Independent Assessment Committee Report

Constituted under Article 8.01 of the

Collective Agreement

Between

Nipigon District Memorial Hospital

And

Ontario Nurses' Association

April 22, 2014

April 22, 2014

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

Ms. Sonja Stephenson
Director Patient Services and Chief Nursing Officer
Nipigon District Memorial Hospital
125 Hogan Road
Nipigon, ON, P0T 2J0

Dear Ms. Haynes and Ms. Stephenson,

The members of the Independent Assessment Committee have concluded our review and respectfully submit the Report of the Independent Assessment Committee that was constituted under Article 8.01 of the collective agreement between Nipigon District Memorial Hospital and the Ontario Nurses Association.

This report contains the Independent Assessment Committee's findings and recommendations regarding Professional Workload Complaint submitted by Nurses from the Emergency Department and the Acute Care Unit at Nipigon District Memorial Hospital.

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

Sincerely,

Leslie Vincent

Leslie Vincent RN

Trudy Molke

Trudy Molke RN

Janet Gobeil

Janet Gobeil RN

Table of Contents

Appendices

Appendix 1: Letter from Association to IAC Chair, October 28, 2013

Appendix 2: Letter from the Association to the Hospital regarding Nominee, October 25, 2013

Appendix 3: Letter from Hospital to IAC Chair, October 28, 2013

Appendix 4: IAC Agenda March 4-6, 2014

Appendix 5: IAC Additional Information Request of Nipigon District Memorial Hospital

Appendix 6: Attendees at Independent Assessment Committee, March 4-6, 2014.

1. Introduction

1.1. Organization of the Independent Assessment Committee Report

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

1. **Introduction**

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

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

   This section presents the context of practice relating to the professional workload complaint in the Emergency Department and the Acute Care Unit at Nipigon District Memorial Hospital; summarizes the relevant history leading to the referral of the professional workload complaint to the IAC; and reviews the presentations by the Ontario Nurses' Association ('the Association'), Nipigon District Memorial Hospital ('the Hospital') at the Hearing.

3. **Discussion, Analysis and Recommendations**

4. **Summary and Conclusions**

5. **References and Appendices**

The submissions and exhibits of the Ontario Nurses' Association and Nipigon District Memorial Hospital are on file with both parties.

1.2. Referral to the Independent Assessment Committee

This Report addresses the professional workload complaints of Registered Nurses from the Emergency Department and Acute Care Unit at Nipigon District Memorial Hospital. The Association stated the following in their pre-hearing submission:

"ONA submits this Professional Responsibility Complaint as a result of the employer, assigning a number of patients and a workload to an individual RN, and a group of RNs and implemented a change in Model of care/staffing levels; such that they have cause to believe that they are being asked to perform more work than is consistent with proper patient care."[1]

1.3. Jurisdiction of the Independent Assessment Committee

The IAC is convened under the authority of Article 8.01 on Professional Responsibility in the Central Hospital Agreement between the Ontario Nurses' Association and Nipigon District Memorial Hospital.

Article 8.01 states:[2]

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.

---

[1] Submission to the Independent Assessment Committee by Ontario Nurses' Association, 2014, p.9

[2] Collective Agreement Between the Hospital and Ontario Nurses' Association, Article 8 – Professional Responsibility, March 31, 2014, p.23.

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

(a)

i) at the time the workload issue occurs, discuss the issue within the unit/program to develop strategies to meet patient care needs using current resources

ii) If necessary, using established lines of communication as identified by the hospital, seek immediate assistance from an individual(s) (who could be within the bargaining unit) who has responsibility for timely resolution of workload issues.

iii) Failing resolution of the workload issue at the time of occurrence or if the issue is ongoing the nurse(s) will discuss the issue with her or his Manager or designate on the next day that the Manager (or designate) and the nurse are both working or within five (5) calendar days whichever is sooner. Complete the ONA/Hospital professional Responsibility Workload Report Form. The manager (or designate) will provide a written response on the ONA/Hospital Professional Responsibility Workload Report Form to the nurse(s) within 5 days of receipt of the form with a copy to the Bargaining Unit President.

When meeting with the manager, the nurse(s) may request the assistance of a Union representative to support/assist her/him at the meeting.

iv) Every effort will be made to resolve workload issues at the unit level. A Union representative shall be involved in any resolution discussions at the unit level. The discussions and actions will be documented.

v) Failing resolution at the unit level, submit the ONA/Hospital Professional Responsibility Workload Report Form to the Hospital-Association Committee within twenty (20) calendar days from the date of the Manager's response or when she or he ought to have responded under (iii) above. The Chair of the Hospital-Association Committee shall convene a meeting of the Hospital-Association Committee within fifteen (15) calendar days of the filing of the ONA/Hospital Professional Responsibility Workload Report Form. The Committee shall hear and attempt to resolve the issue(s) to the satisfaction of both parties and report the outcome to the nurse(s).

vi) Prior to the issue(s) being forwarded to the Independent Assessment Committee, the Union may forward a written report outlining the issue(s) and recommendations to

the Chief Nursing Executive.

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

vii) *Any settlement arrived at under Article 8.01 (a) iii), iv), or v) shall be signed by the parties.*

(Article 8.01(a), (viii), (ix) and (x) and 8.01(b) applies to nurses only)

viii) *Failing resolution of the issue(s) within fifteen (15) calendar days of the meeting of the Hospital-Association Committee the issue(s) shall be forwarded to an Independent Assessment Committee composed of three (3) registered nurses; one chosen by the Ontario Nurses' Association, one chosen by the Hospital and one chosen from a panel of independent registered nurses who are well respected within the profession. The member of the Committee chosen from the panel of independent registered nurses shall act as Chair.*

If one of the parties fails to appoint its nominee within a period of forty-five (45) calendar days of giving notice to proceed to the Independent Assessment Committee, the process will proceed. This will not preclude either party from appointing their nominee prior to the commencement of the Independent Assessment Committee hearing.

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

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

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

xii) *The Chief Nursing Executive, Bargaining Unit President and the Hospital-Association Committee will jointly review the recommendations of the Independent Assessment*

Committee and develop an implementation plan for mutually agreed changes. i) The list of Assessment Committee Chairs is attached as Appendix 2. During the term of this Agreement, the central parties shall meet as necessary to review and amend by agreement the list of chairs of Professional Responsibility Assessment Committees.

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

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

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

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

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

In the matter of arbitration between Brantford General Hospital and the Ontario Nurses Association both parties acknowledged that while according to the collective agreement the

IAC's report is not binding upon the parties, "the parties stressed to the board that the association and the participating hospitals all feel bound by the findings of such committees."[3]

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

The members of the Independent Assessment Committee were:

Chairperson
Leslie Vincent

For the Association
Trudy Molke

For the Hospital
Janet Gobeil

[3] Arbitration Hearing Brantford General Hospital and Ontario Nurses Assocation, September 8, 1986.

1.4. Proceedings of the Independent Assessment Committee

Pre-Hearing

On October 28, 2013 the Association notified the Hospital and the IAC Chair in a letter that the Association was confirming an Independent Assessment Committee to investigate a complaint at Nipigon District Memorial Hospital and confirming the Chair as Leslie Vincent (Appendix 1). The Association nominee, Trudy Molke, was confirmed on October 25, 2013 (Appendix 2)

On October 28, 2013 the Hospital sent a letter to the IAC Chair confirming their nominee, Janet Gobeil, to the IAC. (Appendix 3)

On November 5, 2013 the Chair of the IAC contacted the Association and Hospital nominees to set the first meeting of the committee. The IAC met by teleconference on November 8, 2012 and discussed the following issues:

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

On November 5, 2013, the Chair of the IAC contacted the Hospital to set a brief meeting regarding the IAC Hearing. The IAC Chair met by teleconference with the Hospital on November 11, 2013 and discussed an overview of the IAC process and timeframes, and proposed dates for a hearing.

Following communication with all parties, the IAC hearing date was confirmed for March 4-6, 2014. It was agreed to convene the hearing at the Nipigon Memorial District Hospital in Nipigon, Ontario.

On December 4, 2013 the IAC chair communicated by email with the Hospital and the Association with regard to the following matters:

- A request that the IAC receive the pre-hearing submissions by January 21, 2014 in order to allow the panel sufficient time to review the briefs and prepare for the hearing.
- A request that the submissions and organizational information when provided to all parties.

On January 30, 2014 the IAC met by teleconference to discuss the following matters:

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

On February 6, 2014 Leslie Vincent sent an email to the Association and the Hospital to thank both parties for their comprehensive briefs regarding workload issues at Nipigon Memorial District Hospital. In addition, the agenda for the IAC was provided (Appendix 4).

The IAC panel also requested a tour of the Emergency and Acute Care unit on Tuesday March 4, 2014. Each party was also asked to provide the names of individuals who would be attending the tour and/or the hearing. An additional data request was also made to the hospital (Appendix 5).

The following ground rules for conduct during the IAC were provided:

1. Adhere to the agenda and timeframes for presentation;
2. Opportunity will be given to ask questions for clarity at the end of each presentation. If you have a question, indicate this to the chairperson;
3. Speak from your own perspective and experience;
4. Do not raise issues related to individuals; the panel is not convened to address any concerns regarding individual performance;
5. The proceedings of the hearing are confidential and not to be discussed outside of the hearing except for the purpose of preparing for the IAC meeting;
6. The briefs, presentations, discussion and any distributed documents in this hearing are not be shared with other parties;

7. Observers cannot participate in the hearing and are asked to enter or leave at the beginning or ending of a session. A list of expected observers must be provided to the chair prior to the hearing.
8. Maintain a professional demeanor at all times during the hearing.

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

Hearing

Tuesday, March 4, 2014

The IAC met at the Hospital at 0900 Hours on March 4, 2014 and were greeted by representatives of the Hospital and members of the Association. The IAC was provided with an extensive tour of the Emergency Department and the Acute Care unit. The tour served to familiarize the IAC with the work environment and physical layout of the units.

The following individuals from the Hospital were on the tour:

- Sonja Stephenson, Director Patient Services and Chief Nursing Officer;
- Denis Nault, Human Resources

The following individuals from the Association were on the tour:

- Diana Lebar, RN
- Jen Hart, RN

The Hearing convened at 1300 hours at the Nipigon District Memorial Hospital as per the agenda (Appendix 4). Participants and Observers on the respective hearing dates are listed in Appendix 6.

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

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

Ms. Rozanna Haynes, Professional Practice Specialist (PPS), presented on behalf of the Association. The Association's presentation was based on their written Pre-hearing submission and supporting exhibits as well as a summary of the Professional Responsibility Workload Report Forms (PRWRFs) submitted by the Registered Nurses of the Emergency Department and the Acute Care Unit in 2012 and 2013.

During the presentation the Association stated that the following themes consistent with the issues identified in the PRWRFs have been increasing the workload of nurses in the acute care unit and emergency:

- Insufficient RN staffing levels related to ability to cover sick calls/vacation; and ability to increase staffing when acuity is heightened;
- Increase in nursing workload due to staffing levels and lack of other support from other services;
- Patient transfers that require nursing escort;
- Fragmented and interrupted care;
- Role of various team members such as the Flex Nurse; unregulated care providers; and
- Registered Nurse (RN) and Registered Practical Nurse (RPN) practice issues including consultation, scope of practice, replacing RNs with RPNs.

The Association recommendations for resolution were in the areas of:

- Staffing levels;
- Nursing workload;
- Patient transfers;
- Fragmented and interrupted care;
- Role of the Flex Nurse;

- RN and RPN practice;
- Unregulated care providers;
- Replacing “Like with Like”;
- Nursing leadership; and
- Excellent Care for All Act, 2010.

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

Ms. Sonja Stephenson presented on behalf of the Hospital. The content of the Hospital’s presentation was based on their written pre-hearing submission. The presentation provided the Hospital’s view on two main issues:

- Staffing; and
- Administrative support.

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

Wednesday, March 5, 2014

The IAC Chair resumed the Hearing at 0900 hours. The ground rules for the Hearing were reviewed and all participants were introduced. Ms. Stephenson provided the Hospital’s response to the Association’s submission. Members of the Hospital participated in the subsequent discussion. Ms. Rozanna Haynes provided the Association’s response to the Hospital’s submission. Other members of the Association also participated in the subsequent discussion.

The IAC Chair adjourned the Hearing at approximately 1700 hours. Following adjournment of the Hearing, the IAC met during the evening to review and synthesize the information provided, and to identify key issues requiring additional clarification and their respective questions for the final day of the hearing.

Thursday, March 6, 2014.

The IAC Chair resumed the Hearing at 0800 hours. The ground rules were reviewed and all participants were introduced.

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

The IAC Chair concluded the hearing by thanking Ms. Trudy Molke, Association Nominee and Ms. Janet Gobeil, Hospital Nominee; as well as all the participants for their engagement and contributions in the Hearing process. The IAC Chair also communicated the hope that the parties will be able to move forward to seek resolution to the issues. The Chair also confirmed that IAC anticipated providing the final report within 45 days. The IAC Chair closed the Hearing at approximately 1100 hours.

Post Closure of Hearing

The IAC met by teleconference on March 24, 2014. At this meeting, the IAC had extensive discussion and reviewed the draft recommendations and analysis. Following the teleconference, all IAC members contributed to the next version of the report and recommendations. The report was finalized on (date).

2. Presentation of the Professional Responsibility Workload Complaint

2.1. Information on Nipigon District Memorial Hospital

Nipigon District Memorial Hospital is located in Nipigon, Ontario and is a 37-bed facility providing health and wellness promotion services to the residents of the Nipigon area.[4] The hospital is part of the Northwest Local Health Integration Network (LHIN). The Northwest LHIN has the largest geographic area for a LHIN in Ontario; and serves 2% of the population of Ontario. [5] The Nipigon District Memorial Hospital Strategic Plan outlines the vision, values and strategic directions of the hospital.[4] The vision of the hospital is excellence in rural health and wellness promotion. The Hospital values include accountability, accessibility, collaboration, safe environment, personal and professional growth, and people as their most important resource.[4]

The Acute Care Unit has 15 beds and has an average occupancy of 60% to 68% over the fiscal years 12/13 and 13/14.[6] Alternate level of care days were 30% in 11/12; 42% in 12/13 and are currently at 31% in 13/14.[7] The Emergency Department volumes in 11/12 were 5,538; 5,844 in 12/13 and based on two quarters will be 4,680 in 13/14.[8] The CTAS score distribution has been stable over the last 3 years.[9]

---

[4] Nipigon District Memorial Hospital Strategic Plan 2012-2015, March 25, 2013.

[5] North West LHIN, Population Health Profile, Updated Summer 2011. http://www.northwestlhin.on.ca/uploadedFiles/Home_Page/Integrated_Health_Service_Plan/Population%20Report%202012%20English.pdf

[6] Additional Documents Brief in Support of the Submission for the Nipigon District Memorial Hospital, Tab K.

[7] Additional Documents Brief in Support of the Submission for the Nipigon District Memorial Hospital, Tabs J and K

[8] Additional Documents Brief in Support of the Submission for the Nipigon District Memorial Hospital, Tabs J and K

[9] Additional Documents Brief in Support of the Submission for the Nipigon District Memorial Hospital, Tabs J and K

2.2. Context of Staffing on Acute Care Unit and Emergency Department

The Acute Care Unit and the Emergency Department are on the same floor of the hospital and are co-located.

The current staffing in the Acute Care Unit and Emergency is:[10]

- 64 hours of RN staffing Monday to Friday;
- 60 hours of RN staffing on Saturday and Sunday;
- 8 hours of RPN staffing Monday to Friday; and
- 8 hours of ward clerk staffing Monday to Sunday.

There is one RN assigned to the Emergency Department from 0730-1930 hours Monday to Friday; and 0900-2100 on weekends. After 2330, a nurse in the Acute Care Unit is also assigned to cover the Emergency Department. If required by census or acuity, the hospital policy is to schedule additional staffing.

The staffing for the acute care unit and the Emergency Department is based on the average occupancy in the acute care unit and average number of Emergency Department visits.

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

According to the Association, three Professional Responsibility Workload Responsibility Forms (PRWRFs) were submitted during 2012; and eight were submitted during 2013.

The Issues regarding nursing workload identified by the Association in the PRWRFs include:

- Insufficient RN staffing levels related to ability to cover sick calls/vacation; and ability to increase staffing when acuity is heightened;

[10] Additional Documents Brief in Support of the Submission for the Nipigon District Memorial Hospital, Tab M.

- Increase in nursing workload due to staffing levels and lack of other support from other services;
- Patient transfers that require nursing escort;
- Fragmented and interrupted care;
- Role of various team members such as the Flex Nurse; unregulated care providers; and
- Registered Nurse (RN) and Registered Practical Nurse (RPN) practice issues including consultation, scope of practice, replacing RNs with RPNs.

The issues identified in the PRWRFs from the Hospital's perspective include:

- Staffing; and
- Administrative support.

There have been PRWRFs submitted by the nurses since 2008. There were several meetings between ONA and the Hospital during the period of 2009-2012, resulting in two Minutes of Settlement (February 8, 2010 and March 20, 2012). Additional workload complaints since March 2012 remain unresolved. Both parties agree that the current process to resolve workload complaints is not working well.

In October 2013 the Association notified the Hospital that outstanding issues were being referred to the IAC.

3. Discussion, Analysis and Recommendations

3.1. Registered Nurse Staffing

Registered Nurses form the largest group of health care providers in Canada. Ongoing nursing human resource workforce planning and effective implementation is essential to ensure adequate nurse staffing on a day-to-day basis in health service organizations.[11] Strategies include the consistent use of needs based human resource planning tools and appropriate data to assist in decision making. Organizations must address both short and long-term planning.[11] Forecasting models in nursing human resources provide a predictive model to determine staffing requirements for the future. One such model is the toolkit published by HealthForceOntario - Building Capacity for Nursing Human Resource Planning: A Best Practice Resource for Nursing Managers.[11]

There is a growing body of literature supporting the conclusion that nurse staffing and workload affect nurse satisfaction, nurse turnover, and patient outcomes.[12] Understaffing and the increased complexity of work have been identified as contributors to work overload. Work overload was also identified as a contributing factor to fatigue.[13]

---

[11] Beduz, M.A., Vincent, L., Pauze, E. (2009). Building Capacity in Nursing Human Resource Planning: A Best Practice Resource for Nursing Managers. The Nursing Human Resource Planning Best Practice Toolkit, HealthForceOntario.

[12] Neill, Denise (2011). Nursing workload and the changing health care environment: a review of the literature. Retrieved April 17, 2013, from the Administrative Issues Journal Web site http://www.swosu.edu/academics/aij/2011/issue2.asp

[13] Registered Nurses' Association of Ontario. (2011). Preventing and Mitigating Nurse Fatigue in Health Care Healthy Work Environments Best Practice Guideline. Toronto, ON: Registered Nurses' Association of Ontario

Research on both the type of nursing staff and the amount of nursing care is demonstrating a relationship to patient outcomes and safety. Improved nurse staffing is associated with lower mortality and adverse patient events.[14]

Decisions to change skill mix on a nursing unit must be considered within a robust framework. The Canadian Nurses Association Staff Mix Framework for Quality Nursing Care[15] outlines the guiding principles that should be utilized:

- *Decisions concerning staff mix respond to clients' health- care needs and enable the delivery of safe, competent, ethical, quality, evidence-based informed care in the context of professional standards and staff competencies*
- *Decision-making regarding staff mix is guided by nursing care delivery models based on the best evidence related to (1) client, staff and organizational factors influencing quality care and work environments, and (2) client, staff and organizational outcomes.*
- *Staff mix decision-making is supported by the organizational structure, mission and vision and by all levels of leadership in the organization.*
- *Direct care nursing staff and nursing management are engaged in decision-making about the staff mix*
- *Information and knowledge management systems support effective staff mix decision-making*.[15]

It is important for all hospitals to regularly monitor and measure metrics on staff levels, nursing and patient outcomes in order to assess human resource management, work environment, quality of care and outcomes. Such measures can include:

- Nursing hours per patient day;
- Patient outcomes;
- Patient safety incidents;
- Paid education hours;

---

[14] Kane R.L., Shamlivan, T.A., Mueller C., Duval S. & Wilt T.J. (2007) The association of registered nurse staffing levels and patient outcomes: systematic review and meta-analysis. Medical Care, 45, 1195-1204.
[15] Canadian Nurses Association. March 2012. Staff Mix Decision Making Framework for Quality Nursing Care.

- Staff satisfaction; and
- Patient satisfaction.

Current State of Staffing at NDMH:

The current staffing in the Acute Care Unit and Emergency is[16]:

- 64 hours of RN staffing Monday to Friday;
- 60 hours of RN staffing on Saturday and Sunday;
- 8 hours of RPN staffing Monday to Friday; and
- 8 hours of ward clerk staffing Monday to Sunday.

There is one RN assigned to the Emergency Department from 0730-1930 hours Monday to Friday; and 0900-2100 on weekends. After 2330, a nurse in the Acute Care Unit is assigned to also cover the Emergency Department. If required by census or acuity, the hospital policy is to schedule additional staffing.

Figure 1 is a staffing worksheet that shows the current staffing on days, evenings and nights, including weekends. Figure 1 provides a calculation of required staffing in FTEs based on the staffing pattern, including estimated replacement for statutory holidays (12 days per year), vacation (20 days per year) and sick time (7 days per year). Based on the current staffing a budget of 15.41 FTEs would be required to staff the acute care unit and Emergency Department. This estimate does not include any requirement for patient escort or other needs for increased staffing.

[16] Additional Documents Brief in Support of the Submission for the Nipigon District Memorial Hospital, Tab M.

Figure 1: Staffing Worksheet Based on Current Staffing

STAFFING PATTERN	Monday to Friday						
Personnel	0730-1130	1130-1530	1530-1930	1930-2330	2330-0330	0330-0730	Total # of Regular shifts [A]
Flex Nurse	1	1	0	0	0	0	5
RN Acute Care	1	1	2	2	2	2	25
RN ER	1	1	1	1	0	0	10
RPN	1	1	0	0	0	0	5
Unit Clerk	1	1	0	0	0	0	5
Total # RN Shifts	3	3	3	3	2	2	

STAFFING PATTERN	Saturday to Sunday								
Personnel	0730-1130	1130-1530	1530-1930	1930-2330	2330-0330	0330-0730	Total Number of Regular Shifts [B]	A+B	Regular Shifts in FTEs [C]
Flex Nurse	0	0	0	0	0	0	0	5	1
RN Acute Care	2	2	2	2	2	2	12	37	7.4
RN ER	1	1	1	0	0	0	3	13	2.6
RPN	0	0	0	0	0	0	0	5	1
Unit Clerk	1	1	0	0	0	0	2	7	1.4
Total # RN Shifts	3	3	3	2	2	2	2		

	Regular FTEs	Relief Required			Total Relief Shifts	Total Relief FTEs	Total FTEs
		Stat Holidays [cx12]	Vacation [Cx20]	Sick Time [Cx7]			
	[C]	[D]	[E]	[F]		[G]	
Flex Nurse	1	12	20	7	39	0.15	1.15
RN Acute Care	7.4	88.8	148	51.8	288.6	1.11	8.51
RN ER	2.6	31.2	52	18.2	101.4	0.39	2.99
RPN	1	12	20	7	39	0.15	1.15
Unit Clerks	1.4	16.8	28	9.8	54.6	0.21	1.61
							15.41

The Hospital is proposing to increase the Registered Nurse hours on weekends by four hours (providing 16 hours of RN staffing from 0730-2330) in the Emergency Department. At the same time, the Hospital proposes to replace the Registered Nurse evening shift Monday to Friday with a Registered Practical Nurse. The Hospital rationale for this staffing change is based on both an analysis of patient care needs as well as financial considerations. Figure 2 shows the proposed staffing model. In this staffing model, the required FTEs for staffing would be 15.64.

Figure 2: Staffing Worksheet Based on Hospital's Proposed Staff

STAFFING PATTERN	Monday to Friday						
Personnel	0730-1130	1130-1530	1530-1930	1930-2330	2330-0330	0330-0730	Total # of Regular shifts [A]
Flex Nurse	1	1	0	0	0	0	5
RN Acute Care	1	1	1	1	2	2	20
RN ER	1	1	1	1	0	0	10
RPN	1	1	1	1	0	0	10
Unit Clerks	1	1	0	0	0	0	5
Total # RN Shifts	3	3	2	2	2	2	

STAFFING PATTERN	Saturday to Sunday								
Personnel	0730-1130	1130-1530	1530-1930	1930-2330	2330-0330	0330-0730	Total Number of Regular Shifts [B]	A+B	Regular Shifts in FTEs [C]
Flex Nurse	0	0	0	0	0	0	0	5	1
RN Acute Care	2	2	2	2	2	2	12	32	6.4
RN ER	1	1	1	1	0	0	4	14	2.8
RPN	0	0	0	0	0	0	0	10	2
Unit Clerks	1	1	0	0	0	0	2	7	1.4
Total # RN Shifts	3	3	3	3	2	2	16	16	

	Regular FTEs	Relief Required			Total Relief Shifts	Total Relief FTEs	Total FTEs
		Stat Holidays [cx12]	Vacation [Cx20]	Sick Time [Cx7]			
	[C]	[D]	[E]	[F]		[G]	
Flex Nurse	1	12	20	7	39	0.15	1.15
RN Acute Care	6.4	76.8	128	44.8	249.6	0.96	7.36
RN ER	2.8	33.6	56	19.6	109.2	0.42	3.22
RPN	2	24	40	14	78	0.30	2.30
Unit Clerks	1.4	16.8	28	9.8	54.6	0.21	1.61
							15.64

The Ontario Nurses Association proposes the following model for staffing:

1. Increase the Emergency Department RN hours on weekends by 4 hours and maintain the current RN evening shift Monday to Friday.
2. Provide an additional 12 hours of time per week to RNs to provide support for infection control, education, wound care which would support the Flex Nurse to spend more time in the acute care unit and long term care on a daily basis.
3. Increase the Float RPN time on weekends to 4 hours from 1 hour.

Figure 3 shows the proposed staffing by the Association.

Figure 3: Staffing Proposed by the Association

STAFFING PATTERN	Monday to Friday						
Personnel	0730-1130	1130-1530	1530-1930	1930-2330	2330-0330	0330-0730	Total # of Regular shifts [A]
Flex Nurse	1	1	0	0	0	0	5
RN Acute Care	1	1	2	2	2	2	25
RN ER	1	1	1	1	0	0	10
RPN	1	1	0	0	0	0	5
Unit Clerks	1	1	0	0	0	0	5
Total RN Shifts	3	3	3	3	2	2	

	Saturday to Sunday								
Personnel	0730-1130	1130-1530	1530-1930	1930-2330	2330-0330	0330-0730	Total Number of Regular Shifts [B]	A+B	Regular Shifts in FTEs [C]
Flex Nurse	0	0	0	0	0	0	0	5	1
RN Acute Care	2	2	2	2	2	2	12	37	7.4
RN ER	1	1	1	1	0	0	4	14	2.8
RPN	0	0	0	0	0	0	0	5	1
Unit Clerks	1	1	0	0	0	0	2	7	1.4
Additional RN HRs									0.32
Total RN Shifts	3	3	3	3	2	2			

	Regular FTEs	Relief Required			Total Relief Shifts	Total Relief FTEs	Total FTEs
		Stat Holidays [cx12]	Vacation [Cx20]	Sick Time [Cx7]			
	[C]	[D]	[E]	[F]		[G]	
Flex Nurse	1	12	20	7	39	0.15	1.15
RN Acute Care	7.4	88.8	148	51.8	288.6	1.11	8.51
RN ER	2.8	33.6	56	19.6	109.2	0.42	3.22
RPN	1	12	20	7	39	0.15	1.15
Unit Clerks	1.4	16.8	28	9.8	54.6	0.21	1.61
Additional RN HRs	0.32	0	0	0	0	0	0.32
Total							**15.96**

The current staffing complement for Registered Nurses is:[17]

1. 8 full time;
2. 5 regular part time (one of whom is working a temporary full time line); and
3. 4 casual.

An analysis of the PRWRFs showed that the most common identified staffing issue was challenges in obtaining additional staff to work due to volume/acuity requirements, or when an RN was required to escort a patient by ambulance to Thunder Bay.

A number of factors were identified that contribute to challenges in staffing.

1. The Hospital has a small RN staffing base and a further decrease in a full time RN position based on the hospital proposal is likely to exacerbate the current staffing challenges. Given the current occupancy and patient mix on the acute care unit, patient volumes in the Emergency Department, and demand for patient transfers, the ability to effectively and safely staff both the acute care unit and the emergency department on evenings Monday to Friday would be compromised with only 2 Registered Nurses in the Hospital.

2. The Regular Part Time staff is currently being scheduled for a minimum of 45 hours in two weeks; and some for up to full time hours. Historically, as occurs in many organizations, the casual staff do not work very many hours and there are retention challenges. During the IAC hearing, the majority of RNs who attended stated that they do not wish to regularly work beyond their normal full time or part time allocation.

3. The NDMH has a consistent and frequent volume of scheduled, urgent/emergent patient transfers to Thunder Bay that requires a staff escort. RNs are regularly required to do a portion of the patient transfers due to the complexity of the patients. Current challenges in the Hospital's ability to bring in additional staffing at short notice for transfers results in having to frequently draw an RN from acute care or the emergency department, thereby causing either a staffing shortage or replacement of a RN with a RPN for a period of time. Therefore the removal of the third RN on the evening shift may be detrimental to providing

[17] Additional Documents Brief for the Nipigon District Memorial Hospital, Tab 4K.

care for these urgent/emergent transfers or fluctuating volumes of patients in the acute care unit and the emergency department. The number and type of patient transfers is not monitored in as fulsome a manner as necessary by the hospital therefore making it a challenge to determine the pattern of transfers and the resulting staff requirements for escort.

4. A voluntary on-call system for patient care transfers and/or other staffing needs has been considered but not implemented. Other staffing strategies such as a position for a casual transfer nurse could be considered, particularly during the summer months.

5. Changing patient care needs and volumes in acute care can require additional RN or RPN staffing depending on the nature of care requirements.

6. Changing patient care needs in long-term care require RN consultation. This results in a registered nurse from acute care or the emergency department either directly managing the patient care for a period of time, transferring the patient to acute care, and/or consulting with the RPN.

7. The Registered Nurses and the Registered Practical Nurses at NDMH on all shifts must work in a collaborative and flexible manner to manage fluctuating patient care volumes and care requirements across the acute care unit, long-term care unit and the emergency department. This becomes even more challenging when a staff member is utilized for a patient transfer and cannot be replaced; or when additional required staff cannot be obtained.

8. The RN overtime has increased in the last year. In the calendar year 2012 the total overtime (including banked overtime hours) was 465.41 hours (including 146.25 hours for consecutive weekends). In 2013, the total over time was 855.51 hours (including 348.90 hours for consecutive weekends). Opportunity exists to decrease the overtime through more effective staffing patterns and resources.
9. There are additional factors to be considered in the staffing of the hospital. During the course of the hearing, it was established that all of senior administration lives outside of

Nipigon with the closest being 20 minutes away. NDH has 3 senior administrators on call: CEO, CFO and CNO. Senior administration is accessible by phone at all times but is not on site after hours. Therefore, it is expected that the RN's handle emergent/urgent situations until senior management can arrive.

Recruitment of Registered Nurses

NDMH, like many small rural hospitals, faces special recruitment challenges due to location and the small number of positions that are available. The Hospital hired one nurse in the past year under the New Graduate Initiative. This was a very successful strategy and should be continued to support long term nursing human resource planning.

The number of part time RN positions was increased by one position this year in anticipation of the proposed staffing changes. Given that the part time RN staff availability is almost completely utilized in the current schedule, it would seem prudent to maintain the additional part time position and evaluate the impact on staffing.

RN and RPN Collaborative Practice

The hospital proposal to replace the evening 8 hours shift Monday to Friday and replace with an RPN is based on the expectation that RPN's will work at full scope. The RNs stated at the hearing that they had not had any input into the plan to increase RPNs in acute care. Full scope was described as being able to do more advanced physical assessment appropriate to an acute care patient; and various tasks such blood administration, intravenous insertion, intravenous antibiotics and infusions. Currently only two Registered Practical Nurses, work at what the Hospital describes as a full scope of practice; and one is on a maternity leave. Currently there is an insufficient number of RPNs working at full scope and they have also not had sufficient exposure to working acute care. It is essential to ensure that the RPNs are all working at a full scope of practice and to feel confident and able to work in acute care in order to support this type of staffing change. A learning needs assessment on all staff was initiated in the last year, but a comprehensive action plan and timelines to support this significant staffing model change

is required. The Hospital stated their commitment to staff development and to meeting the learning needs of staff and are planning to hold a physical assessment course for staff.

The RNs stated that they have a collegial working relationship with RPNs but as would be expected, they find that those RPNs who do not work regularly in acute care require more supervision and direction when they are assigned to acute care. The RNs feel that increased education, experience and exposure to acute care and emergency department would be required to bring them up to full scope. The RNs identified that a physical assessment course would be necessary.

The RNs consistently identified concern regarding the replacement of an RN by an RPN in situations where there is an urgent staffing need because of the complexity of patient care in acute care and/or the emergency department. The RNs stated that they feel this is due to the lack of RNs who are available to work at short notice. They expressed concerns regarding fragmented care when they have to support and consult with the RPNs and provide care to their clients. With the reduction of the RN shift on evenings, the RNs felt that this would result in increased staff call-ins. The RNs expressed concern that they already work short when they are unable to replace sick time or find staff to do a patient transfers. The RNs stated that the evening 8-hour RN or an RPN often gets utilized to go on transfer and the removal of this position on evenings would not allow for an RN to go on a transfer.

Although a few educational sessions on collaborative practice have been provided to the staff including some learning modules, the outcomes and impact on practice were not formally evaluated. Additional and ongoing practice support and development for both RNs and RPNS on collaborative practice would effectively support a healthy work environment.

Decision Making regarding Staffing

The Hospital evaluates staffing requirements on a daily basis. The Chief Nursing Officer consults with the Flex Nurse on required staffing. The Flex Nurse assesses staffing on a daily basis Monday to Friday. The Registered Nurses may also communicate their assessment of staffing requirements to the Flex Nurse during the weekdays; on evenings/nights and weekends, the

RNs speak directly to the Administrator on Call. There is not a formal daily process such as a nursing huddle to discuss daily staffing needs that regularly engages the staff in assessing staffing needs for the short-term future. A more formal process would support staff engagement and transparency of decision-making.

The Hospital identified the staffing tool "We Need Help" is not consistently completed by nurses when the need for additional staff is identified. This tool is helpful to the Hospital in assessing staffing.

Non-Patient Care Issues

The RNs identified on evenings, nights and weekends that non patient care issues such as calling in staff, housekeeping, physical plant and maintenance issues create additional work and detract from patient care. There are few on site resources for the nurses beyond the day shift Monday to Friday.

Recommendations:

1. Maintain the current Registered Nurse staffing on evenings Monday to Friday. Do not replace the Registered Nurse with a Registered Practical Nurse.

2. Increase the Registered Nurse staffing in the emergency department on weekends by 4 hours to provide staffing from 0730 to 2330.

3. The current full time Registered Nurse position that is being considered for elimination should be filled with either a full time RN or 2 regular part time RNs. This position could also be considered for job sharing.

4. Develop a nursing human resource plan to support short and long term nursing human resource needs at NDMH. Engage and empower the nursing staff in the development of the plan. This resource plan should be evaluated annually and revised every five years.
   The HealthForceOntario publication on Building Capacity for Nursing Human Resource Planning: A best practice resource for Nursing Managers could also be utilized to support this process. [11]

5. Formally engage the Registered Nurses and the Registered Practical Nurses in the development and implementation of a nursing delivery model of care for NDMH. Utilize evidence-based resources on skill mix and nurse staffing.

6. Develop a set of outcomes measures that can be utilized to assess quality of care, nurse and patient volumes and outcomes; and any change in skill mix or model of care. A monitoring process should be established and the outcomes should be shared with nursing staff on a regular basis. This information should be shared with nursing staff on a regular basis.

7. Implement a regular and reliable method to monitor the number and type of patient transfers including the type of required staff escort.

8. Implement a position for a casual nurse to do patient transfers especially during the summer months when there is considerable demand for staff vacation time.

9. Implement a voluntary on call system for long weekends, and during summer holiday periods.

10. Establish a daily nursing huddle with the Flex Nurse, Registered Nurses and the CNO if possible to discuss staffing requirements for the next 24-48 hours. This could be integrated with the already existing Rocket Rounds with a follow-up later in the day shift to ascertain if there are any changes necessary.

11. Continue to utilize the New Graduate Initiative to support recruitment and orientation of new nurses to the Hospital.

12. Provide additional education and practice support on collaborative practice in nursing teams with a special focus on consultation in order to improve confidence in both the RNs and RPNs.

3.2. Leadership

It was evident to the IAC committee that senior administration at NDMH are committed to providing high quality and safe patient care to their community and that they have a strong desire to provide a healthy, quality work life environment for the nurses. However, their ability to meet this is challenged by the fiscal responsibility to provide a balanced budget to the Northwest Local Health Integration Network in the face of shrinking financial resources and the identified need for an increase in RN staffing in the Emergency Department.

Senior administration has been streamlined to the point that formal human resource support is limited. The Chief Nursing Officer (CNO) does not have a non-union nurse manager to assist in overseeing the three areas of nursing care. The CNO's ability to create an empowering working environment and create a culture that supports collaborative practice is hindered by a considerable span of control and multiple competing demands on her time.

The IAC had the opportunity to meet with the current incumbent in the Flex Nurse role, which was very helpful in understanding the current situation at NDMH with regard to workload. The flex nurse role was developed in 2010 as part of a resolution related to the elimination of two nursing positions – a nursing supervisor role for acute care and the emergency department and a charge nurse role in long term care.[18] The role as described in the Memorandum of Settlement in 2010 was to be one of the two RNs on Acute Care and would be the nurse educator. The Memorandum of Settlement in 2012 further describes processes for backfilling the Flex Nurse for new nurse orientation or when absent; and the role accountabilities for leading discharge planning rounds.[19] The role currently includes responsibilities for wound management, education, infection control and discharge planning. Some but not all of the responsibilities of discharge planning have been assumed by the CCAC who have an office in the hospital. Discussion during the three days of the hearing indicated that the flex nurse is challenged to fulfill all parts of her role on a consistent basis due to workload and fluctuating demands on her time related to patient care. Education, wound care and infection control roles

---

[18] Additional Documents Brief in Support of the Submission for the Nipigon District Memorial Hospital, Tab A.

[19] Additional Documents Brief in Support of the Submission for the Nipigon District Memorial Hospital, Tab B.

responsibilities have not had optimal attention. While this role has great potential, the fluctuating workload demands are stressful. Long Term Care has not had regular RN involvement and is primarily managed by a lead RPN. The role of flex nurse is not always easy as the flex nurse is not part of management and has limited authority.

It was identified during the tour of the facility that the pharmacy department is staffed by one full time RN with access to a consultant pharmacist. This RN works Monday - Friday and is in charge of the ordering and dispensing of medications for acute care. This RN had the following duties identified: chemotherapy mixing, and some medication reviews on inpatients. The IAC panel heard during the hearing that this position is in the Unifor union.

Recommendations:

1. Implement a non-union clinical manager to assist CNO in her duties with managing and leading clinical operations and hospital management.

2. Revise the Flex nurse role in consultation with the Flex Nurse, focusing on the role of leadership, support and guidance for patient care on acute care, emergency and long term care.

3. Determine if some non-nursing duties that are currently being done by the Flex Nurse or the CNO could be added to the role of the nurse in the Pharmacy, such as:
    - infection control duties;
    - occupational health activities e.g. N95 mask fitting, staff flu clinics;
    - medication incident reviews and reporting NSIR; and
    - support for data management and entry.
    - Determine if a purchasing agent could assist with ordering medication.

4. Redistribute some of the current role of the flex nurse, i.e. education, infection control, wound management to the RNs in order to enhance their work-life, professional and leadership development. Provide education and support to enable the RNs to take on these roles.

3.3. Professional Practice and Education

Both NDMH Administration and the RNs identified that the scheduling of Nursing Practice Meetings and education sessions were challenging during normal working hours. Nurses would rather not come in on their days off, particularly given the continuing demand for overtime hours. The RNs did not seem to be as engaged with the Nursing Practice Committee as they should be in order to influence professional practice at NDMH.

A new nurse is not oriented to the Emergency Department until the nurse has two years of experience in acute care. In many jurisdictions in Ontario, novice nurses with less than 2 years of experience are being successfully employed in emergency departments.

1. Continue the Nursing Practice Committee meetings on a regular basis and focus on practice issues and the learning needs of staff that should also include leadership development, team building, critical thinking and analysis.

2. Develop a comprehensive plan to support operationalizing the full scope of role of the RPN as well as collaborative practice between RNs and RPNs.

3. The RNs should increase their engagement and participation in the Nursing Practice Committee.

4. Begin the orientation of nurses to the Emergency Department at an earlier point in their experience trajectory.

3.4 Morale

Discussions during the IAC indicated the RN staff morale is low in the hospital. Nurses identified feeling burnt out and often working beyond their capacity. Nurses identified that their primary sense of reward comes from providing patient care. There did not seem to be formal processes to recognize staff contributions and accomplishments.

Recent evidence supports the link between physical and psychological responses to work and intention to remain employed.[20] Work related stress and burnout are predictors of intent to turnover in Canadian Nurses. [21] Other factors associated with intention to remain employed are relationships with co-workers, relationship and support from manager, organizational support and practices, work rewards, patient relationships and job content, condition of the work environment, nurse characteristics and external factors. [18] Organizational supports that influence intention include having meaningful input on committees, support for participation, scheduling practices, and funding for education.

Recommendations:

1. The RNs and hospital leadership, as well as other staff representatives, should collaborate in development of staff recognition processes and events. This could include debriefing and celebrating efforts at the end of a busy shift, employee of the month, staff recognition awards.

2. The Nursing Practice Committee should familiarize themselves with the Registered Nurses' Association of Ontario (RNAO) suite of Healthy Work Environments Best Practice Guidelines; and consider implementing an appropriate guideline to support team and practice development at NDMH.

3. The Hospital should continue to support the development of staff through education and other opportunities. Consider applying to the Late Career Initiative that is currently funding by the Ministry of Health and Long Term Care.

---

[20] Tourangeau A.E., Cummings G., Cranley L.A., Ferrone E.M. & Harvey S. (2010) Determinants of hospital nurse intention to remain employed: broadening our understanding. Journal of Advanced Nursing 66(1), 22-32.

[21] Zeytinoglu E.U., Denton M., Davies S., Baumann A., Blythe J. & Boos L. (2007) Deteriorated external work environment, heavy workload and nurses' job satisfaction and turnover intention. Canadian Public Policy 33, 31-47.

3.5 Process for PRWRFs

All parties agreed that the current process for the management of PRWRFs could be improved. It was noted by the IAC that even the versions of the PRWRFs was different in the submitted briefs. The Hospital versions had the management comments and the Association version did not. Formal documentation of discussion of meetings regarding PRWRFs was lacking. Hospital Association Meetings do not seem to occur on as regular a basis as might be appropriate to ensure timely consideration of PRWRFs.

Recommendations:

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

2. Review the process for the management of PRWRFs to ensure timely submission to management so that a formal response can be provided to staff.

4. Summary and Conclusions

The process undertaken through an Independent Assessment Committee provides a unique opportunity for discussion and dialogue between all parties regarding the complex issues and conditions that underlie a Professional Workload Complaint.

The Committee has made twenty-five recommendations in five areas regarding issues that directly or indirectly impact the workload of Registered Nurses:

1. Registered Nurse Staffing
2. Leadership
3. Professional Practice and Education
4. Morale

5. Process for PRWRFs

The members of the Independent Assessment Committee unanimously support all recommendations in this report. The Independent Assessment Committee hopes that the recommendations in this report will assist the Hospital and the Association to find mutually agreeable resolutions with regard to nursing workload issues on the Acute Care Unit and Emergency Department at Nipigon Memorial District Hospital.

Appendix 1: Letter from Association to IAC Chair, October 28, 2013

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

www.ona.org

October 28, 2013

Sent By E-Mail and Regular Mail

Leslie Vincent, RN, MScA
716 Windermere Ave.
Toronto, ON M6S 3M1

Dear Leslie,

RE: Nipigon District Memorial Hospital and Ontario Nurses' Association: Professional Responsibility Complaint: – Independent Assessment Committee – ONA File 200902677

This letter is in follow up to our recent telephone conversation. Thank you for accepting the nomination to chair an Independent Assessment Committee (IAC) investigating a complaint at Nipigon District Memorial Hospital. I consulted with Mr. David McCoy, Manager, Labour Relations at the Ontario Hospital Association on August 01, 2013 and both parties have agreed to you chairing this IAC.

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

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

Yours truly,

ONTARIO NURSES' ASSOCIATION

Rozanna Haynes

Rozanna Haynes
Professional Practice Specialist

C: Sandra Ryder, Local Coordinator
Diana LeBar, Bargaining Unit President
Michele Martin, Labour Relations Officer, ONA
Trudy Molke, ONA Nominee
Sonja Stephenson, Chief Nursing Executive
Carl White, Chief Executive Officer
Denis Nault, Human Resources
David McCoy, Manager of Labour Relations, Ontario Hospital Association

Encl.

Appendix 2: Letter from Association to Hospital Regarding Nominee, October 25, 2013

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

October 25, 2013

Sent By E-Mail and Regular Mail

Sonja Stephenson
Chief Nursing Executive
Nipigon District Memorial Hospital
125 Hogan Road, PO Box 37
Nipigon, ON P0T 2J0

Dear Sonja,

RE: Nipigon District Memorial Hospital and Ontario Nurses' Association: Professional Responsibility Complaint: – Independent Assessment Committee – ONA File 200902677

This letter in follow up to several verbal notifications of ONA's IAC nominee's name – Trudy Molke.

Contact information is as follows:

Trudy Molke RN BScN
48 Overbank Crescent
Don Mills, Ontario
Canada M3A 1W2
Telephone: 416 447-7738

trudy.molke@sympatico.ca

ONA has shared our nominee's name at several HAC meetings but to date has not been notified of the Hospital's nominee name or contact information. Please forward this information to ONA and the IAC Chair - Leslie Vincent as soon as possible.

Thank you for your attention to this matter.

Yours truly,

ONTARIO NURSE'S ASSOCIATION

Rozanna Haynes

Rozanna Haynes,
Professional Practice Specialist

C: Sandra Ryder, Local Coordinator
Diana LeBar, Bargaining Unit President
Michele Martin, Labour Relations Officer, ONA
Trudy Molke, ONA Nominee
Carl White, Chief Executive Officer
Denis Nault, Human Resources

Appendix 3: Letter from Hospital to IAC Chair October 28, 2013

PO Box 37 Nipigon, ON P0T 2J0 www.ndmh.ca
(807) 887-3026 Fax (807) 887-2800

October 28, 2013

SENT BY EMAIL AND REGULAR MAIL

Leslie Vincent, RN MScA
716 Windmere Avenue
Toronto, ON M6S 3M1

Dear Leslie,

RE: Nipigon District Memorial Hospital and Ontario Nurses' Association: Professional Responsibility Complaint: - Independent Assessment Committee - ONA File 200902677

This letter is in follow-up to ONA's correspondence dated October 25, 2013.

As committed to, we have just firmed up our Employer IAC nominee and are communicating that it will be Janet Gobeil.

Contact information is as follows:

Janet Gobeil RN
Chief Nursing Officer
Wilson Memorial General Hospital
Bag W, 26 Peninsula Road
Marathon, Ontario
P0T 2E0
807-229-1740 ext 225
fax 807-229-1721
jgobeil@nosh.ca

Yours truly,

Sonja Stephenson
Director Patient Services and Chief Nursing Officer

C: Trudy Molke, ONA Nominee
Carl White, Chief Executive Officer
Rozanna Haynes, Professional Practice Specialist
Denis Nault, Manager, Employee Relations

Appendix 4: Agenda for IAC

Agenda

Tuesday March 4, 2014

Nipigon District Memorial Hospital

Time	Item	Participants
09:00 – 11:00	Tour of Emergency Department and Acute Care Unit	IAC, NDMH and ONA
11:00 — 13:00	Lunch and IAC Panel Meeting	IAC
13:00 — 13:15	Introduction and Review of Proceedings by Chairperson	IAC Chair
13:00 — 14:30	Ontario Nurses' Association Submission Presentation Response to questions of clarification from: • Independent Assessment Committee • Nipigon District Memorial Hospital	IAC, NDMH and ONA
14:30 — 14:45	Break	All
15:15 — 16:45	Nipigon District Memorial Hospital Submission Presentation Response to questions of clarification from • Independent Assessment Committee • Ontario Nurses' Association	IAC, NDMH and ONA
16:45 — 17:00	Review of Process for Tuesday, April 9, 2013.	IAC Chair
17:00	Adjournment of Hearing	IAC Chair

Agenda

Wednesday March 5, 2014

Nipigon District Memorial Hospital

Time	Item	Participants
09:00-12:00	Nipigon District Memorial Hospital Response to Ontario Nurses' Association Submission Response to questions from • Independent Assessment Committee • Ontario Nurses' Association • Discussion	IAC, NDMH and ONA
12:00-13:00	Lunch	All
13:00-16:00	Ontario Nurses' Association Response to Nipigon District Memorial Hospital Response to questions from • Independent Assessment Committee • Nipigon District Memorial Hospital • Discussion	IAC Chair
16:00 – 16:15	Review of Process for Wednesday, April 10, 2013	IAC Chair
16:15	Adjournment of Hearing	IAC Chair
16:15 onwards	Independent Assessment Committee Meeting	IAC

Agenda

Thursday March 6, 2014

Nipigon District Memorial Hospital

Time	Item	Participants
09:00— 12:00	Questions to both Parties by Independent Assessment Committee	IAC, NDMH and ONA
12:00— 12:30	Closing Remarks and Identification of Next Steps by Chairperson	IAC Chair
12:30	Closure of Hearing	All
12:30— 13:30	Independent Assessment Committee Meeting	IAC

Appendix 5: Nipigon Regional Memorial Hospital IAC - Additional Information Request

1. HAC agendas and minutes from 2012 and 2013: we noted that some of the items in the briefs are handwritten; we would like to see the approved agendas and minutes for HAC.
2. Agendas and minutes of any meetings with regard to workload forms;
3. Copy of local collective agreement;
4. Staffing information and data:
    a. Hospital human resource plan for RNs and RPNs.
    b. Job descriptions for RN, RPNs and PSWs;
    c. Job description for Flex Nurse Role;
    d. Budgeted FTEs for RNs and RPNs for acute care and ER for 12/13 and 13/14 fiscal years;
    e. Total paid hours for RNs and for RPNs for acute care and ER for 12/13 and 13/14 fiscal years broken down by FT, PT, Casual.
    f. Sick time in hours and as percentage of total paid hours;
    g. OT as percentage of paid hours;
    h. Paid education time in hours for 12/13 and 13/14 for RNs;
    i. Recruitment and retention data
        i. Hires in last two year – RNs, RPNs, FT/PT/Casual
        i. Turnover in last two years for RNs, RPNs, FT/PT/Casual
        ii. Number and type of RN and RPN positions posted in the current fiscal year;
        iii. Current vacancies for RNs and RPNs;
        iv. Retirement projections to end of 2014 for RNs and RPNs;
        v. Confirmed internal or external recruitment (have not yet started work);
    b. Number of FT, PT, Casual positions (i.e. head count) for RNs and RPNs
    c. Future LOAs for RNs and RPNs e.g. MLOA in 2014; and LOAs returning in 2014;
5. Patient Data
    a. HPPD for acute care and ER for 12/13 and 13/14 to date; by month; and comparison to other small hospitals in Ontario
    b. Admissions by CTAS level for 12/13 and 13/14 fiscal years
    c. Performance indicators (including Pay for Results) for ER and Acute Care
    d. Quarterly Improvement Plan Progress Report for 12/13
    e. Number of transfers requiring staff escort by month for the last 2 years.
    f. Patient Satisfaction Results for 2012 and 2013
    g. Number and type of critical incidents in 2012 and 2013
6. Copy of posted schedules for 2012 and 2013.
7. **Professional Practice**
    d. Orientation program for new nursing staff in the emergency department (length and outline of content)
    e. Description of preceptorship and/or mentorship program in emergency department for nursing staff

Appendix 6: Attendees at the IAC

Association Attendees:

March 4, 2014

1. Rozanna Haynes, Professional Practice, Ontario Nurses Association
2. Lorrie Daniels, Professional Practice ONA
3. Michele Martin, Labour Relations Officer
4. Pam Mancuso, Vice President for Region 1, Ontario Nurses Association
5. Sandra Ryder, Local Coordinator Local 014
6. Diana Lebar, Bargaining Unit President, Local 014
7. Jennifer Hart , Vice President of the Bargaining Unit Local 014
8. Donna Leonzio, RN
9. Laura Geiger, RN

March 5, 2014

1. Rozanna Haynes, Professional Practice, Ontario Nurses Association
2. Lorrie Daniels, Professional Practice ONA
3. Michele Martin, Labour Relations Officer
4. Pam Mancuso, Vice President for Region 1, Ontario Nurses Association
5. Sandra Ryder, Local Coordinator Local 014
6. Diana Lebar, Bargaining Unit President, Local 014
7. Jennifer Hart , Vice President of the Bargaining Unit Local 014
8. Laura Geiger, RN
9. Mary Ann Malley, Flex Nurse
10. Donna Leonzio, RN

March 6, 2014

1. Rozanna Haynes, Professional Practice, Ontario Nurses Association
2. Lorrie Daniels, Professional Practice ONA
3. Michele Martin, Labour Relations Officer
4. Pam Mancuso, Vice President for Region 1, Ontario Nurses Association
5. Sandra Ryder, Local Coordinator Local 014
6. Diana Lebar, Bargaining Unit President, Local 014

7. Jennifer Hart , Vice President of the Bargaining Unit Local 014

8. Karen Huls, RN
9. Wendy Dupuis, RN
10. Laurie Croker, RN
11. Brittany Clowes, RN

Hospital Attendees:

1. Sonja Stephenson, Director Patient Services and Chief Nursing Officer
2. Dan Hill, Chief Financial Officer
3. Denis Nault, Human Resources
4. Carl White, Chief Executive Officer