

Independent Assessment Committee Report

Constituted under Article 8.01 of the

Collective Agreement

between

**Ontario Nurses Association and Perioperative
Services, Orillia Soldiers Memorial Hospital**

and

Ontario Nurses' Association

March 25th 2013

March 25, 2013

Cheryl Harrison
Vice President, Patient Services, Chief Nursing
Executive
Orillia Soldiers Memorial Hospital
170 Colborne Street West
Orillia, ON, L3V 2Z1

Jo Anne Shannon
Professional Practice Specialist
Ontario Nurses Association
85 Grenville Street, Suite 400
Toronto, ON M5S 3AW

Dear Cheryl and Jo Anne

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 Day Surgery Unit and Operating Room areas of the Perioperative Services, Orillia Soldiers Memorial Hospital.

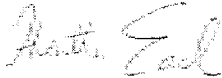
The Complaint was presented to the Independent Assessment Committee in accordance with Article 8.01 of the Collective Agreement (expiry March 2014) between the Orillia Soldiers Memorial Hospital and the Ontario Nurses' Association.

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 within the Perioperative Services, to prepare and present information and respond to our questions prior to and during the three day hearing.

The IAC process provides for the opportunity for extensive dialogue and in-depth discussion. This process has resulted in the development of 70 recommendations many of which are interdependent in nature and serve to reinforce the many elements which impact day to day nursing practice. The 70 recommendations cover the areas of communication, healthy workplace culture, patient safety, staffing model of care, patient flow, change management and supports, practice supports, perioperative self assessment competency/skills check list, documentation, staff professional development and lastly, the patient experience. Of the 70 recommendations 69 are unanimously agreed. There is a letter of dissent from the ONA nominee Glenda Hubley regarding exception of any and all references to PAC Staffing Model of Care and can be found in the appendices.

The process of the IAC is forward orientated and therefore, we hope this report will assist all parties to continue to work together, in good faith, to provide optimal care to patients receiving care within the Perioperative Services, Orillia Soldiers Memorial Hospital and with the submission of this report the IAC is dissolved.

Respectfully submitted



Heather Ead RN MHSc



June Duesbury-Porter RN, MScN, MBA

I partially dissent- dissent attached
Glenda Hubley, RN CPN © RNFA

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PART I INTRODUCTION

1.1 Organization of the Independent Assessment Committee Report

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

Part I

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

Part II

Presents the context of practice relating to the professional workload complaint in the Perioperative Services, Orillia Soldiers Memorial Hospital; briefly summarizes the relevant history leading to the referral of the professional workload complaint to the IAC; and reviews the presentations by the Ontario Nurses' Association ('the Association') and Orillia Soldiers Memorial Hospital ('the Hospital') at the Hearing.

Part III

Presents the IACs' discussion, analysis and recommendations.

Part IV

Summary and Conclusions.

Part V

Contains Appendices referenced in the Report.

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

1.2 Referral to the Independent Assessment Committee

This Report addresses the professional workload complaints of Registered Nurses Perioperative services, Orillia Soldiers Memorial Hospital. The Association Local 92 outlines in their pre-hearing submission that the:

The RNs working in the Hospital's Day Surgery Unit began consistently document their workload and practice concerns in earnest on Professional Responsibility Workload Report forms November 2010 to today's date. The Hospital and the Association discussed the workload concerns specific to the Day Surgery Unit through the Hospital Association Committee (HAC) process since December 2010. The Professional Responsibility Pre-Complaint Letter was forwarded to the Hospital on October 26th 2012. An Association's Professional Practice Specialist has been involved since May 12th 2012.

Therefore in the Association's Professional Responsibility Complaint to the IAC Chairperson, in a letter dated Friday, October 26th 2012 requested the IAC assess the nursing practice and workload concerns put before them from the perspective of being able to provide safe, ethical, competent and professional quality patient care in a quality practice setting in accordance with the College of Nurses of Ontario Practice Standards and Guidelines

1.3 Jurisdiction of the Independent Assessment Committee

The IAC is convened under the authority of Article 8.01 of the Central Hospital Agreement between the Ontario Hospital Association/Orillia Soldiers Memorial Hospital 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 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 IACs' jurisdiction thus relates to whether registered nurses are being requested and/or required to assume more work than is consistent with the provision of proper patient care. Workload is influenced by both direct factors (e.g. nurse-patient ratio, patient acuity/complexity of care requirements, patient volume) and indirect factors (e.g. roles and responsibilities of other care providers, physical environment of practice, standards of practice, and systems of care). The IAC is responsible for examining all factors impacting workload, and for making recommendations to address workload issues. Concerns outside of workload are beyond the jurisdiction of the IAC.

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 report carries considerable weight and is accepted by the parties as a method of obtaining a final dispute resolution in these difficult areas.¹

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

For the Hospital:

Heather Ead

For the Association:

Glenda Hubley

Chairperson

June Duesburry-Porter

¹ Arbitration Hearing Brantford General Hospital and Ontario Nurses Association, September 8th 1986

1.4 Proceedings of the Independent Assessment Committee

1.4.1 Pre-Hearing

The Association in a letter dated Friday, October 26th 2012 (Appendix 1) notified the Hospital that in accordance with Article 8.01 of the Central Hospital Agreement between the parties, ONA was forwarding this Professional Responsibility Complaint to the Independent Assessment Committee (IAC). Within a letter dated October 26th 2012 the Association advised the Hospital that the Association's nominee to the IAC was Glenda Hubley.

On Wednesday, December 6th 2012 the Hospital advised the Association that the Hospital's nominee was Heather Ead as well as that the dates of the hearing for Monday, February 5th- Thursday, February 7th 2013 in accordance with Article 8.01.

A teleconference was held on Monday, January 28th 2013 between the Hospital's nominee Heather Ead and the Association's nominee Glenda Hubley. The IAC Nominees discussed potential dates for the Hearing with their respective parties over the following weeks which were also shared with both the Hospital and Association.

The IAC, the Hospital and the Association agreed that the Hearing would be held on the Hospital premises on February 5th-7th 2013.

The IAC requested the Hospital and the Association to forward the Hearing Submission and associated exhibits to the Chairperson by Thursday January 17th 2013 in order to support the principle of full disclosure and to streamline the process of the Hearing by enabling the IAC to become familiar with the issues in advance. The IAC Chairperson received the Association Submission Briefs and associated exhibits on Thursday January 17th 2013 as requested, and distributed the briefs and exhibits by courier to all parties on January 18th 2013. The Hospital's copy was couriered to Cheryl Harrison.

The IAC held a teleconference Pre-Hearing Meeting on Monday January 28th 2013. The IAC during this meeting:

- Reviewed the anticipated process of the Hearing;
- Discussed the themes arising from the pre-hearing submissions and exhibits provided by both the Hospital and the Association;
- Determined the additional information requirements in selected areas;
- Constructed a draft agenda;
- Identified the key issues for in depth clarification and exploration at the Hearing.

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

- Confirming the plans and attendees for the Tour of the following areas within the Perioperative Services:
 - Pre-Admission Clinic
 - Day Surgery Unit
 - PAC
- Providing the Hearing Agenda;
- Requesting the Hospital to provide selected additional information by the close of the Hearing (Appendix 2).

The Association and Hospital provided the IAC Chair with their respective lists of tour participants on Thursday, January 24th 2013 and Wednesday, January 30th 2013. On the morning of Tuesday February 5th 2013 the IAC were greeted in the lobby by tour representatives from both the Hospital and Association. The IAC was provided a place for their personal effects prior to commencing the tour.

On behalf of the Association on the site tour:

- Jo Anne Shannon, Professional Practice Specialist
- Lynn Stevenson, Registered Nurse
- Robin Stoer, Registered Nurse
- Teresa Robson, Registered Nurse

On behalf of the Hospital::

- Tammy Gallagher, Program Manager
- Andrea Farkas, Program Director Surgical, Cancer Care and Complex and Rehabilitation Care
- Barb Jones, Director of Performance
- Rob Joseph, Senior Human Resources Business Partner

1.4.2 Hearing

The Hearing convened at 1300 hours in several venues within the Hospital in concordance with the Agenda (Appendix 3), the Hearing was held over three days:

Tuesday	February 5 th 2013:	0730 – 1700 hours
Wednesday	February 6 th 2013:	0730 – 1600 hours
Thursday	February 7 th 2013:	0800 – 1100 hours

Participants and Observer on the respective hearing dates are listed in Appendix 4.

Tuesday February 5th 2013

The IAC arrived at the Hospital at 730 hours and were met by both Hospital and Association tour members prior to proceeding with a tour beginning with Day Surgery and subsequently included the following areas:

- Reception
- Change and waiting area
- Endoscopy recovery bays
- Day Surgery recovery bays
- Isolation admission/recovery capacity
- Dedicated Cataract pre and post operative bays
- Post-anesthetic care unit
- Operating Room holding area
- Location of Endoscopy, Cystoscopy and C-section suites; and
- Pre-Admission Clinic

The tour facilitated a greater understanding of the patient flow from the point of presentation for pre-assessment in preparation for day surgery patients on their day of surgery through until discharge.

During the tour the IAC had the opportunity to observe the following:

- Fast tracked post-operative cataract patient and handover to Day Surgery staff;
- Post endoscopy patient handover to Day Surgery staff;
- Pick up of cataract patient for transportation to the OR;
- Admission of post op surgical patient to PACU

Within the Pre-Admission Clinic the IAC had an informative conversation with the Booking Clerk learning more about the following:

- Colour coding of:
 - In-patient charts
 - Day surgery patient
 - Telephone pre-admission assessments
- Concerns expressed by the Association regarding the distance between the Pre-Admission Clinic (PAC) and the Day Surgery Unit where the RN nurse who is the dedicated Resource Nurse for the RPN in PAC

The IAC did not observe a Pre-Admission Assessment (face to face nor by means of the telephone) nor a RPN working in collaboration with a RN either face to face or by means of a telephone.

Hearing

The IAC Chairperson opened the Hearing shortly after 1300 following introduction of the IAC Committee members and round-table introductions of the Association and Hospital participants, the IAC Chairperson reviewed:

- The jurisdictional scope of the IAC, including the purpose of the IAC,
- The scope of its recommendations, and the processes agreed to by the Hospital and the Association as outlined in Section 8.01 of the Collective Agreement.
- The 'ground rules' for the Hearing procedure including confirmation that all participants understood and agreed.

Jo Anne Shannon, Professional Practice Specialist presented on behalf of the Association. The content of the Association's presentation was based on their written Pre-hearing submission and exhibits of supporting / explanatory information, as well as a summary of the PRWRFs submitted by the Registered Nurses within the Perioperative services between December 2010 until present date. During the presentation the Association reaffirmed their position that the introduction of the new skill model within the Pre-Admission Clinic and Day Surgery had negatively impacted the workload of the Registered Nurses and patient care within the Day Surgery and Operating Room areas of the Perioperative Services.

During and following the presentation, the Association responded to clarification questions posted by both the Hospital and IAC.

Andrea Farkas, Program Director Surgical, Cancer Care and Complex and Rehabilitation Care for the Hospital presented the submission on behalf of the Hospital. The content of the Hospital's presentation was based on their written Pre-hearing submission and their position that the new skill model did not negatively impact patient care nor the workload of the Registered Nurses working within the Day Surgery Unit and Operating Rooms of the Perioperative Services.

During and following the presentation, the Hospital responded to clarification questions posted by the Association and IAC.

The IAC Chairperson adjourned the Hearing at 1700 hours and outlined the proceedings for Day 2.

Following adjournment of the tour the IAC met over dinner 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 February 6th 2013

Prior to the commencement of the second day of the hearing, the IAC had requested and the Hospital had arranged an opportunity for the committee to meet with Susan Gibbon, Risk Manager. The purpose of the meeting was to seek clarification regarding the IAC's outstanding requests for information, questions and concerns with respect to the Risk Monitor Pro (RMPs) and an inability to reconcile differing perspectives regarding RMPs.

There was also Pat Carr, Labour Relations Officer, from the Association and Andrea Farkas, Program Director Surgical, Cancer Care and Complex and Rehabilitation Care for the Hospital present, however, at the request of the IAC were not to take notes.

Andrea Farkas as the author of several RMP reports which the IAC were particularly interested in, augmented the information provided by the Risk Manager.

During the meeting it became clear that there were in fact actual RMPs and also categories of RMPs which had not been included in the report provided by the Hospital to the IAC for reasons which were subsequently explained at a relatively high level. It was not clear to the IAC why a RMP report would have been provided without clearly stating its limitations in the opening paragraph as to appropriately manage the expectations of the reader.

It was clear to the IAC that when RMP reports of this nature are shared with end users it is imperative that the limitations/parameters be clearly delineated at the commencement of the report to ensure that readers' expectations are aligned within the subsequent content. This is not withstanding those not included as they are protected under the Quality of Care legislation.

Hearing

The IAC Chairperson opened the Hearing at 0915 hours, reviewed the ground rules and asked the Hospital and Association to introduce any new participants.

The IAC would like to draw attention to the fact that the Hospital's Legal Counsel made reference to the pending Ontario Labour Relations Board which was referenced in their written pre-hearing submission and during their hearing presentation. In response to this the IAC Chair made it categorically clear that labour relation issues, grievances, arbitrations etc. are not within in the scope of Article 8.01 nor the IAC and therefore would not be entertained. The Chair further stated that the IAC were neither interested in perusing this train of thought nor would the IAC factor information of this nature provided by either the Hospital or the Association into their report and the recommendations contained within.

Andrea Farkas, Program Director Surgical, Cancer Care and Complex and Rehabilitation Care for the Hospital provided their response to the Association's submission and reaffirmed the Hospital's position. Members of the Hospital team participated in the discussion following as appropriate.

Jo Anne Shannon, Professional Practice Specialist, for the Association, provided their response to the Hospital's submission. Other members of the Association team participated in the discussion following as appropriate.

At the end of the hearing, the IAC indicated that time for a further meeting with the Risk Manager would not be required given the information regarding RMPs provided earlier in the day was sufficient. The IAC Chairperson adjourned the Hearing at approximately 1600 hours.

Following adjournment of the Hearing, the IAC had a working dinner on the evening of February 6th 2013 to again 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 February 7th 2013

Hearing

The IAC Chairperson opened the Hearing at 0915 hours, reviewed the ground rules and asked the Hospital and Association to introduce any new participants.

The IAC Chair took the opportunity to acknowledge to both the Hospital and the Association stating that the IAC has heard their positions and therefore there was no need for them to recap, rather any closing remarks were for the provision of information not put forward earlier. The Chair further added that it was therefore the intent of the IAC to focus on the respective questions they had and also ensure that the staff had an opportunity to speak.

Members of the IAC posed a range of questions to review issues in more detail and requiring further clarification arising from both parties' presentations and ensuing discussion with both the Hospital and the Association in an open Question and Answer session. All hearing participants actively participated.

The IAC Chairperson thanked the participants for their commitment to the Hearing process and for their active and open discussion during the Hearing. The Chair noted the IACs' recognition of the challenges, for both parties, associated with open and honest dialogue, and reiterated the IACs' hope that the opportunity for discussion during the Hearing would enable both parties to move forward. She reaffirmed that the IACs' Report and associated recommendations are intended to provide all concerned (Registered Nurses, the Association and the Hospital) with an independent external perspective to aid in the resolution of outstanding issues, and are not binding. She confirmed that the IACs' Report would be distributed by e-mail and courier within the required 45 days.

The IAC Chair closed with acknowledging that following the recent externally facilitated mediation and subsequent IAC hearing both the Hospital and the Association had an opportunity for a fresh start.

The IAC Chairperson closed the Hearing at 1130 hours.

Post Closure of Hearing

The IAC met briefly immediately following the hearing on Thursday February 7th 2013 over a working lunch to reflect on the issues identified, confirm themes and outline how the construction of the recommendations would unfold. The IAC also confirmed the date of their next meeting which was to be Tuesday March 5th 2013 to review and refine the recommendations.

Between the close of the Hearing and submission of the electronic and locked PDF Report on March 25th 2013 by e-mail, followed by a hard copy being couriered to both the Hospital and Association the IAC undertook the following in the development of this report:

- A number of the recommendations were assigned to individual members of the IAC
- All three members of the IAC drafted specific recommendations in addition to putting forth their respective ideas for recommendations where there were not assigned the initial drafting of inclusive of the Model of Care;
- A full-day meeting on Tuesday March 5th 2013 to draft the outline of the Report and to fully discuss the findings and proposed recommendations in depth;
- From Wednesday March 6th 2013 through 19th the recommendations underwent further revisions by all three members;
- Independent review of the first draft;

- The IAC agreed that there would not be consensus on staffing model for PAC recommendation on Wednesday March 12th 2013 and the ONA nominee was advised to write a letter of dissent;
- The IAC report was agreed upon on Sunday March 17th 2013 after a series of phone calls and of e-mails;
- Between Monday March 17th and March 25th 2013 the report was proofed, subsequently appropriately edited, formatted and printed for distribution
- The Final Report was submitted to the Association and the Hospital by e-mail and courier on March 25th 2013.

PART II PRESENTATION OF THE PROFESSIONAL RESPONSIBILITY WORKLOAD COMPLAINT

2.1 Context of Practice

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

The Hospital began looking at making changes in order to utilize its nursing resources in the most appropriate manner as recommended by the Health Force Ontario, The Ministry of Health and Long Term Care and the Nursing Secretariat through the Health Human Resources demonstration Project (2009), RN/RPN Utilization Toolkit Project. As part of its annual review process, the Hospital undertook a review of the delivery of all patient care services to ensure the most effective and efficient use of resources, while ensuring quality and safe patient care, including the Perioperative service areas.

After an analysis of the options utilizing the College of Nurses of Ontario (CNO) practice guideline: Utilization of RNs and RPNs, 2009 (since revised in 2011 and now known as RN and RPN Practice: The Client, The Nurse and The Environment and commonly referred to as the Three Factor Framework) the Hospital made a decision to include RPNs into the skill mix into Pre-Admission Clinic and Day Surgery. Alterations to the nursing model were implemented in August 2010.

In August 2010 the Hospital implemented the decision and the nursing model was altered to include Registered Practical Nurses (RPN) in some of these areas and was fully implemented in January 2011.

The new skill mix model reflects a combination of RNs and RPNs in Day Surgery and an RPN only staffing model for Pre-Admission Clinic. In accordance with the Three Factor Framework, the Hospital indicated that RPNs have access to resources and supports for consultation. The Hospital indicated that all RPNs work to the full scope to their practice as defined by the College of Nurses of Ontario and by means of their pre-hearing submission feel that they have demonstrated that the PRWRFs brought forward by the Association since the introduction of RPNs to Day Surgery have been resolved. With respect to Pre-Admission Clinic the Hospital's position is that the PRWRFs were not well founded.

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

The RNs, management and the Association have discussed the concerns since December 2010 specific to the Professional Responsibility complaint related to issues reported by RNs working in the Operating Room (OR) and Day Surgery Unit (DSU), associated with issues arising in Day Surgery and the Pre admission clinic (PAC). A Labour Relations Officer (Pat Carr) became involved in April 2012 and a Professional Practice Specialist (Jo Anne Shannon) has been involved since May 12th 2012. Meetings attended by the Professional Practice Specialists are described as "Special HAC" Special HACs are those held over and above the regular Hospital Association Committees.

Although there were several meetings to attempt to address the issues identified by the OR and DSU RNs, there remained serious endemic practice and workload concern arising in the PAC. Therefore, the Association submitted the Professional Responsibility Complaint as a result of the Hospital assigning a number of patients and a workload to an individual RN, and a group of RNs working in the Operating Room and Day Surgery Units, such that they have cause to believe that they are being asked to perform more work than is consistent with proper patient care.

Beginning in December 2010 the Association cited concerns with fluctuating staffing and workload, patient acuity and professional responsibility for RNs working within the Day Surgery Unit and Operating Room(s) citing common concerns which included:

- *RPNs introduced into DSU and PAC without the required practice supports, appropriate evaluation, conflict resolution mechanisms or clearly defined scope of practice;*²
- *RPNs practicing autonomously in the PAC without the required consultative and collaborative RN resources*³
- *RNs working in DS and OR identified errors and omissions in patient care in the PAC, increasing the workload of the RNs and resulting in incidences of delayed and cancelled surgeries;*⁴
- *Improper application of the CNO Practice Guideline RN and RPN Practice: The Client, the Nurse and the Environment*⁵

The Association indicated that the schedule change in Day Surgery whereby an RN was always scheduled in the Post Operative Day Surgery Unit and the recent implementations of several policies, procedures and protocols have resolved most of the issues arising in the Day Surgery Unit. Outstanding and being referred to IAC is the model of care in the PAC.

2.1.1 Hospital

The Hospital is a 230 bed, full service acute care community facility located within the Simcoe Muskoka Local Health Integration Network (LHIN).

2.1.2 Patient Population

The residents of the North Simcoe Muskoka region have higher obesity, smoking and alcohol consumption compared to the provincial average. The incidence of chronic diseases; such as arthritis, hypertension, heart disease, diabetes, depression and cancer are also higher than the rest of the province. The largest disparity is for diabetes in the 65-74 year old range (22% versus 14%).

2.1.3 Hospital Surgical Patient Profile

The Hospital's surgical program offers a range of surgical procedures including general surgery, gynecology, ear nose and throat (ENT), plastic surgery, urology, ophthalmology, and endoscopy.⁶

2.1.4 Structure of the Perioperative Services

The Perioperative Surgical Program includes:

- Pre Admission Clinic
- Endoscopy/Cystoscopy
- Day Surgery Unit/Post Recovery Phase II
- Post Anaesthetic Care Unit and
- Operating Rooms

The Pre Admission Clinic is open from 0730 to 1530 hours five (5) days per week, for the purpose of undertaking pre-operative assessments prior to patients' scheduled surgical procedures and is staffed with 1.6 FTEs.

² ONA pre-hearing submission pages 85

³ ONA pre-hearing submission pages 54 and 82

⁴ ONA pre-hearing submission page 88

⁵ ONA pre-hearing submission page 88

⁶ <http://www.osmh.on.ca/areasofcare/surgicalseervices.aspx>

The Day Surgery Unit is open five (5) days per week from 0600 hours to 1900 hours.

The Endoscopy Unit provides pre and post procedure services to patients who have undergone endoscopic or bronchoscopic procedures and is also open five (5) days per week from 0730 to 1530 hours.

PART III DISCUSSION, ANALYSIS AND RECOMMENDATIONS

Introduction

The IAC believes that it has obtained a comprehensive understanding of the professional responsibility concerns relating to the Perioperative services of the Hospital. This was achieved through review and analysis of the written pre-hearing submissions and exhibits, tour, 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' has been 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.

The Hospital did not provide all of the requested additional material in support of their pre-hearing submission during the hearing from February 5th-7th.

BACKGROUND

IMPLEMENTATION OF NEW MODEL OF CARE

Throughout the pre-hearing submission and hearing presentation, Orillia Soldiers Memorial Hospital (OSMH) and hereafter referred to as the 'Hospital' reinforced the fact that the change in skill mix was a result of an obligation to submit a balanced budget. OSMH was advised by the North Simcoe Muskoka Local Health Integration Network (LHIN) to work with the Hay Group consulting firm who would lead a benchmarking exercise with the hospital leadership team to examine its administrative and operational structure and make recommendations to improve its operating position and to develop strategies to deal with an expected funding shortfall and related budget issues. The Hay Group presented the final results of the review process to the hospital's senior team in August 2009. Members of hospital management met with union representatives, including ONA representatives in January/February 2009 to review the Hay Group's recommendations and results. Union representatives on the hospital Fiscal Advisory Committee (FAC), including ONA representatives, were regularly informed of the progress of the work undertaken by the Hay Group.

INDEPENDENT ASSESSMENT COMMITTEE RECOMMENDATIONS

The IAC believes that the key issues impacting the professional practice environment in the areas covered by the Professional Responsibility complaints regarding the Perioperative Services relate to communication, healthy work place culture, patient safety, staffing model of care, patient flow, change management and supports, practice supports, perioperative self assessment competency/skills check list, documentation, staff professional development and lastly, the patient experience.

COMMUNICATION

Communication is an integral part of a healthy and safe work environment and is inclusive of all interactions among providers as well as the management team. Effective communication is essential in establishing a firm foundation of trust and the first essential ingredient in the Hospital and Association moving forward.

Recommendation 1: *The Hospital must improve communications among key stakeholders*

The Independent Assessment Committee (IAC) identified the need for improved communication as a recurrent theme throughout the hearing. During the hearing one of the panel members was sought out and approached by one of the anesthetists for the purpose of inquiring why they were in the PACU the previous day. While the panel member shared the purpose and nature of this presence the IAC was left wondering why they were not aware. During the hearing the Hospital explained that all staff including physicians had been communicated with by means of e-mail regarding the tour arrangements. The IAC recognizes that the hospital has a foundation on which to build and create broader and more frequent, lines of communication.

Recommendation 2: *The hospital needs to respond to RMP concerns raised by nurses within 28 calendar days*

During the hearing the IAC heard the nurses express concerns regarding the absence of feedback as well as the prolonged time that it took for the feedback loop to be closed especially regarding RMPs. The IAC appreciates that it does take time for the Risk Manager and in this case the Perioperative Manager to investigate issues appropriately however, the IAC considers it reasonable that the nurse or nurses would receive a response within 28 calendar days. If the issue resolution is complicated, an extension period is reasonable and could be mutually discussed. If a longer investigation is warranted, an update must be brought to the nurse or nurses involved at frequent intervals. In the absence of information, frustration and cynicism fills the void.

Timely resolution and closure of issues provides nurses with the reassurance that their issues are taken seriously. Any critical incident, i.e. any sudden unexpected event that has emotional impact that can overwhelm the usually effective coping skills of an individual or a group ⁷ should include a debriefing during which the nurses are allowed time to reflect. This will also foster an environment where nurses are allowed time to extract learnings and develop future strategies to prevent similar incidents. If a debriefing is unable to be accommodated within a reasonable period of time, this should be communicated to key stakeholders and provisions made to secure an appropriate date. This would also in some way ensure that there are no ongoing discrepancies between the RMPs reported on and those provided with feedback.

Recommendation 3: *RNs and the Hospital adherence to Article 8 reporting process*

There has been non adherence to article 8 reporting process (verbal communication by RN and follow-up by manager). A review of the intended process of completing work load incident reports should be shared with staff and managers.

Recommendation 4: *Utilize methods of communication that match the intended or required outcome.*

From the Hospital's pre-hearing submission and discussion during the hearing the IAC learned that given the recent appointment of a new Manager it was still early days especially given the recent mediation and pending IAC to firmly establish formal communication within the program.

⁷ CON, 2009

In addition to these effective face to face opportunities, the IAC believes that there are opportunities to expand the range of avenues of communication in order to optimize reach. The IAC also heard references to information being communicated by e-mail. While e-mail can be effective in sharing information, it is not always the preferred method for communicating changes in practice and or process. The IAC recommends that the hospital use the suggestions illustrated in **Figure 1** to match communication to the desired or intended outcome.

Matching Communication to the Intended Outcome

Share Information

←

Shape Behaviour

→

General Publications	Personal Invitation	Interactive	Face to Face
<ul style="list-style-type: none">• flyers• newsletters• videos• articles• posters	<ul style="list-style-type: none">• letters• reports• postcards	<ul style="list-style-type: none">• telephone• list server• visits• workshops• modeling	<ul style="list-style-type: none">• one-to-one• mentoring• shadowing• paired

The Patient Safety movement has been afoot since the late 1990s with the real catalyst being the release of the Institute of Medicine's report 'To Err is Human'⁸, there has been an unprecedented movement to significantly reduce preventable errors by means of building a safer healthcare system. The report stated that most medical errors do not result from individual recklessness, but instead from basic 'flaws' in the way the delivery of healthcare is designed. The report further signaled a shift away from assigning blame to one finding the reasons and fixing them. Patient safety serves to support the elimination of rework in the system, a contributor to nursing workload in addition to the enormous benefits to patient care. Promoting a "Safety Culture" involves all perioperative staff and stakeholders to embrace the belief that safety is a priority.

Independent Assessment Committee's report
Perioperative Services, Orillia Soldiers Memorial Hospital and Ontario Nurses Association
March 25th 2013

Risk Monitor Pro

Risk Monitor Pro, is a powerful web based tool that allows healthcare personnel to easily submit, refine, analyze and communicate critical incident information for the purpose of achieving a safer working environment for themselves and their patients. The system captures both adverse events and safe catches.

Data generated from the Risk Monitor Pro incident reporting system was noted to be flawed. Inconsistencies and anomalies were present in the reports and in the Hospital's analysis report. Reliance on this source of data can be used in a limited manner in light of the anomalies/inconsistencies noted in reports provided to the IAC. This feedback was provided to those present during the meeting on the morning of Wednesday February 7th prior to the commencement of the hearing. It is also not appropriate the length of time deemed acceptable to leave Risk Monitor Pro reports as open; "some of the cases stay open for 18 months if we are working on a related project".

Recommendation 5: *Communication must be transparent in that the RMP reports need to be shared with staff on a regular basis in their totality. Targeted analysis and reports are to be shared and need to be inclusive of the scope and or limitations of the report.*

The Association had identified in their pre-hearing submission and during the hearing the discrepancies between known RMPs by means of RNs recording them on PWRPFs and RMP reports that the Hospital had shared. The IAC found in reviewing the Risk Monitor Pro (RMP) documentation, also experienced difficulty in reconciling information and while maintaining both patient and staff confidentiality required clarification of a number of events. As the RMP reports are shared with end users it is important to acknowledge the context and or limitations of the report from the onset to set expectations of the readers and enable them to derive meaning.

The IAC recognizes that the Hospital and the Association having recently undertaken a Joint Staff / Management Mediation via 3rd Party on January 26th 2013 have established a point from which to move forward on from.

Recommendation 6: *The Hospital should respond to substantive RMPs raised by nurses within 28 calendar days*

During the hearing the IAC heard the nurses express concerns regarding the absence of feedback as well as the prolonged time that it took for the feedback loop to be closed especially regarding RMPs. The IAC appreciates that it does take time for the Risk Manager and in this case the Perioperative Manager to investigate issues appropriately. The IAC cannot support the length of time deemed acceptable by the Hospital to leave Risk Monitor Pro reports as open; "some of the cases stay open for 18 months if we are working on a related project". The IAC considers it reasonable that the nurse or nurses would receive a response within 28 calendar days. If the issue resolution is complicated, an extension period is reasonable and could be mutually discussed. If a longer investigation is warranted, an update must be brought to the nurse or nurses involved at frequent intervals. In the absence of information, frustration and cynicism fills the void.

Timely resolution and closure of issues provides nurses with the reassurance that their issues are taken seriously. Any critical incident, i.e. any sudden unexpected event that has emotional impact that can overwhelm the usually effective coping skills of an individual or a group ⁹ should include a debriefing during which the nurses are allowed time to reflect. This will also foster an environment where nurses are allowed time to extract learnings and develop future strategies to prevent similar incidents. If a debriefing is unable to be accommodated within a reasonable period of time, this should be communicated to key stakeholders and provisions made to secure an appropriate date.

⁹ CON, 2009

The hospital should utilize their Employee Assistance Program (EAP) or an internal resource with similar skills to support the staff/team.

Recommendation 7: Provide patient safety education to all the pre-admission, day surgery and operating room staff.

The IAC strongly believes that through the provision of Patient Safety education to the staff there would facilitate a common understanding of what constitutes a safe catch (near miss), specifically the importance of reporting same for the purpose of learning as opposed to the assignment of blame. There also needs to be an appreciation of what is referred to as the 'human factor' and the importance of a preventable error, the importance of reporting 'safe catches' (otherwise known as near misses) and errors 'for the purpose of learning as opposed to the assignment of blame'. The Hospital indicated they are familiar and support of the aviation approach, however, the IAC found numerous examples of gaps in knowledge with respect to the essential of the principles of Patient Safety.

Recommendation 8: Need to reframe the constructive nature and purpose of RMPs to promote the quality practice settings

There is an opportunity to better utilize Risk Monitor Pro as a tool to leverage quality improvement, team building and communication across the organization; e.g. the large number of errors around obtaining consent can be used to increase awareness of nurses of the consent act and internal policy. This information in future can be shared at huddles, quality boards, and other venues available.

Using Risk Pro to support more quality improvement projects is strongly recommended to optimize patient care and allow a productive approach in utilizing staff's efforts to report safe catches and actual incidents; e.g. create more resources to support staff and prevent recurrent errors around consent. Create learning plans out of data generated from Risk Pro.

- 1. Reframe the completion of a RMP as a staff member's personal contribution to achieving patient safety;***
- 2. Learning plans should be generated where recurrent errors/incidents are reported.***

The RMP effectively enables the evaluation of trends, assess high risk areas and develop action plans to eliminate and or mitigate future risk.

Recommendation 9: Use the Professional Responsibility Workload Report Forms (PRWLFs) to serve as a source of learning needs when directly linked to a RMP

The IAC encourages the hospital and the Association to utilize the Professional Responsibility Workload Report Forms (PRWLFs) as a source of data and opportunities for learning and identification of knowledge gaps. The IAC heard that the Association is promoting the recording of the Risk Monitor Pro tracking number on the PRWLF. While the IAC appreciates that there may be value in doing so, it is also recognized that the two serve distinct purposes.

Recommendation 10: Identify system and process issues by means of a failure modes analysis (FMA) should be completed from surgeon consult, to PAC, DSU, OR, PACU, DSU, and home discharge.

The IAC heard that there were ongoing concerns regarding the nature and volume of RMPs. Spherically, those related to medication errors, consent, missed laboratory tests, patient identification, and correct site surgery to name a few. The IAC by means of the pre-hearing submissions material from both the Association and the Hospital reviewed RMP data representing timeframes from pre and post skill mix changes. Regardless of the change in skill mix the IAC was actually quite shocked to see the ongoing prevalence of adverse events.

The above would enable the Hospital to look at the processes related to medication and laboratory processes in the way they occur as opposed to the way they are supposed to.

The IAC cannot state strongly enough that there needs to be definitive action taken in terms of delineating the root cause of these ongoing adverse events, combined with concurrent patient safety education (see Recommendation 17, targets set with frequently shared measurements within an evaluation framework.

Surgical Safety Check List/Correct Side Surgery (Best Practices)

The utilization of a surgical safety check list/correct side surgery is considered best practice and has benefited from widespread implementation within healthcare for a number of years.

The Surgical Safety Checklist is intended as a tool to be used by clinicians interested in improving the safety of their surgical operations and reducing unnecessary surgical deaths, complications and negative outcomes.

The most common errors in safety-related behavior in the operating room can be attributable to inadequate communication and teamwork. The Surgical Safety Checklist, which was introduced by the World Health Organization (WHO) in 2007, has improved communication of the most important pieces of information immediately before the induction of anesthesia, before the skin incision and before the patient leaves the operating room.

The Surgical Safety Checklist also allows the surgeon, anesthetist and circulating nurse to review the post-operative recovery and management plan prior to leaving the operating room, focusing in particular on intraoperative or anesthetic issues that might affect the patient. Events that present a specific risk to the patient during recovery and that may not be evident to all involved are especially pertinent. The aim of this step is the efficient and appropriate transfer of critical information to the entire team.

Recommendation 11: Need to reassess the effectiveness of the visual cuing utilized for classifying pre admission charts

The IAC learned that currently the Hospital utilized red dots and blue and green file folders for within PAC for to differentiate their telephone, day and inpatient surgical pre admission patient documentation.

During the tour of PAC the IAC when viewing the reassessment patient documentation inquired what was meant by a 'red' dot as in some cases it was marker with a red marker and in other cases it wasn't. The IAC was surprised to hear that it was also referred to as an 'orange' dot was actually the way patient charts were identified for telephone assessments. The IAC was further informed that same day and inpatient surgery charts were differentiated by means of a blue or green file folder.

The IAC recognised that while visual cuing can be effective, given that the orange dot had transitioned to a red dot there may also be unidentified risks associated with missed medications and or laboratory work if the patient chart was inadvertently placed in the wrong colour and negatively impact nursing workload and patient care.

Recommendations 12-16: The IAC recommends by the end of 2013 the following be implemented:

- 12. The Hospital develop a policy and corresponding procedure to support the implementation of the Surgical Safety Checklist detailing expected outcomes, responsibilities and actions, similar to the Hospital's policy Universal Standard of Care for Preventing Wrong Site, Wrong Procedure, Wrong Person Surgery: Operating Room.***
- 13. The Hospital's policy Universal Standard of Care for Preventing Wrong Site, Wrong Procedure,***

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Wrong Person Surgery: Operating Room be amended to be inclusive of stating when and where surgical site markings are to occur.

14. *The Hospital's policy (Universal Standard of Care for Preventing Wrong Site, Wrong Procedure, Wrong Person Surgery: Operating Room and Surgical Safety Checklist Policy) will endorse a consistent communication process/tool when transferring a patient from one health care provider to another health care provider i.e. SBAR, CHAT (CHECK?) TOA (transfer of accountability).*
15. *The Hospital's Surgical Safety Check list content be appropriately embedded in the patient record in accordance with the requirements of Health Records and the respective regulatory colleges of the health care professionals involved in the overall process.*
16. *The Hospital's Surgical Safety Check list or SBAR tool etc. be amended to be inclusive of a record of the last dose of intravenous sedation or analgesic given and or intravenous reversal agent give if the patient is being fast tracked (bypass PACU).*

The Hospital's Surgical Safety Check or SBAR list needs to be amended to reflect/record key concerns for patient's recovery and management. The documentation needs to reflect an area for nursing staff to document a concern or comment, follow up required and by whom and when.

During the tour the IAC Panel observed patients going into the operating room via the Day Care department (by passing Holding Room) with only one surgical site marking per the nurse in the Day Care department. During the IAC hearing there was discussion from the nurses present that patients are marked in the Day Care department by the nurse for one type of procedure (marking x 1) and then by the surgeon in the Holding Room and nurse in the Day Care department for other procedures (markings x 2). Thus there appears to be two different standards of care within the perioperative setting with regards to surgical site markings.

The Hospital's policy "Universal Standard of Care for Preventing Wrong Site, Wrong Procedure, Wrong Person Surgery: Operating Room" states under Site Marking; The physician performing the procedure marks at or near the incision/insertion site. Both the Nurses and Hospital also informed the IAC Panel, that the Surgical Safety Checklist is not a hardcopy document. The Surgical Safety Checklist is in each Operating Room Theater, laminated on the wall.

The IAC panel strongly believes that good communication is an integral part of the culture of teamwork and as such, an important surrogate of patient safety. Post-briefings provide the Peri-operative/anesthesia team members with opportunities to identify any deviations from the surgical plan and to uncover any defects that may not be apparent at the time of the surgery. Post-briefings encourage a culture of learning that involves action, reflection and revision. Consistent application of safety policies in the same manner for all patients and good communication is paramount to patient safety.

Recommendation 17: Within three (3) months establish an evaluation framework inclusive of measurements, targets and reporting timeframes appropriate for the measurement and target.

The IAC heard that the change in skill mix had not benefited from an evaluation framework inclusive of measurement, targets and reporting timeframes.

The IAC recommends that the Perioperative program establish clear targets on metrics within an evaluation framework inclusive of:

- Surgical cancellations
- Surgical delays
- Surgical late starts
- Errors regarding consents
- Absence, missed labeled specimens

- Positive patient identification compliance
- Safety surgical checklist compliance
- Patient satisfaction
- Adverse events and safe catches

An example would be the establishment of a goal within the Perioperative Program of 100% compliance with consent with monitoring in place weekly, monthly, quarterly, bi-annually. Another example would be a 50% reduction in medication errors, laboratory work in the Perioperative Program.

The progression is when eight (8) data points have indicated a trend and twenty (20) have demonstrated a definitive change.

STAFFING MODEL

Recommendation 18: Regarding the Three-Factor Model in PAC:

Further delineate the pre admission needs of the patient population the Hospital serves and in doing so the IAC does not rule out a role of the RN in PAC over and above that of having a Resource Nurse in DSU available to the RPN for consultation

Role of The Three-Factor Framework

The three factor framework takes into account the nurse's knowledge, skill and judgment; the client's health condition, care needs and situation; as well as the environment in which the care is being provided, including the specific supports it provides¹⁰.

Currently, the PAC is staffing with RPNs and utilizes a RN in the DSU who is the identified as their Resource Nurse at the beginning of each shift. The IAC remains unclear how the Hospital assessed the characteristics of the nurse, client population and environment prior to implementing the change in skill mix introduced in pre-assessment. During the tour the IAC learned that patients in pre-assessment have either a telephone or face to face assessment. Further to this, the face to face assessment may be with the nurse or an anesthetist. The IAC heard that there work is planned to further delineate the pre admission needs of the patient population the Hospital serves and in doing so the IAC does not rule out a role of the RN over and above that of having a Resource Nurse in DSU available to the RPN for consultation.

While it can be argued that patients presenting in pre-assessment are considered less complex, what can be unknown is the well-defined nature of their health care education/teaching needs, coping mechanisms and supports in place in the context of their pending surgery. By this the IAC means:

- Their knowledge of the impact of the pending surgery on pre-existing conditions;
- Subtle signs and symptoms of underlying co-morbidities which may be difficult to detect;
- The necessary supports which need to be in place post discharge.

All of above may be of particular importance and potentially magnified by a patient especially when their procedure is booked as a surgical day case.

In undertaking the assignment of a patient to a RN or RPN, one should review the Three-Factor Framework of the College of Nurses of Ontario (2011). The three factors serve to assist both nurses and employers in the decision to utilize individual nurses to provide safe care to all patients. The factors are:

¹⁰ RN and RPN Practice: The Client, the Nurse and the Environment, College of Nurses of Ontario, 2011

1. Client (patient)
2. Nurse, and
3. The environment

The Patient

This aspect of the three factor framework refers to the patients cared for within the PAC and Day Surgery Unit. The patients are primarily elective cases with an ambulatory care focus, but recurrent issues around consent process. Does the patient understand inherent risks of procedure, benefits, alternatives, and risks in not having procedure? Further patient educational information should be provided than generic surgical pamphlet.

Further, development of a "Criteria for Same Day Surgery" policy (Recommendation 60) will further support the third parameter of the 3-factor framework.

Patient assignment policy is followed; assignment of bays is solely a logistical or real estate issue. TOA report is used to determine if there are any issues that deem the RN in phase II recovery care for the patient. A debriefing section/separate document should be included to ensure fast tracking policy is followed, and the patient is suitable for care within the Phase II recovery area.

The Nurse

This aspect of the three factor framework refers to the knowledge and understanding of the nurse's understanding of revised procedures, the model of care, scope of practice, and the nature of informed consent need to be validated through testing/demonstration back.

The nurses have not received a review/mock code blue. All staff in DSU should be ACLS certified and supported to have PALS.

NAPANAc Standards of Practice

The next NAPANAc standards publication is set for 2014. The current 2011 edition was developed for RNs, and therefore provides no guidance regarding roles such as the RPN, RNFA, and RT within the perianesthesia setting. NAPANAc was established in 2004, and "*provides standards to support the practice of RNs working in the specialty of perianesthesia nursing*".¹¹ Given NAPANAc does not provide direction to RPNs, RNFAs and RTs, Hospitals and specifically these roles must look to regulative bodies such as CNO and the College of Respiratory Therapists for direction regarding patient care.

OPANA Standards of Practice

The OPANA standards do not provide specific recommendations on the utilization roles such as the RPN, RNFA and RT within the preoperative/preadmission clinic setting, but note that "*the Perianesthesia nurse and the RPN working within the perianesthesia environment remain accountable to the College of Nurses standards of practice*"¹²(page 6 of OPANA standards). The next OPANA standards publication is set for early 2014. OPANA standards committee members continue to work on revising the individual sections of the standards, but having experienced a significant change in membership presents this work with a challenge. Where OPANA does not provide direction to the utilization of RPNs in the PAC, we must look to regulative body of the CNO for direction around delivery of patient care. In a recent conversation by an IAC member with the OPANA it was

¹¹ NAPANAc Standards, 2001, page 3

¹² OPANA Standards 2009, page 6

understood that it should come as no surprise that the next issue of the standards will align with the CNO's in that using the term 'nurse' will be applicable to both the RN and RPN.

Environmental factors include:

- Practice supports,
- Consultative supports and
- The stability/predictability of the environment

The less stable the environment factors are, the greater the need is for RNs to assume care for the patients. The less available practice supports and consultation resources are; the greater the need for more in-depth nursing competencies and skills in the areas of clinical practice, decision-making, critical thinking, leadership, research utilization and resources management.¹³ These include clear policies, assessment tools and well delineated pre admission needs.

According to the CNO's Three-Factor Framework RPNs and RNs can practice independently when there are less complex patients, the environment is stable and there are many practice supports and resources available. RPNs and RNs may collaborate when the client needs are moderately complex, environment moderately stable and predictable and has some practice supports. When the environment becomes less stable and/or predictable, the RN can practice independently whereas the RPN cannot. If any of these areas change then there would be the need for a reassignment of category.

Recommendation 19: *The Hospitals' resources that support quality patient care in the perioperative services need to be more robust. There are gaps in policies/procedures which are necessary to support consistency and best practices in care. Some examples include:*

1. *The Discharge from PACU policy should be updated to include oxygen saturation, sensory and pain level (section 29, exhibit 1). There should be a policy developed for care of the patient with Obstructive Sleep Apnea (OSA) to guide care of patients with suspect or confirmed OSA.*
2. *Preoperative orders should be completed by the surgeon based on an individualized assessment with consideration being given to the invasiveness of surgery, age of patient, co-morbidities, family supports, proximity to hospital, etc. to ensure an individualized assessment.*
3. *Documentation tools (PACU and DS record) are dated and needing revision (there are 2 different assessment forms to be merged to one form) see Recommendations 35 and 36.*

Overall the pace at which policies are updated, Risk Monitor Reports are closed off is unacceptable to support the nursing staff in what would be considered a stable environment. The IAC were informed that it has taken two (2) years to update the consent policy, and another subsequent two (2) years to roll out the change which reflects a total timeline of four (4) years. Timelines need to be significantly shorter to enable the implementation of efficient and sustainable changes.

Role Clarity

Recommendation 20: *Preoperative requirements should be undertaken by a regulated health care professional in PAC. Alternatively, a preprinted order set could be completed by the surgeon at the same time informed consent is provided (patient sign off/verification can be done at preoperative clinic).*

¹³ CNO, RN and RPN Practice: The Client, the Nurse and the Environment. 2011

During the tour the IAC saw that there appears to be too much dependence upon the clerk in PAC to assess the patient's need for laboratory work and consults. This piece of work should be removed from the clerk's duties, and be taken over by regulated healthcare staff in the PAC. The preoperative requirements policy should not be initiated or triggered by the clerk.

Recommendation 21: *Review policies, medical directives and the respective role and scope of practice of all staff within PAC inclusive of the RN Resource Nurse*

The policies, medical directives and scope of the clerk, RPN, RN need to be clearly outlined and reviewed with staff. The staff are challenged to follow procedures when there is confusion in what is the current process (i.e. what staff are to do with an incorrectly signed consent form; discard or note on consent form it is incorrect, and retain as a piece of the patient record). There was also confusion around the medication reconciliation piece when asked for a description

Unless the practice environment and its respective supports substantial increase having a RN present in the Pre admission clinic may be beneficial.

In summary

The tour of OSMH, IAC processes and review of relevant documents illustrate that the numerous errors and PRWR forms submitted by RNs are symptoms of issues with five (5) themes of deficiencies and include:

1. Communication
2. Workplace culture
3. Practice supports
4. Education
5. Documents and documentation to support and guide staff (e.g. policies, physician orders, documentation forms),

By addressing the recommendations of the IAC, these five (5) parameters will improve over time with persistence and involvement of all staff to enable a sustainable resolution, and a culture dedicated to moving forward and promoting quality patient care in a collaborative manner.

Critical thinking is the intellectual process of analyzing, evaluating and reflecting on information and facts without making assumptions or applying bias. Critical thinking is a skill which is learned over time, and is not solely gained through academia. Regarding utilization of RNs and RPNs, it would be a display of a gap in critical thinking to make assumptions of the staff member's ability to apply critical thinking, based on whether the nurse has "RN" or "RPN" designation beside their signature. Therefore the Hospital must consider the environment, the staff and the resources available to support a successful model of care in all health care settings.

The entry level competencies for an RPN include *"use of critical thinking skills to support clinical decision making and reflect upon practice experiences"*¹⁴

Finally, considering the rapid pace of change within health care, the Hospital must evaluate on a regular basis the utilization of RNs and RPNs and the patient population particularly before considering any future changes in models of care or processes. An example of this would include the introduction of a new surgical procedure and or specialty. The RN RPN Utilization Toolkit is a document that can support this step.¹⁵

¹⁴ CNO Entry to Practice Competencies, (2011). http://www.cno.org/Global/docs/reg/41042_EntryPracRPN.pdf

¹⁵ [http://www.rpnao.org/sites/default/files/RN_RPN_Utilization_Toolkit_\(Apr30\)_0.pdf](http://www.rpnao.org/sites/default/files/RN_RPN_Utilization_Toolkit_(Apr30)_0.pdf)

- 1 The IAC support the anticipated work in which patients will be appropriately streamed to a telephone, face to face nurse or anesthetists pre assessment, based well defined criteria which are transparent to Family Practitioners, Surgeons and staff within all areas of the Perioperative Services.
- 2 Patients' who present with complex pre or post operative care needs and where the environment is unpredictable the CNO clearly states if one of these factors is missing, that care must be with a RN.

HEALTHY WORKPLACE CULTURE

A healthy work culture is a setting that maximizes the health and well being of the interprofessional staff in supporting quality patient outcomes and overall organizational performance. The IAC by means of the prehearing submissions, tour and hearing saw that while there has been a significant step taken by means of externally facilitated mediation the Perioperative Services would benefit from a review of the Hospital's current Conduct and Workplace Harassment Bullying/Violence and other supportive actions.

Recommendation 22 - 27: The IAC recommends the following regarding an ensuring compliance with the Hospital's Code of Conduct and Workplace Harassment Bullying/ Violence

22. *Immediately: Chief of the Perioperative program review and reinforce with all physician the Hospital's policy-Code of Conduct and Workplace Harassment Bullying/Violence and confirm to the perioperative surgery meetings that this action has taken place.*
23. *Immediately: The Manager and enforce with all Nursing groups and Allied Health the hospital's policy - Code of Conduct and Workplace Harassment Bullying/Violence and reinforce with all staff the Hospital's policy-Code of Conduct and Workplace Harassment Bullying/Violence and confirm to the perioperative surgery meetings that this action has taken place.*
24. *The Hospital's policy (Code of Conduct Implementation Process & Workplace Harassment Bullying/Violence) be added to the Competency skills checklist Annual Review document (See Recommendation 49).*
25. *The Hospital's policy (Code of Conduct Implementation Process & Workplace Harassment Bulling/Violence) would benefit from be added to the Medical Advisory Committee (MAC) agenda to promote ongoing awareness.*
26. *Provide mandatory education sessions to the Peri Anesthesia/Operative nurses on:*
 - *Workplace Harassment*
 - *Assertiveness training*
 - *Communication Skills*

The IAC suggest that the College of Nurses be considered as a potential for delivery of this education

27. *The IAC strongly recommend that the Hospital and Association work in collaboration to implement the recommendations arising from the Mediation held on January 26th 2013 by an external facilitator. The IAC would further recommend that all staff support and recognize the value in being a full and active participant in the implementation process.*

The IAC heard during the hearing that behavior within the perioperative services was not reflective of staff working within a healthy workplace culture. Disruptive behavior occurs when the use of inappropriate words, action or inactions by a person interferes with his/her ability to function well with others to the extent that the behavior interferes with, or is likely to interfere with, ones work.

Organizations must take steps to prevent the occurrence of unprofessional behavior. We are all expected to take responsibility for our behavior.

The most common form of inappropriate behavior in an Operating Room is auctioned by means of verbal abuse. Verbal abuse from physicians, patients and other staff members account for the highest incidence of aggression towards perioperative nurses. Verbal abuse may lead to negative personal feelings and relationships and it can negatively impact patient care. Conflicts between physician and nurses or between nurses and nurses or other staff may occur due to various personalities in close working environment, frustration when one party does not complete his or her expected role responsibilities/care activities.

Research shows that healthcare workers have a higher incidence of stress-related illness, depression, fear and job turnover as well as decreased self esteem when working in a stressful, abusive situation. Hospitals, Physician and Nursing leaders can support themselves and staff in working through conflict by normalizing conflict, employing proven proactive and reactive interventions and by helping to build integrated conflict management systems.

Recommendation 28: *Leverage the College of Nurses Quality Assurance program to promote a respectful work environment by modeling professional behaviours* ¹⁶

The College of Nurses of Ontario has updated the Learning Plan to make it more user-friendly and meaningful to nurses. While nurses are still required to develop two (2) learning goals each year, but this year the College has empowered each nurse to choose which College practice document each goal relates to based on their own personal self-assessment.

The IAC strongly recommend that the nurses within the Perioperative Program collectively choose the Conflict Management Practice Guideline and Professional Standards, revised (2002)¹⁷ to review for one of their learning goals for the purpose of promoting a respectful work environment by modeling professional behaviours.

When staff make a commitment to move toward the same goal, energy is directed and the group creates a synergy — a force greater than the combined energy of its individual members. Strong team commitment holds groups together and allows them to stretch for collective excellence. With commitment, everyone aligns in the same direction, travelling the same path to arrive at an agreed upon destination.

Recommendation 29: *Improve accessibility of PAC RPN to DS RN (resource nurse); employ voicera system used in PACU and DSU, rounding by manager to PAC during day to confirm no concerns, regular staff meetings and follow-up).*

While the IAC appreciate that this may well be partially due to geographic location as PAC is physically located on a different floor, the IAC was also concerned with hearing from Day Surgery RNs who assume the role of Resource Nurse for the Pre-Assessment Clinic (PAC) that they do not receive calls for collaboration from PAC. While the IAC could accept that calls may not be required on an hourly or even daily basis, the total absence of calls was seen as of concern in the context of patient care.

The IAC also feels that increased visibility of the manager in PAC would be useful in confirming no concerns.

Ensure weekly huddles and regular staff meetings occur to support communication across the team.

¹⁶ College of Nurses, Conflict Prevention and Management, Practice Guideline, 2009

¹⁷ College of Nurses, Professional Standards, revised (2002)

CHANGE MANAGEMENT

A change management model provides both an organization and its staff with a structured approach to the need for, implementation and evaluation of a change. Every step of a change initiative is carefully constructed to enable the organization to create capacity for staff to assimilate the need for and operationalized readiness for implementation and subsequent evaluation.

The IAC saw limited use of a formalized change management model underpinning the introduction of the new model of care.

Recommendation 30: *Communicate and utilize a formalized Change Management Framework*

Regardless of the need for change, there are substantive benefits to an organization and its employees in adopting and utilizing a formalized change management framework such as Kotter model (1995) which is used widely in both private and public sector organizations. Kotter is suggested as an illustrative model as it is only one framework or approach. The issue at hand is the use of a structured framework or approach for the change process.

The philosophy behind the Kotter theory in managing change is:

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

When there is to be a change in model of care and or skill mix it should be approached as a method of organizational change which requires careful planning, communication, implementation and evaluation if it is to achieve its intended objectives.

SUPPORTING THE CHANGE PROCESS

Recommendation 31: *Clinical and administrative supports to facilitate the necessary changes*

The IAC recognizes that the relevant members of the Hospital and the Association Perioperative Program have recently undergone externally facilitated mediation. The undertaking of this process in the context of a pending IAC is indicative of a very unhealthy work place culture and certainly not one in which change and professional practice would readily be expected to flourish.

Organizations often do not always have processes in place to support nurses through a systematic approach for developing, implementing and evaluating nursing interventions, protocols, critical pathways, and policies.

The IAC strongly feel that there needs to be supports put in place to achieve the necessary changes in the Perioperative Services and they include:

- Professional Practice Coordinator dedicated for a minimum of 3 days per week x 6 months to assist with policy, process and form revisions, implementation and evaluation
- Dedicated support from the Performance Excellence, a corporate resource team to lead and support the recommended quality improvement opportunities
- Patient Safety Risk Management Coordinator support in undertaking FMAs to identify and solution underlying inherent system issues
- Hospital support for the identification of unit champions to lead and sustain best practice

Mentorship

Mentorship is central to a successful transition of new and also experienced nurses into new areas and or ways of working. Mentoring is a collegial relationship between two nurses formed on a basis of mutual respect with a common goal of guiding nurses towards enhanced personal and professional growth. It is a relationship where a mentee can develop his/her practice safely and competently, while being supported by an experienced mentor. The benefit to this complex relationship is sharing, growing, learning and empowering.

Recommendation 32: *Immediately identify unit champions who can provide mentorship and support to the implementation of the new consent policy, and other initiatives be they RNs or RPNs. Over the next 12-18 months develop and formalize a Mentorship Program for the purpose of synthesizing the key elements for mentors and mentees in the Perioperative/Anesthesia Program, implement and evaluate.*

At the IAC hearing the Hospital confirmed that there was no formal Mentorship Program (Corporate or Unit Level) within the organization. The IAC were quite surprised to hear the hospital further acknowledge the length of time to orientate a scrub nurse (Registered Practice Nurse) in the Operating Room is taking as long as two (2) years. This length of orientation is impacting the Registered Nurses workload and working relationships between the two categories of nurses.

The Hospital has no well-defined Unit Orientation guidelines for nurses within the peri-operative/anesthesia program.

The IAC strongly believes that a formal mentorship relationship and support to new hires is of tremendous benefit in an active acute department as is the peri-operative/anesthesia program. The concept of mentorship has been in place for many years, and has many definitions. A mentor can be a wise and trusted advisor to a novice individual, tutor or coach' or clinical role model.

Mentoring can be seen as a way of upholding the Practice Standards and Guidelines of the regulated professional colleges according to the Canadian Nurses Association

Professional Practice Governance Structure

The IAC believes that the use of different strategies to support current and any future changes related to professional nursing practice will facilitate a more positive outcome than that experienced with the staff mix change in the Day surgery / Phase II unit.

Shared governance models, in which staff nurses collaborate on decisions that impact patient care, quality improvement and nursing practice at the unit and or program level, have been found to be an effective way to improve the quality of the workplace environment. The more opportunity nurses have to have a 'voice' in decisions impacting their nursing practice and outcomes of patient care, the more likely they are to support change.

Recommendation 33: *Within six (6) months the Hospital implements an inter-disciplinary Practice Council within the perioperative program .*

The IAC strongly feel that this will serve as a mechanism for discussion of and resolution of issues relating to operational functioning and clinical practice issues related to the provisions of patient care within the perioperative program.

Terms of Reference should include;

- i. 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

- ii. The IAC feels it may be beneficial for the council to be initially chaired by the manager and a unit champion
- iii. Membership to reflect all aspects of the Perioperative program and be inclusive of RNs, RPNs, allied health members as appropriate, Operating Room Team Leader, Manager and a volunteer (especially given their presence in DSU) with a defined membership term of two years
- iv. Meetings of focused and purposeful nature held bi-weekly initially may be beneficial in moving high priority items (may only be 1-2 items to start) towards implementation in a timely fashion
- v. Agenda: developed jointly by the co-chairs and published in advance of the meeting
- vi. Minutes: mutually agree to a format
- vii. Distribution of minutes: Establish a communication book specific to Practice Council Minutes for all staff to review

There is currently no venue within the Peri Operative/Anesthesia Program at the Hospital that enables staff (RNs and RPNs) and nursing leadership to discuss challenges / opportunities / differences of opinion with respect to practice issues, and for staff nurses to have 'voice' in terms of operational or clinical decision making.

The IAC believes that the skill mix changes would have had a greater change of successful implementation if it had been approached from a change management perspective that involved the RNs in the decision, helped them to understand that similar fiscal / resource challenges are being experienced in other perioperative/anesthesia units throughout the province. There appeared to be no engagement of the individuals most impacted (the RNs) by the skill-mix change in Day Surgery. The RNs were presented with the skill-mix change by management re: why the skill-mix change was acceptable from a regulatory perspective, but there was no opportunity for the RNs to become actively involved in the change and be supported through the change.

Celebrating Success

Recommendation 34: *Develop and action daily ways of recognizing and celebrating of success however small*

The IAC sees recognition and celebration of success however small as a critical ingredient in moving forward from both a Perioperative Program level and that of the daily staff to staff interface. Building on the recent mediation the Perioperative Program has an opportunity to hit the 'refresh button' and work towards achieving success no matter how small.

The IAC feels strongly that nursing and other staff must demonstrate a willingness to put aside their own personal agendas. Patients need a great team, not a collection of individual performances. Imagine five hockey players who each decide to follow their personal instincts about how to go about winning the game. One player might decide to emphasize defense, another offense; one might experiment with new plays, another might stick to old ways and one thing is for certain, chaos would reign.

PATIENT FLOW

Standards of Practice for Perioperative RNs

Nurses are responsible to practice in accordance with CNO practice standards and guidelines. For specific specialties there are also clinical standards available and include OPANA, NAPANac and ORNAC Standards of Practice provide a framework for competency development for Peri-Anesthesia/Operative Nursing practice. A standard is a desired and achievable level of performance against that which can be measured as actual performance.

Whether nurses describe their practice or roles as peri-operative or peri-anesthesia, the foundation of nursing practice remains the same; high quality care for the surgical patient. Patient hand offs today are extremely variable and standardizing a process in which all information about patient care is communicated in a consistent manner assures that the information about the patient will be accurate and pertinent.

Standards are written evidence based, best practices defining the performance of specific "specialty" nursing practice that is predetermined and acceptable to authority. These standards have contributed to the development of Peri Anesthesia/Operative Nursing Certification Exam, and reflect what is the minimal accepted competence level of the RN practicing in the perioperative care setting.

Transfer of Accountability (TOA)-

During the review of prehearing submissions and the on-site tour the IAC had the opportunity to review the documentation tools used within the Hospital's perioperative program. The IAC noted gaps around 'transfer of accountability' (TOA) and therefore have the following recommendations which the IAC feels will positively impact RN workload;

Recommendation 35: *The IAC supports the Hospital's intention to revise and update the documentation form used by the PACU RNs.*

Currently the documentation form used by the RNs in PACU is dated and does not flow in such a way as to easily capture key elements of information that should be included in the TOA process from the OR nurse and Anaesthesiologist to the PACU nurse. Revision should be inclusive of an area to place a print out of the cardiac monitoring strip should also be considered. The Hospital's nominee Heather Ead during the tour and hearing indicated that examples of form would be shared with the Manager.

Recommendation 36: *The IAC supports the Hospital's intention to revise and update the documentation form used by the DSU nurses.*

The documentation form used by RNs and RPNs in the Day Surgical area is dated, and should also be improved to facilitate capture of the information that should be included in the TOA process from the PACU RN (and in cases of fast tracking from the OR nurse and anesthesiologist and/or surgeon), to the receiving nurse in the day surgical area. It was observed that a volunteer was the first to attend to a patient following cataract surgery, and 'report' was not provided by an OR nurse. The surgeon's report was simply 'she will see me in 4 weeks'. The Hospital's nominee Heather Ead during the tour and hearing indicated that examples of form would be shared with the Manager.

Recommendation 37: *The IAC strongly recommends that the documentation form used by the anaesthesiologists revise and updated.*

The documentation form used by the anesthesiologist does not capture their assessment of the patient that the patient meets criteria for fast tracking. A small section for scoring parameters used to complete fast tracking should be added to this document to facilitate communication and assess trending of vital signs and level of consciousness. (see Recommendation 53)

Recommendations 38-41:

38. *In the absence of a clear and consistent transfer of care communication the IAC does not support the current practice of fast tracking of patients to DSU*

39. *The Fast Track – Bypassing PACU Phase I – II policy makes reference to the OPANA position statement 7. The IAC strongly feels that the policy not be limited to the position statement but also be inclusive of the OPANA guidelines as contained on pages 220-221 6th edition*

immediately. In the absence of this the IAC does not support the current practice of fast tracking of patients to DSU

40. Ensure all nurses in Phase II (Day Surgery) are competent to handle any unexpected outcomes (Cardio/Respiratory) that may be a direct result of fast-tracking a patient

41. The IAC encourages the Hospital and Association to collaboratively explore ways of encouraging and promoting RNs to enhance their professional development and undertake further educational opportunities such as CNA certification. The IAC also strongly encourages the Hospital to explore joint professional development opportunities with other healthcare providers/organizations within their LHIN

The IAC believes that the RNs in perioperative program should move forward to obtaining their Canadian Nurses Association Certification. Certification serves to broaden one's perspective by means of exposure to alternative ways of working, particularly for RNs who have developed their specialty expertise in working in only one hospital/program. Continuing competency is essential for nurses' professional growth and development in the workplace as well as for safe and positive outcomes for the patient. The IAC believes that support for the nursing staff to develop/gain additional competencies, including active engagement for the RNs in certification process would be beneficial.

Day Surgery (Phase II Recovery) Schedule / Staffing Supportive of Patient Flow

During the IAC tour the following surgical specialties had procedures scheduled GYN, Orthopedics and Cataracts. During the IAC tour the panel observed the Ophthalmologist bring his patient into the Phase II Recovery at 0824. Both the Hospital and the Association confirmed that all cataract surgery patients are fast tracked (bypass PACU). The first person to attend to the patient was a volunteer. The Registered Nurse who started at 0830 arrived on the unit at 0826. The IAC Panel was informed that Cataract surgery is performed every Monday and Tuesday.

The IAC Panel was informed during the hearing that Tonsillectomies are recovered in Post Op Day Care Phase II for four hours. Tonsillectomies (+/-) Adenoidectomies are booked at the beginning of the day and admitted patients are booked towards the end of the day to accommodate discharge and bed availability on the surgical floor.

Recommendation 42: Change the 0830 start time to a 0800 start time to ensure a RN is available when patient(s) are being fast tracked to arrive in DSU prior to 0830, otherwise the patient should remain under the care of a RN from PACU until the 0830 RN arrives.

Recommendation 43: The Hospital undertake a review with active participation by the staff to identify the profile (i.e. nature and characteristics) of the patient population in DSU between 1630 – 1900 hours by day of week to identify and match the appropriate RN:

The review may include the following:

- a. Volume of patients*
- b. Average and median LOS post 1630 hours*
- c. Nature of surgery*
- d. Reasons for delayed discharge up to and beyond 1900 hours*
- e. Admissions to DSU from the 'Emergency List'*
- f. Decisions to admit*

There are times in day where one RN is staffed in Day Surgery, this is unsafe. A second individual should be staffed between 1730-1900 in the absence of a review of the patient population in DSU between 1630 – 1900 hours by day of week to identify and match the appropriate RN resources.

In addition to providing a safe environment for both patients and staff, this additional staff could undertake postop telephone call backs. Seeking assistance is not a smooth process for staff in PAC (anesthesia is on call in another dept; RN has an assignment in DSU). This is an opportunity for improvement by looking at scheduling of Day Surgery.

Appropriate staffing is essential to the delivery of safe and effective patient care and it helps to ensure efficient throughput of processes in perioperative/anesthesia units. Staffing based solely on nurse-to-patient ratios or nursing hours per patient visits are limited in scope and do not consider the variables that affect the consumption of nursing resources in a perioperative/anesthesia setting.

Both the Ontario Peri-Anesthesia Nurses Association (OPANA) and the National Association of Peri-Anesthesia Nurses of Canada (NAPAN) provide a clinical framework for Peri-Anesthesia nursing care in diverse settings and for diverse patient populations. Both OPANA and NAPAN Standards are evidence-based.

Table 1: Current daily staffing for Phase II-Day Surgery

Recovery Stage	Designation	Hours of Work
Pre-Op	1 RN	0630-1430
	1 RPN	0630-1430
Post-Op	1 RN	0830-1630
	1 RPN	0830-1630
	1 RN	1100-1900

Both OPANA and NAPANac state that in *“Phase II Recovery minimum staff is two nurses, one of whom is a Registered Nurse competent in peri-anesthesia nursing (the other may be a Registered Practical Nurse), shall be present whenever a patient is present in this phase of recovery.”* If not formalized then the IAC would strongly recommend that the DSU admitting RPN, given their close proximity and familiarity with the patient that they admitted only a few hours prior, be willing and able to assist the RN as required.

During the hearing the IAC panel also heard that the Operating Room “Emergency List” starts between 1530-1600 hours. The Hospital stated that with the increase recruitment of Orthopedic Surgeons the Orthopedic trauma list has increased. Other surgical issues impacting Phase II recovery are:

- Surgeons add patients to the Emergency list based on the need from their respective clinics that are operating on any given day
- On many occasions three Operating Rooms are running at the end of the day.
- As many as 4-5 patients in Phase II Recovery after 1730
- Tonsillectomy (+-) Adenoidectomies patients (Adults and Pediatric) stay a minimum of 4 hours in Phase II Recovery

Both the Hospital and Association confirm that nurses have never been denied overtime to meet the needs of safe quality patient care.

Recommendation 44: Advance the start time of the early RN to ensure coverage of Fast Track patients into DSU

Table 2: Recommended daily staffing for Phase II-Day Surgery.

Recovery Stage	Designation	Hours of Work
Pre-Op	1 RN	0630-1430
	1 RPN	0630-1430
Post-Op	1 RN	0800-1600
	1 RPN	0830-1630
	1 RN	1100-1900

In the event changes to the start time of the RN is not possible the IAC strongly recommends that patients eligible for 'fast tracked' remain in PACU until the RN arrives at 0830 in the DSU.

Recommendation 45: Assigning location of patients to support safety and comfort

The IAC heard during the tour that cataract patients are left in the OR hallway while the OR room is turned over. Any patient who has received sedation should not be left in hall unobserved by an anesthesiologist or nurse while awaiting transfer back to day surgery. There are delays in such transfers as the porter is cleaning the room before taking the patient back to the day surgery. Patients who are awake should not be placed in a location where they can observe other patients who are sedated and intubated being transferred (some patients on stretchers wait in OR hall or in "pre-cataract procedure" assigned bays). This creates an uncompassionate atmosphere and assembly-line feel. The departments have a congested feel, which adds to the challenge of providing clear communication (e.g. TOA processes).

PROFESSIONAL PRACTICE SUPPORTS

Professional practice demands competence in relation to knowledge and technical skills. This requires not only a broad base of knowledge, but also depth of knowledge in a chosen area of practice, a desire and ability to continue developing that knowledge base and to share it with others and critical thinking in decision-making.¹⁸ It is imperative that the Hospital provide practice supports which include clear and identified procedures, policies, medical directives, protocols, plans of care, care pathways and assessment tools appropriate to the patient population who access care.¹⁹

Recommendation 46: Orientation and ongoing support of continued education and learning

The IAC in reviewing the documents outlining orientation provided to staff (presentations, competency skills check lists); the content was found to be generic and lacking of specifics to support a smooth transition to the perianesthesia area. Dedicated time to ongoing education needs to be secured to enhance staff's knowledge and understanding of updates in policies.

¹⁸ Francine Girard et al, Professional Practice in Nursing: A Framework, Nursing Leadership 18(2) 2005:

¹⁹ CNO, Practice Guideline, RN and RPN Practice: The Client, the Nurse and the Environment, 2011

PERI-OPERATIVE SELF ASSESSMENT COMPETENCY/SKILLS CHECK LIST

According to NAPAN nursing competencies are specific knowledge, skills, judgment and personal attributes required for nurses to practice safely. Competency assessment involves more than a checklist and a test. Hospitals are required to assess, maintain, demonstrate, track, and improve the competence of the nursing staff. Competency assessment is an ongoing process of one's initial and ongoing professional development, maintenance of knowledge and skills, educational consultation, remediation and practice safely and ethically in a designated role and practice setting. One of the requests of the IAC Panel to the Hospital was a copy of their peri-operative/anesthesia competency skills checklist. During the hearing the Hospital was only able to provide to the IAC Panel an Orientation Checklist for the Pre-Operative Admission Clinic and an Orientation Package for the Day Surgery.

On the last day of the hearing, during open and frank dialogue RNs shared with the IAC Panel that yearly performance/competency reviews were not common practice. Many had not received one for years. It is important to note that the Hospital did not provide a difference of opinion.

The IAC believes that regular annual reviews inclusive of self assessment competency/skills checklists would serve to support progress towards a "culture of learning and sharing" and in the context of patient safety, building trust etc. will be a valuable initiative for the perioperative program to actively embrace. In a learning culture, people take responsibly and support one another. They share experience and learn from mistakes as well as successes. A learning culture will support the nurses to move forward in terms of professional nursing practice and a personal level, through continued professional development. Self-reflection and self-assessment are necessary components of competency evaluation for each nurse to improve.

Recommendations 47- 48: *Within 3 months have reviewed and revised the Nursing Skill Competency Checklists/Tool for the following perioperative nursing roles to ensure that it is fully comprehensive. The IAC feel strongly that all staff undertake to annual review and sign off their personal checklist. The Nursing Skill Competency Checklists/Tool (NSCC) should be reviewed annually and prior to any new hire into the appropriate role/department.*

47. *The Unit Competency Skills Checklists will include but not be limited to:*

- *Core competencies*
- *Surgical subspecialties competencies (Orthopedics/ENT/General/Urology/etc) that nurses will work in*
- *New/revised annual policies, protocols, medical directives*
- *The individual staff learning plans flow from the completion of the checklist themselves and are to be supported by the mentorship program and education as required*

48. *All new hires to the perioperative services must demonstrate the required knowledge base and associated competencies using a range of evaluation methods prior to commencement of autonomous practice.*

To assist the Hospital and the nurses in progressing the review and revision of the NSCC the IAC has provided more specific recommendations below:

Recommendation 49: *Enhance the specific competency skills check lists used to be inclusive of more specific and measurable outcomes*

a) *Enhance the competency skills check list used in the PAC*

The purpose of enhancing them is to include more specific and measurable outcomes. i.e. change "knowledge of CNO Standards of Practice", to "demonstrates understanding of the CNO Practice

Standards (Documentation, Professional Standards, etc.), through completion of the on-line CNO learning modules. Demonstrates knowledge of the CNO Practice guidelines (Consent, Utilization of RNs and RPNs, etc.), through completion of the on-line CNO learning modules"). These can be accessed at: <http://www.cno.org/en/learn-about-standards-guidelines/educational-tools/learning-modules/>.

Further, the nurses within the PAC should complete at hire and annually a written test linked to case studies that examine Practice Guidelines such as Directives. The IAC feels that this will serve to positively impact recommendations regarding Patient Safety and the Patient Experience and therefore ultimately positively impact RN workload.

b) Enhance the competency skills check list used in the Day Surgery Unit

The purpose of enhancing them is to include more specific and measurable outcomes. e.g. demonstrates understanding of the CNO practice guidelines (Directives, Consent, Working with Unregulated Healthcare Providers, etc), through completion of a written test linked to case studies, and/or the CNO on-line learning modules.

Link to the competency checklists of all nursing staff within perianesthesia and perioperative departments (Day Surgery/Phase II Recovery, PACU, OR, PAC, and Endo/Cysto nurses) a written test on department-relevant scenarios that examine the CNO Practice Guideline "The RN and RPN Practice: The Client, the Nurse and the Environment".

c) Provide a forum/venue where staff can provide input and suggestions for current and future learning needs.

The IAC heard that there is a need for the Hospital and the staff to have a forum or venue by which they can provide input and suggestions for current and future learning needs. e.g. include "staff education and competency" as a regular agenda item at staff meetings. Further, at the completion of an educational session staff be provided with an evaluation tool that includes suggestions for future topics to be considered inclusive to ongoing education.

Polices and Plan for Revision/Development

In reviewing the pre-hearing submission, during the tour and the hearing the IAC identified the need for significant policy renewal. Policy renewal is seen to be inclusive a need to review, revise, update, educate, audit adherence and finally sustain the related improvements. Further to ensure minimal impact of workload nurses need to have timely access to the most current policy and this should be ensured, with any risk of version control removed.

Recommendation 50: Develop with a sense of urgency and implement a policy renewal program for the Perioperative Services

As noted by the CNO, work place environments should have the appropriate resources to support RPN and RNs practice such as "support tools (for example, assessment tools, protocols and policies); and clear role descriptions and responsibilities of care providers (RPN, RN and unregulated care provider)". Further, the RPN should have access to a RN for consultation/clarification as needed.²⁰

To assist with the development of a policy renewal process the IAC has listed a number of areas where the Hospital should initially start and they include:

²⁰ <http://www.cno.org/en/learn-about-standards-guidelines/educational-tools/ask-practice/ask-practice-workplace-environments-supporting-rpn-practice/>

Recommendation 51: Update 'Discharge Policy from PACU'

Specify the expectations of oxygenation, sensory return and pain control as criteria to be included within the criteria for transfer to Phase II recovery. As part of the policy clearly outlines situations where the PACU RN must ensure that transfer of accountability in Phase II recovery is to be a RN and when the transfer of accountability can be given to a RN/RPN.

Recommendation 52: Update 'The Admission Criteria for Day Surgery Recovery Policy'

Remove 'Ramsay Sedation score' as an assessment parameter (this tool was designed to be used in an ICU setting with patients receiving mechanical ventilation). The assessment completed in Phase I recovery is to include the Aldrete scoring tool. A score of 9 or greater must be achieved prior to transferring the patient to the Phase II recovery area. Where scores are lower, the Phase I RN consults the anesthesiologist and/or surgeon to discuss the patient's plan of care. Identify the level of return of sensation and or movement required (this is vaguely noted in the last bullet of the policy); e.g. utilization of Bromage Scale for patients who have received neuraxial anesthesia intraoperatively.

Recommendation 53: Update 'Fast Tracking – Bypassing PACU Phase I to Phase II'

Remove 'Ramsay Sedation score' as an assessment parameter. The assessment should be consistent with that completed in Phase I recovery, to include the Aldrete scoring tool. A score of 9 or greater must be achieved prior to transferring the patient to the Phase II recovery area. Where scores are lower, the Anesthesiologist collaborates with nursing staff in Phase I and/or Phase II recovery to confirm the most suitable location and staff to assume the TOA process.

Recommendation 54: Update 'Pre-Admission Clinic Patient Standard of Care'

The identification of need for an Anesthetic consult, and types of lab testing will be identified by the surgeon and documented on a Physician's order for the Clerk to arrange.

- Preoperative test results should be considered valid for a consistent period of time of 60 days (a variance exists between surgical patients and cataract surgery; 60 days is the industry norm).
- A screening tool be completed at the surgeon's office to determine the type of PAC visit warranted (on-site vs. telephone, Anesthesiology or internist consult, lab testing as outlined in the preoperative guidelines). The surgeon uses this tool to order these preoperative tests/consults and documents this order for clear communication to the PAC staff.

Recommendation 55: Update the protocol 'Tests Performed Preoperatively for Surgery'

To ensure the policy is consistent with the guidelines from Canadian Association of Anesthesiologists.²¹ This document is not referenced in the current policy of OSMH.

Recommendation 56: The policy 'Transfer of Patient from Recovery room to Day Surgery Unit' must be revised

The current policy is dated (1993), and incomplete and provides only 3 sentences of vague directions. It is understood that this is one of the many policies set for revision in the coming months.

²¹ https://www.cas.ca/English/Page/Files/97_Guidelines_2013 . Page 67

Recommendation 57: The policy "Guidelines for Transfer of Care" must be revised.

This policy is dated 2004 and does not specify the patient information that must be included in the 'transfer of accountability process', nor does it provide any direction to documentation of this process.

Recommendation 58: The policy "Guidelines for Anesthetic Consults" must be revised

The current policy is dated (2008), and in need of revision. The point that a consult is not required if the patient has had a recent GA is vague and erroneous.

Please refer to the guidelines for the Canadian Association of Anaesthesiologists.²² This document is not referenced in the current policy of OSMH.

Recommendation 59: The policy "Day Surgery Postoperative Routine and Scoring Guidelines" must be revised

Although the policy was revised in 2011, it does not reference the Post Anesthesia Scoring System (PADSS), nor does it outline how frequently vital signs of a PAD score must be assessed.

Recommendation 60: A policy for "Criteria for Same Day Surgery" must be developed

This policy would serve to outline the standards for ambulatory surgery, and patient populations where admission to the facility is warranted (e.g. elevated BMI, severe OSA with airway surgery and non-compliance to CPAP monitor). Such a policy would support evidence-based care of patients with complex histories, not uncommon in the Orillia LHIN.

There needs to be developed a policy to provide guidance on completion of lab testing. This would provide direction in special circumstances such as the contraindication to draw lab specimens on the same arm that will receive vascular surgery or patients who have had an Axillary Node Dissection.

Outline a plan which includes time lines for revision, education, auditing, and annual review of policies relevant to staff working within the perianesthesia environment. A working group should be developed to revise and review these policies, that includes the nursing manager and a nursing representative from PAC, PACU, OR, Endo and Day Surgery. Initial orientation and annual review of education of RNs and RPNS can be guided by the CNO document "Requisite skills and abilities for Nursing Practice in Ontario".²³

DOCUMENTATION

Nursing documentation is an important component of nursing practice and the interprofessional documentation that occurs within the client health record. Documentation whether paper, electronic, audio or visual is used to monitor a client's progress and communicate with other care providers. It also reflects the nursing care that is provided to a client²⁴

The IAC notices significant inconsistency in how physicians direct nursing staff within the PAC to follow the preoperative requirements policy of the Hospital. There have been occasions where nurses are completing implementing laboratory testing procedures (i.e. drawing blood for cross match, type and screen), without the direction of a physician's order or medical directive but based on commonly understood routines. Development of a pre-printed order sheet that is completed by the surgeon at

²² https://www.cas.ca/English/Page/Files/97_Guidelines_2013.

²³ <http://www.cno.org/Global/docs/reg/41078%20SkillAbilities%204pager-Final.pdf>

²⁴ CNO Practice Standard, Documentation (revised 2008)

the surgical consult appointment is a strategy to resolve this issue, and support nurses to work within their scope.

Therefore the IAC identified the need for significant documentation renewal to ensure minimal impact of workload nurses while practicing in accordance with the College of Nurses expectations

To assist with the documentation renewal process the IAC has listed a number of areas where the Hospital should initially start and they include:

Recommendation 61: *Revise the preoperative checklist*

The preoperative checklist needs to be revised to clearly capture the staff who have performed a check and when. Beside each test there should be a spot for date and initials of the nurse. Further, a section for the nurse's full signature must be provided to capture which staff member has documented their initials.

Recommendation 62: *Amalgamate the preoperative questionnaire for In-patient admissions and DSU patients*

During the tour the IAC heard that from the new manager that these questionnaires will be revised in the coming months. The IAC recommends that the preoperative questions for both in-patient and DSU patients become the same form regardless if the patient is having a day surgical procedure or a more invasive surgery requiring admission to an inpatient unit. One preoperative questionnaire would also eliminate the need for the in-patient and DSU pre-assessment charts to be colour coded (see Recommendation 11)

Recommendation 63: *Revise the "Anesthetic Questionnaire for Nursing Assessment" form*

This can be adapted to serve as another trigger for the nurse in the PAC to contact the Anesthesiologist to inquire if a consult by the Anesthesiologist is required. i.e. bold questions that if the patient answers "yes", require the nurse in the PAC to notify the Anesthesiologist. Such questions would include "have you ever had a problem with local or general anesthetics", and "Do you or anyone in your family have a history of malignant hyperthermia". Further, the question "are you at risk for sickle-cell disease" is erroneous. The question can be worded to "do you have sickle cell disease, as the concern is risk for sickle cell crises, which can be triggered by hypothermia, dehydration or intensive pain.

STAFF PROFESSIONAL DEVELOPMENT

Self Assessment Competency/Skills Check list (Peri-Operative/Anesthesia Departments):

The IAC believes that a move towards a "culture of learning and sharing" will be a valuable approach for the peri-anesthesia/operative program. In a learning culture, people take responsibly and support one another. They share experience and learn from mistakes as well as successes. A learning culture will support the nurses to move forward in terms of professional nursing practice and a personal level, through continued professional development. Self-reflection and self-assessment are necessary components of competency evaluation for each nurse to improve.

Recommendations 64-65:

- 64. *Within 3 months have reviewed and revised the Nursing Skill Competency Checklists/Tool for the following Peri-Operative / Anesthesia nursing roles to ensure that it is fully comprehensive. The IAC feel strongly that all staff undertake to annual review and sign off their personal checklist. The NSCC should be reviewed annually and prior to any new hire into the appropriate role/department.***

- i. *Scrub Nurse (Operating Room)*
 - ii. *Circulating Nurse (Operating Room)*
 - iii. *Endoscopy Unit*
 - iv. *Post Op Anesthetic Care Unit (PACU)*
 - v. *Pre-Assessment Clinic*
 - vi. *Day Surgery/Phase II Recovery*
65. *The Unit Competency Skills Checklists will include but not be limited to:*
- I. *Core competencies*
 - II. *Surgical subspecialties competencies (Orthopedics/ENT/General/Urology/etc) that nurses will work in*
 - III. *New/revised annual policies, protocols, medical directives*
 - IV. *The individual staff learning plans flow from the completion of the checklist themselves and are to be supported by the mentorship program and education as required*
66. *All new hires to the Peri-anesthesia/operative program must demonstrate the required knowledge base and associated competencies using a range of evaluation methods prior to commencement of autonomous practice.*

According to NAPAN nursing competencies are specific knowledge, skills, judgment and personal attributes required for nurses to practice safely. Competency assessment involves more than a checklist and a test. Hospitals are required to assess, maintain, demonstrate, track, and improve the competence of the nursing staff. Competency assessment is an ongoing process of one's initial and ongoing professional development, maintenance of knowledge and skills, educational consultation, remediation and practice safely and ethically in a designated role and practice setting. One of the requests of the IAC Panel to the Hospital was a copy of their peri-operative/anesthesia competency skills checklist. During the hearing the Hospital was only able to provide to the IAC Panel an Orientation Checklist for the Pre-Operative Admission Clinic and an Orientation Package for the Day Surgery.

On the last day of the IAC hearing, there was open and frank dialogue where nurses shared with the IAC Panel that yearly performance / competency reviews were lacking. Many had not been done for years. It is important to note that the Hospital did not dispute this claim.

PATIENT EXPERIENCE

During the tour and throughout the hearing the IAC was left feeling that more could be done to improve the overall surgical patient experience. Specifically, understanding the perioperative experience from the perspective of the patient and their family: i.e. what do patients and their families' inquire about during the pre-assessment, and or upon admission and discharge from the day surgery unit, what was the impact of the missed medication and or laboratory test from the patients' perspective – how did they feel as opposed to how it impacts nursing workload.

Recommendation 67: *Need to frame the perioperative experience from the patient perspective*

Patients need to be provided within pre-assessment specific information regarding what to expect from the operation, admission care, and discharge. This information should be day surgery/in patient surgery specific and should included details of what to expect in terms of the procedure, pain and discomfort. The more information patients are given the better prepared they are for what is to come. Having patients and family who are well prepared positively impacts both their overall experience and the workload of the nurses caring for them.

Recommendation 68: *Create opportunities for nurses to job shadow in other areas*

As a result of the tour and hearing the IAC were left with the impression that the Perioperative Services hasn't realized its potential in becoming more than the sum of its parts. Rather, currently they are a

collection of units which provide care to patients as opposed to a seamless process by which the patient experiences all aspects of their surgical experience effortlessly. The IAC feels strongly that staff would benefit from having an increased awareness of how their interaction with the patient and their families impacts other aspects of their overall experience.

Recommendation 69: *Increase the awareness of the individual units within the perioperative services to the overall patient care experience by creating opportunities for nurses to job shadow in other areas*

As a result of the tour and hearing the IAC were left with the impression that the Perioperative services is a collection of units which provide care to patients as opposed to a seamless service.

The IAC was left with a sense that it was an overall lack of awareness of the nature of the work and the contribution of other units to the overall patient's care. The IAC felt that in the context of a new Manager this presented the Perioperative services with an exciting opportunity to increase their awareness of their specific areas to others. In doing so the IAC also felt this would positively impact efforts to reduce adverse events and or safe catches such as missed medication, laboratory tests, and consent anomalies (see **Recommendation 11**). That is the staff within the Perioperative Services need to have an awareness of how their actions or inaction impact their colleagues downstream and more importantly the overall patient experience.

The IAC felt that 'job shadowing' would be an effective method of creating greater understanding and appreciation of their colleagues' role and contribution in the overall Perioperative patient experience.

Recommendation 70: *Standardized pre and post-operative patient information*

When touring the Day Surgery Unit (DSU) the IAC became aware of the presence of surgeon specific post-operative information. While the IAC appreciates the need for individualized patient education, this does have an impact on workload on the RN.

An example of where the IAC feels improvements in patient information is outlined in the following paragraph:

The IAC during the tour was also informed of the specific practice of one of the Ophthalmologists who utilizes the dedicated isolation room for 'group' post-operative cataract information sharing. The IAC further understood that given this is done when there is a group of about four patients, while they may be technically discharged they are still present in the DSU and therefore increase the overall patient population at any given time. When the IAC inquired they were informed that this is not standard practice and therefore, the IAC feel that standardize pre and post operative information for this patient population would positively impact the following:

- Reduced length of stay for post operative cataract patients;
- Align the patient census in the DSU relative to the OPANA recovery phase 2 requirements;
- Ensure the dedicated isolation room is available at all time for the intended purpose;
- Cease the need for DSU staff to find an alternative space when the dedicated isolation room is being used for its intended purpose.

The IAC is cognizant that the above is only one example, and that there are numerous other opportunities to standard pre and post-op patient information which would not only serve to improve patient care, and also positively impact the workload of the RN staff therefore enabling them to focus on individual patient care needs.

Part IV SUMMARY and CONCLUSIONS

The IAC was requested to specifically address the issue that the workload complaint arising from the Hospital *"assigning a workload to an individual RN and group of RNs working in the Perioperative services such that they have cause to believe that they are being asked to perform more work than is consistent with proper patient care"*.

The IAC has made 70 recommendations following a comprehensive process involving review of written and oral presentations focused conversations, and ensuring discussion and clarification during the three (3) day hearing and extensive Committee analysis and discussion following the Hearing.

The 70 Recommendations address the areas of communication, healthy work place culture, patient safety, staffing model of care, patient flow, change management and supports, practice supports, perioperative self assessment competency/skills check list, documentation, staff professional development and lastly, the patient experience and were therefore referenced accordingly.

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

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

Appendices



Ontario Nurses' Association

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

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October 26, 2012

VIA EMAIL

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

Dear Ms. Duesbury-Porter,

RE: Professional Responsibility Complaint Operating Room, Day Surgery and Preadmission Clinic; Orillia Soldiers Memorial Hospital (ONA Files 201101719 and 201101865)

Thank you for accepting the nomination to Chair an Independent Assessment Committee (IAC) investigating a Professional Responsibility Complaint arising in the Operating Room, Day Surgery and Preadmission Clinic at Orillia Soldiers Memorial Hospital. I have spoken with Mr. Stephen Green at the Ontario Hospital Association, and both parties have agreed to you chairing this IAC.

The attached letter provides the Union's nominee name and contact information. The Hospital will forward you their nomination letter. Please set up dates with the nominees, who will confirm with their respective parties.

Yours truly,

ONTARIO NURSES' ASSOCIATION

Jo Anne Shannon
Professional Practice Specialist

Encl.

C: Linda Haslam-Stroud, President, Ontario Nurses' Association (ONA)
Sandra Tansley, Local Coordinator and Bargaining Unit President (ONA)
Pat Carr, Labour Relations Officer (ONA)
Glenda Hubley, ONA Nominee
Elisabeth Riley, President and CEO, Orillia Soldiers Memorial Hospital (OSMH)
Mary Catherine Masciangelo, Director of Human Resources (OSMH)
Ron Joseph, Senior Human Resources Business Partner (OSMH)
Stephen Green, Director, Hospital Employee Relations Services, OHA

Provincial Office: Toronto

Regional Offices: Ottawa • Hamilton • Kingston • London

Orillia • Sudbury • Thunder Bay • Timmins • Windsor





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October 26, 2012

HAND DELIVERED

Cheryl Harrison
Vice President, Patient Services, Regional Programs and Chief Nursing Executive
Orillia Soldiers' Memorial Hospital
170 Colborne Street West
Orillia, ON
L3V 2Z3

Dear Ms. Harrison,

RE: Professional Responsibility Complaint Operating Room, Day Surgery and Preadmission Clinic; Orillia Soldiers Memorial Hospital (ONA Files 201101719 and 201101865)

The Registered Nurses (RNs) working in the Operating Room (OR) and Day Surgery (DS), Orillia Soldiers' Memorial Hospital have consistently identified ongoing serious practice and workload concerns as evidenced by the data submitted on Professional Responsibility Workload Report Forms (PRWRFs) from November 2010 to today's date.

The RNs working in the OR and DS have documented that the current practice, patient care, and workload environment does not allow them to meet *College of Nurses of Ontario (CNO) Standards and Practice Guidelines*, *Operating Room Nurses Association of Canada (ORNAC) Standards, Guidelines and Position Statements for Perioperative Registered Nursing Practice*, or *Ontario PeriAnesthesia Nurses Association (OPANA) Standards of PeriAnesthesia Nursing Practice*; and they believe they are being asked to perform more work than is consistent with proper patient care. Effective staffing patterns, skill mix and supports have not been provided to respond to patient acuity and volumes, fluctuating workloads, fluctuating staffing and professional practice issues.

The parties have been meeting regularly to attempt to resolve the issues. We are close to reaching resolution in the issues affecting Day Surgery. Despite this, the Hospital has been unwilling to propose or agree to sufficient measures to resolve the very serious practice and workload concerns identified by ONA members relating to patients that have been screened in the Preadmission Clinic.

The Union is seeking resolution of the concerns on behalf of our members and the patients that they care for, and remains very concerned regarding the risks to patient safety and the real potential for negative patient outcomes. Accordingly, the Union is forwarding the complaint to an Independent Assessment Committee as per Article 8 of the collective agreement.

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

Provincial Office: Toronto

Regional Offices: Ottawa • Hamilton • Kingston • London

Orillia • Sudbury • Thunder Bay • Timmins • Windsor





Ontario Nurses' Association

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Glenda Hubley RNFA CPN (c)
 84 Primrose Drive
 Sault Ste Marie ON
 P6B 4E6
 Cell 705 971 3510
 Home 705 942 2094
 Fax 705 942 3262
 E-mail glenda.hubley@sympatico.ca

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

June Duesbury-Porter will be invited to Chair the Independent Assessment Committee as per the rotation of Appendix 2 as confirmed with the Ontario Hospital Association.

The Union remains committed to continue to work with the Hospital to resolve this PRC, or to narrow the issues being referred to the IAC. We believe that the significant human, public and financial costs of an Independent Assessment Committee hearing can be much better applied to improving the practice and workplace environment of our members and the patients that they care for.

Yours truly,

ONTARIO NURSES' ASSOCIATION

Jo Anne Shannon
 Professional Practice Specialist

- C: Linda Haslam-Stroud, President, Ontario Nurses' Association (ONA)
 Sandra Tansley, Local Coordinator and Bargaining Unit President (ONA)
 Pat Carr, Labour Relations Officer (ONA)
 Glenda Hubley, ONA Nominee
 Elisabeth Riley, President and CEO, Orillia Soldiers Memorial Hospital (OSMH)
 Mary Catherine Masciangelo, Director of Human Resources (OSMH)
 Ron Joseph, Senior Human Resources Business Partner (OSMH)
 Andrea Farkas, Program Director (OSMH)
 Dr. Anton Gagnon, Chief of Anesthesiology (OSMH)
 Dr. Lloyd Harrison, Chief of Surgery (OSMH)
 Greg Gee, Chair, OSMH Board of Directors
 Paul Leskew, First Vice-Chair, OSMH Board of Directors
 Jeffrey French, Second Vice-Chair, OSMH Board of Directors
 Dr. Don Atkinson, Chief of Staff (OSMH)

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George Beatty, OSMH Board of Directors
 Ken Brownlee, OSMH Board of Directors
 John Cameron, OSMH Board of Directors
 Patt Carter, Representative, Nurses' Alumni, OSMH Board of Directors
 Judith Cox, Representative, County of Simcoe, OSMH Board of Directors
 Ted Edmond, OSMH Board of Directors
 Tony Katarynych, OSMH Board of Directors
 Micheal McMurter, OSMH Board of Directors
 Angelo Orsi, Mayor, City of Orillia, OSMH Board of Directors
 Dr. Don Sangster, Vice-President, Medical Staff Association, OSMH Board of Directors
 Ted Sasaki, OSMH Board of Directors
 Al Scott, OSMH Board of Directors
 Bob Thomas, Representative, Royal Canadian Legion, OSMH Board of Directors
 Dr. Rebecca Van Iersel, President, Medical Staff Association, OSMH Board of Directors
 Paulette Wilson, OSMH Board of Directors
 Jill Tettman, Interim CEO, North Simcoe Muskoka LHIN
 Robert Morton, Chair of the Board of Directors, North Simcoe Muskoka LHIN
 L. Anne Gagne, Vice Chair, North Simcoe Muskoka LHIN
 Peter Brown, Member, North Simcoe Muskoka LHIN (Orillia)
 Stephen Green, Director, Hospital Employee Relations Services, Ontario Hospital Association

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Pre-Hearing Meeting was held by teleconference on January 28th from 7-9pm

The IAC reviewed the anticipated process of the Hearing and included an agreed request for additional information in selected areas from the employer. The IAC recognizes that some of the above information will be readily available, other information may take time to access. We request that as much as possible be provided to the IAC and ONA by the conclusion of the Hearing on April 5th 2013 and that the remainder be provided at the latest by April 7th 2013 with the exception of access to the RMPs as we have allotted time to view during the hearing time.

Surgical Metrics

- Conversion rate for Day Surgery over above the 5 planned admissions
- Day Surgery throughput per patient space
- Query reference to post-op nausea and vomiting among Day Surgery patients
- Average LOS has limited use, Please provide the mean/mode LOS within Day Surgery
- Item 50 please outline the complexity of surgery under general and vascular surgery

Mediation January 26th 2013

- Copy of Mediation Report (Jan 26th 2013) Joint Staff / Management Mediation via 3rd Party

Risk Monitor Pro

- Define which RMPs are practice related issues
- Provision of specific dates and numbers for each RMP that they used in their detailed analysis in their tabs N and O.
- Request to view the full reports (RMPs) to ensure reconciliation of the reports regarding "professional practice" issues as many of these reports deal with incidents outside of the DS & PAC setting as well many are non-nursing issues (equipment and ordering issues).

Item 49 in the pre-hearing submission – please elaborate in writing or during OSMH's Hearing regarding *how ONA members have failed to consistently follow the process articulated in Article 8*

Item 62 and 63 – processes can directly impact workload, therefore, please provide prior to or during the Hearing the pre-procedure testing protocol and an outline of the refinement which are underway.

Item 66

- The term nurse is utilized – please confirm if this refers to both a RN and RPN
- Confirm if abnormal blood results are inclusive of 'critical or equivalent' per OSMH
- Please clarify if all patients have a Family Doctor

Item 70

Please provide the baseline and ongoing measurements in support of the identified 'opportunity to enhance the delivery of quality and safe patient care'

Item 74

- *Please outline how the Hospital assess the effectiveness of strategies and structure in place to support the model of care as established within Day Surgery and Pre-Admission Clinic.*
- *Itemize improvements in addition the pre-procedure testing*

Change Management

- The Change Management Model utilized to plan for and implement the 'look of the Day Surgery/PAC Team'
- Outline how the staff provided input into the job descriptions (mentioned in the June 22 and 29th Team Building exercise) which can only be assumed were required for the posting completed June 11th 2010,

Perioperative Service

- Telephone PAC assessment – is there educational material provided prior to commencement of this activity – are these calls recorded for quality purposes?
- ASA Classification broken down into 1/2/3/4's: (how many cases of each classification on average per year)
- Copy of PAC's Pre-operative Testing Grid
- Copy of all Medical directives that PAC nurses follow when ordering blood work
- Copy of PAC Job Description
- Copy of any and all Health Teaching Material the patient is provided with at their PAC visit- Panel has "About your Surgery"
- Competency skills check list
- Regional Blocks- what medications are given by Anesthetists
- What percentage of patients are seen by the Anesthetist in PAC
- What type of sedation is given in Endo (by nurse and or by anesthetist)
- Mentorship and learning plan framework/supports for the RPNs

Scope of Practice

Memo dated May 25th 2010 from Cheryl Harrison to ONA Local 92

- Clarify what is within the scope of practice of an appropriately skilled RPN

Copy of all Collaborative Practice Policies for units where there is an RN/RPN skill mix

Recovery Phases

Page 94: Provision of rationale for utilization of the Ramsey Sedation score utilized for the transfer from Phase1 to Phase 2 recovery Appendix one and two

Page 91: Concern regarding the admission criteria policy to Phase 2 recovery.

- Copy of Local C/A

- Copy of Anesthesia Record + copy of PACU Order Sheet including Epidural/Spinal, PCA order sheet

Criteria for Phase 2 – what is meant by no signs?

Medication Administration

- Medication administration policy (including independent double check)
- Schedule of pharmacy deliveries
- Process for locating/replacing lost/missing medication

Quality and Patient Safety

- Description of Quality/Continuous Improvement projects over the past two years relating to nurses and/or nursing practice for the Perioperative Unit
- Copy of the last Accreditation recommendations/comments/praise for the Surgical Program
- Specific measures to evaluate the implementation of the RN/RPN skill mix
- FMEA – has one ever been undertaken on processes/policies which contribute to RMPs such as missing/errors in labs, consent, etc.

**Independent Assessment Committee Hearing Agenda
Ontario Nurses' Association and Orillia Soldiers Memorial Hospital**

Tuesday February 5th 2013, OSMH, 4th Floor

Time	Item	Participants		
		IAC	OSMH	ONA
7:15	IAC to meet OSMH and ONA in hospital entrance	June Duesburry-Porter Glenda Hubley Heather Ead	All OSMH attendees	All ONA attendees
7:30-11:30	Tour <ul style="list-style-type: none"> Day surgery unit 0730-0830 Proceed to Endo RR-Phase I PAC RR-Surgical Daycare and maybe Endo again <i>Break to be incorporated</i> 	IAC	All OSMH attendees	All ONA attendees
11:30-13:00	12:00 Lunch - OSMH 4 th floor	IAC		
13:00-13:10	Introduction and Review of Proceedings	IAC Chair	All OSMH attendees	All ONA attendees
13:10 - 14:40	Ontario Nurses' Association Submission Presentation Response to questions of clarification from: <ul style="list-style-type: none"> Independent Assessment Committee OSMH 	IAC	All OSMH attendees	All ONA attendees
14:40 - 15:00	Break - OSMH 4 th floor	IAC		
15:00 - 16:30	OSMH Presentation Response to questions of clarification from <ul style="list-style-type: none"> Independent Assessment Committee Ontario Nurses' Association 	IAC	All OSMH attendees	All ONA attendees
16:30 - 17:00	Review of Process for Wednesday February 6 th 2013	IAC Chair	All OSMH attendees	All ONA attendees
17:00	Adjournment of Hearing	IAC Chair		

**Independent Assessment Committee Hearing Agenda
Ontario Nurses' Association and Orillia Soldiers Memorial Hospital**

Wednesday February 6th 2013, OSMH

Time	Item	Participants		
		IAC	OSMH	ONA
7:30-9:25	IAC to spend time to go through requested RMP information on site with Risk Manager	IAC	1 representative from OSMH	1 representative from ONA
	Break	IAC		
9:30-11:30	OSMH Response to Ontario Nurses' Association Submission Response to questions from <ul style="list-style-type: none"> • Independent Assessment Committee • Ontario Nurses' Association • Discussion 	IAC	All OSMH attendees	All ONA attendees
11:30 – 13:00	11:45 Working Lunch – OSMH 4 th floor	IAC		
13:00-13:10	Welcome	IAC Chair		
13:10-15:10	Ontario Nurses' Association Response to OSMH Submission Response to questions from <ul style="list-style-type: none"> • Independent Assessment Committee • OSMH • Discussion 	IAC	All OSMH attendees	All ONA attendees
15:15 - 15:20	Review of Process for Thursday January 17 th 2013	IAC Chair	All OSMH attendees	All ONA attendees
15:25	Adjournment of Hearing	IAC Chair		
15:25 – 17:00	IAC to spend time to go through requested RMP information on site with Risk Manager	IAC	1 representative from OSMH	1 representative from ONA
18:30 - 21:30	Working Dinner Mariposa Inn & Conference Centre	IAC		

OSMH is able to accommodate some time during the shaded areas above however the exact time remains fluid at this point

**Independent Assessment Committee Hearing Agenda
Ontario Nurses' Association and Orillia Soldiers Memorial Hospital**

Thursday February 7th 2013, OSMH

Time	Item	Participants		
		IAC	OSMH	ONA
07:00 - 8:30	Working breakfast Mariposa Inn & Conference Centre	IAC		
09:00 - 11:00	Questions to both Parties by Independent Assessment Committee	IAC Chair	All OSMH attendees	All ONA attendees
11:00 - 11:10	Closing Remarks and Identification of Next Steps by Chairperson	IAC Chair	All OSMH attendees	All ONA attendees
11:10	Closure of Hearing	IAC Chair	All OSMH attendees	All ONA attendees
11:10 - 13:00	IAC Meeting - Working Lunch - OSMH	IAC		

Tour Participants

ONA	OSMH
Jo Anne Shannon	Tammy Gallagher
Lynn Stevenson	Andrea Farkas
Teresa Robson	Barb Jones
Robin Stoer	Ron Joseph

Hearing Attendees

ONA	OSMH
Jo Anne Shannon	Tammy Gallagher
Lynn Stevenson	Andrea Farkas
Teresa Robson	Barb Jones
Robin Stoer	Ron Joseph
Sandra Tansley	Cheryl Harrison
Gloria Martin	Mary Catherine Masciangelo
Pat Carr	Shane Smith
ONA Observer	
Vanessa Kee, Practice Specialist	

Partial Dissent of Independent Assessment Committee Report
Orillia Soldiers' Memorial Hospital and Ontario Nurses' Association

In my expert opinion, the nursing staffing model in the OSMH Pre-Admission Clinic should be two (2) Registered Nurses.

I strongly disagree with the recommendation of my colleagues on the Independent Assessment Committee (IAC) regarding the Staffing Model in the Pre-Admission Clinic that "does not rule out a role of the RN" in the Pre-Admission Clinic (PAC) over and above that of having a Resource Nurse in the Day Surgery Unit available to the RPN for consultation.

This recommendation is weak, vague and supported by insufficient evidence; and does not address the issues and nursing care and practice concerns presented to the IAC in any meaningful way as related to the current staffing model in the PAC, which is 1-2 RPNs/shift.

After reviewing the Three Factor Frame Work from the College of Nurses of Ontario, consulting with both the Ontario PeriAnesthesia Nurses Association (OPANA), and the National Association of PeriAnesthesia Nurses of Canada (NAPAN®), and reviewing data comparing Industry Standards for Pre-Admission/Assessment Clinics in other Ontario Hospitals; I have no choice but to conclude that my IAC colleagues have not considered nor provided me with **documented evidence based on best practices** to support their recommendation related to the nursing staffing model in the PAC.

1. Review of the **Three Factor Frame Work**, according to the **College of Nurses of Ontario (CNO)** in relation to its application to the Pre-Admission Clinic;

Client Factors:

In my view it is inaccurate of the IAC to characterize Pre-Admission Clinic (PAC) patients prior to surgery or anesthesia, as being "less complex" at the time of their Pre-Admission appointment.

The Nurse responsible for performing the comprehensive surgical pre-assessment must assess patients for their status level according to the American Society of Anesthesiologists (ASA) Patient Status Classification, which includes co-morbidities and overall health status, and the ability to withstand anesthesia and surgery with the focus of reducing negative risks/outcomes for that particular surgical patient. The nurse is assessing for potential surgical and anesthetic risks, and the assessment is systematic, intensive and complex utilizing a variety of secondary sources. This assessment includes the need to recognize when to refer for anesthetic and/or other consultations, the need for laboratory and diagnostic testing, and the appropriate post operative care that can be anticipated to be necessary upon discharge to the community.

The need for an RPN to consult with an RN increases as the client's situation becomes more complex. The more complex the care requirements, the greater the need for consultation and/or the need for an RN to provide the full spectrum of care.

Partial Dissent of Independent Assessment Committee Report
Orillia Soldiers' Memorial Hospital and Ontario Nurses' Association

OPANA states that the PeriAnesthesia Nurse's interviewing and assessment skills identify actual or potential problems that may adversely affect patient care during the surgical and anesthetic experience. The Canadian Nurses Association (CNA) states in their article Nursing Staff Mix: A Key Link to Patient Safety *"The consequences of uninformed and cost-driven decision-making can be serious: the nursing staff mix itself may create the conditions that could lead to clinical errors and result in negative outcomes for patients, nurses and organizations."* (CNA, 2005)

The outcome of an inadequate assessment of any patient in the Pre-Admission Clinic may result in a negative outcome for the patient if she/he is not properly optimized for surgery. The Union's submission to the IAC outlined several incidences (documented on PRWRFs and RMPs) where surgeries have been delayed or cancelled as a direct result of inadequate assessment of patients in the Pre-Admission Clinic. The IAC has failed to appropriately consider this evidence.

Nurse Factors:

Autonomous practice is described as the ability to make decisions and independently carry out nursing responsibilities. RPNs have greater autonomy to care for clients with less-complex conditions, while RNs can autonomously provide care to clients regardless of the complexity of their conditions. *"The more complex the client situation and the more dynamic the environment, the greater need for the RN to provide the full range of care, assess changes, re-establish priorities and determine the need for additional resources."* (CNO, 2011, p.11).

Pre-Admission Clinic nursing assessments require critical inquiry skills, an in-depth knowledge of pathophysiology and experience in all types and techniques of anesthesia and surgery.

Examples would be but not limited to:

- Further assessment and knowledge of those at high risk for perioperative hypothermia and perioperative nausea and vomiting can prevent the incidence of either with their resulting effects/outcomes (surgical site infections, aspiration, dehiscence of wounds, etc.).
- Hemodynamic instability in relation to existing co-morbidities and the effects of each type of anesthesia/surgery on each co-morbidity
- Respiratory status/distress and the effects of existing co-morbidities on airway management including history of obstructive sleep apnea
- Neurological status in relationship to pre-existing co-morbidities, and the effects of anesthesia/surgery on these, renal status, etc.
- Knowledge of all types of anesthesia/surgical risks and negative outcomes of each is necessary in order to best instruct the patient on the type of anesthesia that will be offered to them, including postoperative pain management and the event of rescue analgesia, effects and side-effects of long-term neuraxial anesthesia versus regional blocks and effects/side-effects of prolonged regional anesthesia.

Partial Dissent of Independent Assessment Committee Report
Orillia Soldiers' Memorial Hospital and Ontario Nurses' Association

The Nurse in the Pre-Admission Clinic must be educated and trained on the efficient, effective and safe patient optimization for surgery and anesthesia, which includes knowing when and how to refer for consultation, what type of testing and investigations are required, with sufficient planning for post operative care including community resources in place prior to surgery.

The IAC commented that the CNO's 'Entry to Practice Competencies for Ontario Registered Practical Nurses' describe the use of critical thinking skills by RPNs. The IAC states *"it would be a display of a gap in critical thinking to make assumptions of the staff member's ability to apply critical thinking, based on whether the nurse has "RN" or "RPN" designation beside their signature."*

The IAC is making this statement out of context as they have failed to consider or include the CNO's 'National Competencies in the context of Entry Level Registered Nurse Practice' which state that RNs use critical inquiry. *"This term expands on the meaning of critical thinking to encompass critical reflection on actions. Critical inquiry means a process of purposive thinking and reflective reasoning where practitioners examine ideas, assumptions, principles, conclusions, beliefs and actions in the context of nursing practice. The critical enquiry process is associated with a spirit of inquiry, discernment, logical reasoning and application of standards."* (CNO, 2009, p.22) As such, the IAC has failed to differentiate the level of depth and breadth between the practice of RNs and RPNs, and the use of critical inquiry by RNs vs. critical thinking by RPNs.

Overall, critical and scientific inquiry is required by nurses assessing patients in the PAC. The patients presenting to the PAC require the advanced assessment skills of an autonomously practicing RN.

Environmental Factors:

The CNO describe the environmental factors as including practice supports, consultation resources and the stability/predictability of the environment. The availability and accessibility of consultative resources must be considered. Depending on the complexity of client care needs, consultation may result in receiving advice or transferring care. An RN must be immediately available to consult and collaborate with an RPN, or to assume transfer of care.

"The less stable these factors are, the greater the need for RN staffing. The less available the practice supports and consultative resources are, the greater the need for more in-depth nursing competencies and skills in the areas of clinical practice, decision-making, critical thinking, leadership, research utilization and resource management." (CNO, 2011, p. 11)

The Hospital has not implemented the required practice supports, and this is supported by the IAC. The IAC goes as far as to state *"Unless the practice environment and its respective supports substantially increase having a RN present in the Pre Assessment Clinic may be beneficial"*, yet they fail to make a meaningful recommendation addressing this issue.

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While the IAC acknowledges that there are recurrent issues around consent processes, they fail to adequately address the lack of sufficient practice supports in the PAC. The IAC has ignored the importance of the advanced assessment and interviewing skills of the RN in ensuring accurate and informed consent.

Further, a Registered Nurse is not immediately available to consult with or to assume transfer of care. The "Resource Nurse" to the RPN carries a full patient assignment, and is physically located in Day Surgery on a different floor of the Hospital. I would also like to highlight that since the implementation of the RPNs into the Pre-Admission Clinic, it has been extremely rare for an RPN to consult with an RN regarding the assessment of the Surgical Patient. This is despite documented evidence on both PRWRFs and Risk Monitor Pros (RMPs) related to ongoing inadequate nursing assessments in the PAC. This concerns me greatly, and signals a lack of knowledge regarding self-recognition of limitations of individual competence, and the need/requirement to consult with RNs when this limit is exceeded. The IAC has agreed with this perspective, and has stated: *"The IAC was also concerned with hearing from Day Surgery RNs who assume the role of Resource Nurse for the Pre-Assessment Clinic (PAC) that they do not receive calls for collaboration from PAC. While the IAC could accept that calls may not be required on an hourly or even daily basis, the total absence of calls was seen as of concern in the context of patient care."* However, the IAC has failed to make any meaningful recommendations to address this concern.

Overall, an analysis of the CNO's Three Factor Framework indicates that the appropriate category of care provider in the Pre-Admission Clinic is the Registered Nurse.

2. Consultation with the Ontario PeriAnesthesia Nurses Association (OPANA) and the National Association of PeriAnesthesia Nurses of Canada (NAPAN©)

Nurses are expected to adhere to **industry standards, best practices and or professional standards, which are written and approved by Health Care Professionals**. The standard of care that nurses will need to meet is an objective standard, a standard that is generally accepted by other nursing professions. (*Canadian Nurse and the Law*; JJ Morris, second edition p. 154)

This is supported by the IAC report in the section titled Standards of Practice for Perioperative RNs:

"The OPANA, NAPAN and ORNAC Standards of Practice provide a framework for competency development for Peri-Anesthesia/Operative Nursing practice. A standard is a desired and achievable level of performance against that which can be measured as actual performance...Standards are written evidence based, best practices defining the performance of specific "specialty" nursing practice that is predetermined and acceptable to authority".

The CNA Position Statement: Staff Mix Decision-making Framework for Quality Nursing Care (CNA, 2012) highlights that decisions concerning staff mix must reflect nurses' scope of practice, and conform to legislation and professional standards. The use of outcome

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measurement data must be rigorously used by administrators to inform decision making regarding safe and effective staffing practices.

Neither the Hospital nor my IAC colleagues should arbitrarily choose to follow only some of the OPANA and NAPAN© Standards to suit their means and/or operating budgets. **Professional Association Standards are best practices** founded upon and grounded in **evidence-based** research and expert opinion, and should be **supported in their totality** to ensure the delivery of safe, ethical and competent nursing care.

My findings as a result of my consultation with OPANA and NAPAN©, which I shared with the IAC, are described below:

Ontario PeriAnesthesia Nurses Association (OPANA):

The Ontario PeriAnesthesia Nurses Association (OPANA) President has advised me in an e-mail that the current 6th edition of the standards are currently under review. She was unable to share any potential revisions with me at this time, as once the Standards Committee has completed their work; all standards will be reviewed by professional advisors to OPANA (medical and nursing) and by the OPANA Board of Directors.

Despite this, the IAC has stated *"In a recent conversation by an IAC member with the OPANA it was understood that it should come as no surprise that the next issue of the standards will align with the CNO's in that using the term 'nurse' will be applicable to both the RN and RPN."*

It is dangerous for the IAC to place any weight on such a theoretical and vague statement which can only be described as hearsay, and to assume that this means that there will be no differentiation between the role of the RN and the RPN as currently exists in the OPANA Standards, simply because OPANA might, in future, use the term "nurse" to describe both categories. The CNO uses the term "nurse" to describe both categories, but clearly delineates both the similarities and differences in practice expectations between RNs and RPNs.

Thus to date, there is no concrete evidence regarding what content might or might not be contained in the next version of the OPANA Standards, and it is irresponsible and unacceptable of the IAC to make assumptions, and base their recommendations on those assumptions.

It is important to note that the Hospital's brief, the OSMH's unit policies and the IAC make references to OPANA standards continuously, yet they choose to deliberately ignore the one pertinent component that has brought the parties to the forum of an Independent Assessment Committee Hearing. **The 2009 OPANA Standards clearly state that Registered Practical Nurses are not the appropriate care provider in the Pre-Admission Clinic. OPANA only refers to the PeriAnesthesia Nurse as a care provider within this unit, who they have made very clear is a Registered Nurse. OPANA Standards only reference the RPN as "may" be considered part of the nursing care team in Phase II recovery and beyond, and further**

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rule out autonomous RPN practice in those environments, stating that they must never work alone. (OPANA, 2009. p. ix, 54, and 197)

National Association of PeriAnesthesia Nurses of Canada (NAPAN®):

The president of NAPAN® has advised me in writing, in an official capacity on behalf of the NAPAN® Executive, that they are currently revising their 2011 standards, and will publish again in May, 2014. Further, NAPAN® indicates that OPANA is the only provincial association that continues to write/publish standards. Should they continue to do so, NAPAN® states that OPANA must align their Standards with the National Standards for Practice, or show clear evidence that their revised Standard is correct, and that the National Standard is incorrect. To date, the OPANA Board has not indicated or disclosed any specific details regarding revising their standards of practice to the NAPAN® Board of Directors. In any event, OPANA agreed to, and approved of, the National Standards for Practice, 2011 (2nd edition).

I refer you to the attached letter dated February 13th 2013, from the NAPAN® President regarding NAPAN®'s position on R/LPNs working in Pre-Admission/Assessment Units. **NAPAN® clearly states that it seems unreasonable to consider the R/LPN for a role in the Pre-Admission Clinic. Further, NAPAN® states that there is a wealth of qualitative and quantitative evidence supporting the autonomous role of the RN in the PAC, and it would not be best practice to include R/LPNs in this unit.** The letter concludes that *"It seems unlikely that NAPAN® will revise the standards to recommend that this role will now be taken on by R/LPNs who do not have the assessment skills to perform the kind of in-depth assessment required of the PeriAnesthesia Nurse"*.

There is no ambiguity in NAPAN®'s written position, and it is troubling and unacceptable that my IAC colleagues are failing to give NAPAN®'s expert opinion any weight in their deliberations. NAPAN® is comprised of the provincial associations, and an Associate member of the Canadian Nurses Association (CNA). NAPAN® worked with CNA to implement the designation of PeriAnesthesia Nursing as a Specialty in June, 2010, and on the formation of the content of the certification examination, which is based on the National Standards for Practice (NAPAN®, 2011, 2nd edition).

By declining to consider NAPAN®'s expert written position, and by giving more consideration to unsubstantiated, theoretical and vague potential changes to the OPANA Standards (which can only be best described as hearsay), my IAC colleagues are failing to recommend a model of care in the Pre-admission Clinic that provides for safe, ethical and competent patient care and ensures patient safety and optimal patient outcomes.

Both the OPANA and NAPAN Standards describe the in-depth and advanced interview and systematic assessment skills required by nurses in the Pre-Admission Clinic, and the level of critical inquiry necessary to assess and evaluate surgical and anesthetic risks that may adversely affect patient care. **Overall, an analysis of both the OPANA and NAPAN® Standards currently clearly outline that the PeriAnesthesia Nurse working in the Pre-Admission Clinic is a Registered Nurse.**

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3. The Comparison of Industry Standards for Pre-Admission/Assessment Clinics in other Ontario Hospitals:

The ONA submission to the IAC outlined at page 66-69 their survey of all Ontario Hospitals which showed:

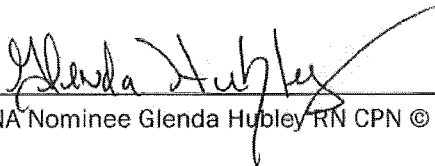
- 117 Hospitals report having a Pre-Admission Clinic, and of these:
- 101 report an all RN skill mix model = 86%
- 13 reported an RN/RPN mix = 11%
- 3 reported an all RPN skill mix = 3%

The IAC has chosen to ignore this data that shows unequivocally that OSMH is not meeting industry standards or best practices in regards to their staffing model of their Pre-Admission Clinic, as an **overwhelming 86%** of Ontario Hospitals with PACs utilize an **all RN skill mix**.

4. Conclusion:

For the reasons above I strongly dissent to any and all references pertaining to the Pre-Admission Clinic (PAC) Staffing Model within the IAC Report. My recommendation is to revert back to an all RN model of care in the Pre-Admission Clinic at the OSMH to ensure optimization of the surgical patient and decrease the risks of negative outcomes.

Dated in Sault Ste Marie Ontario, March 17, 2013


ONA Nominee Glenda Hubley RN CPN © RNFA

Attachment: Letter from NAPAN©



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February 13, 2013.

To Whom It May Concern:

RPNs in the PreAdmission Unit: NAPAN©'s Position

The National Association of PeriAnesthesia Nurses of Canada (NAPAN©) is an Associate member of the Canadian Nurses Association (CNA). The CNA represents Registered Nurses and Nurse Practitioners only, and does not represent the RPN or LPN.

As such, NAPAN© is a Canadian national association for **Registered Nurses** working in all domains of the PeriAnesthesia environment. The NAPAN© *Standards for Practice*, 2nd ed. (2011) reflect practice guidelines for Registered Nurses only. This document is entirely evidenced-based. NAPAN© does not include RPNs/LPNs in these standards, since it is the role of the RN to work in all perianesthesia areas. In the NAPAN© *Standards for Practice*, the "PeriAnesthesia nurse" is defined as a "Registered Nurse" (see definitions) throughout the document.

As per the NAPANc Mission Statement (2011):

"The National Association of PeriAnesthesia Nurses of Canada (NAPAN©) promotes *leadership to PeriAnesthesia nurses in education, research and adapting to evolving practices in client and health services needs within the Canadian health care system* by:

- Advancing professional, **competent**, efficient, compassionate PeriAnesthesia **nursing** practice through ongoing educational opportunities that identify current, comprehensive practice **standards**."

"Nurse" is defined in the "Definitions" section of the *Standards for Practice* 2nd ed., 2011, as "Nurse: Refers to a Registered Nurse in this document" (NAPANc, 2011, p. 241).

Historically, the initial assessment now being completed in the PreAdmission unit (PAU), was completed by the Anesthesiologist the night prior to surgery with the client who was admitted to hospital for preoperative assessment, diagnostic testing, and if required, treatment (i.e. blood transfusion, medication, etc.) to optimize the client undergoing anesthesia. In the 1990's with the introduction of day surgery procedures and admission on the day of surgery this role was transitioned to the Registered Nurse who received extensive training and education in

assessment, evaluation and identification of client needs. Although, initially there was some mistrust by the Anesthesiology community, confidence in the role of the RN to perform this vital and autonomous role has developed over time. It seems unreasonable now to consider the RPN for this role.

There is a wealth of qualitative and quantitative research available in the literature comparing the RN to R/LPN care throughout multiple health care settings, which all indicate that best practice and best client outcomes are met with an all RN staff, and secondly to higher ratios of RN:RPN nurse staff mixes. The evidence supports the autonomous role of the RN in the PAU. To include R/LPNs in this location of the hospital would not be best practice. It would also create a burden on the RN staff to monitor the practice of the R/LPN while performing other client assessments. We would refer you to the Canadian Nurses Protective Society website:

"Because the nurse is responsible for evaluating nursing care by monitoring patient outcomes, she must supervise workers to whom she has delegated. Supervision entails initial direction, periodic inspection and corrective action when needed." (CNPS, 2013: Retrieved from <http://www.cnps.ca/index.php?page=90>)

We have attached literature to support our findings. We could find nothing which points to the R/LPN role in PAU or other ambulatory setting. There is no evidence-based research to support the R/LPN role showing improvement in client outcomes. The opposite is the case: increased surgical cancellations, missed information, and increased hospital admissions following surgery.

It seems unlikely that NAPAN© will revise the standards to recommend that this role will now be taken on by R/LPNs who do not have the education or assessment skills to perform the kind of in-depth assessment required of the PeriAnesthesia nurse.

The next and 3rd edition of the NAPAN© *Standards for Practice* are due for publication in May 2014.

Sincerely,

Paula Ferguson, President NAPANc 2009-14,

on behalf of the NAPANc Executive, 2013.

References

- Allen, P. EdD, RN, CNE, ANEF, Lauchner, R. PhD, RN, K., Bridges, RN, BC, MSN, Francis-Johnson P., RN, MSN, McBride S. G., PhD, RN, & Olivarez A. Jr, PhD, (2008). "Evaluating Continuing Competency: A Challenge for Nursing". *The Journal of Continuing Education in Nursing*, 39(2), 81-85. doi: 10.3928/00220124-20080201-02
- Brinkert, R. (2010), "A Literature Review Of Conflict Communication Causes, Costs, Benefits And Interventions In Nursing". *Journal of Nursing Management*, 18: 145–156. doi: 10.1111/j.1365-2834.2010.01061.x
- Cook, J., Green, M., & Topp, R. (September 2001). Exploring the Impact of Physician Verbal Abuse on Perioperative Nurses. *AORN Journal*, 74(3), 317-331. doi: 10.1016/S0001-2092(06)61787-0
- Dickerson, P., PhD, RN-BC & Allison, M. M. MHSE, BSN, RN, CAE, (2008). "Assessing Competency: A New Accreditation Resource." *The Journal of Continuing Education in Nursing*, 39(6), 244-245. doi: 10.3928/00220124-20080601-01
- Ead, H. (2006). "From Aldrete to PADSS: Reviewing Discharge Criteria After Ambulatory Surgery". *The Journal of Perianesthesia*. 21, 259-267.
- "Guidebook for Managing Disruptive Physician Behaviour." *College of Physicians and Surgeons of Ontario, Ontario Hospital Association Publication*. (2008).
- "Legislating Nurse to Patient Staffing Ratios." *Wisconsin Hospital Association Publication*. WHA: toolkit, 2005. Print. <http://www.wha.org/toolkit/nursetoPatient.pdf> February 10, 2013
- Nursing Competence Self-Assessment Tools. (n.d.). *LearningNurse.com*. Retrieved February 11, 2013, from <http://www.learningnurse.com/content/view/36/52>
- Odom-Forren, J., & Drain, C. B. (2013). *Drain's Perianesthesia Nursing: A Critical Care Approach*. St. Louis, Mo: Elsevier/Saunders. (2008). 23
- Peri-Anesthesia/Operative Competency Skill Checklist. *Sault Ste Marie Area Hospital* (2011). Unpublished. Author: Ontario: Canada.
- Saxton, R. PhD, RN, CNOR, (2012). "Communication Skills Training to Address Disruptive Physician Behavior". *AORN Journal*, 95(5), 602-611. doi: 10.1016/j.aorn.2011.06.011
- "Second Edition of the Standards for Practice" (2011). (2nd Edition). *National Association of PeriAnesthesia Nurses of Canada, Standards Committee*. Oakville, ON, 117. 234.
- "Standards, Guidelines and Position Statements for Perioperative Registered Nursing Practice" (10th Edition). *Operating Room Nurses Association of Canada*. (2011)
- "Standards of PeriAnesthesia Nursing Practice" (2009). *Ontario PeriAnesthesia Nurses Association*. (Sixth Edition), 197
- Whelan, L. (2006 (May-June). "Competency Assessment of Nursing Staff". *National Association of Orthopaedic Nurses*, 25(3), 198-202. Retrieved from <http://www.ncbi.nlm.nih.gov/pubmed/16735851> February 11, 2013

Wilkinson, C. RN, MN (2013). "Competency Assessment Tools For Registered Nurses: An Integrative Review". *The Journal of Continuing Education In Nursing*, 44(1), 31-37. doi: 10.3928/00220124-20121101-53

Vandewater, MN, RN, GNC[c], D. "Best Practices in Competence Assessment of Health Professionals©". *College of Registered Nurses of Nova Scotia*, (2004).. Retrieved from website: <http://www.crnns.ca/documents/competenceassessmentpaper2004.pdf> February 11, 2013