment on whether the above reported incidents are at a higher or lower level than other Emergency Departments within Ontario. However, the literature indicates a relationship between staffing challenges and incidents/near misses/adverse events. The IAC believes that the staffing instability resulting from 'working short', and the high levels of sick time, overtime and turnover have likely contributed to the documented events.

#### 2.1.5 Workload Measurement

The data provided to the IAC indicated that the Worked Hours per Equivalent Visit for the Emergency Department was 2.0122 (December 2008 YTD). This places the SCG Emergency Department above the median (1.8161) among the 23 peer hospital with whom the NHS is ranked



by the Ministry of Health and Long Term Care. Five of the 23 hospitals, including the SCG ER, are above the median. Therefore, in comparison with the peer hospitals, the SCG ER is 'less efficient' (spending more time/hours per patient) than at least 18 of the peer hospitals<sup>10</sup>.

The Monthly Statistics data provided to the IAC indicated that although the number of patients has decreased, the care requirements, evident by the change in CTAS levels and Average Length of Stay (ALOS) of patients has increased, as indicated in Table 7. The age breakdown of patients has remained consistent.

The continued presence of ANB patients in the ER has been very difficult for the nursing (and medical) staff, both in terms of patient flow and in terms of the nature of patient care requirements. As noted in Section 2.1.2.2, implementation of the Medical Holding Unit appeared to have a significant impact on the ALOS of admitted patients (the December ALOS was lower than at any time since January 2008). It is hoped that this trend will continue.

**Table 7: SCG Emergency Room Workload Statistics**

	07/08 Fiscal YTD (30/11/07)		08-09 Fiscal YTD (30/11/08)		% Change
Total ER Patients (inpatient and outpatient)	30,979		29,521		- 4.7%
Patient Age:	0 – 17	4,376 14%	4,272 14%		0%
	18 – 64	18,350 59%	17,598 60%		+ 1.0%
	65 – 74	3,025 10%	2,772 9%		- 1.0%
	75+	5,228 17%	4,879 17%		0%
		30,979 100%	29,521 100%		
CTAS Triage Level:	Level 1	219 1%	287 1%		0%
	Level 2	4,200 14%	5,647 19%		+ 5.0%
	Level 3	17,515 57%	15,618 53%		- 4.0%
	Level 4	8,298 26%	7,188 24%		- 2.0%
	Level 5	747 2%	781 3%		+ 1.0%
		30,979 100%	29,521 100%		
EMS: Arrival by ambulance	7,565 24.4%		7,235 24.5%		+ 0.1%
ALOS: Triage to 'Left ER to Admitted Bed'	16.3 hrs		20.8 hrs		+ 27.6%
ALOS: Triage to 'Left ER Discharged'(not admitted)	4.6 hrs		4.5 hrs		- 1.3%

<sup>10</sup> The IAC had difficulty ascertaining the correct WHPV value; the initial data provided indicated a lower value, suggesting that the SCG ER was more efficient in relation to its peers.



### 2.1.6 Emergency Department “Sense of Team”

The Emergency Department is staffed with physicians with active privileges at the St Catharines General Site. Although ‘shift MDs’ from MedEmerg are occasionally scheduled to ensure coverage, this occurs only rarely (less than once per month). The physicians practice under a Fee for Service (FFS) model. The physicians’ schedule (double coverage from 1300 – 0100 hours) reflects the peak presentation times of patients. Physician leadership is provided by the SCG Site ER Chief.

The relationship between the nurses and physicians appeared to the IAC to be fairly positive (or, stated differently, the IAC was given no reason to believe the relationship was negative). The development and implementation of the 23 Medical Directives suggests a positive level of collaboration and a trustful working relationship. On the day of the Site Tour, the nurses were hanging a photograph of an ER physician who had recently died; their comments and demeanor again suggested a positive relationship.

The IAC was unable to evaluate any other inter-professional team dynamics.

## **2.2 Development of the Professional Responsibility Workload Complaint**

As noted in Part I, Section 1.2, concern regarding workload/professional responsibilities of the registered nurses in the Emergency Department at the St Catharines General Site has been ongoing since 2004. Since then, the expressed concerns have continued to increase, as evident from the number of Professional Responsibility Workload (PRW) Report forms completed (Table 8).

Table 8: SCG Emergency Department PRW Reports by Year

Year	# PRW Reports
2004	18
2005	31
2006	29
2007	51
2008	60

The Association and the Hospital have held regular Emergency Department specific Hospital-Association Committee (HAC) meetings over the past five years, at which Professional Workload Complaints and other related workload issues have been discussed. Since late 2004, these meetings have also been attended by a Professional Practice Specialist from the Association (external to the Hospital). Although each year some issues were resolved, many of the issues of concern remained year to year and some of the resolutions were not sustained.

A Quality of Worklife Nursing Unit Profile Survey was completed in the Emergency Department in January 2006. Although only 48% of the staff responded to the survey, 78% indicated that the current system of practice was unacceptable, and identified the issues as staffing, inpatients in the ER, inconsistent work practices among staff, lack of leadership within the Department, insufficient support for professional development, poor relationships with other Departments, and unavailability of equipment and supplies required for patient care.

The survey outcomes resulted in the creation of a Patient Care System Review (PCSR) Committee, comprised of both staff and management, which met frequently throughout most of 2006 and into 2007 to address the issues identified in the QWL Survey. The PCSR Committee developed a status report spreadsheet as a mechanism to both track and communicate the status of issues, actions, timelines and responsibilities. The PCSR Update became a standing agenda item at HAC meetings.

In March 2007, Linda Haslam-Stroud, President of the Ontario Nurses' Association, wrote to the Chair of the NHS Board of Trustees, expressing concern regarding unresolved issues relating to nursing workload, quality of patient care, nursing leadership and occupational health and safety/security within the Emergency Department, and requesting attendance at the April 2007 Board Meeting to 'explain ONA's next steps in assisting the RNs in an external resolution process'.<sup>11</sup> Ms Haslam-Stroud did not meet with the Board, but did subsequently meet with Debbie Sevenpifer, NHS CEO, and the Chief Nursing Executive; the Association again identified key issues, and the Hospital again presented the actions taken to address them.

The Patient Care System Review Report was completed in August 2007. The Report contained five key recommendations:

1. Establish and implement Standardized Medical Directives, Clinical Pathways, Treatment Protocols and policies and procedures as soon as possible based on best practice to expedite safe treatment and patient flow through the ED as mentioned in the Emergency Program Directional Plan.
2. Provide the necessary physical structural changes / renovations as needed on the SCG ED Unit.
3. Develop and implement a formal sustainable education plan. This plan should include a comprehensive and consistent orientation program, specialized training/re-training programs such as ACLS (costs incurred by the NHS), career laddering, peer mentoring and succession planning. Education and mentorship programs provide career enhancement for staff retention and, at the same time, addresses the need to more effectively orient, train and support new workers in order to reduce turnover.
4. Establish a rapid diagnosis and treatment area or Clinical Decision Unit for rapid assessments of patients in ED considering expanding ED coverage with 2 physicians on days and evening shifts.
5. Develop and implement a form to fax patient report to inpatient units that will be receiving patients from ED to address delays in patient transfers and communication issues.

The Report was presented to the staff at an Emergency Department Staff Meeting on January 9, 2008.

In addition to regular HAC meetings held throughout the year, efforts to address issues increased throughout 2008.

The Emergency Baseline Staffing Project was completed in February 2008. The purpose of the Project, which began in May 2007, was to 'provide a framework to those in leadership roles and to nurses in direct care when collaboratively making staffing decisions'.<sup>12, 13</sup> The goal was to develop a staffing framework which would be piloted and evaluated at the SCG site, and then

<sup>11</sup> March 14, 2007 letter, Linda Haslam-Stroud, President ONA to Betty-Lou Souter, Chair Niagara Health System Board of Trustees.

<sup>12</sup> Emergency Baseline Staffing Project Report, February 2008, Submitted by Marcia Ladouceur, Acting Health Program Director Emergency Program and Sue Payeur-Grenier, Project Leader Patient/Client Centred Care.

<sup>13</sup> Baseline staffing was defined as "the process of determining the appropriateness of the number of nursing staff, type or level of patient/client care required, skill level of nursing personnel and mix of nursing personnel categories to yield positive cost efficient and effective outcomes for patients, clients and nurses".

used as a resource for the other five Emergency Departments within NHS, as well as the other clinical Departments.

The Report contained five recommendations specific to the St Catharines General Site Emergency Department:

1. Introduce one Registered Respiratory Therapist 24/7 working to full scope of practice within the RN rotation to support the Inter-professional Collaborative Care Model.
2. Add one RPN (0700-1900) for providing care for patients who are waiting in the ED waiting room, especially Levels 4s and 5s. The RPNs, working to full scope of practice, will also provide assessments and treatments to patients in fast track. This will ensure patient safety, improve patient satisfaction and decrease patient and family complaints.
3. Add one unregulated care provider (HCA) on the night shift (7.5 hours) to appropriately and thoroughly re-stock the ED department thereby utilizing HCAs on the dayshift and evenings shifts to porter patients and assist with non-nursing activities. This will free up RNs to perform comprehensive assessments and treatments, and provide emotional support and health teaching to patients.
4. Add one RPN at the OSS site (0800-2200) as reflected by the increased volumes.
5. Add appropriate category of care providers over and above the base line staffing to care for admit no bed patients. This determination will be based on an interdisciplinary assessment of patients' acuities, complexities and patient flow.

The Association and the Hospital jointly sponsored a "Fireside Chat" meeting in early May 2008, to enable the staff nurses in the Emergency Department to speak directly with the Vice President Patient Services responsible for the Emergency Program and the St Catharines General Site. A key area of concern was the proposed introduction of the Registered Respiratory Therapist (RRT) into the RN rotation. It was hoped that a more trusting relationship between staff and upper management could be achieved.

This was followed by an "IAC Prevention Meeting" in early July 2008. Each of the Association and the Hospital nominated 3 RNs, who met with the Emergency Department leadership team (VP Patient Services, Regional Emergency Program Director, and Clinical Manager) and representatives from the Association (Professional Practice Specialist and Labour Relations Officer). The purpose of the meeting was stated as "*Notice of an impending IAC was given and this meeting is being held as an act of good faith on both parties to try and work together to address outstanding issues. The hope is to resolve these issues before it is necessary to continue with an IAC*".<sup>14</sup> The key issues discussed related to Admit No Bed issues, staffing, scheduling, and communication.

In August 2008, Linda Haslam-Stroud wrote to the SCG Site Emergency Registered Nurses. She highlighted the successes achieved, changes currently underway and the challenges remaining relating to the Professional Responsibility Complaint process. The feedback from the nurses indicated that they felt that many of the 'successes' had either not been sustained or did not positively impact their workload.

The Hospital engaged Siemens to provide recommendations regarding the SCG Emergency Department work flow and patient care. The Siemens Report, received in September 2008, provided a number of recommendations relating to monitoring of quality indicators, including development of a Balanced Scorecard, developing a comprehensive communication strategy

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<sup>14</sup> Minutes of SCG Emergency Department Issues, Actions and Deliverables Meeting, July 7, 2008

within the Emergency Program across sites, and developing a formal Recruitment and Retention Strategy for Emergency Department staff.<sup>15</sup>

The Hospital and the Association sponsored a Staff, Management and ONA Mandatory Meeting in early October. This meeting, held on three dates to enable as many staff as possible to attend, included a discussion regarding the letter from Linda Haslam-Stroud and a summary of the Pay for Results initiative which began October 1, 2008. This was followed by a facilitated focus group discussion regarding satisfiers/dissatisfiers and what was/was not working well, and brainstorming regarding approaches/solutions.

The Association sent a letter to the Interim Chief Nursing Executive on October 20, 2008, in accordance with Article 8.01 (a) v) of the Collective Agreement, outlining 20 unresolved issues identified at the October Mandatory Meeting. The letter identified the issues within the areas of workload/competence, professional development, practice support, time off and scheduling issues and 'part of a team', and provided immediate, short and long term suggested resolutions, emphasizing that each resolution required a plan for implementation, follow-up and sustainability.

On October 25, 2008, the Association notified the IAC Chairperson of the Hospital and Association Nominees for the Hearing, and requested the Chairperson to proceed to organize the Hearing (Appendix 1).

The Hospital responded in writing to the Association's October 20, 2008 letter on November 13, 2008, provided comment on each of the issues identified by the Association, and assigned accountability for follow-up and priority of resolution (immediate, short or long term).

The Hospital's response was discussed at a special HAC meeting held December 1-2, 2008, with follow-up teleconferences held December 5, and 10, 2008. As both parties were unable to achieve satisfactory resolution to the issues, it was agreed to proceed to the IAC Hearing in January 2009.

## **2.3 Hearing Presentations**

The Hearing was held on January 26 – 28, 2009. The process of the Hearing was structured such that each of the Association and the Hospital made a 90 minute oral presentation, highlighting the key elements of their written Submission. On the following day, each of the Hospital and the Association made a Response presentation, during which each party clarified / discussed / challenged information presented by the other in its oral and written submissions.

### **2.3.1 Ontario Nurses Association Submission Presentation**

The Association presentation, comprised of an oral presentation provided by Rozanna Haynes, was based on the Association's written Submission Brief and 96 exhibits of supporting/explanatory material.

The Association began its presentation by confirming that registered nurses have an obligation to report professional practice concerns to the employer, and to attempt to resolve them. The

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<sup>15</sup> The IAC was not provided with a copy of the full Siemens Report or recommendations.

professional responsibility complaint process was historically developed to assist registered nurses through the sometimes challenging experience of raising professional practice concerns to the employer. The first step in the professional responsibility complaint process is the completion of a Professional Responsibility Workload (PRW) Report form.

The Association stated that the employer has a responsibility to provide a quality practice setting that permits nurses to provide quality care and practice in accordance with professional standards.

The Association stated that since 2004, significant efforts have been made to address the workload concerns expressed by the registered nurses in the Emergency Department. While some issues have been resolved, a number of the resolutions have not been securely implemented or sustained. Other issues have not been resolved. The Association stated that the registered nurses have tried various methods of communication, including group letters, individual emails, anonymous letters, letter to the local media, and group presentations of the issues at staff meetings. In addition, they have participated in every survey and review that the Hospital has requested. Despite these efforts, the registered nurses feel that their concerns have not been heard.

The Association has worked with the Hospital in an attempt to resolve issues, including jointly sponsoring “fireside chat” and “mandatory focus group” meetings between staff and management, and inviting the Association President to meet directly with staff and senior management of the Hospital. The Association has found working with the management team to be a challenge, partly because of the extensive turnover in nursing leadership positions: since 2004, there have been four Chief Nursing Executives at NHS and five Clinical Nurse Managers in the Emergency Department<sup>16</sup>.

The Association stated from their perspective that the issues of concern fall within seven categories:

- Workload/competence/professional practice
- Professional development
- Practice support
- Professional respect
- Staffing resources and other resource access
- Part of a team
- Time off and scheduling issues

The Association then reviewed the PRW Reports filed since 2004. The presentation identified the nature of the workload complaints, actions taken by the Hospital which achieved partial or full resolution, and ongoing unresolved issues. The Association emphasized that both the Hospital and the Association have worked hard, but that many of the changes agreed to have not been implemented, either fully or in a timely fashion, and have not been sustained. The information presented is included in Appendix 8.

The Association expressed concern with the Hospital’s statement, made in September 2007, that the Emergency Baseline Staffing Review was being aligned “with the work underway provincially with ONA, the OHA and the Nursing Secretariat”<sup>17</sup>. The Association indicated that this statement left the impression with the nurses that the ONA, OHA and Nursing Secretariat

<sup>16</sup> The IAC was not provided with any information related to the turnover in the management positions.

<sup>17</sup> September 5, 2007 Letter to SCG Site Emergency RNs, signed by Marcia Ladouceur, Acting Health Program Director Emergency Services NHS and Pam Sheptenko, Bargaining Unit President Local 26.



were in agreement with the proposals in the Baseline Staffing Report, which the Association believes is not the case.

The Association also expressed concern regarding the communication process relating to funding of ACLS and PALS<sup>18</sup>. The November 2007 memo announcing the funding support gave the impression that all ACLS and PALS programs would be funded, when in fact tuition costs are being covered only for recertification (not initial certification) programs. The memo also did not mention that the Hospital planned to fund these costs through the RNAO Nursing Education Initiative. In January 2009, nurses seeking tuition reimbursement were required to sign an Employer Education Form which stated “Your signature acknowledges that you are aware that your employer’s application may also affect your eligibility to access full funding through the Nursing Education Initiative in the future.”<sup>19</sup> This caused concern among nurses who had already applied for and received maximal funding through the Nursing Education Initiative for other educational programs (e.g. degree programs). Although it was later clarified that the Hospital’s application for group funding from the Nursing Education Initiative would not impact the status of individual nurse’s requests, the Association stated that communication gaps such as this lead to a decreased sense of trust and openness between nurses and their nursing leaders.

The Association indicated that the relationship between the registered nurses and first-line leadership (Manager, Supervisor and Educator) has deteriorated over the past 8-10 months. The current Clinical Manager and Clinical Supervisor assumed their positions in mid-2007 (Clinical Manager came from outside the hospital; Clinical Supervisor was promoted from within), and initially, the nurses felt that they were supportive and provided effective leadership. However, the relationship began to erode in mid-2008. The Clinical Supervisor began to cover the Emergency Department at the Douglas Memorial Site of the NHS in September (and will continue in this role until a new Clinical Manager is recruited) and is now away from the SCG Emergency Department 1-2 days per week. The Educator has a number of corporate responsibilities (e.g. providing Hospital Orientation on a rotating schedule, participating in the implementation of the AUDD system) and is away from/outside of the Emergency Department as much or more than she is available for staff support within the Department. Although the Clinical Manager and Clinical Supervisor discuss the Emergency Department status with the incoming Manager-on-Call each afternoon, the nurses do not feel that the Manager-on-Call system is effective to facilitate patient flow (especially transfer of patients from the ER to inpatient beds) on evenings, nights and weekends.

The Association stated that the Hospital has attempted to address workload concerns, and over the past four years has indeed added RN, RPN, HCA, and Ward Clerk hours of care. However, the Association does not feel that all of the additional hours of care agreed to at HAC have in fact been implemented. The Association gave the example of the addition of one RN position 24/7 in the Treatment Room, which was agreed to in 2007; while an additional RN position has been added on the day shift, full 24/7 coverage has never been implemented. In addition, the Association stated that those nursing hours which have been added have related to Triage Nurse and Charge Nurse positions, rather than direct patient care, and that the base patient-nurse hours have not increased in relation to the increase in patient acuity and volume.

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<sup>18</sup> November 29, 2007 Memo stating that ACLS and PALS tuition costs would be funded by the NHS for nurses in the Emergency Department, signed by Marcia Ladouceur, Acting Health Program Director Emergency Services NHS and Carol Bergeron, Regional Director Facility Services NHS

<sup>19</sup> January 5, 2009 Memo 2008 from Tracey Davey, Nursing Education Initiative Employer Application

The Association stated that the Emergency Department now has higher volumes, more ambulances, and longer wait times. There is an increased number of 'Admit no Bed' (ANB) patients, and a huge increase in the numbers of junior and agency staff. The Emergency Department has lost over 100 nurses over the past four years. Nurses are stressed and state that they cannot meet expected standards of practice. The SCG Emergency Department is recognized by the Ministry of Health and Long Term Care as being one of the 23 'worst' Emergency Departments in the province (and hence received \$1.2M Pay for Results Initiative Funding in October 2008).

In conclusion, the Association stated the registered nurses working at the SCG Emergency Department believe that the current model of care and the practice environment do not allow them to meet CNO, CTAS and Emergency Nurses Association (ENA) standards and guidelines. The Emergency Department is trying to function with decreasing numbers of experienced ER RNs and increasing numbers of novice ER RNs and other health care providers. The Association believes that the current overcapacity situation in the ER cannot be continued, and urged the IAC to consider the suggestions for improvement contained in the Association's proposed recommendations (located in Appendix 9).

### 2.3.2 Niagara Health System St Catharines General Site Submission Presentation

The Niagara Health System presentation, comprised of an oral presentation by Brent Labord and Kathryn Meehan, was based on the Hospital's written Submission Brief and 34 exhibits.

The Hospital opened its presentation by highlighting a number of contextual factors:

- the NHS is a multi-site hospital with seven sites,
- the staff work under four separate collective agreements,
- of the 1800 nurses (RNs and RPNs) within the NHS, 57 are registered nurses in the SCG Emergency Department,
- the NHS currently has a deficit of \$17M,
- a new hospital is being built to replace the St Catharines General site (completion 2012/13), but until that time, the 'bricks and mortars are fixed',
- there are 5 Emergency Departments within the NHS, of which the St Catharines Site is the largest and busiest, and
- the ONA collective agreement allows for mobility rights, which enable qualified RNs to move between the various Emergency Departments within the NHS without impacting seniority.

The Hospital reviewed, from its perspective, the role and jurisdiction of the IAC. The Hospital emphasized that the IAC's jurisdiction relates only to workload issues only. As the recommendations are non-binding, useful recommendations will be those which have a realistic chance of being implemented without requiring oversight or monitoring. In addition, the Hospital believes that the IAC's jurisdiction is limited to the current circumstances, and recommendations must address the current situation, not the past.

The Hospital stated that the SCG ER sees approximately 45,000 patients annually<sup>20</sup> and that the volume has decreased 4.7% over the past 8-9 months. The SCG site has the highest acuity (59%

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<sup>20</sup> The NHS website indicates that the 2007-08 fiscal year volume was 45,823 patient visits.

of patients are CTAS 1/2/3) and receives the largest number of ambulances of any of the Emergency Departments within the NHS, due to the jurisdictional boundaries drawn by Emergency Medical Services (EMS).

The Hospital reviewed the current baseline staffing model for the SCG Emergency Department. The baseline staffing includes:

- 10 RNs on 12-hour shifts, inclusive of the Charge Nurse, on days and nights,
- 4 RNs who work between 0900 and 2300 (including 1 unbudgeted RN position 1100-2300 hours),
- 1 RPN on days,
- 1 HCA on days and evenings and
- 2 Ward Clerks on days and 1 Ward Clerk on nights.

The Hospital has supplemented the baseline staffing model with RRTs, RPNs and PSWs. The Hospital emphasized that in making the decision to include other registered and unregistered staff, its goal is to ensure that proper patient care is provided and that workload is consistent with this.

The Hospital reviewed the nursing leadership positions supporting the Emergency Department, including the Regional Emergency Program Director, Clinical Manager, Clinical Supervisor, Clinical Resource Nurse and Clinical Educator. The latter two positions are within the bargaining unit. Each of the Regional Director, Clinical Manager and Clinical Supervisor has 30 years of experience. The Clinical Resource Nurse and Clinical Educator positions are both specific to the SCG Emergency Department; the other four ERs within the NHS do not have a Clinical Resource Nurse position and share one Educator between four sites. The Hospital stated that because the SCG has the largest, busiest and most acute Emergency Department within the NHS, it has provided additional resources to support staff.

The Hospital stated that the Emergency Department has struggled with recurring vacancies. It believes that the opportunity for mobility rights within the NHS has resulted in at least part of the turnover, and has contributed to a high novice to expert ratio (29% of SCG ER RNs have less than 2 years experience in the Emergency Department), which in turn exacerbates turnover and further staff shortages.

In light of the number of vacancies and the difficulty in recruiting RNs to the Niagara Region, the Hospital has looked to provide patient care through other regulated health professions. The Hospital has hired, on a one-year (July 2008 – July 2009) temporary basis, 4 RPNs and 2 HCAs, and is hiring 4 RRTs who are beginning employment between January and June 2009. The Hospital believes that as a result of these significant recruitment efforts, the baseline staffing of the Emergency Department will be improved in 2009. The Hospital noted that hiring other health care providers is contemplated within the Collective Agreement 10.12(a), on the understanding that other regulated health professions act within their scope of practice.

The Hospital stated that the 'admit no bed' (ANB) issue is not unique to the NHS, but is a challenge for all hospitals within Ontario. It is a system-wide problem, caused in part by Alternate-Level-Care (ALC) patients remaining in active treatment beds awaiting discharge to long term care (LTC) facilities. There is a shortage of LTC facilities in the Niagara Region, which exacerbates the bottleneck. The Emergency Department has in the past been required to care for ANB patients. The Hospital has implemented a number of changes to address the ANB



issue, including creating the 10-bed Medical Holding Unit (using Pay for Results funding), located and staffed outside of the Emergency Department.

The Hospital presented a summary of actions that have been taken in 2008 to address workload issues (included in Appendix 10).

The Hospital then reviewed the October 20, 2009 letter from the Association to the Interim Chief Nursing Executive. The Hospital reviewed each of the Association's recommendations included in the letter, and provided a response. In particular, the Hospital emphasized the following:

- The Hospital has filled a number of the RN vacancies temporarily with RPNs and HCAs. Currently, the 8 beds in the OBS area are staffed with an RN and an RPN, based on the Charge Nurse's assessment of patient care needs. The Clinical Manager provided clear definition of the RPN scope of practice to the staff in November 2008. Although the Association does not wish RPNs to have a defined patient assignment, the Hospital believes the RPNs are practicing appropriately.
- In light of the number of RN vacancies, and in order to address staffing shortages due to sick leave, the Hospital is hiring four full time RRTs. The Hospital feels that the RRT recruitment was successful due to the fact that it offered permanent (vs. temporary) full-time positions. The Hospital indicated that it was not willing to sign a Letter of Understanding with the Association about staffing the ER while maintaining RN positions.
- The Hospital feels that the RNs in the Emergency Department have had a significant amount of input into changes within the Department, such as the development and implementation of CSI, which included four days of 'practice runs' to engage the staff and increase their awareness.
- The Hospital believes that hospitals do not generally provide a reduced workload to mentors, and that the additional premium included in the Collective Agreement is to cover any additional effort/time required for the mentor to explain/demonstrate roles, responsibilities, procedures etc. to the mentee.
- The Hospital values the professional contributions of RNs and believes that the efforts taken to date to address workload issues demonstrate the value and respect it has for the nursing staff. The Hospital believes it has engaged in every means possible to address these issues, and as such, has not been responding to each individual PRW Report form as the issues have been or are in the process of being addressed.
- The Hospital must operate within its defined budget, and therefore cannot provide additional positions which are outside of the current resources of the Hospital.
- The Hospital believes that a proportion of the staffing shortage in the Emergency Department has flowed from the inability to fill vacancies, and that the Department has often not worked with the full complement of staff (10 RNs) included in the baseline staffing. The Hospital believes it is therefore premature to recommend that the baseline staffing level be increased to 11 RNs.

The Hospital concluded its presentation by stating that it values the nursing staff and their contributions. It recognizes that both parties have experienced challenging circumstances. The

NHS believes it has addressed, and has or is implementing, processes and resources necessary to provide workload consistent with proper patient care within current resources.

The specific recommendation proposed by the Hospital is included in Appendix 11.

### 2.3.3 Niagara Health System St Catharines General Site Response Presentation

The Hospital opened its presentation by clarifying comments provided in its written and oral Submission regarding the scope of practice. The Chief Nursing Executive clarified that the RRT and the RN have differing scopes of practice; there is an overlap in the area of cardio-respiratory care, but the Hospital did not mean to suggest that the RN and RRT scopes of practice are similar. While the scope of practice statement is the same for RNs and RPNs, there is a difference in the nature, scope and complexity of patient care provided by RNs and RPNs. The NHS believes that collaboration is a core element of the profession of nursing, and is concerned with the Association's desire for additional time for RNs to collaborate with RPNs.

The Hospital expressed concern with the increasing number of workload complaints (PRW Reports) despite the many changes that have been mutually developed and implemented, and stated that there is a cultural problem that needs to be addressed. There is a mutual and reciprocal obligation to recognize the changes and move forward, to look at issues from a positive rather than negative viewpoint, and to be part of the solution rather than always raising the problems. The Hospital referenced a number of examples where a 'fact' (e.g. use of agency nurses) can be considered from a positive as well as negative perspective. The Hospital stated "we need to change the culture and it is both of our obligations to do so".

The Hospital concluded its Response by reaffirming the importance of two-way communication, including the effective use of email as an example.

### 2.3.4 Ontario Nurses' Association Response Presentation

The Association opened its response by confirming that the number of nurses within Local 26 is 1400 (not 1800) and that the number of RN positions in the SCG Emergency Department is 57 FTEs (not 57 registered nurses).

The Association stated that it does not believe that everything that could have been done has been done. There is a four-year history at the SCG ER of not enough staff; the Association has not had an experience with any other hospital in the province where this level and severity of decreased staffing has existed for this long.

The Association reviewed in detail its perspective regarding a number of issues identified in the Hospital's submission. Issues particularly emphasized were the following:

- The Association agrees that the NHS has qualified individuals in leadership positions, and the nurses do acknowledge improvements since the Clinical Manager and Clinical Supervisor assumed their positions in 2007. However, some of the support systems have been clawed back: the Clinical Supervisor is not in the unit two days per week, the Clinical Resource Nurse frequently (50% of the time) has a patient assignment and is not available to provide resource support to junior/novice nurses, and the Clinical Educator is frequently unavailable to the Department and cannot even provide consistent time for on-demand education. The

nurses do not feel supported, especially on evenings, nights and weekends, and are asking for someone from management to be available for support and assist with decision-making.

- The Association expressed concern with the communication of the outcomes of the various internal and external reviews that have occurred in the Emergency Department. For example, the Association is concerned that neither the Association nor the registered nurses have had the opportunity to review the Siemens Report. The Hospital's plan to place all Review Reports in one binder in the Emergency Department for the nurses to review has not occurred.
- The Association is concerned regarding the emphasis being placed on the Pay for Results Initiative, as a strategy for dealing with workload issues in general and ANB patients in particular, as the Pay for Results funding is not secure past March 31, 2009. The Association feels that some of the initiatives are not yet implemented (e.g. wireless phones, portable ultrasound machine), some may not be able to be sustained (e.g. Medical Holding Unit), and some do not provide assistance to the ER nurses (e.g. Admissions Nurse – admission paperwork is completed by the inpatient nurses, not the ER nurses). The Association is very concerned about the impact on workload in the ER if the Pay for Results funding is not continued, and is not confident that the Hospital has a back-up plan.
- The Association emphasized that it was never either the Association's or the nurses' understanding that RRTS would replace RNs; this strategy was always presented as a supplement. The Association understood that the RRTs would be hired permanently into the NHS staff, but not permanently into the ER RN baseline 'lines'. This was a huge communication issue in 2008, and led to the "FireSide Chat" meeting with the Vice President Patient Services. The Association noted that at the Inter-Professional workshop, there was discussion regarding the roles and responsibilities of RNs, RPNs, RRTs in relation to resuscitation situations, but never any discussion of 'what do I do on a day-to-day situation when I have less RNs – how do I make it work?'.
- The Association is concerned regarding the lack of communication and follow-through with new initiatives. While the initiatives themselves are positive, the manner in which they have been implemented creates concern. The Association cited two examples: the CSI Unit and the EMS Off-load nurse. The CSI unit has been of benefit, but the Association is concerned with the lack of clear expectations regarding practices and processes.....different nurses and physicians do different things. Post-implementation meetings to review systems, successes, challenges have been requested but have not occurred. The Off-load nurse position has been implemented (this week) without a clear position description for the role or discussion with the Permanent Charge Nurses, leaving the Charge Nurses unsure of how care responsibilities should be assigned.
- The Association agrees that management is responsible for appropriate staffing on a Unit. The Association is concerned however, that the Charge Nurses, to whom some staffing responsibility has been delegated, e.g. to contact the Schedulers at 0600 each day to confirm the day shift staffing, are being put in a difficult position. It is one thing to say that the Hospital is empowering the Charge Nurses to take responsibility for daily shift assignments; it is a very different scenario if the Charge Nurse does not have the resources, either in terms of numbers of staff or mix/classification of staff, to develop an appropriate nurse-patient assignment.

The Association concluded its Response by reaffirming that notwithstanding the many actions and initiatives undertaken to date, what is happening in the ER now is not working for the nurses or the patients, and that the Association looks forward to the IAC's recommendations in assisting both parties to resolve these issues.

## **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 Emergency Department at the St Catharines General Site of the NHS. 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 recognized the scope of Emergency Nursing as a unique specialty which crosses all body systems, disease processes and age groups. Two statements, the first from the Emergency Nurses Association and the second from the Emergency Nurses Association of Ontario, explain the scope, breadth and depth of the Emergency Nursing role as the IAC understands it:

*The scope of emergency nursing practice involves the assessment, analysis, nursing diagnosis, outcome identification, planning, implementation of interventions, and evaluation of human responses to perceived actual or potential sudden, urgent, physical or psychosocial problems that are primarily episodic or acute and which occur in a variety of settings. These may require minimal care to life-support measures; patient, family, and significant other education; appropriate referral and discharge planning; and knowledge of legal implications. Emergency nursing practice includes the provision of care that ranges from birth, death, injury prevention, women's health, and life and limb-saving measures.<sup>21</sup>*

*As a primary care practitioner, the Emergency Nurse is a visible community resource both in terms of health care delivery and health teaching. Emergency Nursing is the nursing care of a constantly changing variety of clients, who present with health problems which are undiagnosed from both a nursing and medical perspective. The environment is unique in terms of the fluctuating volume of clients, the variety of health problems and the dynamic nature of client activity, and the unscheduled and unpredictable manner in which clients arrive<sup>22</sup>.*

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<sup>21</sup> Emergency Nurses Association (ENA): Emergency Nursing Scope of Practice. [www.ena.org](http://www.ena.org)

<sup>22</sup> Emergency Nursing Association of Ontario (ENAO): What is Emergency Nursing [www.enaon.on.ca](http://www.enaon.on.ca)

The IAC believes that the key issues negatively influencing the professional practice environment in the SCG Emergency Department relate to staffing and scheduling, communication and culture, leadership and professional development support. Other factors identified in the literature to impact the quality of the practice environment did not appear to the IAC to be materially significant as key issues of concern within the SCG Emergency Department.

### **3.2 Staffing and Scheduling**

As noted in Sections 2.1.3.3 and 2.3.2, the ER Department has a current budget of 23 RNs per day; 10 RNs (including the Charge Nurse) who work 12-hour shifts days and nights, and 3 RNs who work 8 or 12 hour shifts between 0900 and 2300. (A fourth RN 1100-2300 position is unbudgeted). However, the Department has worked on a daily basis with 4-6 RNs “short” per shift, and it appeared to the IAC that working below the budgeted complement of staff has been the norm.

As noted previously, the Hospital has attempted to address staffing shortages by using RN salary resources to recruit other health care professionals (RPNs and HCAs, and more recently, RRTs) and by using agency nursing staff.

#### **3.2.1 Inter-Professional Model of Care**

The IAC understood that the Hospital made the decision to introduce the RRT positions into the ER Department on the basis of a recommendation in the Emergency Baseline Staffing Project Report. The IAC heard mixed messages at the Hearing: the Association stated that it understood that RRTs would be hired to augment, not replace RNs, while the Hospital stated that the per-shift budget will move from 10 RNs to 9 RNs and 1 RRT. This suggested to the IAC that in terms of per-shift availability, the RRT will in fact replace an RN.

Although there have been six drafts of a proposed Letter of Understanding to confirm that the existing and approved RN positions will be maintained, the Hospital stated at the Hearing that it was not now prepared to sign the letter. The Hospital reversed its position during the Hearing, in the presence of the IAC, and verbally agreed to sign the letter<sup>23</sup>. Accordingly, the IAC expects that the Hospital has hired RRTs into 4 vacant RN positions in order to offer them indeterminate positions (a requirement for successful recruitment), that as RNs are recruited the RRTs will be moved out of the RN positions and into other positions elsewhere in the NHS, and that in the long-term the 4 RN positions will be maintained.

The IAC’s concern does not lie with the mechanics associated with the hiring of the RRTs, which it believes will be successfully addressed through the Letter of Understanding, but rather with the fact that the impact of this strategy on the workload/practice of RNs is very unclear. The Hospital’s approach appears to be ‘we are putting these (RRTs) in here because we haven’t got RNs’, but there does not appear to be a mutually discussed and clear plan for how the RN and RRT roles will practice together on a day-to-day basis. At the Hearing, the IAC heard the RNs question how patient care will be provided in the ER with 9 RNs and an RRT rather than 10 RNs,

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<sup>23</sup> The IAC assumes that the Hospital and Association have taken the steps discussed at the Hearing to finalize the Letter of Understanding and that this has now been completed.



but heard the Hospital's explanation of the Inter-Professional Model at a high level only, not how the RRT role will effectively integrate into and 'actually work' in the ER Department.

The RRT scope of practice focuses on the provision of cardio-respiratory care; as discussed in Section 3.1, Emergency Nursing is much broader. While bringing a value-added role to patient care, RRTs will not be able to replicate the nature and type of care provided by RNs in the Department.

The IAC understands that the Hospital has hired two RRTs and plans to hire two more by June 2009. The IAC supports the concept of Inter-professional care, and believes that there is definitely a role for the RRT in the ER Department. The IAC believes, however, that the patient care requirements in the SCG ER Department require the resources of 10 RNs 24/7 (plus the 3 additional RN shifts per day), and that the RRTs should be expected to provide cardio-respiratory care that will complement the patient care provided by the RNs.

The IAC believes that the Hospital must immediately clarify the roles of the RN and RRT within an inter-professional model of practice at a concrete, day-to-day shift-by-shift patient assignment level. Mutual understanding and consensus must be reached before the end of April when the first two RRTs complete their orientation. The IAC further believes that, because of the duration and magnitude of this issue, the Chief Nursing Executive must be personally and actively involved in its resolution.

***The IAC recommends that:***

- 1. The Chief Nursing Executive personally lead discussion with the ER Department RNs, Clinical Manager and Health Program Director, and Allied Health Director to achieve consensus regarding how the RNs and RRTs will practice together on a daily basis. This discussion must be completed by April 30, 2009, before the RRTs assume an independent practice role within the Department.***
- 2. The Hospital staff the ER with 10 RNs 24/7 (plus the 3 additional RN shifts).***

### 3.2.2 RN – RPN Collaborative Practice

The IAC understands that the ER Department has traditionally had one RPN within the Department, who provided patient care but did not have a defined patient assignment. The RPN role changed in the fall of 2008, following the hiring of 4 RPNs (and 2 HCAs) into 4 of the vacant RN positions. RPNs now have a patient assignment, usually working with an RN in the OBS area. The Association expressed significant concern with this, saying that the RNs feel responsible to be available for and provide support to RPNs who have a different level of expertise and knowledge, and that they do not feel they have sufficient time to appropriately collaborate with RPNs in light of the size and complexity of the Department. The Hospital believes that collaboration is part of professional nursing practice and should not require extra time.

From the IAC's perspective, the Hospital is correct in believing that collaboration is part of nursing practice, and that the RN collaborates with, but is not responsible for, the care provided by the RPN. The Association is also correct in feeling that appropriately assigning and providing support as required to RPNs is difficult given the layout of the Department (the OBS area is quite

isolated), the number of junior/novice and agency nurses, the frequent need for patient transport to other centres and the level of care required by many CTAS-3 and all CTAS-1 and CTAS-2 patients. The IAC believes that this is an example where a difference in perspective leads to difficulty when there is insufficient communication and mutual respect between the two groups. A frank discussion regarding the perceptions of and expectations of the roles of the RNs and RPNs within the Department is required. The IAC believes that it will be important to ensure that 'professional practice' and 'operational requirements' perspectives are aligned, particularly in the current environment of acute fiscal restraint. Personal involvement of the Chief Nursing Executive will be beneficial, partly in light of her knowledge and expertise and partly because she is new to the organization and has no vested 'history'.

The IAC expects that the number of temporary RPNs in the ER Department will decrease as the vacant RN positions are filled. In the meantime, the IAC believes that the Clinical Manager and Clinical Supervisor need to be reviewing instances where patient care needs are beyond the autonomous practice of the RPN, and working with the Charge Nurse(s) to ensure that patient care needs can be met. Review of skill mix in light of patient care needs is a responsibility of management; the IAC anticipates that patient volumes in the SCG ER may change in light of future changes within the Niagara health system as a whole, and that the appropriateness of the RPN role within the ER will require extremely careful evaluation.

***The IAC recommends that***

3. ***The Chief Nursing Executive personally lead discussion with the ER Department RNs and RPNs, Clinical Supervisor, Clinical Manager and Health Program Director to achieve consensus on criteria for RN and RPN patient assignment.***
4. ***In situations where patient care needs are beyond the scope of the RPN to practice autonomously as determined by the above criteria, the Charge Nurse discuss the issue with the Clinical Supervisor and jointly determine how the RPN will be (re)assigned to an appropriate role.***
5. ***The one-year temporary RPN-HCA positions not be renewed after July 2009, and these positions revert to RN positions.***

### 3.2.3 Agency Nurses

The IAC understands the Hospital's decision to integrate nurses employed by external Nursing Agencies into the staff mix in order to ameliorate the staffing shortage within the ER Department. Agency Nurses are both 'a blessing and a curse': while they are able to augment staffing, they are not Hospital employees and cannot assume full responsibility for patient care as they do not have access to the Hospital computer system or automated medication system, cannot implement medical directives etc. Responsibility for these patient care requirements therefore default to the SCG ER RNs, further increasing both their workload and their stress level.

The Hospital indicated that it maintains a maximum of three agency nurses per shift in the ER Department, and books Agency nurses before calling full-time nurses for overtime shifts whenever possible (both as a cost-saving measure due to the Superior Condition and to lessen staff exhaustion and burnout).



The IAC believes that as the number of vacant positions decreases, the Hospital must ensure that the routine use of/dependency on Agency nurses in the SCG ER Department decreases. In the interim, the IAC does not support the Hospital's potential plan to provide Agency nurses with a computer password and access to the AUDD system, as this will decrease motivation to discontinue the Agency positions. Nurses choose to work for a Nursing Agency when they know they can get shifts of their choice; when there is less/no work available through the Agency, nurses will move to direct employment by Hospitals (and other facilities). The IAC believes that decreasing the use of Agency nurses in concert with rebuilding the baseline staff in the ER Department will make a very positive difference to the practice environment in the ER Department.

***The IAC recommends that***

- 6. The Hospital develop a defined plan to decrease Nursing Agency usage in the ER Department, (move from maximum of 3/shift to 2/shift to 1/shift) with a goal of eliminating Nursing Agency use in the ER when all vacant positions are filled, at the latest by April 2010.***

**3.2.4 Recruitment and Retention**

The IAC believes that a significant part of the workload challenges the RNs have encountered relates to the fact that the ER Department is chronically under-staffed. Rather than working with the approved 10 SCG RNs 24/7 and 3 RNs for additional shifts, the ER Department appears to function with a maximum of 5-6 SCG RNs, with an additional 3-4 RNs coming from the NHS multi-site pool or Nursing Agencies. This has put a tremendous strain on the core SCG ER Department RNs.

Recruitment and retention need to be considered hand-in-hand. Recruitment becomes a zero-sum game if retention issues are not addressed and nurses leave the Department at the same rate as they enter it. Even if recruitment and retention are successful and all positions remain filled, an internal shortage situation will occur if nurses are frequently unavailable for work due to short-term (for example due to illness) or long-term (for example LTD, MLOA) issues.

In the SCG ER over the past year, recruitment has become a zero-sum game as nurses left the Department at the same rate as they joined it (22% vs 23%). Although the IAC understands that 'calling in sick' is one of the very few ways for RNs to feel a sense of personal control within a challenging practice environment, the abnormally high level of sick time, together with the number of nurses on long-term leave, has resulted in a significant internal shortage which has further exacerbated the day-to-day staffing situation. The IAC noted that the literature indicates that increased overtime has a direct relationship to sick time, and that relying heavily on overtime to cover baseline staffing is counterproductive.

The Association and the Hospital both confirmed that the hiring process, once an application is received by the NHS, has improved over the past year and is now fairly streamlined and quick.

The IAC was very concerned, however, with the apparent lack of evidence of active current recruitment initiatives. At a minimum, the IAC believes that the NHS should be profiling ER RN positions in the 'employment' section of its website, be using other common web-based recruitment tools, such as Workopolis and HealthForce Ontario, and publications such as

*Hospital News* the six currently vacant positions<sup>24</sup>. Although the Hospital stated in its Pre-Hearing Brief and at the Hearing that recruitment in the Niagara Region is difficult and that it is taking all possible steps to recruit registered nurses, in the month following the Hearing, the IAC checked both the NHS website and Workopolis on a number of occasions, and could not find any active job postings for the SCG ER. The current period of 'economic downturn' may (in fact will likely) result in nurses being laid off in other facilities within and outside the Niagara region. The IAC strongly believes that the Hospital should move quickly to take advantage of this situation and fill vacancies as soon as possible.

The IAC strongly believes that the NHS needs to clearly identify a creative recruitment and retention strategy, and within this, a specific plan for the SCG ER, with defined implementation goals and individually assigned responsibilities. Although the number of RN 'not actively working' positions will decrease from 40% to 25% by the end of June, additional efforts must be taken to decrease both the vacancy and turnover rates further. The instability that has been caused by the external shortage (vacant positions) and exacerbated by the internal shortage (short and long-term absences) has had an extremely negative impact on the quality of the practice environment in the SCG ER.

A key element of successful recruitment is validation of the practice environment by currently employed nurses. The NHS is currently one of two hospitals in Ontario censured by the Ontario Nurses' Association. Although specific comment regarding censure is outside the IAC's jurisdiction, the continuing censure impacts both registered nurses and the employer and the IAC encourages the Association and Hospital to work together towards eventual lifting of the censure.

A key element supporting retention is the provision of feedback regarding practice and a sense of valuing regarding contribution to patient care. The IAC was concerned by the comments made by some of the registered nurses that they had never had a formal performance review. The IAC supports the Human Resource Department's plan to establish a corporate standard for performance reviews, and in the meantime, encourages the provision of informal feedback whenever possible.

***The IAC recommends that:***

- 7. The Hospital consultatively develop and implement a comprehensive strategy for recruitment and retention in the SCG ER, with a recruitment goal of filling all vacant positions and retention goal of decreasing turnover to 10% by October 1, 2009.***
- 8. The NHS Human Resources Department develop and provide support for the implementation of corporate standards for performance review.***

### **3.2.5 Scheduling and Patient Assignment**

Both the Hospital and the Association spoke at length during the Hearing regarding the efforts that have been taken to improve the scheduling process, and the challenges that continue to exist in developing an appropriate patient assignment with the available scheduled staff.

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<sup>24</sup> The funds for these six positions are currently temporarily allocated to RPNs/HCAs (2 positions) and RRTs (4 positions). These positions are designated RN positions, and require active recruitment.

In terms of scheduling, the IAC supports the changes made to improve the 'mechanics' regarding scheduling (allocation of a dedicated Scheduler for the ER Department, use of a designated fax machine for the majority of scheduling information, improved communication between the Scheduler and Charge Nurse(s)) and recognizes the efforts the Hospital has made, through recruitment of RPNs, HCAs and RRTs, to provide increased resources in the face of RN staff shortages. The IAC also supports the decision to implement self-scheduling, and recognizes the considerable effort on the part of both the nurses and the Clinical Manager to ensure its continuation over the past 18 months.

The IAC believes that the scheduling 'mechanics' currently in place will continue to be effective once the ER Department is fully staffed. In the meantime, the IAC believes that increased collaboration is required between the Charge Nurses and the Clinical Supervisor and Clinical Manager, as the risks associated with under-staffing need to be assumed jointly.

The IAC recognizes that staffing the ER Department is currently dependent on the use of overtime. As staffing resources improve and vacancies are filled, the need for overtime on the part of full-time and part-time staff will decrease. In the meantime, the IAC believes that the Hospital needs to more carefully monitor the extent to which ER RNs are working overtime. The current rate of 20.3% of total worked hours being premium pay is unacceptable, both in terms of staff fatigue and patient safety if the majority of these hours are in fact 'overtime shifts' (vs. regular shifts paid at premium rate), and in terms of the Hospital budget.

With respect to the shift-by-shift patient assignment, the Association believes that implementation of the CSI should have been accompanied by the addition of one RN 24/7; the Hospital believes that as the CSI has not changed the number or acuity of patients, an additional RN is not required. The IAC considers it unfortunate that at the time the CSI was implemented, mutually determined changes were not made to the 'assignment sheet' to match the flow and location of patients with assignment of staff. It appeared to the IAC that the Assignment Sheet allocates staff on the basis of number of stretchers, rather than where patients are receiving care. When the CSI is functioning, the CTAS 3-4-5 patients are not receiving care in the Treatment Areas.

In addition, CSI requires physician involvement to function effectively. The IAC noted that a number of ER Departments have introduced a model to reduce wait times, in which MD resources are increased when the volume of patients and/or wait times exceed established thresholds. The IAC believes that the ER Department (including the physicians) needs to make a decision as to when the CSI will be open, and to allocate one of the four RNs in the Treatment Area (Team 1/Team 2) to CSI for this period.

The IAC recognized the acute frustration felt by the Association and registered nurses, and by the Hospital leadership team, regarding scheduling and patient assignment. As noted in Section 3.2.4, the IAC strongly believes that filling the approved baseline staffing positions is the fundamental building block to achieving a more stable and predictable work environment, and, further, that if the vacant baseline staffing positions are not filled, the current challenges regarding staffing and scheduling will continue. Over the next several months, as the new staff become integrated and full-functioning within the ER Department, the IAC believes that it will be extremely important to ensure that the ER Department is fully staffed on a day-to-day basis. The IAC believes that, once the approved budgeted baseline staffing has been consistently in place for a period of time (9-12 months), a comprehensive evaluation of staffing, patient volumes/patient flow and workload will be required to determine if additional registered nurses are required. The

IAC believed it would be premature to recommend an alteration in the RN budgeted resources until the current approved baseline staffing has been fully implemented and evaluated.

***The IAC recommends that***

9. ***Until the baseline staffing positions are filled and predicable staffing levels are achieved, the Clinical Supervisor meet with the Charge Nurse each morning to review the anticipated staffing, and associated patient assignment implications for the next 24 hours (Friday discussion to include review of the weekend), and make a joint decision regarding staff assignment.***
10. ***The Hospital and the Association jointly review the self-scheduling parameters, to ensure that self-scheduling is improving quality of work-life and control for nurses and is enabling the Hospital to effectively meet scheduling requirements.***
11. ***The Hospital ensure that coding for “premium pay due to Superior Condition” is differentiated from “premium pay for overtime shifts” and carefully monitor actual overtime worked hours.***
12. ***The Hospital review, in conjunction with the Site ER Chief, the daily hours of CSI operation, and assign dedicated RN and MD resources to the CSI to ensure optimal efficiency and reduction of wait times.***
13. ***The Hospital and Association jointly undertake a comprehensive evaluation of staffing, patient care needs and workload in September 2010 to determine whether additional staff resources are required.***

### **3.2.6 Workload Measurement**

There are, unfortunately, no reliable nursing workload measurement tools in place for Emergency Departments in Ontario. Although Worked Hours per Equivalent Visit (WHPV) is a crude measurement which does not adequately reflect either the components of quality nursing care, or the specifics of the practice environment (physical layout, staff mix, numbers of novice/agency staff etc), it is currently all that is available. Although nurses often find workload measurement tools time-consuming to complete, objective tools to measure nursing workload are necessary, particularly in the current health care environment focusing on improving patient safety, increasing efficiency and reducing wait times. The need for an effective workload measurement system in ERs across the province needs to be addressed by the Nursing Secretariat at the Ministry of Health and Long-term Care.

***The IAC recommends that:***

14. ***The Hospital write to Vanessa Burkoski,, Provincial Nursing Coordinator, to support the Provincial Workload Group’s efforts to develop objective nursing workload measurement tools.***

### 3.3 Communication and Culture

The NHS recognizes that there are definite challenges at the SCG site with respect to the existing workload environment. At the Hearing, the Hospital, the Association and individual registered nurses all referred to the culture at the SCG as being “difficult”... “not supportive or collegial” .... “concern with reprisal if you speak out” .... “units do not work with each other” .... “an environment where open dialogue with senior management is not the norm” .... “lack of a sense of teamwork between Departments” etc.. The IAC is concerned that this dynamic will make a positive culture change within the SCG ER more difficult to achieve.

The IAC believes that effective communication, which is built on a mutual sense of trust and respect, needs to exist between the registered nurses in the Emergency Department and all levels of Hospital management. The extensive turnover in nursing leadership positions has negatively impacted continuity of both the process and content of communication, and has made it difficult for the registered nurses to make an investment in working with a frequently changing leader. At the same time, the nurses and the Association clearly stated that the current Clinical Manager is trying hard and that they wish to support her efforts.

The IAC feels that this communication breakdown and lack of trust has had a sentinel impact on the stresses, actual and perceived, experienced by the nurses in the ER Department and contributes substantially to professional responsibility workload issues. The IAC believes that achieving mutually respectful communication and an associated positive cultural change is essential. Everyone, regardless of position and tenure, has a responsibility to be accountable for behaving with courtesy, honesty and respect, for bringing concerns forward in a respectful manner and listening to the response, for taking the initiative to identify solutions and evaluate changes, and for celebrating the positives that have been achieved.

The IAC is aware of the economic and employment difficulties within the Niagara region, and knows that in many families the nurse is currently the major or only wage earner. She/he absolutely cannot afford to put her/his position in jeopardy, and so may be hesitant to ‘speak up’. In such an environment, the need for supportive and effective communication based on trust and respect is even more critical.

#### 3.3.1 Communication re Professional Responsibility Concerns

The IAC supports the Association’s perspective that the professional responsibility workload process is intended to provide a constructive avenue for discussion regarding workload issues/concerns. The IAC understands that disagreements about workload can be difficult. The Association expressed concern that the Clinical Manager rarely completed the Section 7 ‘Management Comments’ section of the Professional Responsibility Workload (PRW) Report Forms. The Hospital stated in response that as many of the PRW Forms address similar issues, a specific response to each PRW Form was unnecessary, and that the Clinical Manager often took action on identified issues which were communicated through other means (such as email). Unfortunately, while the actions taken may be appropriate and effective, this approach does not provide direct feedback to the nurses who expressed the concern, or reflect recognition of the challenges existing at the time the Report was written. The IAC believes that one reason the number of PRW Reports continued to increase each year was due to the nurses’ sense that no-one was listening to their concerns.....if it wasn’t heard once, try again. Perception becomes reality;



if the nurses believe that their concerns are not being recognized, this becomes the reality that management must deal with, be it right or wrong.

The IAC believes that it is important that the nurses feel that their leader(s) understand the challenges they face and respect the decisions they make in the course of the daily provision of patient care. It is equally important that the leader(s) feel that the nurses recognize and respect the actions the leader(s) take to fix, or at least ameliorate, issues.

The goal of the Professional Responsibility Clause of the Collective Agreement is that as many PRW Report issues as possible be addressed at the Department (unit) level, and that only those issues which result from or result in a broader, systemic impact be discussed at HAC. Although “addressing” a problem may not mean that the problem is totally fixed (particularly if the problem relates to a systemic issue that goes beyond the ER Department), it does mean that the nurses and their first-line leaders have agreed a problem, perceived or real, does exist and needs to be resolved over time.

*The IAC recommends that:*

- 15. *The Clinical Manager and/or Clinical Supervisor complete the Section 7 ‘Management Comments’ section on each PRW Report and speak directly with the writer to discuss the situation, how it was handled and what supports/resources/approaches would be most effective in the future.***
- 16. *The Hospital develop and provide a concise education update for all Clinical Managers regarding workload reporting, to increase consistency and understanding regarding effective use of the Professional Responsibility Workload Reporting process.***

### 3.3.2 Hospital-Association Committee (HAC) Meetings

The Association and the Hospital have held regular HAC meetings for the past five years, and have made tremendous efforts to address identified workload concerns (Appendix 8). The IAC was concerned, however, with the process and structure of the HAC meetings. The IAC was told that the draft agenda is set by the Association and finalized by the Association the night prior to the meeting when the Local 26 Executive meets with the Professional Practice Specialist from the Toronto Association office. The Hospital is not informed of the agenda items in advance, although the Association did indicate that it does not expect the Hospital to resolve “new” agenda items at that meeting. The IAC was unclear as to who chairs the meetings. The minutes, which are documented in a chart format jointly agreed upon in 2005, provide a “rolling summary” of discussion. If an issue has been ‘on the table’ for several months, the minutes include the discussion at previous meetings, with discussion at the current meeting added at the bottom.

The IAC believes that this does not support a joint team approach or promote a sense of progress, and that the SCG Site HAC needs a ‘fresh start’.

*The IAC recommends that*

**17. The HAC meeting process be revised to the following:**

- a) The Hospital and Association jointly determine membership at regular SCG Site HAC meetings.**
- b) The meetings be chaired by the Association and the Hospital on a rotating basis;**
- c) The Chairperson for the upcoming meeting receive agenda items (including new and unresolved issues) from both the Association and the Hospital and distribute the Agenda five working days in advance of the meeting;**
- d) The first item of business at the meeting be Approval of the Agenda;**
- e) The minutes be taken by the Association and the Hospital on a rotating basis, and be reviewed by the Chairperson prior to the next meeting;**
- f) The minutes reflect discussion and decisions taken at the current meeting only, and specify actions to be taken, accountability and report-back expectations; and**
- g) Minutes be posted.**

### 3.3.3 Intra-Department Communication and Decision-Making

It appears to the IAC that there are two main avenues for intra-department communication and decision-making, individual/group emails and staff meetings, and that neither of these is resulting in effective outcomes.

As in many work environments, email is the vehicle of choice for inter-departmental and corporate communication at NHS. The Hospital placed a computer in the Staff Lounge to enable nurses (and other staff) to access email during breaks; there also appears to be an unwritten assumption that to remain current, staff will access hospital email from home. The IAC understood that the Clinical Manager prefers email as a communication mechanism as she feels it is the most efficient way to reach a large number of rotating staff. The clear message from the registered nurses, however, is that email, as the 'prime mode' of communication within the Hospital, and especially within the Department, is not working for them. The Hospital does not currently have a system to differentiate emails directly relating to ER Department operations/staffing/issues from those relating to the SCG Site or NHS as a whole. Therefore, nurses who have been away on scheduled days off can be faced with many ("150") emails on their return. They have little time during work hours to sift through these, and so may miss important communications from the Clinical Manager, Clinical Supervisor, Educator or their peers. As there is no hard-copy "communication book", it is difficult for an RN to access information in April regarding a policy change documented in email the previous January unless she/he has an effective email folder system.

Having said this, email is definitely used as a means of communication within the Department. The IAC was impressed by the number of personal, passionate, emails which have been written by individuals over the past several years regarding professional practice/workload concerns. Although the IAC was not privy to the authors (names etc were blacked out in the documentation provided), it was evident that individual nurses at both a direct care and management level have taken significant time and effort to express their concerns, but as these have generally not resulted in desired change, their sense of frustration re lack of positive progress has increased.

The IAC believes that the NHS needs to develop clear protocols for use of corporate email, including clear labeling in the subject line, restrictions on the use of "all staff" emails etc.



Currently, it appeared to the IAC that the 'burden' of email was resulting in the loss of timely communication.

The Clinical Manager has been holding Staff Meetings on a relatively regular basis. It appeared to the IAC that she has been hoping/expecting to use Staff Meetings as a vehicle for operational decision-making, but has become discouraged that only a few (the same few) staff attend. Staff choose not to attend for a range of reasons .....are new to the Department and don't feel they have anything to contribute.....feel that there is never any change so why come.....the nurses who do attend will reflect my opinion.....all of which contribute to a sense of apathy. In an attempt to move decision-making forward, the Clinical Manager has had no choice but to work with a select few staff (who actively participate) to make operational decisions (such as the assignment sheet, CSI protocols etc).

Timely and consistent communication has to be an ongoing goal for the ER Department. The IAC believes that once the staff and management nurses have agreed on their desired communication mechanisms and a decision has been made (i.e. communication book, email, notice board, staff meeting etc) regarding communication protocols within the Department, everyone must be accountable for adhering to these.

In addition, the IAC feels that an effective mechanism for provision of up-to-date information may not be the same as an effective mechanism for decision-making, and that one approach should not try to achieve both goals. The IAC believes that Terms of Reference for information sharing and decision-making groups need to be developed, so that there is clarity and mutual understanding re how, when and by whom decisions regarding operations and practice within the ER Department are made and the information is shared across the SCG ER Department as a whole.

***The IAC recommends that***

- 18. The NHS implement a process to streamline the "all staff" email communication to ensure that direct care providers (including RNs, RPNs etc) do not miss key information.***
- 19. The Clinical Manager survey all staff within the ER to determine the most effective/desired mechanism for communication of general information/updates. Mechanisms could include, for example, hard copy communication book in the Nurses Charting Area, posting on bulletin boards in selected areas within the Department, ER Department group email etc. Once the desired approach is implemented, all staff must be responsible and held accountable for accessing it on a regular basis.***
- 20. The Clinical Supervisor be responsible for ensuring that the agreed upon communication system is implemented, consistently monitored and effective.***
- 21. The Clinical Manager continue to hold monthly Staff Communication Meetings. Terms of Reference to include the following:***
  - a) Purpose: provide a forum to provide information/updates regarding activities within the SCG Emergency Department and the SCG/NHS as a whole, to identify issues for referral to the Unit Council, and to celebrate achievements / successes within the Department;***
  - b) Chair: Clinical Manager;***

- c) **Membership:** all staff within the Department (whoever is available attends);
- d) **Minutes:** document information shared; distributed as per communication process (Recommendation 17) above.

**22. The Emergency Department implement a multi-disciplinary Unit Council as the mechanism for discussion of and resolution of operational and practice issues/opportunities. Terms of Reference to include the following:**

- a) **Purpose:** to work collaboratively on decision-making related to practice and procedures that enhance the quality of patient care, work environment and relationships among staff;
- b) **Chair:** co-chaired by one staff member and one management member;
- c) **Membership:** defined membership, selected by nomination, including RNs and other health care providers within the Department, not to exceed 8, defined term;
- d) **Meetings:** held bi-weekly or monthly as required for timely decision-making;
- e) **Agenda:** published in advance of meeting;
- f) **Minutes:** document discussion of issues, actions decided upon, timelines, and accountability for action/follow-up; distributed as per the communication method (Recommendation 17) selected above.

### **3.4 Leadership**

#### **3.4.1 Nursing Leadership**

Effective nursing leadership is a key requirement for professional practice within a quality practice environment. Effective strategic, operational and clinical leadership requires both the correct number and nature of leadership positions and a participative approach on the part of the nursing leaders that supports and respects staff involvement in organizational and clinical decision-making.

At a strategic level, the RNAO Best Practice Guideline *Developing and Sustaining Effective Staffing and Workload Practices* identifies that the senior management team include “a senior nurse executive who is involved at all phases of the organizations’ strategic planning, policy, evaluation and reporting processes”<sup>25</sup>. The NHS has recently hired a new Chief Nursing Executive, who comes to the organization with substantial expertise in professional practice leadership at both an organizational and provincial level. The IAC believes that she must actively participate in guiding critical thinking and decision-making relating to professional nursing practice, skill mix and inter-professional practice in a manner that will optimally support quality patient care. Her expertise will be especially required during the turnaround period in the ER over the coming months, as the ER Department seeks to integrate RRTs into the care delivery model, and to move from a high level concept of inter-professional practice to actual operational implementation.

Nursing leadership at the operational level rests with the Clinical Manager of the SCG ER, who reports to the Health Program Director (HPD) for Emergency Services, who is in turn responsible for care delivery and operations in all five Emergency Departments within the NHS and reports to the Vice President Patient Services responsible for the Emergency Services Program. The HPD

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<sup>25</sup> RNAO Best Practice Guideline: Summary Recommendations for Developing and Sustaining Effective Staffing and Workload Practices, Recommendation 2.1.

assumed the role in March 2008. The Clinical Manager has been in the role since June 2007. As noted in Section 3.2.2, the frequent turnover at both the strategic and operational levels has negatively impacted the provision of consistent leadership. Further turnover within these positions, especially the Clinical Manager, in the near future will be very detrimental.

As the Health Program Director was unable to attend the Hearing, the IAC did not have the opportunity to gain an understanding of her approach to leadership and decision-making. The IAC was impressed with the Clinical Manager's open attitude and desire to involve the staff in decisions regarding Department functioning. The IAC felt that she clearly gave the message that she is open to feedback, stating at one point "all feedback is a gift, and the stuff you don't want to hear is the biggest gift". However, the IAC was concerned about the apparent gap between her stated desire for staff involvement and the staff's perception that operational decisions (such as the implementation of the EMS Off-Load Nurse role, the replacement of tympanic thermometers) have been made without their awareness. The IAC believes that effective operational leadership requires a balance between supporting staff involvement/autonomy on issues and providing guidance, direction and articulating boundaries regarding these issues.

Operational leadership after-hours is provided by the Manager-on-Call, who may or may not be familiar with the Emergency Department (but is familiar with SCG). The nurses expressed their concern regarding the level of support that the Manager on Call provides; while usually sympathetic, the Manager on Call frequently makes no suggestions or takes no action to deal with the issue and sometimes says "why are you calling?". This leaves the nurses feeling that they are assuming all the risks associated with short staffing etc. The IAC believes that the Hospital will need, in the near future, to reconsider the resources dedicated to managerial coverage after hours. In an environment where the demand for beds exceeds available resources and there are common staffing shortages, the role of the in-house supervisor/on-site coordinator is re-emerging in many hospitals.

At a clinical level within the Department, nursing leadership is provided by the Clinical Supervisor, Charge Nurses, Resource Nurse, and Clinical Educator.

- The Clinical Supervisor provides ongoing support and visibility to the ER Department staff through handling operational issues re equipment, staffing and scheduling, communicating with other Departments/disciplines and coaching/mentoring the Charge Nurses.
- The Charge Nurses are responsible for the overall smooth running of the Department on a daily basis, determining the nurse:patient assignment, acting as a clinical resource for the staff, and ensuring that the timeliest and most appropriate patient care is provided.
- The Resource Nurse supports new nursing staff on a day-to-day basis, and works with the ER staff to expand their skills and expertise (e.g. orientation to triage).

Although these on-site clinical leadership resources appear generous, their ability to provide effective support has been challenged over the past 6-12 months. Since September 2008, the Clinical Supervisor has been seconded to the Douglas Memorial ER Department 1-2 days per week, limiting her visibility and active involvement in the SCG ER. Staffing shortages have required the Resource Nurse to assume a direct patient care role up to 50% of the time, substantially decreasing the support she is able to provide novice nurses. In addition, the Clinical Supervisor, Charge Nurses and Resource Nurse all report directly to the Clinical Manager, as do all the staff within the ER. This means that the clinical leaders are at a peer level with the staff,

and so have no authority to effect change or to require their peers to adhere to agreed processes/protocols.

The IAC was concerned that neither the operational nor clinical leaders appeared to be directly accountable to follow up/monitor the process of implementation and/or the impact of new policies / standards / protocols / approaches within the ER Department, or to take action to address issues identified. As noted in Section 2.1.2.1, it appeared to the IAC that no-one was 'on top of' and/or taking action to address the challenges being experienced with the implementation of the CSI. The IAC was very concerned regarding the imminent implementation of the RRT role within the ER: it did not appear to the IAC that a clear implementation strategy has been developed, a monitoring process identified or evaluative criteria defined. The IAC was also concerned by the patient safety issue resulting from the apparent use of both a computer-generated and handwritten MAR; the IAC understood that the RNs chose to use one or the other based on personal preference. The IAC believes once a standard of practice has been determined and implemented, all staff are accountable for practicing accordingly. Effectively managing change, including monitoring, requiring adherence to, and revising as required the new standards/expectations is a key component of effective leadership.

The Clinical Educator reports to the Regional Education Director in a centralized model. Although she is "dedicated" to the SCG ER, she has a number of corporate education responsibilities, such as general Hospital orientation, implementation of new processes and procedures such as the AUDD etc. which take her out of the Department frequently. While understanding the need to support corporate initiatives, the IAC was disturbed by the information (presented by the Association but not refuted by the Hospital) that during the entire month of January 2009, the Clinical Educator had no designated time in the ER Department to work with the staff.

***The IAC recommends that***

- 23. The Chief Nursing Executive be proactively involved in discussions relating to inter-professional practice and RN-RPN collaboration during this turnaround period, and at least for the next 12 months receive quarterly progress reports on improvements achieved.***
- 24. The Hospital revise the reporting relationship within the Emergency Department so that the staff RNs and RPNs report to the Clinical Supervisor, in order to provide her with direct line authority. The Charge Nurses and Resource Nurse continue to report to the Clinical Manager.***
- 25. The Clinical Supervisor assume increased accountability for day-to-day staffing and patient assignment and be relieved of responsibility for the Douglas Memorial Site ER.***
- 26. The Hospital review the resources required to integrate an on-site Clinical Coordinator position 1500 – 2300 hours Monday through Friday and 1100 – 1900 hours weekends and holidays, and if possible, trial this position for a six month period.***
- 27. The Clinical Manager and Clinical Supervisor, in collaboration with the Clinical Resource Nurse and Charge Nurses, develop and consistently implement a process(es) to monitor implementation of new protocols/standards, take action to address implementation issues as required, and evaluate outcomes. The IAC further***



***recommends that this initiative begin with analysis of the functioning of the CSI and the use of a consistent MAR.***

- 28. The Hospital clarify the corporate and clinical expectations of the Clinical Educator, and communicate these clearly to the nursing staff, so that expectations are understood and consistent. At a minimum, the IAC believes that the Clinical Educator should be available for in-Department educational support 60% of the time (average 3 days per week) over the course of each month.***

### **3.4.2 Corporate Leadership**

As noted in discussions at the Hearing, the issue of 'admit no bed' (ANB) patients in the Emergency Department and the associated challenge of 'alternate level care' (ALC) patients in inpatient beds within the Hospital is not unique to the NHS. Although the ALC situation within the Hamilton Niagara Haldimand Brant LHIN is one of the most acute in the province, strategies to minimize the impact of ALC patients on inpatient beds are being discussed at LHINs across the province, and creative approaches are being taken. A community hospital within the Champlain LHIN, for example, has contracted with a local retirement home to provide care for 20 ALC patients; the availability of these inpatient beds within the hospital has made a very positive difference to patient flow within the ER.

Although not addressing the issue of ALC patients directly, the IAC was impressed with the SCG's strategy of creating the 10-bed Medical Holding Unit (MHU) to care for ANB patients outside of the ER. This demonstrated to the IAC that the Hospital recognizes that the management of ANB patients is a corporate responsibility, not just an ER Department problem. In light of the impact that the MHU had on ALOS of admitted patients in the ER in the first month of its operation (a decrease of 3 hours per day), the IAC encourages the Hospital to make continuation of the MHU a priority with Pay for Results Funding received for the 2009-2010 fiscal year. The IAC also encourages continuation of the porter positions in the ER Department.

The IAC also encourages the NHS to provide frequent updates to hospital staff regarding funding. The IAC believes it is important that staff understand that hospitals are, and will increasingly be, funded on a volume / outcomes / performance driven models rather than base funding adjustments.

In an environment in which change is pervasive, evaluation becomes an extremely important mechanism to determine where consistency will be beneficial and where change is required. Although the Hospital has demonstrated creativity and initiative in implementing strategies to deal with issues, such as staffing, the IAC believes that the culture of the Hospital will benefit if considered/focused evaluation efforts, that involve and are credible to key stakeholders, are implemented.

***The IAC recommends that***

- 29. The Hospital continue to support the Medical Holding Unit and the designated ER Department porter positions until such time as alternative programs to address ALC realities are negotiated and implemented.***

- 30. *The Hospital implement a comprehensive strategy to evaluate the impact of the IAC recommended changes one year following implementation.***

### **3.5 Professional Development**

Access to and support for relevant professional development opportunities, including orientation, is a key element supporting both quality practice environments and retention. The IAC believes that articulation of a formal plan for professional development and career planning is required for all nurses. The IAC was impressed with the extensive professional development some nurses had undertaken, both personally and with Hospital support, (such as CNA ER Certification, baccalaureate degree program, RNAO Advanced Clinical Practice Fellowship) but was not able to determine the extent of the participation.

There was extensive discussion at the Hearing regarding support for mentorship, with the Association believing that mentors were receiving insufficient support and the Hospital believing it was acting appropriately as per Article 9.08 (c) of the Collective Agreement. The IAC believes that the ER Department has a supportive orientation program in place, and that new orientees, especially those within the New Graduate Initiative, are receiving mentorship support. However, the IAC understands that the effectiveness of this support has been negatively impacted by the staffing shortage, which has limited the ability of both the Clinical Resource Nurse and staff RNs to provide mentorship without feeling overwhelmed, and by the lack of availability of the Clinical Educator. The IAC believes that as the staffing situation improves, the number of 'actively working' RNs increases and number of Agency nurses decreases, and the roles of the RPNs and RRTs are clarified, the registered nurses will be able to provide effective mentorship within their daily workload assignment.

## **PART IV: CONCLUSION AND SUMMARY OF RECOMMENDATIONS**

### **4.1 Conclusion**

The IAC was requested to specifically address the issue of whether or not registered nurses in the Emergency Department at the St Catharines General Site of the Niagara Health System are being requested to perform more work than is consistent with proper patient care.

Through a comprehensive process involving review of written and oral submissions, focused discussion at a 2-1/2 day Hearing, and extensive Committee analysis and discussion following the Hearing, the IAC concluded that the current budgeted resources of 10 RNs 24/7 plus 3 'float' RNs within the SCG ER is appropriate.

The IAC concluded, however, that the registered nurses have been required to perform more work than is consistent with safe patient care due to the fact that the ER Department has not been staffed with the approved complement of RNs. The impact of the large number of vacant RN positions on staff availability has been exacerbated by high levels of sick time secondary (at least in part) to high levels of required overtime. The IAC recognizes that the Hospital has attempted to address the staffing shortage by hiring other health care professionals (RPNs and RRTs) into RN positions on a temporary basis, and by extensive use of nurses employed by external Nursing Agencies. While RPNs and RRTs provide a value-added role to the Department, they cannot replicate the level, nature, and complexity of care provided by SCG staff ER RNs. The difficulties resulting from consistent under-staffing have been further increased by the gap in relational capital (trust, confidence, respectful communication) between the registered nurses and the nursing leaders at all levels, strategic, operational and clinical.

The IAC concluded that the key, sentinel requirement for effective functioning of the SCG ER in the short and long term is a successfully focused and sustained recruitment program to ensure that baseline budgeted RN positions in the SCG ER are consistently filled. The IAC recognized the challenges the NHS is facing in terms of its \$17M shortfall, but believed that as baseline positions are filled and less costs are required for payment of sick time, premium pay and external Nursing Agency support, the overall staffing costs within the SCG ER will decrease.

The IAC identified the need for immediate short-term intervention by the Chief Nursing Executive regarding implementation of the inter-professional model of care in the SCG ER. Development of a thoughtful, respectful and mutually supported implementation strategy that is monitored and revised as required will assist the SCG ER to move towards a more collegial and cooperative practice environment. The IAC also identified the need for more extensive involvement of the Clinical Manager and Clinical Supervisor in operational decision-making re staffing and patient assignment, monitoring of practice standards, and more focused communication regarding workload concerns.

Finally, the IAC concluded that the NHS must continue to actively address, at a site, corporate and LHIN level, the issue of "admit no bed" (ANB) and "alternate level care" (ALC) patients. At a minimum, the Medical Holding Unit needs to be maintained until alternative strategies to address ALC realities are negotiated and implemented.



## 4.2 Summary of Recommendations

The IAC identified 30 recommendations relating to staffing and scheduling, communication and culture, and leadership.

### Staffing and Scheduling:

1. The Chief Nursing Executive personally lead discussion with the ER Department RNs, Clinical Manager and Health Program Director, and Allied Health Director to achieve consensus regarding how the RNs and RRTs will practice together on a daily basis. This discussion must be completed by April 30, 2009, before the RRTs assume an independent practice role within the Department.
2. The Hospital staff the ER with 10 RNs 24/7 (plus the 3 additional RN shifts).
3. The Chief Nursing Executive personally lead discussion with the ER Department RNs and RPNs, Clinical Supervisor, Clinical Manager and Health Program Director to achieve consensus on criteria for RN and RPN patient assignment.
4. In situations where patient care needs are beyond the scope of the RPN to practice autonomously as determined by the above criteria, the Charge Nurse discuss the issue with the Clinical Supervisor and jointly determine how the RPN will be (re)assigned to an appropriate role.
5. The one-year temporary RPN-HCA positions not be renewed after July 2009, and these positions revert to RN positions.
6. The Hospital develop a defined plan to decrease Nursing Agency usage in the ER Department, (move from maximum of 3/shift to 2/shift to 1/shift) with a goal of eliminating Nursing Agency use in the ER when all vacant positions are filled, at the latest by April 2010.
7. The Hospital consultatively develop and implement a comprehensive strategy for recruitment and retention in the SCG ER, with a recruitment goal of filling all vacant positions and retention goal of decreasing turnover to 10% by October 1, 2009.
8. The NHS Human Resources Department develop and provide support for the implementation of corporate standards for performance review.
9. Until the baseline staffing positions are filled and predicable staffing levels are achieved, the Clinical Supervisor meet with the Charge Nurse each morning to review the anticipated staffing, and associated patient assignment implications for the next 24 hours (Friday discussion to include review of the weekend), and make a joint decision regarding staff assignment.
10. The Hospital and the Association jointly review the self-scheduling parameters, to ensure that self-scheduling is improving quality of work-life and control for nurses and is enabling the Hospital to effectively meet scheduling requirements.

11. The Hospital ensure that coding for “premium pay due to Superior Condition” is differentiated from “premium pay for overtime shifts” and carefully monitor actual overtime worked hours.
12. The Hospital review, in conjunction with the Site ER Chief, the daily hours of CSI operation, and assign dedicated RN and MD resources to the CSI to ensure optimal efficiency and reduction of wait times.
13. The Hospital and Association jointly undertake a comprehensive evaluation of staffing, patient care needs and workload in September 2010 to determine whether additional staff resources are required.
14. The Hospital write to Vanessa Burkoski,, Provincial Nursing Coordinator, to support the Provincial Workload Group’s efforts to develop objective nursing workload measurement tools.

**Communication and Culture:**

15. The Clinical Manager and/or Clinical Supervisor complete the Section 7 ‘Management Comments’ section on each PRW Report and speak directly with the writer to discuss the situation, how it was handled and what supports/resources/approaches would be most effective in the future.
16. The Hospital develop and provide a concise education update for all Clinical Managers regarding workload reporting, to increase consistency and understanding regarding effective use of the Professional Responsibility Workload Reporting process.
17. The HAC meeting process be revised to the following:
  - a) The Hospital and Association jointly determine membership at regular SCG Site HAC meetings;
  - b) The meetings be chaired by the Association and the Hospital on a rotating basis;
  - c) The Chairperson for the upcoming meeting receive agenda items (including new and unresolved issues) from both the Association and the Hospital and distribute the Agenda five working days in advance of the meeting;
  - d) The first item of business at the meeting be Approval of the Agenda;
  - e) The minutes be taken by the Association and the Hospital on a rotating basis, and be reviewed by the Chairperson prior to the next meeting;
  - f) The minutes reflect discussion and decisions taken at the current meeting only, and specify actions to be taken, accountability and report-back expectations; and
  - g) Minutes be posted.
18. The NHS implement a process to streamline the “all staff” email communication to ensure that direct care providers (including RNs, RPNs etc) do not miss key information.
19. The Clinical Manager survey all staff within the ER to determine the most effective/desired mechanism for communication of general information/updates. Mechanisms could include, for example, hard copy communication book in the Nurses Charting Area, posting on bulletin boards in selected areas within the Department, ER Department group email etc. Once the desired approach is implemented, all staff must be responsible and held accountable for accessing it on a regular basis.

20. The Clinical Supervisor be responsible for ensuring that the agreed upon communication system is implemented, consistently monitored and effective.
21. The Clinical Manager continue to hold monthly Staff Communication Meetings. Terms of Reference to include the following:
  - a) Purpose: provide a forum to provide information/updates regarding activities within the SCG Emergency Department and the SCG/NHS as a whole, to identify issues for referral to the Unit Council, and to celebrate achievements / successes within the Department;
  - b) Chair: Clinical Manager;
  - c) Membership: all staff within the Department (whoever is available attends);
  - d) Minutes: document information shared; distributed as per communication process (Recommendation 19) above.
22. The Emergency Department implement a multi-disciplinary Unit Council as the mechanism for discussion of and resolution of operational and practice issues/opportunities. Terms of Reference to include the following:
  - a) Purpose: to work collaboratively on decision-making related to practice and procedures that enhance the quality of patient care, work environment and relationships among staff;
  - b) Chair: co-chaired by one staff member and one management member;
  - c) Membership: defined membership, selected by nomination, including RNs and other health care providers within the Department, not to exceed 8, defined term;
  - d) Meetings: held bi-weekly or monthly as required for timely decision-making;
  - e) Agenda: published in advance of meeting;
  - f) Minutes: document discussion of issues, actions decided upon, timelines, and accountability for action/follow-up; distributed as per the communication method (Recommendation 19) selected above.

#### Leadership:

23. The Chief Nursing Executive be proactively involved in discussions relating to inter-professional practice and RN-RPN collaboration during this turnaround period, and at least for the next 12 months receive quarterly progress reports on improvements achieved.
24. The Hospital revise the reporting relationship within the Emergency Department so that the staff RNs and RPNs report to the Clinical Supervisor, in order to provide her with direct line authority. The Charge Nurses and Resource Nurse continue to report to the Clinical Manager.
25. The Clinical Supervisor assume increased accountability for day-to-day staffing and patient assignment and be relieved of responsibility for the Douglas Memorial Site ER.
26. The Hospital review the resources required to integrate an on-site Clinical Coordinator position 1500 – 2300 hours Monday through Friday and 1100 – 1900 hours weekends and holidays, and if possible, trial this position for a six month period.

27. The Clinical Manager and Clinical Supervisor, in collaboration with the Clinical Resource Nurse and Charge Nurses, develop and consistently implement a process(es) to monitor implementation of new protocols/standards, take action to address implementation issues as required, and evaluate outcomes. The IAC further recommends that this initiative begin with analysis of the functioning of the CSI and the use of a consistent MAR.
28. The Hospital clarify the corporate and clinical expectations of the Clinical Educator, and communicate these clearly to the nursing staff, so that expectations are understood and consistent. At a minimum, the IAC believes that the Clinical Educator should be available for in-Department educational support 60% of the time (average 3 days per week) over the course of each month.
29. The Hospital continue to support the Medical Holding Unit and the designated ER Department porter positions until such time as alternative programs to address ALC realities are negotiated and implemented.
30. The Hospital implement a comprehensive strategy to evaluate the impact of the IAC recommended changes one year following implementation.



## Ontario Nurses' Association

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

October 25, 2008

Joan Cardiff  
306 Freedom Private  
Ottawa, ON K1G 6W4

Dear Ms. Cardiff,

**Re: Niagara Health System and Ontario Nurses' Association: Professional Responsibility Complaint – St. Catharines General Hospital Site (SCGH): Emergency Department- Independent Assessment Committee**

Thank you for accepting the nomination to chair an Independent Assessment Committee investigating professional responsibility complaint at the SCGH site of the Niagara Health System in the Emergency Department.

The Association's nominee and contact information is:

Trudy Molke,  
Trudy Molke Practice Consulting  
48 Overbank Crescent  
Toronto, ON M3A 1W2

Tel.: 416-447-7738  
Email: [trudy.molke@sympatico.ca](mailto:trudy.molke@sympatico.ca)

The employer's nominee and information is:

Winnie Doyle  
VP Clinical Services LHIN 4A  
St. Joseph's Health Centre  
50 Charlton Avenue East  
Hamilton, Ontario  
Canada L8N 4A6

Tel: 905-522-1155 ext 6253  
Email: [wdoyle@stjosham.on.ca](mailto:wdoyle@stjosham.on.ca)

As discussed, please set up dates with the nominees, who will confirm with their respective parties.

Sincerely,  
**ONTARIO NURSES' ASSOCIATION**

*for* Ann Lokre  
Rozanna Haynes  
LRO, Professional Practice Specialist

rh/al

C: Trudy Molke  
Heather Cross, LC ONA Local 26  
Cindy Forster, LRO, ONA  
Sam Mandelbaum, OHA

Winnie Doyle  
Pam Sheptenko, BUP  
Donna Rothwell, NHS

Provincial Office: Toronto

Regional Offices: Ottawa • Hamilton • Kingston • London  
Orillia • Sudbury • Thunder Bay • Timmins • Windsor







November 28, 2008

Appendix 2

306 Freedom Private  
Ottawa, Ontario  
K1G 6W4

Ms Rozanna Haynes  
LRO, Professional Practice Specialist  
Ontario Nurses' Association  
85 Grenville Street  
Suite 400  
Toronto, Ontario  
M5S 3A2

Dear Ms. Haynes :

**Re : Niagara Health System and Ontario Nurses' Association : Professional Responsibility Complaint – St Catherine's General Hospital Site (SCGH) Emergency Department – Independent Assessment Committee Hearing**

I am writing to confirm that the Independent Assessment Committee (IAC) Hearing regarding the above issue will be held at the St Catherines General Site of the Niagara Health System on Monday January 26<sup>th</sup>, Tuesday January 27<sup>th</sup> and Wednesday January 28<sup>th</sup>, 2009, as per the attached Hearing Agenda.

The IAC will tour the Emergency Department on the morning of Monday January 26<sup>th</sup>, 2009. The Tour will begin at 1000 hours. I am requesting that the Ontario Nurses' Association work with the St Catherines General Hospital Site (SCGH - Niagara Health System) to coordinate the arrangements for the tour, specifically:

- how many ONA and SCGH representatives will accompany us on the tour, and who these representatives will be,
- who will lead the tour through the Emergency Department, and
- where the IAC members should arrive to begin the tour.

Please ensure that I receive this information by Friday January 16<sup>th</sup>, 2009.

The Hearing will begin at 1300 hours on Monday January 26<sup>th</sup>, 2009. As indicated on the Hearing Agenda, each of the Ontario Nurses' Association and the St Catherines General Site will have one and one half (1-1/2) hours to present their submission. Please confirm whether you will require an LCD projector; if you plan to use a powerpoint presentation, please bring your own laptop. The afternoon will adjourn following presentation of both submissions, in order to enable each party to prepare their Reply.

The Hearing will recommence on the morning of Tuesday January 27<sup>th</sup>, with the Reply from the St Catherines General Site, followed by the Reply from the Ontario Nurses' Association. The Hearing will adjourn following presentation of both Reply submissions; the time of adjournment will depend on the extent of discussion required. The IAC will meet following the Hearing adjournment to determine areas/issues requiring further clarification.

The Hearing will recommence on the morning of Wednesday January 28<sup>th</sup>, with Questions to both the Ontario Nurses' Association and the St Catherines General Site by the IAC. The Hearing is currently scheduled to close as 1200 hours on Wednesday January 28<sup>th</sup>; if additional time is

*Niagara Health System – St Catharines General Site  
Independent Assessment Committee Report  
March 13, 2009*



required, arrangements will be made at that time for continuation of the Hearing at a mutually convenient date.

The Hearing will be held in the Boardroom of the St Catherine's General Site. Refreshments will be available in the morning and afternoon, but lunch will not be provided. I have requested the Hospital to provide a caucus room for the Ontario Nurses' Association for the full three days (i.e. 0900 Monday January 26<sup>th</sup> to 1600 Wednesday January 28<sup>th</sup>).

In order to support the principles of full disclosure and to enable the IAC to effectively prepare for the Hearing, the IAC requests individual, independent written submissions be provided by the close of business day (1600 hours) on Friday January 9, 2009. Please submit five copies of your submission and attachments in hard copy to my address above. As Chair of the IAC, I will retain one (1) copy of each submission, and will distribute the remaining four (4) submissions with attachments by courier on Monday January 12<sup>th</sup>, 2009 as follows:

- one (1) copy of the St Catherine's General Site submission and one (1) copy of the Ontario Nurses' Association submission to Winnie Doyle (Hospital Nominee);
- one (1) copy of the St Catherine's General Site submission and one (1) copy of the Ontario Nurses' Association submission to Trudy Molke (ONA Nominee);
- two (2) copies of the St Catherine's General Site submission to the Ontario Nurses' Association (attention Rozanna Haynes); and
- two (2) copies of the Ontario Nurses' Association submission to the St Catherine's General Site (attention Christopher Cecchini).

In the event that the Ontario Nurses' Association wishes to provide supplemental information after January 9<sup>th</sup>, 2009, supplemental information will be accepted to the close of business (1600 hours) on Friday January 16<sup>th</sup>, 2009. Supplemental information will be distributed by the IAC Chairperson as above. Supplemental information will not be accepted after this date. Supplemental information may be sent via email, with hard copy to follow. Please note that supplemental information is information to support/clarify the Ontario Nurses' Association presentation; it is not information to respond to the St Catherine's General Site submission.

The IAC will meet the week of January 19<sup>th</sup>, 2009 to review the submissions in detail in advance of the Hearing.

Please confirm who will be representing the Ontario Nurses' Association at the full Hearing by Friday January 16<sup>th</sup>, 2009. The IAC anticipates that additional Registered Nurses from the Emergency Department will attend part or all of the Hearing.

If you have any questions, please contact me by phone at 613-260-2415, or by email at [jcardiff@cheo.on.ca](mailto:jcardiff@cheo.on.ca).

Sincerely

Joan Cardiff  
Chair, Independent Assessment Committee

cc. Winnie Doyle, Hospital Nominee  
Trudy Molke, ONA Nominee  
Chris Cecchini, Director Labour Relations, St Catherine's General Site

November 28, 2008

Appendix 2

306 Freedom Private  
Ottawa, Ontario  
K1G 6W4

Mr. Christopher Cecchini  
Director, Labour Relations  
St Catherine's General and Ontario Street Sites  
Niagara Health System  
142 Queenston Street  
St Catharines, Ontario  
L2R 7C6

Dear Mr. Cecchini:

**Re : Niagara Health System and Ontario Nurses' Association : Professional Responsibility Complaint – St Catherine's General Hospital Site (SCGH) Emergency Department – Independent Assessment Committee Hearing**

I am writing to confirm that the Independent Assessment Committee (IAC) Hearing regarding the above issue will be held at the St Catharines General Site of the Niagara Health System on Monday January 26<sup>th</sup>, Tuesday January 27<sup>th</sup> and Wednesday January 28<sup>th</sup>, 2009, as per the attached Hearing Agenda.

The IAC will tour the Emergency Department on the morning of Monday January 26<sup>th</sup>, 2009. The Tour will begin at 1000 hours. I am requesting that the St Catharines General Hospital Site (SCGH - Niagara Health System) work with the Ontario Nurses' Association to coordinate the arrangements for the tour, specifically:

- how many SCGH and ONA representatives will accompany us on the tour, and who these representatives will be,
- who will lead the tour through the Emergency Department, and
- where the IAC members should arrive to begin the tour.

Please ensure that I receive this information by Friday January 16<sup>th</sup>, 2009.

The Hearing will begin at 1300 hours on Monday January 26<sup>th</sup>, 2009. As indicated on the Hearing Agenda, each of the Ontario Nurses' Association and the St Catharines General Site will have one and one half (1-1/2) hours to present their submission. Please confirm whether you will require an LCD projector. The afternoon will adjourn following presentation of both submissions, in order to enable each party to prepare their Reply.

The Hearing will recommence on the morning of Tuesday January 27<sup>th</sup>, with the Reply from the St Catharines General Site, followed by the Reply from the Ontario Nurses' Association. The Hearing will adjourn following presentation of both Reply submissions; the time of adjournment will depend on the extent of discussion required. The IAC will meet following the Hearing adjournment to determine areas/issues requiring further clarification.

The Hearing will recommence on the morning of Wednesday January 28<sup>th</sup>, with Questions to both the Ontario Nurses' Association and the St Catharines General Site by the IAC. The Hearing is currently scheduled to close as 1200 hours on Wednesday January 28<sup>th</sup>; if additional time is

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Independent Assessment Committee Report  
March 13, 2009*

required, arrangements will be made at that time for continuation of the Hearing at a mutually convenient date.

In order to support the principles of full disclosure and to enable the IAC to effectively prepare for the Hearing, the IAC requests individual, independent written submissions be provided by the close of business day (1600 hours) on Friday January 9, 2009. Please submit five copies of your submission and attachments in hard copy to my address above. As Chair of the IAC, I will retain one (1) copy of each submission, and will distribute the remaining four (4) submissions with attachments by courier on Monday January 12<sup>th</sup>, 2009 as follows:

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- one (1) copy of the St Catherines General Site submission and one (1) copy of the Ontario Nurses' Association submission to Trudy Molke (ONA Nominee);
- two (2) copies of the St Catherines General Site submission to the Ontario Nurses' Association (attention Rozanna Haynes); and
- two (2) copies of the Ontario Nurses' Association submission to the St Catherines General Site (attention Christopher Cecchini).

In the event that the St Catherines General Site wishes to provide supplemental information after January 9<sup>th</sup>, 2009, supplemental information will be accepted to the close of business (1600 hours) on Friday January 16<sup>th</sup>, 2009. Supplemental information will be distributed by the IAC Chairperson as above. Supplemental information will not be accepted after this date.

Supplemental information may be sent via email, with hard copy to follow. Please note that supplemental information is information to support/clarify the St Catherines General Site presentation; it is not information to respond to the Ontario Nurses' Association submission.

The IAC will meet the week of January 19<sup>th</sup>, 2009 to review the submissions in detail in advance of the Hearing.

The IAC appreciates the opportunity to hold the Hearing in the Hospital, as this will enable a larger number of Registered Nurses to attend the Hearing as participants or observers. We will require the following 'logistical support':

- Hearing and IAC:
  - Use of the Boardroom for the full three day period (0900 Monday January 26<sup>th</sup> to 1600 Wednesday January 28<sup>th</sup>)
    - Please configure the Boardroom in a U-shape, with 3 seats (for the IAC) at the head of the table, and 10 seats on either side.
    - Please ensure that an extension cord is available if an electrical plug is not close to the IAC (I will be using a laptop).
    - Please provide an LCD projector and flipchart.
    - Please ensure that the IAC has access to a printer after regular business hours (i.e. into the evening) on Monday January 26<sup>th</sup> and Tuesday January 27<sup>th</sup>.
- Caucus room
  - Please provide a caucus room for the ONA team for the full three day period (0900 Monday January 26<sup>th</sup> to 1600 Wednesday January 28<sup>th</sup>), equipped with telephone and internet access, and seats for 10 people.
  - Note: The IAC will use the Boardroom as a caucus room when the Hearing is not in session.
  - If the SCGH team also requires a caucus room, please ensure it is made available.

- Catering:
  - Please arrange for tea, coffee, juices and water to be available in the Boardroom for all times that the Hearing is in session. Please provide muffins for the morning break on Tuesday and Wednesday, and cookies/fruit for the afternoon break on Monday and Tuesday.
  - Please arrange for tea, coffee and water to be available in the ONA caucus room over the full three days
  - Please provide a working lunch for the three IAC members on all three days (Monday January 26<sup>th</sup> through Wednesday January 28<sup>th</sup>) in the Boardroom.

Please confirm who will be representing the St Catherines General Site at the full Hearing by Friday January 16<sup>th</sup>, 2009. The IAC anticipates that additional Registered Nurses from the Emergency Department will attend part or all of the Hearing.

If you have any questions, please contact me by phone at 613-260-2415, or by email at [jcardiff@cheo.on.ca](mailto:jcardiff@cheo.on.ca).

Sincerely

Joan Cardiff  
Chair, Independent Assessment Committee

cc. Winnie Doyle, Hospital Nominee  
Trudy Molke, ONA Nominee  
Rozanna Haynes, Professional Practice Specialist, ONA



January 10, 2009

Appendix 3

306 Freedom Private  
Ottawa, Ontario  
K1G 6W4

Ms Rozanna Haynes  
LRO, Professional Practice Specialist  
Ontario Nurses' Association  
85 Grenville Street  
Suite 400  
Toronto, Ontario  
M5S 3A2

Dear Ms. Haynes :

**Re : Niagara Health System and Ontario Nurses' Association : Professional Responsibility  
Complaint – St Catherine's General Hospital Site (SCGH) Emergency Department –  
Independent Assessment Committee Hearing**

Thank you for forwarding the Ontario Nurses' Association Pre-Hearing Brief for the above Independent Assessment Committee Hearing, which I received as requested on January 9, 2009.

I am distributing the Pre-Hearing Briefs by courier today as follows:

- Two copies of the Niagara Health System Brief and supporting documents to the Ontario Nurses' Association:
  - Attention Rozanna Haynes
- Two copies of the Ontario Nurses' Association Brief and supporting documents to the Niagara Health System:
  - One copy attention Christopher Cecchini
  - One copy attention Brent Labord, Hicks Morley
- One copy of the Niagara Health System Brief and one copy of the Ontario Nurses' Association Brief, with all supporting documents, to each of:
  - Joan Cardiff: IAC Chair
  - Winnie Doyle, Hospital Nominee
  - Trudy Molke, Association Nominee

In the event that the Ontario Nurses' Association wishes to provide supplemental information prior to the Hearing, supplemental information will be accepted to the close of business (1600 hours) on Friday January 16<sup>th</sup>, 2009; information received after this date will not be accepted in order to enable all parties to effectively prepared for the Hearing. I will distribute any supplemental information received as per the distribution of the Pre-Hearing Briefs. Supplemental information may be sent via email, with hard copy to follow. Please note that supplemental information is information to support/clarify the Ontario Nurses' Association presentation; it is not information to respond to the St Catharines General Site submission.

*Niagara Health System – St Catharines General Site  
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At your convenience, please confirm who will be attending the Hearing and who will join the Committee on the Tour of the Emergency Department on the morning of January 26<sup>th</sup>, 2009. In addition, please confirm whether the Association will require AV support for your Submission presentation.

The Independent Assessment Committee is looking forward to meeting the members of your team on January 26, 2009. In the meantime, please contact me by phone at (613)260-2415 or email ([jcardiff@cheo.on.ca](mailto:jcardiff@cheo.on.ca)) if you have any questions.

Sincerely

Joan Cardiff  
Chair, Independent Assessment Committee

cc. Chris Cecchini, Director Labour Relations, Niagara Health System  
Winnie Doyle, Hospital Nominee  
Trudy Molke, Association Nominee



January 10, 2009

Appendix 3

306 Freedom Private  
Ottawa, Ontario  
K1G 6W4

Mr. Christopher Cecchini  
Director, Labour Relations  
Niagara Health System  
Welland Hospital Site  
65 Third Street  
Welland, Ontario  
L3B 4W6

Dear Mr. Cecchini:

**Re : Niagara Health System and Ontario Nurses' Association : Professional Responsibility  
Complaint – St Catherine's General Hospital Site (SCGH) Emergency Department –  
Independent Assessment Committee Hearing**

Thank you for forwarding the Niagara Health System Pre-Hearing Brief for the above  
Independent Assessment Committee Hearing, which I received as requested on January 9, 2009.

I am distributing the Pre-Hearing Briefs by courier today as follows:

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  - Attention Rozanna Haynes
- Two copies of the Ontario Nurses' Association Brief and supporting documents to the Niagara Health System:
  - One copy attention Christopher Cecchini
  - One copy attention Brent Labord, Hicks Morley
- One copy of the Niagara Health System Brief and one copy of the Ontario Nurses' Association Brief, with all supporting documents, to each of:
  - Joan Cardiff: IAC Chair
  - Winnie Doyle, Hospital Nominee
  - Trudy Molke, Association Nominee

In the event that the Niagara Health System wishes to provide supplemental information prior to the Hearing, supplemental information will be accepted to the close of business (1600 hours) on Friday January 16<sup>th</sup>, 2009; information received after this date will not be accepted in order to enable all parties to effectively prepared for the Hearing. I will distribute any supplemental information received as per the distribution of the Pre-Hearing Briefs. Supplemental information may be sent via email, with hard copy to follow. Please note that supplemental information is information to support/clarify the Niagara Health System presentation; it is not information to respond to the Ontario Nurses' Association submission.

*Niagara Health System – St Catharines General Site  
Independent Assessment Committee Report  
March 13, 2009*

At your convenience, please confirm who will be attending the Hearing and who will be accompanying the Committee on the Tour of the Emergency Department on the morning of January 26<sup>th</sup>, 2009.

In addition, please confirm that the 'logistical supports' required for the Hearing, as identified in my November 28, 2008 letter, will be arranged. If there are any questions regarding these, please contact me by Tuesday January 20<sup>th</sup>, 2009.

The Independent Assessment Committee is looking forward to meeting the members of your team on January 26<sup>th</sup>, 2009. In the meantime, please contact me (by phone at 613-260—2415 or email at [jcardiff@cheo.on.ca](mailto:jcardiff@cheo.on.ca)) if you have any questions.

Sincerely

Joan Cardiff  
Chair, Independent Assessment Committee

cc. Rozanna Haynes, Ontario Nurses' Association  
Winnie Doyle, Hospital Nominee  
Trudy Molke, Association Nominee

**Cardiff, Joan**

**From:** Cardiff, Joan **Sent:** Tue 1/20/2009 9:13 AM  
**To:** christopher.cecchini@niagarahealth.on.ca; brent-labord@hicksmorley.com; rozannah@ona.org  
**Cc:** trudy.molke@sympatico.ca; wdoyle@stjosham.on.ca  
**Subject:** Niagara Health IAC: Supplemental Material  
**Attachments:**

Thank you for the supplemental material received yesterday by email and courier from both Niagara Health and ONA.

I will forward a hard copy of the material as follows:

- one copy of the ONA material to Chris Cecchini - by overnight courier, arrival Wednesday
- one copy of the ONA material to Brent Labord - by overnight courier, arrival Wednesday
- two copies of the Niagara Health material to Rozanna Haynes - by overnight courier, arrival Wednesday
- one copy of each of the Niagara Health and ONA material to Winnie Doyle - in person, at IAC meeting Wednesday
- one copy of each of the Niagara Health and ONA material to Trudy Molke - In person, at IAC meeting Wednesday

Thank you for the information regarding the arrangements for room booking, catering etc. All looks fine. I am not sure what 'only as per request' means in relation to arrangements for break food, but assume this means that the muffins/scones and fruit/cookies will arrive on Tuesday and Wednesday as indicated.

With respect to the issue of observers at the Hearing, the IAC assumes that staffing arrangements have been made to enable at least several RNs from the Emergency Department to attend the full Hearing as participants, and that additional RNs from the Department will attend on an ad hoc basis as observers.

The IAC is meeting tomorrow (January 21st) for a Pre-Hearing meeting, and will discuss the issue of attendance of RNs from other than the Emergency Department. I will forward our decision on Thursday January 22nd.

Thank you.

Joan Cardiff

<https://www3.cheo.on.ca/exchange/jcardiff/Sent%20Items/Niagara%20Heath%20IAC:%20...> 20/01/2009



January 23, 2009

Appendix 5

306 Freedom Private  
Ottawa, Ontario  
K1G 6W4

Ms Rozanna Haynes  
Professional Practice Specialist  
Ontario Nurses' Association  
85 Grenville Street  
Suite 400  
Toronto, Ontario  
M5S 3A2

Dear Ms Haynes:

**Re: Niagara Health System and Ontario Nurses' Association: Professional Responsibility Complaint – Niagara Health System St Catherines General Site Emergency Department – Independent Assessment Committee Hearing**

I am writing to confirm the final details of the IAC Hearing scheduled for next week. The Hearing Agenda is attached.

**Tour of the Emergency Department:**

- The Tour is scheduled for 1000 – 1200 hours on Monday January 26, 2009. I understand that the Association will be represented on the Tour by Sharon Phair, Vera Girard and Penny Kyle, and that the Tour will be led by Elaine Burr. The group will convene in the Moore 1 Boardroom at 1000 hours.

**Hearing:**

- The Hearing will be held in the Moore 1 Boardroom at the St Catherines General Site. The Hearing will commence at 1300 hours on Monday January 26, 2009 and will close at 1200 hours on Wednesday January 29, 2009
- The Hearing will take a one hour break on Tuesday January 27<sup>th</sup> for lunch. Lunch will be provided for the IAC members only.
- AV equipment (LCD projector) will be available for use on Monday January 26<sup>th</sup> and Tuesday January 27<sup>th</sup>.
- Please confirm by email later today the names of those attending the Hearing on behalf of the Association.
- As noted in my January 20<sup>th</sup> email, the Hearing is open to RNs from the Emergency Department at the St Catherines General Site. The IAC is assuming that arrangements

have been made to enable at least several RNs to attend the full Hearing, and that others may attend for short periods as observers. At its Pre-Hearing Meeting on January 21, 2009, the IAC discussed the issue of whether the Hearing would be open to RNs from other than the Emergency Department. While the IAC supports the concept of openness and transparency, it believes that attendance by RNs from other areas will not assist in understanding the issues at hand. Attendance (as participant or observer) will therefore be restricted to RNs from the Emergency Department at the St Catherines General Site only.

**Ontario Nurses' Association Caucus Room:**

- The Community Ground Conference Room at the St Catherines General Site has been booked for the Ontario Nurses' Association caucus room. The room will be available at 0800 on Monday January 26, 2009 (it is booked 0800 – 1600 Monday through Wednesday). The room seats 10. It has a phone but no computer.

The IAC is looking forward to meeting with you and your team next week. If you have any questions in the meantime, please call (613-260-2415) or email ([jcardiff@cheo.on.ca](mailto:jcardiff@cheo.on.ca)).

Sincerely

Joan Cardiff  
Chair, Independent Assessment Committee

cc. Trudy Molke, Association Nominee  
Winnie Doyle, Hospital Nominee  
Christopher Cecchini, Director Labour Relations, Niagara Health System  
Brent Labord, Hicks Morley



January 23, 2009

Appendix 5

306 Freedom Private  
Ottawa, Ontario  
K1G 6W4

Mr Christopher Cecchini  
Director, Labour Relations  
Niagara Health System  
Welland Hospital Site  
65 Third Street  
Welland, Ontario  
:3B 4W6

Dear Mr Cecchini:

**Re: Niagara Health System and Ontario Nurses' Association: Professional Responsibility Complaint – Niagara Health System St Catherines General Site Emergency Department – Independent Assessment Committee Hearing**

I am writing to confirm the final details of the Independent Assessment Committee Hearing scheduled for next week, and to request that selected further information be made available to the IAC.

Tour of the Emergency Department:

- The Tour is scheduled for 1000 – 1200 hours on Monday January 26, 2009. I understand that the Hospital will be represented on the Tour by Elaine Burr and yourself and that Pat Morka will be unable to attend the Tour (or the Hearing) due to personal issues. Please confirm by email later today if an alternate will be replacing her. The group will convene in the Moore 1 Boardroom at 1000 hours.

Hearing:

- The Hearing Agenda is attached.
- The Independent Assessment Committee is meeting from 0900 – 1000 hours, prior to the Emergency Department Tour, on Monday January 26<sup>th</sup>. Please confirm whom we should contact, when we arrive at the Hospital at approximately 0845, to access the Moore 1 Boardroom. Please also confirm whether we will be able to lock the room when the Hearing is not in session.
- I understand that the Niagara Health System representatives at the Hearing will be:
  - Anne Atkinson, VP Patient Services
  - Chris Cecchini, Director Labour Relations
  - Elaine Burr, Manager Emergency Department
  - Brent Labord, Hicks Morley

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- Kathryn Meehan, Hicks Morley
- Donna Rothwell, Interim Chief Nurse Executive (attend portions)
- Sue Matthews, Chief Nurse Executive (attend portions)
- Terry McMahon, VP Human Resources (attend portions)
- Please confirm by email later today if there is any change to the above.
- As noted in my January 20<sup>th</sup> email, the Hearing is open to RNs from the Emergency Department at the St Catherines General Site. The IAC is assuming that arrangements have been made to enable at least several RNs to attend the full Hearing, and that others may attend for short periods as observers. At its Pre-Hearing Meeting on January 21, 2009, the IAC discussed the issue of whether the Hearing would be open to RNs from other than the Emergency Department. While the IAC supports the concept of openness and transparency, it believes that attendance by RNs from other areas will not assist in understanding the issues at hand. Attendance (as participant or observer) will therefore be restricted to RNs from the Emergency Department at the St Catherines General Site only.

Request for additional information:

The IAC held a Pre-Hearing Meeting on Wednesday January 21, 2009 to discuss the Pre-Hearing Submissions Briefs. The IAC is requesting the following additional information:

1. Organizational chart for the NHS as a whole, and for the St Catherines General Site.
  - We are specifically interested in the line accountability for operations and for professional nursing practice.
2. Vacancy information, including
  - Sick time: sick rate/FTE for nursing within the NHS, within the St Catherines General Site, and within the Emergency Department
  - Overtime: OT rate/FTE for nursing within the NHS, within the St Catherines General Site and within the Emergency Department
3. Worked hours per visit for the Emergency Department
  - Please compare the WHPV for the St Catherines General Site to that of Emergency Departments of two comparable hospitals (not within the NHS system)
4. Patient satisfaction data relating to the Emergency Department
5. Staff satisfaction/quality of worklife data for Emergency Department staff
6. Medical coverage of the Emergency Department
  - Number of MDs within the Department 24/7, including % of those on active staff vs external (e.g. MedEmerg)
7. Wait time data:
  - Wait time for admission to 'regular' bed and to ICU
  - Wait time for order for medical consult to consult completed

8. Emergency Department documentation forms
  - ER flowsheet, MAR, Transfer Fax form, and any other documents used frequently
9. Adverse and critical incidents
  - Medication incidents and information regarding near-miss events, adverse events, and critical incidents
10. Description of Quality Improvement projects over the past two years relating to nurses and/or nursing practice in the Emergency Department.

The IAC recognizes that some of the above information will take time to access. We request that as much as possible be provided to the IAC and the ONA by the conclusion of the Hearing on January 28<sup>th</sup>, and that the remainder be provided by Monday February 2, 2009.

The IAC is looking forward to meeting with you and your team next week. If you have any questions in the meantime, please call (613-260-2415) or email ([jcardiff@cheo.on.ca](mailto:jcardiff@cheo.on.ca)).

Sincerely

Joan Cardiff  
Chair, Independent Assessment Committee

cc. Winnie Doyle, Hospital Nominee  
Trudy Molke, Association Nominee  
Rozanna Haynes, Professional Practice Specialist, ONA



# Independent Assessment Committee Hearing

**Ontario Nurses' Association  
and  
Niagara Health System – St Catharine's General Site**

## Agenda

**Monday January 26, 2009**

**Moore 1 Boardroom  
Niagara Health System – St Catharines General Site**

- |               |  |
|---------------|--|
| 09:00 – 10:00 | <i>Independent Assessment Committee Meeting (Committee members only)</i>   |
| 10:00 – 12:00 | Tour of the Emergency Department<br>♦Attending:<br>•Independent Assessment Committee<br>•For the Hospital: Elaine Burr, Pat Morka, Chris Cecchini<br>•For the Association: Sharon Phair, Vera Girard, Penny Kyle |
| <b>13:00</b>  | <b>Commencement of Hearing</b>   |
| 13:00 – 13:15 | ♦Introduction and Review of Proceedings by Chairperson   |
| 13:15 – 14:45 | ♦Ontario Nurses' Association Submission Presentation<br>♦Response to questions of clarification from<br>•Independent Assessment Committee<br>•Niagara Health System – St Catharines General Site                 |
| 14:45 – 15:15 | Break  |
| 15:15 – 16:45 | ♦Niagara Health System – St Catharines General Site Submission Presentation<br>♦Response to questions of clarification from<br>•Independent Assessment Committee<br>•Ontario Nurses' Association                 |
| 16:45 – 17:00 | ♦Review of Process for January 27, 2009 by Chairperson   |
| 17:00         | Adjournment of Hearing   |
- Niagara Health System – St Catharines General Site  
Independent Assessment Committee Report  
March 13, 2009*

# Independent Assessment Committee Hearing

**Ontario Nurses' Association  
and  
Niagara Health System – St Catharines General Site**

## Agenda

**Tuesday January 27, 2009**

**Moore 1 Boardroom  
Niagara Health System – St Catharines General Site**

- |               |  |
|---------------|--|
| 08:00 – 09:00 | <i>Independent Assessment Committee Meeting (Committee members only)</i>   |
| 09:00         | Continuation of Hearing  |
| 09:00 – 12:00 | <ul style="list-style-type: none"> <li>♦Niagara Health System – St Catharines General Site Response to Ontario Nurses' Association Submission               <ul style="list-style-type: none"> <li>♦Response to questions from                   <ul style="list-style-type: none"> <li>•Independent Assessment Committee</li> <li>•Ontario Nurses' Association</li> </ul> </li> <li>♦Discussion</li> </ul> </li> </ul>                        |
| 12:00 – 13:00 | Lunch Break  |
| 13:00 – 16:00 | <ul style="list-style-type: none"> <li>♦Ontario Nurses' Association Response to Niagara Health System – St Catharines General Site Submission               <ul style="list-style-type: none"> <li>♦Response to questions from                   <ul style="list-style-type: none"> <li>•Independent Assessment Committee</li> <li>•Niagara Health System – St Catharines General Site</li> </ul> </li> <li>♦Discussion</li> </ul> </li> </ul> |
| 16:00 – 16:15 | ♦Review of Process for January 28, 2009 by Chairperson   |
| 16:15         | Adjournment of Hearing   |
| 16:30 – 20:30 | <i>Independent Assessment Committee Meeting (Committee members only)</i>   |



# **Independent Assessment Committee Hearing**

**Ontario Nurses' Association  
and  
Niagara Health System – St Catharines General Site**

## **Agenda**

**Wednesday January 28, 2009**

**Moore 1 Boardroom  
Niagara Health System – St Catharines General Site**

<b>08:30</b>	Continuation of Hearing
<b>08:30 – 11:30</b>	♦Questions to both Parties by Independent Assessment Committee
<b>11:30 – 12:00</b>	♦Closing Remarks and Identification of Next Steps by Chairperson
<b>12:00</b>	<b>Closure of Hearing</b>
<b>12:00 – 13:30</b>	<i>Independent Assessment Committee Meeting (Committee members only)</i>



## Hearing Participants and Observers

### Monday January 26, 2009:

#### Hearing Participants:

##### For the Association:

- ♦Cindy Forster, Servicing Labour Relations Officer
- ♦Vera Girard, Clinical Resource Nurse, ER Department
- ♦Rozanna Haynes, Professional Practice Specialist
- ♦Penny Kyle, Permanent Charge Nurse, ER Department
- ♦Jodi Morneau, Registered Nurse, ER Department
- ♦Sharon Phair, Site Vice President, Local 26
- ♦JoAnne Shannon, Labour Relations Officer
- ♦Pam Sheptenko, Bargaining Unit President, Local 26

##### For the Hospital:

- ♦Anne Atkinson, Vice President Patient Services, NHS
- ♦Elaine Burr, Clinical Manager, ER Department
- ♦Chris Cecchini, Director Labour Relations, NHS
- ♦Brent Labord, Counsel, Hicks Morley
- ♦Sue Matthews, Vice President Patient Services and Chief Nursing Executive
- ♦Terry McMahon, Vice President, Human Resources, NHS
- ♦Kathryn Meehan, Counsel, Hicks Morley
- ♦Donna Rothwell, Chief Nursing and Professional Practice Officer, NHS

#### Hearing Observers:

##### For the Association:

- ♦Karin Jenkins, Permanent Charge Nurse, ER Dept
- ♦Cindy Burtnek, Registered Nurse, ER Department

### Tuesday January 27, 2009:

#### Hearing Participants:

##### For the Association:

- ♦Cindy Forster, Services Labour Relations Officer
- ♦Vera Girard, Clinical Resource Nurse, ER Department
- ♦Rozanna Haynes, Professional Practice Specialist
- ♦Penny Kyle, Permanent Charge Nurse, ER Department
- ♦Jodi Morneau, Registered Nurse, ER Department
- ♦Sharon Phair, Site Vice President, Local 26
- ♦JoAnne Shannon, Labour Relations Officer, ONA
- ♦Pam Sheptenko, Bargaining Unit President, Local 26

##### For the Hospital:

- ♦Anne Atkinson, Vice President Patient Services, NHS
- ♦Elaine Burr, Clinical Manager, ER Department
- ♦Chris Cecchini, Director Labour Relations, NHS

- ♦Brent Labord, Counsel, Hicks Morley
- ♦Sue Matthews, Vice President Patient Services and Chief Nursing Executive
- ♦Kathryn Meehan, Counsel, Hicks Morley
- ♦Donna Rothwell, Chief Nursing and Professional Practice Officer, NHS

**Hearing Observers:**

**For the Association:**

- ♦Sophie Austin, Registered Nurse, ER Department
- ♦Christine Farrell, Registered Nurse, ER Department
- ♦Lisa Hildebrand, Registered Nurse, ER Department
- ♦Karin Jenkins, Permanent Charge Nurse, ER Dept
- ♦Alaina Kroecker, Registered Nurse, ER Department
- ♦Kathy Kullerkupp, Registered Nurse, ER Department
- ♦Wendy Lee, Registered Practical Nurse, ER Dept
- ♦Deneena Menear, Ward Clerk, ER Department
- ♦Jennifer Mitchell, Registered Nurse, ER Department
- ♦Kim Ricketts, Registered Nurse, ER Department

**For the Hospital:**

- ♦Lorrie Daniels, Registered Nurse, Student
- ♦Mary Jane Stacey, Clinical Supervisor, ER Department

**Wednesday January 28, 2009:**

**Hearing Participants:**

**For the Association:**

- ♦Cindy Forster, Servicing Labour Relations Officer
- ♦Vera Girard, Clinical Resource Nurse, ER Department
- ♦Rozanna Haynes, Professional Practice Specialist
- ♦Karin Jenkins, Permanent Charge Nurse, ER Dept
- ♦Penny Kyle, Permanent Charge Nurse, ER Department
- ♦Jennifer Mitchell, Registered Nurse, ER Department
- ♦Jodi Morneau, Registered Nurse, ER Department
- ♦Sharon Phair, Site Vice President, Local 26
- ♦Pam Sheptenko, Bargaining Unit President, Local 26

**For the Hospital:**

- ♦Anne Atkinson, Vice President Patient Services, NHS
- ♦Elaine Burr, Clinical Manager, ER Dept
- ♦Brent Labord, Counsel, Hicks Morley
- ♦Sue Matthews, Vice President Patient Services and Chief Nursing Officer
- ♦Terry McMahon, Vice President Human Resources, NHS
- ♦Karen MacKenzie, CRP – Finance, NHS
- ♦Mary Jane Stacey, Clinical Supervisor, ER Department

**Hearing Observers:**

**For the Association:**

- ♦Jason Lea, Registered Nurse, ER Department

# **Ontario Nurses' Association Summary of PRW Reports: Professional Responsibility Concerns, Actions Taken and Concerns Unresolved**

Appendix 8

Year	Professional Responsibility Concern	Actions Taken: Partial/Full Resolution	Concerns Unresolved
2004 18 PRW forms	<ul style="list-style-type: none"> <li>• No timely medication administration</li> <li>• No timely completion of MD orders</li> <li>• Unable to meet CTAS standard</li> <li>• No replacement of sick calls</li> <li>• Lack of equipment and supplies</li> <li>• Non-nursing duties</li> <li>• Admit no Bed patients</li> <li>• Charge Nurse role with no orientation</li> <li>• Missed or no breaks</li> <li>• Nursing student used as staff</li> <li>• Missed education opportunity</li> <li>• Patient missed overnight in waiting room</li> <li>• No decreased workload when mentoring</li> <li>• ER RNs on transfer, leaving ER shortstaffed</li> </ul>	<ul style="list-style-type: none"> <li>• Health and Safety inspection completed</li> <li>• Ergonomic assessment recommendations implemented</li> <li>• Personal alarms, code blue buttons installed</li> <li>• RPN: vitals and basic patient care</li> <li>• Implementation of decision tree</li> <li>• Clinical Coordinator positions E/N/Weekend to assist with patient flow and ANB</li> <li>• Equipment purchased and repaired</li> <li>• Formal mentorship being considered</li> </ul>	<ul style="list-style-type: none"> <li>• Need for 24/7 security</li> <li>• Need for 2<sup>nd</sup> triage nurse</li> <li>• Role of volunteers to direct visitors</li> <li>• Improved signage for ER</li> <li>• Need to discontinue/decrease informal clinics in ER</li> </ul>
2005 31 PRW forms	<ul style="list-style-type: none"> <li>• No timely completion of MD orders</li> <li>• Unable to meet CTAS/CNO standards</li> <li>• No replacement of sick calls</li> <li>• Lack of equipment and supplies</li> <li>• Non-nursing duties</li> <li>• Admit no Bed patients</li> <li>• Charge Nurse role with no orientation</li> <li>• Missed or no breaks</li> <li>• Insufficient staff</li> <li>• Errors made at triage</li> <li>• High volume and acuity</li> <li>• Wait times</li> <li>• Required to orient student on RN's first day in ER</li> <li>• Unable to assess and reassess according to hospital policy patients in hall as no beds available</li> </ul>	<ul style="list-style-type: none"> <li>• Camera installed in waiting room, 2<sup>nd</sup> phone and 2<sup>nd</sup> computer at triage</li> <li>• Furniture in psych consult room bolted to Floor</li> <li>• Ortho Clinical Pathway developed (#hips directly to floor prior to consult)</li> <li>• CCAC Case Manager dedicated to ER</li> <li>• Fast track opened</li> <li>• 4 FTE RN relief positions approved - not maintained</li> <li>• Charge Nurse binder developed - not maintained</li> <li>• 'Crisis upstaging': 16 hrs lab tech, 16 hrs ward aide, 1 RN on N and 2 RN D/E in March; lab tech and RN hrs ↓ 1 month later</li> <li>• \$1M one-time investment (October)</li> <li>• 2 RNs 24/7 - not maintained</li> <li>• 1 ortho tech 7.5 hrs- not maint'd 1 RPN 7.5 hrs</li> <li>• 1 ward clerk 7.5 hrs- not maint'd 1 HAC 7.5 hrs</li> <li>• Clinical Resource Nurse (3 month trial)</li> <li>• Mentorship Program implemented</li> </ul>	<ul style="list-style-type: none"> <li>• Need for 24/7 security</li> <li>• Role of volunteers to direct visitors/visitor control</li> <li>• Pharmacy issues: stock meds, night cupboard usage</li> <li>• Many of the \$1M investment positions not filled until 2006</li> <li>• Lab duties transferred to RPN</li> </ul>

Year	Professional Responsibility Concern	Actions Taken: Partial/Full Resolution	Concerns Unresolved
2006 29 PRW forms	<ul style="list-style-type: none"> <li>• ANB patients</li> <li>• Non-nursing duties</li> <li>• Relief unavailable</li> <li>• Unable to meet CTAS/CNO standards: call bells not answered, IV's running dry</li> <li>• Mentorship workload not decreased</li> <li>• ++ vacant shifts on schedule</li> <li>• RN with &lt;1 year experience doing triage</li> <li>• Lack of supplies</li> <li>• No timely medication administration</li> <li>• High volume and acuity: wait times 6-8 hrs, off load delays</li> <li>• Junior staff</li> <li>• Missed or no breaks</li> <li>• IV's running dry</li> <li>• Call bells not answered</li> </ul>	<ul style="list-style-type: none"> <li>• QWL Survey: results reinforced issues identified on PRW forms</li> <li>• Implementation of PCSR teams improved intra-Department communication</li> <li>• Recruitment initiatives (nurse recruiter, exit interviews)</li> <li>• Increased clarity of RN schedule (who is/is not working the shift); baseline staffing to be filled even if overtime required</li> <li>• HCAs retrained to stock rooms; Dept 'decluttered'</li> <li>• Educator position dedicated to ER approved</li> <li>• RN relief positions increased from 4 FTE to 8 FTE</li> <li>• Clinical Supervisor position implemented</li> <li>• RPN not have patient assignment</li> <li>• Overcapacity Protocol implemented: 2 hallway beds</li> <li>• 6W overflow unit opened</li> <li>• Code Blue policy revised</li> </ul>	<ul style="list-style-type: none"> <li>• Manager not responding to PRW forms</li> <li>• 'Slow hiring process'; difficulty filling RN positions</li> <li>• Scheduling issues: denial of vacation</li> <li>• Responsibility for order entry/MARS given to Ward Clerks but not effectively implemented or monitored for compliance</li> <li>• Dedicated ER Educator frequently unavailable to ER</li> <li>• Availability of ER Manual in OBS, Trauma, Treatment and on SharePoint not implemented</li> <li>• Regional float pool (8 RN FTEs) never implemented</li> <li>• Availability of management support E/N/Wkend as Clinical Coordinator positions eliminated and Manager-on-Call support through decision tree not working</li> <li>• Swipe door not installed</li> </ul>
2007 51 PRW forms	<ul style="list-style-type: none"> <li>• Non-nursing duties</li> <li>• ++ Junior/agency staff</li> <li>• Missed or no breaks</li> <li>• RNs mandated to work on days off</li> <li>• Unable to meet CTAS standards</li> <li>• High volume and acuity: ++ wait times</li> <li>• Increased numbers of ANB patients</li> <li>• Lack of equipment, e.g. cardiac monitors</li> <li>• Patients in halls/fast track with no RN assigned</li> <li>• Lack of base and relief staff</li> </ul>	<ul style="list-style-type: none"> <li>• Contracts with 3 agencies implemented to address acute staffing concerns</li> <li>• Clinical Resource Nurse position hired (approved October 2005; hired January 2007)</li> <li>• Charge Nurses given authority to call in staff</li> <li>• New Clinical Manager: improved communication</li> <li>• 1 RN 24/7 added to treatment room</li> <li>• Emergency Baseline Staffing Review initiated</li> <li>• Siemens review to redesign internal processes and expedite patient flow in ER initiated</li> <li>• Transfer of Care policy implemented</li> <li>• Security guard in ER implemented 24/7</li> <li>• Signs posted re expectations re appropriate behaviour</li> </ul>	<ul style="list-style-type: none"> <li>• Ongoing communication gaps between ER and Scheduling</li> <li>• Additional treatment room RN position not implemented 24/7</li> <li>• Transfer of Care policy (EMS to ER within 30 minutes) not met due to staffing shortages resulting in friction with EMS</li> <li>• Slow hiring</li> <li>• Retention issues</li> <li>• Staffing not increased as agreed</li> </ul>



Year	Professional Responsibility Concern	Actions Taken: Partial/Full Resolution	Concerns Unresolved
2008  60 PRW forms	<ul style="list-style-type: none"> <li>• Missed or no breaks</li> <li>• High patient volume/acuity: off-load delays, long wait times</li> <li>• Unable to meet CTAS/CNO standards/ER policy</li> <li>• Lack of base and relief staff</li> <li>• Increased overtime</li> <li>• ++ junior/agency staff</li> <li>• ANB patients</li> <li>• Lack of equipment, supplies, food</li> <li>• Non-nursing duties: lab, ECG</li> <li>• Inability to effectively mentor due to short staffing</li> <li>• ER RNs on transfer, leaving ER shortstaffed</li> </ul>	<ul style="list-style-type: none"> <li>• Self scheduling initiated</li> <li>• Mechanism for booking 3<sup>rd</sup> weekend changed (Schedulers now call on Wednesdays)</li> <li>• New stretchers ordered</li> <li>• Funding for ACLS and PALS recertification provided</li> <li>• CSI area opened</li> <li>• RPNs given patient assignment (as of September 08)</li> <li>• Communication meetings implemented</li> <li>• Fireside Chat with VP Patient Services May 08</li> <li>• IAC Prevention Meeting July 08</li> <li>• Mandatory focus groups October 08</li> <li>• Special HAC Meeting December 08</li> <li>• Pay for Results initiatives implemented</li> </ul>	<ul style="list-style-type: none"> <li>• Non-nursing duties:               <ul style="list-style-type: none"> <li>- RNs doing lab work and ECGs as RPNs too busy</li> <li>- RNs stocking equipment as HCAs too busy</li> <li>- RNs transcribing orders as Ward Clerks too busy</li> </ul> </li> <li>• Scheduling issues: cannot book stats off</li> <li>• Swipe doors not installed</li> <li>• Staffing: insufficient time for effective mentoring, collaboration with RPNs/HCAs, vacant positions</li> <li>• Decreasing communication with Clinical Manager and Clinical Supervisor</li> <li>• Lack of response from Clinical Manager re PRW forms</li> <li>• Clinical Supervisor covering Port Douglas ER; away from SCG 1-2 days per week</li> <li>• RNs unable to book stat holidays</li> <li>• Little perceived support for decision tree</li> </ul>



## Ontario Nurses' Association Recommendations

### A. Workload/Competence

RNs expressed concerns around staff knowledge and skills to perform some jobs, ability to get tasks completed and ability to manage the demands of the job due to the number of ANB patients, overcapacity/offload issues and the unit being short staffed often at the same time. Baseline staffing cannot be provided most of the time and often shifts work 3-5 RNs short.

1. Management needs to accept the responsibility of proper staffing of the unit. Suggest daily meetings with the manager and/or supervisor, CN and ED scheduler to review staffing for the next 48 hours and manager to review staffing issues and solutions with on-call manager every afternoon with Friday's review extending to cover the weekend.
2. RPNs should not be given an ER patient assignment or assigned to an area in the ER, unless there are enough experienced RNs available to consult with and time is allotted to the RNs for this collaboration to take place.
3. Letter of Understanding between ONA and NHS about staffing the SCG ER while maintaining RN lines and positions needs to be signed ASAP.
4. Volunteers and security will direct the public to keep inquires down at triage.
5. Management needs to develop a different process for meal tray delivery as the current process takes housekeeping time away from cleaning beds to deliver meal trays.
6. Reintroduce the lab techs and ortho tech hours that were part of an agreement with ONA at HAC.
7. Maintain and fill a RN baseline staffing of 11 on days and 11 on nights.
8. Provide adequate staffing and hours of admission/discharge area, develop process for quicker notification and cleaning of empty beds to accommodate quicker transfers from ER to floors, develop written process so ER RNs will feel comfortable only doing stat orders and save them time from rewriting a variety of orders and look at all process issues for other solutions.
9. Hire a Geriatric Emergency Medical (GEM) nurse.
10. Staffing decisions re: use of agency and junior staff etc. to be managed fairly to enhance client outcomes and retention of RNs.
11. Provide enough clerical hours for processing and entering of orders.
12. Involve LHIN and EMS and any other key stakeholders in discussions re: need to change boundaries so SCG ER does not receive the bulk of ER patients within the NHS.

### B. Professional Development

ER RNs expressed concerns based on educator and resource nurses availability to function within those roles within the unit, lack of timely learning opportunities to do job appropriately and inability to participate in professional development.

13. Provide timely education on all changes to processes, new equipment, new programs etc. prior to implementation.
14. Manager to reinforce all changes, once education has been completed in as many ways as possible, i.e. communication book, posting info at nursing station etc. and CN to reinforce all changes at the beginning of each shift.
15. Provide a decreased workload for mentors to allow time to properly mentor the mentees.
16. Track when staff is due for re-certification and provide education on ACLS, PALS, WHIS etc. in a timely manner.
17. Mistakes, near misses and critical incidents need to be turned into learning opportunities.
18. Limit corporate responsibilities of the (dedicated) educator so she can be on the unit more and staff ER appropriately so resource nurse is not pulled for patient care.

### C. Practice Support

RNs expressed concerns about not always feeling supported by the leadership team, not always comfortable asking questions of management, not always comfortable with management's responses and not having the needed information and education available to them to be able to perform job.

19. Encourage use of decision tree and strive for turnaround times of 20-30 minutes for resolution from management.
20. Re-introduce the evening/night coordinator role so there is someone on site 24/7 with the authority to move patients between units etc.
21. Move the ER Clinical Supervisor office back to the unit.
22. Split up hours for ER Manager and ER Supervisor so hours extend until at least 2000h.
23. Extremely short staffing is a huge issue on nights and weekends so someone from management (manager, supervisor, on-call manager etc) needs to be available to come into the ER to assist the CN when there is a staffing crisis.
24. Add 1 more CN to day/evening shift (1000n – 2200h)

### D. Time off and Scheduling Issues

The RNs expressed major concerns with the inability to get vacation, paid days, unpaid days, education days or even time to attend a 1 hour HAC meeting and problems with scheduling office have taken on a life of their own on this unit. This unit has not had a full complement of baseline staff in over four years and relief is a major concern.

25. Daily meetings with manager, ER scheduler and CN will help to correct many of the discrepancies between the unit schedule and what the schedulers believe is happening.
26. Schedulers need to be proactive and pre-book RNs within the confines of the collective agreement.
27. Schedulers need to communicate how desperate the need is, i.e. 4 RNs short.
28. ER scheduler needs to spend some time in the ER to experience the activity level and need. This would also allow a more trusting relationship to develop between ER and scheduling.
29. Post staffing needs within the unit.
30. Dedicate ER nurse recruitment campaign so NHS can fill the baseline gaps and relief positions.

### E. Part of a Team

The recent introduction of the inter-professional team has caused some concern and the need to constantly try to get patients out of the ER has assisted in alienating the ER RNs from the staff on other units.

31. Provide written roles and responsibilities for all classifications of staff within the ER.
32. Management needs to develop strategies to shift the culture at SGH about ANB patients being an ER problem to a hospital wide problem.
33. Sign Letter of Understanding with ONA about RTs, RPNs, Medical RNs and HCAs filling RN lines temporarily in the ER.
34. Work with lab, DI and pharmacy to improve turn around times within the ER.
35. Implement a push-pull process to send ANB patients to the floors sooner. Currently ER tries to push patients up but there is nothing in place to encourage the floor to pull patients up.
36. Develop a multidisciplinary council with elected staff that would meet monthly and address the issues in the ER and have a mechanism in place to deal with the issues addressed.

#### F. Resource Access

As previously stated the ER RNs have overwhelming problems accessing enough human resources to staff the unit and accessing beds for admitted patients. Other resource access issues include the new pharmacy system, supplies and equipment.

37. Sort out numerous AUDD issues so that RNs can access meds in a timely, efficient and effective manner.
38. Improve turn-around times for medication delivery and when delivered pharmacy needs to deliver the meds to the specific ER area.
39. Develop a way for RNs to obtain immediate updates of the CMAR.
40. Supply stocking issues need to be fixed to decrease the amount of time spent searching for the right equipment or supplies.
41. Organization, repair and ordering of equipment needs to be fine tuned.
42. Human Resources need to implement ER employment opportunities of interest to nursing students, pre-grad and recent grads to fill some of the long-standing holes in baseline and relief staffing.

#### G. Professional Respect

The ER RNs have been working in a toxic, high stress environment and understandably staff morale is very low. They have expressed concerns with lack of input into new systems, staff safety and staff abuse.

43. Human Resources need to work closely with ER management to develop and implement strategies to help with retention and recruitment.
44. Greater emphasis needs to be paid to retention within the ER.
45. ER RNs complete PRW Report forms and need to know their professional contributions are valued. Management to respond with resolutions in accordance to the NHS decision tree and the collective agreement.
46. Develop a process for dealing with angry families, EMS staff and the public that removes it from RN duties so they can return to patient care, i.e. social work intervention or on site management 24/7
47. Improve receptiveness from On Call Managers and Scheduling Supervisor.





**Niagara Health System St Catharines General Site: Actions Taken in 2008 to Address Emergency Department Workload Issues**

- Emergency Baseline Staffing Report was completed in February 2008 and recommendations implemented:
  - *Introduce 1 RRT 24/7 working to full scope of practice within the RN rotation:*
  - 2 RRTs hired in January, two more following by June 2009.
  - *Add 1 RPN (0700-1900) to care for CTAS 4/5 patients waiting in the ER waiting room:*
  - Not implemented as CTAS 3 patients to be cared for through CSI, leaving more time for triage nurse to monitor CTAS 4/5 patients in the waiting room.
  - *Add 1 HCA on night shift (7.5 hours) to restock the ER thereby utilizing HCAs on the dayshift and evening shift to porter patients and assist with non-nursing activities*
  - PSW hired for 12 hour night shift.
  - *Add appropriate category of care providers over and above the base line staffing to care for ANB patients*
  - Medical Holding Unit opened, with 1 RN and 2 RPNs hired to provide care outside of ER.
  - *Implement Emergency Program Nursing Resource Pool*
  - Not implemented due to vacancies in ER baseline staffing.
  - *1 RN be placed on-call for inter-facility transfers within NHS*
  - Tried with retired RN who worked on on-call basis; ONA requested position be posted and trial ceased.
  - *Fund one education day per year per ER nurse*
  - Not implemented, due to \$1M/year costs relating to superior condition 14.01<sup>26</sup>.
  - *1 Social Worker be added on the day shift to support patient flow within and outside Hospital*
  - Hospital has submitted funding proposal to LHIN for Again at Home Strategy for social worker, geriatric mental health nurse and pharmacist for SCG ER site.
  - *Education re the care of elderly (delirium, cognitive impairments, falls, pain management) be provided to ER staff*
  - LTC Nurse Practitioners will assist with further education re care of the elderly.
  - *Education program re implementation of medical directives, inter-professional collaborative care, change management and team work be provided*
  - 23 medical directives implemented.
- Siemens Report was completed in September 2008; focus was development of an operational improvement plan for the Department and to enhance patient care;
- Hospital was awarded \$1.25M in September 2008 for the Pay for Results Initiative, to improve wait times and process flow in the ER;

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<sup>26</sup> ONA-NHS Local Agreement: St Catherines General Site: Article 14.01 "When a nurse works on her day or days off, such nurse will be compensated at the rate of time and one-half and shall be scheduled for another day or days off with pay."

- Recruiter hired on contract ((July 2006 – March 2008) to focus on the Emergency Department;
- Contracts with three agencies implemented;
- Permanent Clinical Supervisor position created in response to nurses' requests for on-site management support. Although temporarily seconded to manage the Port Douglas Site ER, the Clinical Supervisor will return to the SCG ER full-time when the Port Douglas position is filled;
- Clinical Resource Nurse position created to provide hands on teaching and mentorship and act as resource for new and junior nurses;
- Second Ward Clerk for day shift to address concerns that clerical work was being complete by RNs;
- Dedicated security staff 24/7 for ER;
- Dedicated Scheduler for ER and Prompt Care;
- Implementation of self scheduling, in response to RNs' request;
- Support staff hired to do ECGs, and HCAs upgraded to PSWs;
- Charge Nurse empowered to call in staff if the Scheduler is unable to fill shifts;
- Volunteers were trained to direct traffic and answer general public enquiries in response to the need to reduce time spent by triage nurses;
- HCAs trained to stock supplies;
- Renovations underway for the security (swipe card) doors; the Hospital acknowledges that this process has taken longer than desire, but will be completed by early February;
- Experienced RRTs hired, in follow-up to the Emergency Department Baseline Staffing Report and the Hospital's Inter-Professional Strategic Plan. The Hospital received funding from HealthForce Ontario to help integrate inter-professional care and an interdisciplinary approach at NHS. Introduction of RTs in the ER was identified in the Strategic Plan as one of the ways of implementing the Inter-Professional model at SCG. RTs will be able to assist with care of patients in the ER with respiratory problems.;
- Letter of Agreement permitted full-time nurses from other units (e.g. medicine) to apply for temporary positions in ER;
- Fax transfer reports implemented, to facilitate transfer of patients from the ER to inpatient beds;
- CSI implemented;
- EMS funding received for off-load RN in the ER;
- Pay for Results funding initiatives implemented, including
  - Wireless communication system between Triage, Charge Nurse, Physicians and CSI nurses (phones ordered but not yet arrived);
  - 4 dedicated porters (2 working each day) to transfer patients to inpatient beds, DI etc;
  - Bed flow coordinator to improve flow of ANB patients from ER to inpatient units;
  - Portable ultrasound machine (has been purchased and received; will be implemented following physician education re usage);

- Increased in CCAC ER coverage from 8 to 12 hours per day (position not yet filled by CCAC);
- Medical Holding Unit on 3<sup>rd</sup> floor, to care for up to 10 patients awaiting admission to inpatient beds or who have been discharged and are awaiting transportation home; goal is to decrease the number of ANB patients in the ER;
- Electronic system to monitor bed availability will be installed before March 31, 2009;
- 2 Admissions Nurses to complete admission paperwork;
- Additional housekeeping position added to provide quicker turnaround time for bed cleaning.



**Niagara Health System – St Catharines General Site Recommendations**

1. That ONA remove its censure. One of the primary purposes of the censure was to deter nurses from applying for or continuing to be employed by the NHS. The removal of the censure will facilitate recruiting and thereby maintain appropriate workload. ONA should not be permitted to, on the one hand, complain about the Hospitals' inability to recruit and retain nurses for the Emergency Department, and on the other, to continue the censure to impede any recruitment and retention efforts on the part of NHS.

