Independent Assessment Committee Report
Constituted under Article 8.01 of the
Collective Agreement
between
Peterborough Regional Health Centre
and
Ontario Nurses’ Association

December 2011
December 2011

Dear Mariana and Vicky,

The members of the Independent Assessment Committee respectfully submit the attached Report with findings and recommendations concerning the Professional Workload Complaint presented by Registered Nurses working on the Hemodialysis Unit, Peterborough Regional Health Centre.

The Complaint was presented to the Independent Assessment Committee in accordance with Article 8.01 of the Collective Agreement (expiry March 2014) between the Peterborough Regional Health Centre and the Ontario Nurses’ Association.

The members of the Independent Assessment Committee recognize and appreciate the efforts taken by representatives of the Hospital and the Association and the Registered Nurses of the Hemodialysis Unit, to prepare and present information and respond to our questions prior to and during the three day hearing.

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

Respectfully submitted

June Duesbury-Porter RN, MScN, MBA

Diane Stephenson RN BScN, MA (ED)  Trudy Molke, RN, BScN
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PART 1

INTRODUCTION

1.1 Organization of the Independent Assessment Committee Report

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

- **Part I** Outlines the referral of the Professional Workload Complaint to the IAC, reviews the IAC’s jurisdiction as outlined in the Collective Agreement, and presents the Pre Hearing, Hearing and Post-Hearing processes.
- **Part II** Presents the context of practice relating to the professional workload complaint in the Hemodialysis Unit, 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 Hemodialysis Unit, Peterborough Regional Health Centre (“the Hospital”) at the Hearing.
- **Part III** Presents the IAC’s discussion, analysis and recommendations.
- **Part IV** Summary and Conclusions
- **Part V** Contains Appendices referenced in the Report.

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

1.2 Referral to the Independent Assessment Committee

This Report addresses the professional workload complaints of Registered Nurses from the Hemodialysis Unit at the Hospital.

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

*Workload issues on Hemodialysis Unit have been known to the Hospital since 2009. Communication between the Hospital and Association (Local 051) to address workload complaints relating to professional responsibility have been discussed at the Hospital Association Committee (HAC) meeting, unit Staff Meetings on Hemodialysis Unit and at supplementary HAC-OPRC (Professional Responsibility Concern) meetings. Professional workload complaints have been addressed on a regular basis at Hospital Association Committee (HAC) meetings. However, by July 2011, the Association did not feel that sufficient progress was being achieved, and on JULY 14th 2011 the Association notified the Hospital of its intent to move to an IAC (Appendix 1).*

Throughout 2009-2010, efforts were made on both sides to resolve the outstanding issues. In addition to regularly scheduled HAC meetings, there was correspondence between the Association and the Hospital to address workload issues outside of the HAC process: However, the Association did not feel that sufficient resolution was achieved, and the IAC Hearing proceeded from November 14th-16th 2011.
1.3 Jurisdiction of the Independent Assessment Committee

The IAC is convened under the authority of Article 8.01 of the Central Hospital Agreement between the Ontario Hospital Association/Peterborough Regional Health Centre and the Ontario Nurses Association. Article 8.01 relates to Professional Responsibility and identifies the process to be followed in the event of a concern regarding the provision of proper patient care.

8.01

The parties agree that patient care is enhanced if concerns relating to professional practice, patient acuity, fluctuating workloads and fluctuating staffing are resolved in a timely and effective manner in the event that the Hospital assigns a number of patients or a workload to an individual nurse or group of nurses such that they have cause to believe that they are being asked to perform more work than is consistent with proper patient care, they shall:

(a)  
   i) at the time the workload issue occurs, discuss the issue within the unit/program to develop strategies to meet patient care needs using current resources.
   
   ii) if necessary, using established lines of communication, seek immediate assistance from an individual(s) identified by the Hospital (who could be within the bargaining unit) who has responsibility for timely resolution of workload issues.
   
   iii) Failing resolution of the workload issue at the time of occurrence, the nurse(s) will discuss the issue with her or his Manager or designate on the next day that the Manager (or designate) and the nurse are both working or within five (5) calendar days, whichever is sooner. The manager will provide a written response to the complainant(s), with a copy to the Bargaining Unit President.
   
   iv) Complain in writing to the Hospital-Association Committee within twenty (20) calendar days of the alleged improper assignment. The Chair of the Hospital-Association Committee shall convene a meeting of the Hospital-Association Committee within fifteen (15) calendar days of the filing of the complaint. The Committee shall hear and attempt to resolve the complaint to the satisfaction of both parties and report the outcome to them parties.
   
   v) Prior to the complaint being forwarded to the Independent Assessment Committee, the Union may forward a written report outlining the complaint and recommendations to the Chief Nursing Executive.
   
   vi) Any settlement arrived at under 8.01(a) iv) or v) shall be signed by the parties. The creation of an IAC is referenced in Article 8.01 (a) vii) and Article 8.01 (a) viii)

8.01 (a)  
   vii) Failing resolution of the complaint within fifteen (15) calendar days of the meeting of the Hospital-Association Committee the complaint shall be forwarded to an Independent Assessment Committee composed of three (3) Registered Nurses; one chosen by the Ontario Nurses’ Association, one chosen by the Hospital and one chosen from a panel of independent Registered Nurses who are well respected within the profession. The member of the Committee chosen from the panel of independent Registered Nurses shall act as Chair.
   
   viii) The Assessment Committee shall set a date to conduct a hearing into the complaint within fourteen (14) calendar days of its appointment and shall be empowered to investigate as is necessary and make what findings as are appropriate in the circumstances. The Assessment Committee shall report its findings, in writing, to the parties within forty-five (45) days following completion of its hearing.
   
   ix) It is understood and agreed that representatives of the Ontario Nurses Association, including the Labour Relations Officer(s), may attend meetings held between the Hospital and the Union under this provision.
   
   x) Any complaint lodged under this provision shall be on the form set out in Appendix 6. Alternately the local parties may agree to an electronic version of the form and a process for signing.
(b) i) The list of Assessment Committee Chairs is attached as Appendix 2. During the term of this Agreement, the central parties shall meet as necessary to review and amend by agreement the list of chairs of Professional Responsibility Assessment Committees. The parties agree that should a Chair be required, the Ontario Hospital Association and the Ontario Nurses Association will be contacted. They will provide the name of the person to be utilized on the alphabetical listing of Chairs. The name to be provided will be the top name of the list of Chairs who has not been previously assigned. Should the Chair who is scheduled to serve decline when requested, or it becomes obvious that she or he would not be suitable due to connections with the Hospital or community, the next person on the list will be approached to act as Chair.

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

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

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

**For the Association:**
Trudy Molke

**For the Hospital:**
Diane Stephenson

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

1.4.1 Pre-Hearing

The Association in a letter dated July 14, 2011 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 also dated July 14, 2011, the Association advised the Hospital that the Associations’ nominee to the IAC was Trudy Molke (Appendices 1 and 2). Subsequently, by email on August 19th 2010, the Hospital advised the Association that the Hospital’s nominee was Diane Stephenson (Appendix 3).

The IAC Nominees discussed potential dates for the Hearing with their respective parties over the following weeks. Given that the hospital expressed their preference in an e-mail dated August 26th 2011 to hold the hearing in December, new dates were proposed by the IAC Chair given the elapsed time and that the IAC process needed to proceed in a timely manner. To that effect, the impact of further delays was outlined in a subsequent letter dated August 28th and an e-mail dated August 30th 2011 (Appendix 4). The IAC Chairperson contacted the Association and the Hospital on September 1st by e-mail to confirm the Hearing would be held at the Holiday Inn Peterborough Waterfront on November 14th - 16th 2011.

The IAC requested that the Hospital and the Association forward the Hearing Submission and associated exhibits to the Chairperson by October 14th 2011 in order to support the principle of full disclosure and to streamline the process of the Hearing by enabling the IAC to become familiar with the issues in advance. The IAC Chairperson received the Association Submission Brief and associated exhibits on October 14th 2011 as requested. The Hospital Submission Brief and associated exhibits were late and they were received on distribution of the Briefs and exhibits by courier to all parties on October 17th 2011.

The Hospital and Association provided the IAC Chair with the list of tour participants on October 28th 2011 respectively by e-mail.

The IAC held its first meeting at the Ontario Hospital Association (OHA), 200 Front Street, on Monday, November 7th 2011.

The IAC held a Pre-Hearing Meeting in Toronto on Monday November 7th 2011. During this meeting the following activities were undertaken:

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

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

- Confirming the plans for the Tour of Hemodialysis Unit;
- Providing the Hearing Agenda;
- Requesting the Hospital to provide selected additional information by the close of the Hearing (Appendix 5).

Further to this request, the Hospital provided additional material in support of their pre-hearing submission beginning on November 7th 2011 and was shared with all parties on the same day. The Association and the Hospital provided additional information to supplement their Submission Brief by email on November 15th 2011.
1.4.2 Hearing Process

Monday November 14th 2011

1.4.3 Meeting with Medical Director, Nephrology

The IAC began the day with a meeting with Dr. Garth Hanson, Medical Director Nephrology. Prior to the commencement of the meeting the Chair of the IAC requested to speak with the Hospital’s Counsel as she indicated that she was going to be present during the meeting since the Association representative was not present. In speaking with the Hospital Counsel the IAC Chair was reassured that the Association was informed of the need to have a representative attend. The IAC Chair delayed the meeting for a short time and then commenced. The IAC Chair subsequently spoke with the Association after the meeting and was informed that they were not notified as aforementioned by the Hospital’s Counsel.

The IAC asked the Medical Director a number of questions during the meeting and have included some of the more relevant information below:

- The new unit is more patient friendly in contrast to the previous trailer environment which was small;
- He couldn’t indicate if the unit was a well functioning team or not, given it is a new environment but thought that the nurses were good and all of the patients always got their treatments.
- He acknowledged that the MOHLTC’s funding model for level 1, 2 and 3 patients has been in place for some 18 years. Using this system though, it is estimated that 70-90% of the patients would be in levels 1 or 2.
- He identified the two chart system as problematic which would be eliminated with the implementation of an electronic record. While there is nothing confirmed the IAC understand that this is now being seriously considered given available funding.
- He estimated that up to 15% of patients on a given day ‘would need a lot of assessment and determining which patients these would be, is difficult’. There was no data available to substantiate this information.

This meeting served to give an overview of the regional Hemodialysis program including impressions of quality, work atmosphere, patient safety and areas for improvement from the physician perspective.

1.4.4 Tour of the Hemodialysis Unit

The IAC toured the Hemodialysis Unit, Peterborough Regional Health Centre from 10:00 — 12:15 hours on Monday November 14th 2011. The Site Tour was conducted by the following representatives:

On behalf of the Association:
- Mariana Markovic, Professional Practice Specialist, Labour Relations Officer, ONA
- Jane Mark, RN (Emergency), Workload Chair, ONA / Local Executive
- Julie Sanders, Full Time RN, Hemodialysis Unit
- Karen McNeil, Part Time RN, Hemodialysis Unit

On behalf of the Hospital:
- Jayne White, Chief Practice Officer & CNE
- Jane Parr, VP & Chief Human Resources Officer
- Liz Hawthorne, Program Director
- Sue Haydon, Program Support Partner-Human Resources
- Craig MacVichie, Program Support Partner-Human Resources
- Vicky Satta, PRHC Legal Counsel
The tour allowed the IAC to walk through the layout of the Hemodialysis Unit and in doing so, enabled the IAC to visually see the following:

- Layout of the pods;
- Dedicated isolation pods with the concerns regarding the alarm system associated with the negative pressure room;
- Nurses' work area; and
- Change over following the end of a ‘run’;
- Medication administration room and processes.

The tour finished shortly after 12:15 and the IAC then left the Hospital to prepare for the Hearing which was to convene at 1300 hours in the Saffron room of the Holiday Inn Peterborough.

In concordance with the Agendas (Appendix 6), the Hearing was held over three days:

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<tr>
<td>Monday</td>
<td>November 14th</td>
<td>1300 — 1700 hours</td>
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<tr>
<td>Tuesday</td>
<td>November 15th</td>
<td>0900 — 1600 hours</td>
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<tr>
<td>Wednesday</td>
<td>November 16th</td>
<td>0900 — 1300 hours</td>
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Participants and Observers who were in attendance on the respective hearing dates are listed in (Appendix 7).

1.4.5 Hearing Opened

The IAC Chairperson opened the Hearing at 1315 hours. Following introduction of the IAC Committee members, a round-table of introductions of the Association and Hospital participants was undertaken. The IAC Chairperson then reviewed the following:

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

Mariana Markovic, Professional Practice Specialist/Labour Relations Officer spoke to the Association’s concerns in not being informed of their need to have a designate present during the IAC’s meeting with Dr. Garth Hanson, Medical Director of Nephrology. The concerns of the Association were supported by the IAC. The IAC reassured the Association that neither the hearing nor subsequent report would be disadvantaged as a result of not being in attendance.

Additionally, the following actions were undertaken:

- The IAC would formally acknowledge that the Association had not been notified by the Hospital’s Counsel either directly or through the IAC Chair, even though the IAC Chair was assured by the Hospital’s Legal Counsel that the Association had been notified.
- The Hospital’s Counsel would share photocopies of her notes (as she volunteered) with both the Association and IAC for use during the remainder of the hearing.

1.4.6 Association Presentation

Mariana Markovic, Professional Practice Specialist/ Labour Relations Officer 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, the Association’s summary of the Professional Responsibility Workload Report Forms (PRWRFs) submitted by the Hemodialysis Unit RNs 2009, 2010 until October 2011. Most of the work load report forms identify short staffing in
2009 and 2010. Although more recently, in 2011, the schedule has been fully staffed however, there has not been sufficient coverage for sick time.

The Association described increased acuity and increased numbers of patients. Exacerbating the situation has been the high turnover in RPNs and new graduate RNs who require mentoring during and following orientation. The Association also described an informal retrospective documentation review of 61 patients adapted from a Grasp tool (‘the study’). The Association reported that this tool indicated that the majority of patients were a level 2 with many level 3 based on complexity of care needs and the time required to provide necessary care.

It was also noted that complex patients are transferred from the regional satellite units for stabilization before returning to the satellite.

Lastly there was no relief from workload that was given to the nurse for mentoring new staff. At times the RPNs turn over their patients to RNs too early and at other times later than when they destablize.

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

1.4.7 Hospital Presentation

Vicky Satta, Legal Counsel for the Hospital, presented the submission on behalf of the Hospital. The content of the Hospital’s presentation was based on their written Pre-hearing submission and exhibits of supporting/explanatory information, and PRWRFs submitted by the Hemodialysis Unit RNs were limited to those between June 2010 – September 2010.

The Hospital, prior to the hearing and also during their submission challenged the research methodology of the “study” as referenced by the Association. While the IAC appreciate the Hospital’s concern, the IAC also understand the Association’s need to quantify their ongoing concerns. The IAC did not find the evidence persuasive as there were weaknesses and limitations to the data collection methodology. This only serves to reinforce the need for a formal evaluation inclusive of metrics developed with input from the staff.

The Hospital throughout the prehearing submission and hearing presentation reinforced the fact that the Peer Review Team was mandated by the Central East LHIN to assess and address the ongoing deficit of the hospital. The Peer Review Team developed multiple recommendations for cost savings, including aggressive reduction in absenteeism, a reduction in overtime and specific to the Hemodialysis Unit, the introduction of the RPN into the skill mix. Following the Peer Review recommendations delivered to the LHIN in April 2010, the hospital began to create their Hospital Improvement Plan (HIP). The HIP incorporated the recommendation to introduce RPNs into the Hemodialysis Unit skill mix to realize savings of $200,000.

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

The IAC Chairperson adjourned the Hearing at 1700 hours.

1.4.8 Tuesday November 15th 2011

The IAC Chairperson opened the Hearing at 0900 hours. The ground rules for the Hearing were reviewed and new participants at the Hearing were introduced.

Vicky Satta, Legal Counsel for the Hospital, provided the Hospital’s response to the Association’s submission.

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

The Hospital cited in page six of their prehearing submission that in the spring of 2010 an 80:20 RN/RPN mix was achieved. In a further attempt to establish stability, the 70:30 RN:RPN split which was initially planned (page four of the pre submission brief) was reassessed and deferred. The IAC sought clarification as it became clear to the IAC that the 80/20 RN/RPN split was based on the entire compliment of staff. Therefore, the IAC established that there was actually a 75/25 RN/RPN split when the Float and Venous Access RNs were removed from the calculations.

The IAC Chairperson adjourned the Hearing at 1600 hours.

1.4.9 Wednesday November 16th 2011

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

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

During the course of the entire hearing and on the tour of the unit, there was demonstrable behaviour and evidence of tension which only served to reinforce to the IAC the significant level of distrust, frustration and acrimony on the part of both the Association and the Hospital. While not within the scope of the IAC’s jurisdiction, it is important to note that the IAC heard of several grievances in process and it was extremely obvious to the IAC that the Association and the Hospital differ as to how close they are to resolving the issues.

1.4.10 Hearing Closing

The IAC Chairperson thanked the participants for their commitment to the Hearing process and for their active and open discussion during the Hearing. She noted the IACs’ recognition of the challenges, for both parties, associated with open and honest dialogue, and reiterated the IAC’s hope that the opportunity for discussion during the Hearing would enable both parties to move forward. The IAC Chair reaffirmed that the IAC’s Report and associated recommendations are intended to provide all concerned (Registered Nurses, the Association and the Hospital) with an independent external perspective to aid in the resolution of outstanding issues, and are not binding. She confirmed that the IAC’s Report would be distributed by courier on December 23rd 2011.

The IAC Chairperson closed the Hearing at 1230 hours.

1.4.11 Post Hearing

The IAC met immediately following the Hearing on Wednesday November 16th 2011 to reflect on the issues presented, identify trends in support of recommendation development and assign initial work based on committee skill set.

Between the close of the Hearing on Wednesday November 16th 2011 and submission of the PDF Report on December 23rd 2011 by courier to both the Association and Hospital, the IAC undertook the following in the development of this report:

- Develop a first draft report;
- Attend a full-day meeting on Tuesday, November 29th 2011 to draft the outline of the Report and to discuss the findings and proposed recommendations in depth;
- Independent review of the first draft;
● The 2nd draft was circulated on December 2nd 2011 for comments;
● Independent review of the second draft during the week of December 5th 2011;
● Comments and recommended revisions were received by December 7th 2011;
● A third draft was circulated closely followed by several teleconferences between December 8th and Sunday December 11th 2011, depending on IAC members’ availability, for the purpose of in depth discussion, propose recommendations and to further refine the report; Further comments and recommendation revisions were re-circulated in a fourth draft on Sunday December 11th 2011;
● A fifth draft reflecting additional input was circulated for further final review and comment on December 12th 2011;
● A sixth draft reflecting additional input was circulated for further final review and comment on December 13th 2011;
● A seventh draft reflecting additional input was circulated for further final review and comment on December 14th 2011;
● An eighth draft was circulated on December 16th 2011;
● A ninth draft was circulated on December 17th 2011;
● A tenth draft was circulated on the evening of December 18th 2011;
● A teleconference was held on December 20th 2011;
● The eleventh draft was circulated on the evening of December 20th 2011;
● Final agreement of the IAC report was on December 21st 2011;
● The final report was submitted to the Association and the Hospital by courier on December 23rd 2011.
PART II

PRESENTATION OF THE PROFESSIONAL RESPONSIBILITY WORKLOAD COMPLAINT

2.1 Context of Practice

The Hospital in their pre-hearing submission made reference to the Peer Review Team’s report and the PHC Hospital Improvement Plan (HIP):

In italics below is cited from page 40 of the Hospital’s HIP related to Hemodialysis:

21. Clinical Efficiencies: Hemodialysis

Goal: To find efficiencies in Hemodialysis to ensure staffing benchmarks are in line with peer hospitals.

Target: That by March 31, 2012, PRHC achieves $640K in annualized cost savings through skill mix changes using RPNs and other initiatives.

PRHC currently has an all RN staff in our renal clinics and Hemodialysis areas. Our patients receive excellent, safe care from these RNs. However, there is evidence to support a more cost effective staffing mix which includes the RPN in the Hemodialysis unit. Many Hemodialysis units across Canada have adopted such a skill mix and have maintained an excellent patient safety record. In fact, PRHC is one of very few Hemodialysis units in Ontario that does not employ RPNs. The gradual introduction of RPNs into the skill mix of the Hemodialysis suite will commence in the summer of 2010. A projected mix of 70:30 (RN:RPN) will be completed during 2010-2011. By promoting efficiencies in the Renal Insufficiency (RI) and Peritoneal Hemodialysis (PD) clinics savings and improved utilization will be realized. We have looked at standardized nurse: patient ratios for both areas and will remain within provincial guidelines. Reorganizing the scheduling of the clinics will allow for a reduction of staff in the RI Clinic area and in the PD Clinic area.

During 2011-2012 we plan to introduce a small number of “Self Hemodialysis” patients to the client mix at PRHC. This type of client group completes their own Hemodialysis – including preparations, time on the machine and removing themselves safely from the machine. The Hemodialysis Assistant’s support is not required for machine prep or cleaning with this type of client group. Once this patient group is trained and functional, we will downsize our Hemodialysis Assistant group.

Risk Mitigation: This intervention/change may impact staff satisfaction. To mitigate these risks, PRHC will work on positive employee relations and provide education and training to support changes.

2.1.1 Structure of Hemodialysis Unit

The Hemodialysis Unit is a modern unit with beautiful views overlooking the grounds of the Peterborough Regional Health Centre. Within the unit, there are four pods each capable of holding 6 patients. Typically a pod is staffed with two RNs or an RPN and an RN. One of the pods has three dedicated isolation rooms to accommodate patients who must be restricted due to potential or actual communicable disease. Alongside the isolation rooms are three chairs (from here on in referred to as the isolation pod). Typically this pod is staffed with two RNs or 1 RN and 1 RPN. To accommodate the additional workload associated with the care of isolated patients the float nurse is stationed here when not needed elsewhere in the unit. This designated isolation pod has an inherent design flaw on the door of the room which is equipped to accommodate the rare need for negative pressure. The alarm sounds when the door is open. When the door is closed the nurses cannot see or hear the alarms on the dialysis machines inside the room. The inherent design flaw has yet to be rectified and this unnecessarily increases nurses workload given there are additional direct patient interactions which need to be undertaken given the door must remain closed to prevent the alarm being activated.
The other three pods are set up along the windows of the unit providing a well lit open environment. Not all of the patients are visible from the main desk but each pod of six patients is open and visible to the staff assigned.

There is a fifth pod which is currently used for the Home Hemodialysis aspect of the Renal Program and is where patient training occurs. The Home Hemodialysis program commenced post receipt of funding in December 2009.

Each pod is equipped with a central desk with only one dedicated computer per pod, which given the expectation that the nurses access policies, procedures, e-CPS and e-mail, this is not optimal. As the unit communication streams evolve (Recommendations 18 and 19), easy access to staff meeting minutes is critical. It is noteworthy to mention that there is no computer located in the staff lounge for additional access.

2.1.2 Patient Population

The MOHLTC Joint Policy and Planning Committee (JPPC) identified three levels of Hemodialysis in the late 1990s in order to provide a framework for costing and funding ERSD in Ontario. The definitions describe the staff: patient ratio, length of treatment, and interdisciplinary hours of care for each of the three levels as the following:

**Level I**
Chronic Hemodialysis treatment for stable chronic ESRD patients - self-care, assisted self-care or dependent full care. The interdisciplinary team hours may be variable, as they relate to patient acuity. The team hours per treatment will not exceed 2.25 hours. Staff : Patient Ratio is 1:4. Measured by number of treatments (e.g. patient dialyzes between 3-5 hours per treatment)

**Level II**
Chronic Hemodialysis treatment, performed in an acute care Hemodialysis unit located in a hospital, for unstable, chronic and acute ESRD patients. The patients are of high acuity, may be unstable during the Hemodialysis procedure and must be seen by a Nephrologist each visit. The interdisciplinary team hours may be variable, as they relate to patient acuity. The hours of care will be 2.26 to 3.25 hours. Staff : Patient Ratio 1:3. Measured by number of treatments (e.g., patient dialyzes between 3-5 hours per treatment)

**Level III**
Acute Hemodialysis treatment performed on acutely ill patients in-hospital in an acute care unit outside the Hemodialysis Unit (e.g., adult/paediatric intensive care unit, cardiac care unit, burn unit). The interdisciplinary team hours of care will be equal to or greater than 3.26 hours. Measured by number of treatments.

There was consensus that while there are a number of patients who could move to home Hemodialysis there are insufficient at present to create a critical mass in support of additional MOHLTC funding for an additional nurse. This situation however, is not uncommon and therefore the Hospital needs to be creative in addressing it with the MOHLTC if it is not able to address it internally.

Overall the occupancy rates have increased from 83% in 2009 to 92% as of September 2011. The Hospital stated that the occupancy rate are anticipated to increase. Some reasons for this include the aging demographics and the Peterborough area being a retirement destination.
Table 1: Volumes of Hemodialysis Patients by Level during September for the last three years

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<td>6</td>
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</tbody>
</table>

Off unit Hemodialysis volumes are on average 450 per year, of 1.23 per day. At the time of the hearing there were three long term patients in the ICU which require dialysis three times per week. It is assumed that these three are included in the six patients identified for September 2011 in Table 1.

2.1.3 Hemodialysis Unit Staffing

The unit is currently staffed with RNs, RPNs supported by FTEs for a manager and Educator as outlined in the Hospital’s pre-hearing submission:

**Manager:** This position has most recently been vacant since March 2011; however, the IAC understands that there has been definitive turnover over the last 10 years.

**Educator:** The Educator’s role is to be responsible for improving the patient experience through unit orientation, staff education at both unit and corporate level.

The unit also benefits from a number of professionals in patient care planning and includes:

- Social Worker;
- Dietician;
- Pharmacist;
- Pharmacy Technologists; and
- Assistants.

Their respective FTEs dedicated to the unit are outlined below in Table 2 Hemodialysis Unit Staffing Pre and Post Skill Mix Change.

**Staffing Data**

The overall change in skill mix which occurred from 2010 to 2011 is illustrated below in Table 2.

Table 2: Hemodialysis Unit Staffing Pre and Post Skill Mix Change

<table>
<thead>
<tr>
<th>Designations</th>
<th>Post Skill Mix Change 2011</th>
<th>Pre Skill Mix Change 2010</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td># of FTE</td>
<td># of PTE</td>
</tr>
<tr>
<td></td>
<td>(includes Casual Hours)</td>
<td></td>
</tr>
<tr>
<td>RNs</td>
<td>19</td>
<td>14</td>
</tr>
<tr>
<td>RPNs</td>
<td>4</td>
<td>2</td>
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<tr>
<td>Vascular Access RN</td>
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</tr>
<tr>
<td>PD RNs</td>
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<tr>
<td>R1</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Social Work</td>
<td>3</td>
<td>0</td>
</tr>
</tbody>
</table>
### Designations

<table>
<thead>
<tr>
<th>Designations</th>
<th>Post Skill Mix Change 2011</th>
<th>Pre Skill Mix Change 2010</th>
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<tbody>
<tr>
<td></td>
<td># of FTE</td>
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<tr>
<td></td>
<td>(includes Casual Hours)</td>
<td>(includes Casual Hours)</td>
</tr>
<tr>
<td>Dietitians</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Pharmacist</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Pharmacy Technologist</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Assistants</td>
<td>3</td>
<td>3</td>
</tr>
</tbody>
</table>

There has been a large turnover in staff in the past year. 11 RPNs have been hired and six have remained. Information from the Association indicates that 14 nurses have left the unit since September 2011.

### 2.1.4 Communication

In a hallway leading from the patient care pods towards the staff lounge there was a large white board which serves to facilitate the following two regularly scheduled interdisciplinary communications which are outlined below:

**Bullet Rounds** are held every Wednesday and Thursday at 1430 hours. They offer an opportunity for the multidisciplinary team to discuss clinical issues specific to the unique needs of each patient.

**Clinical Team Rounds** occur Friday at 0900 hours. These rounds expand on clinical information from the Bullet Rounds.
PART III

DISCUSSION, ANALYSIS AND RECOMMENDATIONS

3.1 INTRODUCTION

The IAC believes that it obtained a comprehensive understanding of the professional responsibility concerns of the Registered Nurses relating to the Hemodialysis Unit of the Peterborough Regional Health Centre. This was achieved through review and analysis of the written submissions and exhibits, the oral presentations and discussion, and the thoughtful comments made by the Hearing participants in response to questions posed by the IAC.

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

The IAC believes that the key issues influencing the professional practice environment on Hemodialysis Unit relate to leadership, change management, communication, staffing, professional development, including recruitment and retention, ongoing support, evaluation and measurement.

3.1.1 Prevalence of End Stage Renal Disease

The incidence of kidney disease has tripled in Canada over the past 20 years. As of December 31st, 2009, there were 37,744 people in Canada with end stage renal disease (ESRD), of whom 59% were being treated with Hemodialysis. Since 1990, the rate for patients receiving Hemodialysis has increased 212%, and the average age of new Hemodialysis patients has increased from 55 in 1990 to 65 in 2009. Of the 15,347 ESRD patients being treated in Ontario in 2009, 7,511 (48.9%) received Hemodialysis in an institutional setting. Ontario has almost 43% of the in-centre Hemodialysis patients in Canada and has the second highest patients per station ratio. The experience of the Hospital patient population appears to be mirroring this trend, as the number of Hemodialysis patients continues to increase. This is occurring at a time when long term trends show a decrease in RN registrations in the province. In 2011, there were 93,415 RNs who reported employment in nursing in Ontario, a decrease of 0.5 percent over 2010. This is the first time there has been a decrease since 2002, the time period of statistics available on the College of Nurses (CNO) website. The decrease in employment of nurses is further concerning given that according to the CNO, there were 3,653 new RNs in 2010, an increase of 1.2 per cent over 2009 and the fourth consecutive year of increase.

3.1.2 Standards of Practice for Nephrology Nurses

The Canadian Association of Nephrology Nurses and Technologists (CANNT) describes nephrology nursing as “a specialized area of nursing practice focusing on the needs of patients with kidney disease and their families, across the lifespan and continuum of kidney disease care”. This specialized care requires the nephrology nurse to promote competent, safe, ethical care, and demonstrate current specialty knowledge and practice. The CANNT Nursing Standards and Practice Recommendations identify detailed practice standards in five areas for the nephrology nurse providing Hemodialysis:

- Hemodialysis vascular access,
- Hemodialysis adequacy,
- Hemodialysis treatment and complications,
- Medication management, and
- Infection control practices.
The IAC believes that all nurses providing Hemodialysis must meet these standards in order to ensure safe and effective patient care to their assigned patients.

### 3.1.3 Potential Complications of the Hemodialysis Treatment Procedure

Although the first documented Hemodialysis treatment occurred in Germany in 1924, and the first practical Hemodialysis machine was developed in the Netherlands in 1943, the provision of chronic Hemodialysis on a regular basis did not begin until the 1960s with the development of a vascular access called a Schribner shunt. Hemodialysis technology continued to improve through the 1970s and 1980s, with new machines, more efficient dialysers and the development of a synthetic form of erythropoetin (EPO) that eliminated the need for frequent and ongoing blood transfusions. Home Hemodialysis programs began in the mid-1990s.

Although the safety of the Hemodialysis treatment procedure has improved greatly over the past 50 years, it is not without risk. The commonly experienced complications include the following:

- **Hemodialysis-related hypotension**, an acute symptomatic fall in blood pressure during Hemodialysis requiring immediate intervention to prevent syncope, is the most frequent symptomatic complication of Hemodialysis, occurring in 15-30% of treatments. It is more common in older patients and in women. When fluid is removed during Hemodialysis, the osmotic pressure is increased, prompting filling from the interstitial space, which is in turn refilled by fluid from the intracellular space. Excessive ultrafiltration with inadequate vascular refilling leads to hypotension.

- **Muscle cramps** occur in up to 20% of Hemodialysis treatments during the end of the Hemodialysis procedure after a significant volume of fluid has been removed by ultrafiltration. The likelihood of muscle cramping can be lowered by decreasing the ultrafiltration rate, administering small boluses of isotonic saline, and increasing estimated dry weight.

- **Arrythmias** and angina frequently occur in patients on chronic Hemodialysis, both during treatment and between Hemodialysis treatments. They can be precipitated by hypotension and coronary ischemia. Cardiac arrest is uncommon in outpatient Hemodialysis.

- **Hemodialysis Disequilibrium Syndrome (DDS)** is characterized by nausea, vomiting, headaches and fatigue and can result in life-threatening seizures, coma and arrhythmias. Although DDS was a frequent complication in the early years of Hemodialysis, the full-blown syndrome occurs less often now. It occurs most commonly during initial Hemodialysis treatments and in patients with pre-existing CNS lesions (e.g., recent stroke), cerebral edema (e.g., malignant hypertension), high pre-Hemodialysis BUN and severe metabolic acidosis. The likelihood of DDS can be decreased by identifying high-risk patients, using smaller surface area dialysers, reducing rates of blood and dialysate flow and administering mannitol and diazepam intravenously.

- **Hypoxemia**, a drop in arterial PO2 between 5 to 35 mm Hg, occurs between 30 – 60 minutes of beginning Hemodialysis in up to 90% of patients.

- **Hemolysis** occurs as the half-life of red blood cells in patients with ESRD is one-half to one-third of normal and the cells are susceptible to membrane injury.

- **Dialyser reactions** are divided into two types: anaphylactoid reactions and mild reactions. Anaphylactoid reactions, while rare, are very severe, with an onset within 20 minutes of starting Hemodialysis. Symptoms include dyspnea, a burning/heat sensation at the access site or throughout the body, and angioedema. Mild reactions occur 20 – 40 minutes into the Hemodialysis treatment, and are characterized by chest and back pain that disappears or lessens over the Hemodialysis treatment period.
Given the above information, the IAC believes that all effort must be taken to ensure that the nurse caring for a patient undergoing Hemodialysis treatment has the requisite knowledge, skill and judgment and the appropriate practice supports to effectively manage the anticipated complications of the Hemodialysis procedure, including taking actions to minimize complications before they occur, and to maximize the adequacy of the Hemodialysis treatment.

3.1.4 College of Nurses of Ontario (CNO) Guideline re Utilization of RNs and RPNs

The CNO Practice Guideline Utilization of RNs and RPNs was developed to support nurses, employers and others to make effective decisions regarding the utilization of nurses. The IAC acknowledges that the CNO practice Guideline are general and it would be beneficial for the Hospital to develop the detail required by a specialty such as Hemodialysis to assist with the assignment of appropriate patients to both RNs and RPNs. The decision factors, relating to the client, nurse and environment and known as the “Three Factor Framework” are based on a number of guiding principles:

- RNs and RPNs practice within the same legislated scope of practice;
- RNs and RPNs are accountable for their own decisions and actions, and are not accountable for the actions and decisions made by others;
- The foundational knowledge base of RNs and RPNs differ in the areas of clinical practice, decision-making, critical thinking, leadership, research utilization and resource management;
- RNs and RPNs add to their foundational knowledge base throughout their careers, and can become expert in an area of practice within their category;
- Consultation and collaboration, requiring effective communication skills, are essential elements of nursing practice;
- The nurse’s knowledge and knowledge application affect the level of consultation and collaboration she/he requires to meet client needs; and
- Autonomous practice, that is the ability to make decisions and independently carry out nursing responsibilities, differs between RNs and RPNs as client complexity increases.

The Three Factor Framework provides a mechanism to evaluate the inter-related elements of the client situation, the nurses level of knowledge, skill and judgment and ability to practice autonomously, and the systems in the environment supporting practice.

Client Factors:

- Complexity of care needs are determined by how well the care needs are defined, whether multiple issues exist, the extent of monitoring or reassessment required, the risk of negative outcomes and the level of support systems in place.

- Level of predictability of care needs relates to the possibility of change in the patient’s condition, the timing of such change, and the possible outcomes.

- Risk of negative outcomes relates to the extent to which signs and symptoms are difficult to detect, whether possible negative outcomes will have a localized or systemic effect, and whether the outcomes result in an urgent or emergency situation.

Nurse Factors:

Performance of client care intervention requires
• Knowledge, skill and judgment relating to the technical aspects of performing the care intervention, and

• Cognitive aspects relating to critical thinking and decision-making to manage the intra-intervention and post-intervention outcomes of the care intervention.

The difference in foundational knowledge between RNs and RPNs results in a difference in their ability to practice autonomously/make decisions and independently carry our nursing responsibilities as client care needs increase.

Environment Factors:

a. Practice supports relate to policies, procedures, guidelines, assessment tools, pre-developed care plans etc and the presence of expert nurses familiar with the practice environment.

b. Consultative resources relate to the availability of information, advice or assistance from a more knowledgeable health care provider(s).

c. Stability and predictability relate to the rate of client turnover and extent of unpredictable events.

The CNO Guideline indicates that all three factors must be considered when determining whether an RN or RPN is required to meet the patient’s care needs. When one of the factors changes, re-evaluation of the patient care assignment may be required. The RPNs ability to autonomously provide care to moderately complex clients depends on the availability of practice supports and consultative resources and the predictability of the practice environment. RPNs do not autonomously provide care to complex clients, or to moderately complex clients in the absence of practice supports/consultative resources, or in an unstable/unpredictable environment.

3.2 IMPLEMENTATION OF CHANGE IN SKILL MIX

The Hospital throughout the pre-hearing submission and hearing presentation reinforced the fact that the change in skill mix was a result of a Peer Review Team mandated by the Central East LHIN to assess and address the ongoing deficit of the hospital. The Peer Review Team developed multiple recommendations for cost savings, including aggressive reduction in absenteeism, a reduction in overtime and specific to the Hemodialysis Unit, the introduction of the RPN into the skill mix. Following the Peer Review recommendations delivered to the LHIN in April 2010 the hospital began to create their Hospital Improvement Plan (HIP). The HIP incorporated the recommendation to introduce RPNs into the skill mix to realize savings of $200,000.

Even though the Hospital stated that their change model is Kotter it, by their own omission was not utilized, and therefore the IAC is of the opinion that the change in skill mix was undertaken as just a technical exercise in response to the Peer Review and HIP.

When there is to be a change in 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 objectives, which in this case were financial in nature. The IAC understands that the implementation of a new skill mix did not benefit from an abundance of organizational resources in terms of knowledge of approaches, technical support, data availability, information systems, staff resources etc. Rather, a minimalist approach was employed mainly to cover the direct aspects of skill-mix changes such as orientation for the new RPNs.

In the last two years the hospital has undergone peer review, changes in the senior leadership team and multiple major initiatives to rectify financial crisis and recover $29 million dollars. Included in the Peer Review were program specific financial targets. The Peer Review Team recommended that three
Registered Nurses be replaced by three Registered Practical Nurses on days and evenings and weekends. Simultaneous hospital wide initiatives to decrease excess levels of overtime and absenteeism have effectively been implemented but have contributed to the overall angst and anger in the unit.

3.3 NURSING LEADERSHIP

Recommendation 1: Immediately Recruit and Retain a Strong Front-Line Manager for the Hemodialysis Unit.

A key requirement for both change management and professional practice is effective nursing leadership. While strategic leadership is provided by the Director role, effective operational and clinical leadership requires a manager.

Successful implementation of any change within a specialty program, such as Hemodialysis, requires effective leadership from an experienced Manager. The IAC notes that the Hospital has posted an advertisement on Longwoods.com on November 25th 2011 and has pursued some other recruitment mechanisms. The Hospital, over and above the advertisement, needs to immediately pursue all avenues; including networking and secondment to achieve the appointment of a strong front-line manager for the regional Hemodialysis program. Ideally the manager will have clinical credibility, experience in change management, effective listening and interpersonal skills and conflict resolution skills.

The Hemodialysis program at the Hospital has suffered from management restructuring which has left the unit without a front-line manager. The Director assumed the managerial role at time when her span of control was significantly broadened. Pieces of the role which are typically considered managerial have been picked up by the Charge Nurses or Educator. As there have been four managers and four directors in 10 years, staff has had to adapt to various leadership styles, visions and directions.

The staff in the program was unaware of the “burning platform” for change underpinning the magnitude of the hospital crisis. Therefore they were unprepared to entertain a significant shift in the model of care, and the change in nursing skill mix.

Absence of front line leadership to work with the staff to seek appropriate solutions, to manage the changes and to monitor patient outcomes in an appropriate way has enabled a culture in becoming adversarial and unhealthy. Although the College of Nurses was brought in to educate staff on scope of practice, the session was not specifically tailored to the unique needs of the Hemodialysis program in order for this initiative to support the change in skill mix, a mixed nursing model and the delineation of role clarity. A new manager will need to rebuild trust within the unit and will need to promote a common and accurate understanding of the scope of practice of the Registered Nurse and the Registered Practical Nurse. She or he will need to allocate the Registered Practical Nurses so that the Registered Nurses are not overwhelmed, and so that the Registered Practical Nurses can practice safely in the context of Hemodialysis with the appropriate training.

While the Hospital has been unsuccessful to date in recruiting the right person as a front-line manager the IAC feel strongly that a well functioning unit of staff working together with management can contribute to quality patient care Therefore the Hospital needs to be creative in the provision of organizational supports to ensure that they are able to attract, and sustain a manager. Attention needs to be paid to team building within the unit. Therefore, the IAC has taken this opportunity to offer some suggestions which include:

Recommendation 2: The Hospital Explore Paid Opportunities for the Dialysis Staff to Engage In Paid Meeting Time

The IAC is of the opinion that regular attendance at staff meetings would be extremely beneficial to the dialysis unit as a whole. Regular staff meetings are an important vehicle for the communication and discussion of pertinent information to nursing staff within the unit. In the absence of regular and
consistent communication, the void is filled with erroneous and inconsistent messaging, which will only serve to impede the establishment of trust.

Suggestions for agenda items may well include:

- Recruitment update;
- Infection Control;
- Corporate or unit based policy changes;
- Update on evaluation;
- Unit concerns; and
- Other information as appropriate.

Until the dialysis unit achieves stability (i.e. inclusive of a dedicated front-line manager), the IAC recommends that the Hospital explore paid opportunities for the staff in order that they be able to attend the majority of staff meetings scheduled in a calendar year.

**Recommendation 3:** The IAC Strongly Recommends That There Be No Consideration Given to Increasing in the Skill Mix Of Existing 75:25 RN:RPN until a Dedicated Front-Line Manager has Been Appointed; and on Completion of the Recommended Evaluation (Recommendations 1 and 5)

The Hospital cited in page six of their prehearing submission that in the spring of 2010 an 80:20 RN/RPN mix was achieved. In a further attempt to establish stability, the 70:30 RN:RPN split was reassessed and deferred.

The IAC strongly feel that Hospital continue to defer the decision to move to a 70:30 RN/RPN skill mix until the following has been achieved and sustained for a minimum of 12 months:

- Appointment of a dedicated front-line manager (Recommendation 1);
- Analysis of continuous evaluation data (Recommendation 5);
- Establishment of a formal Mentorship program (Recommendation 9).

### 3.4 MEASURES and EVALUATION

**Recommendation 4:** Immediate Implementation of the Kotter Change Management Model to Support and Oversee the Initiation of an Ongoing Formal Collection of Measure and Evaluation of the Skill Mix Change

The Hospital stated during the hearing that “Kotter” is their change management model as illustrated in Figure 1.

**Figure 1:** Kotter Change Management Model
The Kotter model (1995) is used widely in both private and public sector organizations. The philosophy behind the Kotter theory in managing change is:

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

The Hospital in their prehearing submission stated that they:

"did not utilize a formal ‘change management’ strategy. Clearly this was a mistake. The Hospital misjudged the amount of anxiety, mistrust, anger and animosity that occurred and failed to plan accordingly."

Further to the Hospital’s acknowledgement within their prehearing submission that the change in skill mix had in hindsight been mishandled, it was also found unacceptable to the IAC during the hearing that the Hospital further failed to ‘course correct’ and attempt to effectively mitigate the increasing amount of anxiety, mistrust, anger and animosity that occurred.

The IAC is of the opinion that the Hospital’s continual lack of action to address these issues of the RN staff within the Hemodialysis Unit significantly contributed to the ongoing concerns raised by the Association.

Recommendation 5: Immediately Establish a Balanced Scorecard of Measures and Underlying Methodology for the Evaluation of the Change Impact.

a) Adopt the suggested measures the IAC have outlined in this recommendation;
b) Transparent reporting monthly for six months;
c) Concurrent learning and adjusting as required;
d) At the sixth month mark, the IAC recommends that the Hospital, in consultation with the Association and Hemodialysis Unit staff, establish the frequency of ongoing reporting which will be directly dependent on progress to date.

The Hospital in their pre-hearing submission and during the hearing repeatedly referenced the quality metrics reported to the Ontario Renal Network (ORN) which continue to meet exceed industry benchmarks. The Hospital further stated on numerous occasions throughout the hearing that given this data exceeds industrial benchmarks and therefore “patients are safe”.

While the IAC accepts that the Hospital is meeting these requirements, it is only one aspect of the ongoing measurement which is required to evaluate the impact of the change in skill mix. A change in skill mix should not be regarded as a “one-off” isolated event; there must be a regular process of evaluation to monitor impact on both clients and staff. Evaluation of the change in skill mix is necessary to validate the safety and effectiveness of the care provided. Both staff and management should be involved in the evaluation.

The balanced scorecard was developed in the early 1990s by Robert Kaplan and David Norton as an approach to strategic performance management and measurement. Norton and Kaplan observed that traditional performance measures based on financial accounts gave an incomplete picture of an organization’s performance. They created the balanced scorecard to provide a more rounded view. ¹

The scorecard measures organizational performance across four balanced perspectives: financial, customers, internal business processes and learning and growth. A balanced set of measures will enable to the Hospital’s need to collect data to make informed decisions.

¹
The Hospital should aim to develop specific performance measures relating to these four areas by considering the following questions:

- Clients, Patients and Community;
- Service Coordination and Delivery;
- Learning, growth and innovation;
- Financial.

**Figure 2: Balanced Scorecard**

![Balanced Scorecard Diagram]

**Suggested Measures for this Recommendation Include:**

The IAC heard that there has been no data collected re: central line infections since June 2010 due to lack of human resources in the Infection Prevention and Control Department. The IAC sees a definitive role for the Vascular Access Nurse to contribute to the evaluation process given that she collaborates with the Infection Control Practitioner to monitor and document episodes of access related infection, and tracks all line changes related to infection including: type of infection, treatment and/or length of temporary access required. collect and analyze findings. The IAC has also outlined the following measures for inclusion in the recommended balanced scorecard.

**Clients, Patients and Community:**
- Volume receiving Interdialytic Parenteral Nutrition
- New admissions to the unit
- Patients requiring RN administration medications
- Patients post fistula dilatation and cardiac catheterization
- Numbers of complex patients transferring from satellite units
- Patient complaints and satisfaction scores

**Service Coordination and Delivery:**
- Emergency room visits due to volume overload
- Hospitalizations due to pneumonia
- Vascular access infiltration
- Vascular access thrombosis
- Unusual bleeding from the vascular access
- Falls in the Hemodialysis center with and without injury
- Medication errors
- Hemodialysis hypotension
- Shortened Hemodialysis treatments
- Skipped Hemodialysis treatments
- CVL line infections
- MSRA, VRE, C-dif.
- Near miss and incident tracking and analysis
- Management of Access for HD - i.e. pain and time to initiate

**Learning Growth and Innovation**
- Mentorship (*Recommendation 9*)
- Educational opportunities (*Recommendation 23, 25, 32 and 34*)
- RNs who have successfully completed Charge Nurse education (*Recommendation 25*)
- RNs who have successfully completed Mentorship education (*Recommendation 9*)
- Annual performance management reviews² (*Recommendation 12*)
- Exit interviews (*Recommendation 14*)
- Satisfaction scores
- Sick time trends
- Turnover rates (both RN and RPN)
- Grievance trends

**Finance**
- Net budget surplus (deficit)
- Budget growth less than population growth

Lastly, the IAC strongly feels that the balanced scorecard report on the above indicators under the following headings:
- Status
- Trend
- Target
- Actual
- Action to be taken in not trending in direction of target

**Recommendation 6:** The IAC Strongly Recommends that the Evaluation Team be Immediately Initiated and Include the Following Members:

- Vascular Access Nurse
- Hemodialysis RN
- Hemodialysis RPN
- Patient Safety Specialists
- Designate from Human Resources
- Decision Support or equivalent
- Unit manager (when appointed)

To assist the ‘Evaluation Team’ the IAC strongly suggests in keeping with being fiscally responsible that universities be contacted to ascertain the level of interest this may have for a Masters nursing student. Given the post graduate marketability of a project of this nature the IAC feels that this would be attractive to a Masters Nursing student.

The results of evaluation need to be presented at a dedicated staff meeting, with members of the team present, to enable a fulsome question and answer period. The IAC further recommends that

² *Developing and Sustaining Nursing Leadership* RNAO Best Practice Guidelines, 2006
beyond the initial evaluation, the Hospital seriously consider the value an annual evaluation would bring to the unit, given that patient needs may well change as more patients transition to home Hemodialysis.

3.5 STAFFING

Staffing is a matter of major concern because of the effects it can have on patient safety and quality of care. The quality of nursing care relates to the appropriate execution of assessments and interventions intended to optimize patient outcomes and prevent adverse events.

Recommendation 7: Immediately Clarify the Model of Care

It was evident to the IAC that there is not a definitive model of care within the Hemodialysis Unit. Rather, there exists a hybrid of Primary Nursing and Total Patient Care which has been simply allowed to unfold in an unstructured way that has only served to further exacerbate the need for role clarity.

The Hospital needs to take definitive action to define the model of care for the Hemodialysis Unit.

Recommendation 8: Immediately commence the clarification of the role of the RN and RPN. Immediately Develop and Agree on a set of criteria to support the assignment of ‘appropriate’ patients to RPNs

It was evident to the IAC that the best laid plans to match the RPNs competence to provide patient care for the patients with the most predictable outcomes has not worked. The IAC believes that this situation developed because of a differing interpretation of the CNO Three Factor Framework analysis. The situation also developed because the hospital did not utilize an appropriate change process. The turnover in managers and directors was also a factor.

The Hospital and the Association/Renal RNs approached the concept of patient stability / predictable outcomes from two different paradigms. The Hospital’s perspective indicated that while co-morbidities exist, the patients within the Hemodialysis Unit are mostly stable outpatients who have predictable treatment courses. In contrast the Association’s perspective is that the patient care needs in the Hemodialysis Unit are prone to be unpredictable and the patients have many co-morbidities.

During the tour, the IAC noted that there was confusion as to whether RPNs can administer certain medications. During the hearing, confusion continued as it was noted that information provided to mentors was inconsistent with policy as indicated in the orientation binder.

The IAC understands that RPNs are not to care for:

- Patients receiving Interdialytic Parenteral Nutrition
- The new admissions to the unit for the first 6 treatments
- Patients requiring IV calcium, magnesium, pamidronate and argatroban
- Patients who are post fistulas dilation and cardiac catheterization
- Off unit treatments

Also, RPNs do not do on call for emergency situations after hours.

The IAC was very concerned over the lack of clarity of the roles of RNs and RPNs.

Recommendation 9: Establish formally recognized preceptorship and mentorship programs for new or returning nurses (RNs and RPNs) during and post orientation.

Preceptorship and mentorship in nursing is not a new concept. Florence Nightingale used a mentor style program to promote the concepts and philosophies that she espoused (Tucker-Allen et al 1992; Steele and Baker 1992). The partnerships that Nightingale encouraged between qualified nurses and trainees were based on caring, sharing, support relationships (Tucker-Allen et al 1992) to enhance
nursing practice. Such relationships can be equated to the mentorship programs of today. These programs are used to promote the positive transition for nursing graduates into clinical practice settings (Bidwell and Brasler 1989). Transition to practice includes socialization into the work place (Dorsey 1992), acquisition of psychomotor nursing skills (Butterworth 1992; Hart and Rotem 1994), and promotion of effective communication (Woodrow 1994).

More recent literature has only served to strengthen the fact that nursing preceptorship/mentorship is a key recruitment and retention strategy. It is an essential ingredient to successfully support “new nurses” including nurses new to in Hemodialysis this case.

Similar to the OHA Nurse Mentoring Pilot Project in 2005 the need for mentoring was further reinforced by the MOHLTC initiative when, in 2005/06, they sought applications for the Mentorship and Preceptorship Initiative under the provincial Nursing Strategy.

The IAC sees an opportunity for the Hospital to build on the initial four hour session which was offered by the Nurse Educator to nursing staff on the role of mentors. Given the specialized nature of the Hemodialysis Unit all new nurses need to have a formalized preceptorship plan to compliment the orientation program and ensure a smooth transition to an independent patient assignment. All new nurses at the end of their orientation program need to be assessed to determine if they need to have a formal mentorship plan put in place to facilitate maximizing their clinical practice inclusive with a focus on goal achievement.

The existing staff as required will assume the role of a Mentor.

The IAC was rather surprised to find that the Hospital did not have a formal program in place in 2011. Therefore, to avoid any further delays and to advance the Hospital’s learning curve, the IAC strongly suggests the Hospital take advantage of the numerous programs which are already established such as the programs offered by the Registered Nurses Association of Ontario. Alternatively, the Nursing Leadership Network, Professional Practice Network of Ontario, or Ontario Renal Network to name a few would enable the adoption of the recommendation as opposed to the creation of a mentorship program.

Recommendation 10: **Adjust Individual Staffing Assignments to Accommodate for the Orientation Needs for Precepting and Mentoring of New Staff who are on or have Completed Orientation.**

The IAC would like to reinforce that a review of the literature widely reaffirms that, individual staffing assignments need to be adjusted to accommodate for the orientation needs and or precepting/mentoring of new staff who are on or have completed orientation.

Recommendation 11: **Provide an opportunity for ongoing evaluation by preceptors/mentors of the experience to deal with success and issues as they arise.**

There is also a need for the Hospital to provide an opportunity for ongoing evaluation by mentors of the mentoring experience to deal with success and issues as they arise.

### 3.6 **Skill Mix**

Most health systems are coming under increasing scrutiny with a view to cost containment, often as a direct or indirect result of health sector reform. Health care is labour intensive, and the level and mix of staff deployed is a central element in determining the cost of care and the quality of care. It is important that managers and health professionals in any health care organization strive to identify the most effective mix of staff achievable within available resources and organizational priorities.

Often these reforms are imposed as a direct or indirect result of MOHLTC directives which, in the case of the hospital, was a Peer Review in April 2010. In such a situation, the level and mix of staff deployed to deliver health care becomes a central element in the cost of care, and a major
determinant of the quality of that care. Managers and health professionals are thus striving to identify the most effective mix of staff achievable within available resources.

**Recommendation 12:** *Implement the following: Developing and Sustaining Nursing Leadership RNAO Best Practice Guideline within the Hemodialysis Unit to Effect a Renewal of Trust.*

The Hemodialysis unit is not a healthy environment which was characterized by the interactions between both the Hospital and Association throughout the hearing. It was overtly apparent to the IAC that there is distinct absence of trust within the Hemodialysis Unit. Therefore, the RNAO Best Practice Guideline: Developing and Sustaining Nursing Leadership identifies five transformational leadership practices that result in healthy outcomes for nurses, patients, organizations and systems:

- Building relationships and trust,
- Creating an empowering work environment,
- Creating an environment that supports knowledge development and integration,
- Leading and sustaining change, and
- Balancing competing values and priorities and demands

Trust, is the foundation on which the journey to renew a health work environment rests. In the presence of trust, emotional exhaustion will give way to opportunities for dialogue, sense of direction and willingness to work collaboratively. Factors which serve to instill trust include: empathetic listening, advocacy for staff and patients, constant clear communications, inclusive decision making respect for one another and follow through on decisions. The IAC strongly believes that the Hospital must ensure that the renewal of trust within the Hemodialysis Unit is a high priority.

Effective management of change is a key component of effective leadership (*Recommendation 1*). Successful change can only occur when nurse leaders engage staff by means of creating structures such as:

- Share and act on valid and reliable data (*Recommendation 5*)
- Mentorship (*Recommendation 9*)
- Educational opportunities (*Recommendation 23, 25, 32 and 34*)
- Annual performance management reviews (*Recommendation 12*)

The above recommendation creates opportunities for the building of trust through the team’s involvement during all phases of the change process, and employing these recommendations will assist the team to build confidence in their collective ability to manage the change through training, communication and listening empathetically rather than judgmentally.

The IAC believes that the absence of a healthy environment (in addition to an effective change management plan) significantly contributed to the inability to measure progress and evaluate the impact implementation of the RN/RPN skill mix in a meaningful and productive way.

### 3.7 Staffing Levels

Results of both The Peer Review and HIP directed the Hospital to implement the RN /RPN mix of care in September 2010, a definitive move from an all RN staff. The Hospital announced that six (6) RN positions would be eliminated and six (6) RPNS would be hired to fill the vacated positions. Several nurses read the writing on the wall and pre-empted the lay-off by transferring to other units. The change was chaotic for the unit since no formal change process was instituted. No evaluation pre-change was done and there has been no post change evaluation. Eleven RPNS have been hired but five have left the unit since September 2010. As well, 14 RNs have left the unit for various reasons. The current ratio of RNs to RPNs is 75/25. There are now 37 staff nurses; 11 of whom are new (some of whom have previous Hemodialysis experience).

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3 Developing and Sustaining Nursing Leadership RNAO Best Practice Guidelines, 2006
On the unit, there are 4 pods each capable of holding 6 patients. Typically the pod is staffed with 2 RNs, or an RPN and an RN. One pod consists of three isolation units and three other chairs.

The Charge Nurse, the float, off-unit and vascular nurses are always RNs.

- Two long term Charge Nurses, one for days and one for evenings, typically have no patients but do take patients when the unit is short staffed.
- The float nurse helps out when necessary; most often in the isolation rooms area however, is also known to take a patient assignment when the unit is short staffed.
- An off-unit RN provides care to patients in the hospital who cannot be moved to the dialysis unit because of complexity of care needs such as a ventilator.
- One Vascular Access Nurse works days Monday to Friday coordinates temporary and permanent vascular access insertions. She is also responsible for education and data collection re vascular access.

### Table 3: Daily Staffing Numbers

<table>
<thead>
<tr>
<th>Title</th>
<th>Days</th>
<th>Evenings</th>
</tr>
</thead>
<tbody>
<tr>
<td>RNs</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>RPNs</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Float RN</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Off unit RN</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Charge Nurse</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td><strong>9 + Charge</strong></td>
<td><strong>9 + Charge</strong></td>
</tr>
</tbody>
</table>

The numbers of staff are not currently adjusted for orientation or for precepting/mentoring of new staff who are on or have completed orientation.

**Recommendation 13:** Develop and implement an immediate and a long term recruitment and retention strategy for Hemodialysis to significantly reduce turnover

- a. Forecasting model updated quarterly (Recommendation 22), Performance management reviews annually (Recommendation 12)
- b. Mentorship program (Recommendation 9)
- c. Undertake exit interviews (Recommendation 14)

Forecasting staffing needs beyond the budget year and detailing and implementing strategies for recruitment and retention of these specialized nurses is vital.

Recruitment and retention of nurses in a unit, which has been labeled as “toxic”, is both challenging and necessary. Costs of high turnover in an area which requires extensive orientation and precision balancing of novice and experience are astronomical over time. The literature has been known to cite recruitment in a specialty area such as Hemodialysis costing upwards of $35,000 (.5 FTE) per employee inclusive of labour costs associated with hiring, training, etc.

There is firm evidence in the literature that the caliber of a manager co-relates with the recruitment and retention of staff. Although this is addressed elsewhere in the report, it is crucial that in today's unstable economic hospital environment, that the manager leads as a coach and inspires staff. The staff is the top priority for the manager who genuinely values and respects the contributions and potential contributions of staff members. Retention literature and successful organizations have
retention strategies that link recognition and healthy work environments. Effective hospital leadership at the executive level as well as the unit level is crucial in making a balanced score card that binds optimal patient care, staff satisfaction and financial viability.

**Recommendation 14: Immediately Implement a Process to Consistently Undertake Exit Interviews in the Hemodialysis Unit**

The Hospital stated in their response to the IAC’s request for additional information that ‘exit interviews have been completed intermittently. No long term trends can be summarized from the information collected’.

The IAC strongly recommends that the Human Resource department of Hospital immediately implement a process to consistently undertake exit interviews in the Hemodialysis Unit. Only when exit interviews are consistently undertaken can meaningful information, trends and opportunities for improvement be identified and addressed.

**Recommendation 15: The Hemodialysis Unit Establish a Casual RN Float Pool by April 2012. This Float Pool would Encompass 5 to 10 RNs**

The hospital needs to recruit Hemodialysis staff to obtain a full staffing complement and establish an on-call or casual float pool of experienced Hemodialysis nurses to assist with unanticipated shortages created after the schedule has been posted.

Excessive overtime to cover shifts may create stress and illness and may well contribute to safety risks for patients. Staff identified frustration and filed many workload incident reports on days where staff shortages were evident. Although attempts were always made to replace the shifts through either straight time or overtime, there were outstanding shortages. Existing staffing cannot possibly handle instances such as five sick calls in one day. The IAC understood that there may be nurses who live in the area, and while are working in other agencies, may welcome the opportunity to be available for casual shifts.

Following enhanced accuracy of overtime coding the data (Recommendation 16) the IAC’s conservative estimate for the fiscal year ending 2012 would be two (2) FTEs (3,900 hours), which could be converted to a RN casual float pool positions for staffing relief. The IAC anticipates this will go a long way in ameliorating shifts being worked without the full complement of staff – commonly referred to as ‘working short’.

Building on the ideas of the RNs within the Hemodialysis unit, the Association and the Hospital need to work together to establish a way to establish a casual pool of staff. As the Association has indicated a strong desire to work with the Hospital to resolve workload issues this recommendation can be implemented.

**Recommendation 16: The Hospital Immediately Implement a Process to Correctly Code Overtime**

During the hearing the Hospital stated that given sick time has decreased there was less overtime. Upon review of the overtime data provided by the Hospital the IAC determined that this correlation was not supported by the data. Given a more fulsome discussion of the data it became apparent that there were clearly opportunities for the Hospital to increase the accuracy of the coding of overtime. In the absence of accurate coding, conclusions regarding the association between sick and overtime hours were premature. (See Recommendation 15).

**Recommendation 17: The Hospital seriously consider exercising the opportunity to maintain the skill set of the experienced Hemodialysis nurses in the ICU with the benefit of alleviating staffing pressures in the Hemodialysis unit.**

The IAC recommends that the managers and directors of ICU and Hemodialysis utilize the expertise of experienced Hemodialysis trained nurses in the ICU to maintain their skill set and to alleviate staffing
pressures in the Hemodialysis unit.

Currently, the Hemodialysis unit has three chronic patients in the intensive care each of whom requires Hemodialysis three times per week. The allocated time to care for these patients including transportation, set up and take down of machines, is six (6) hours per treatment. Fifty six hours per week of off unit Hemodialysis is being provided in a unit which has 3 fully trained experienced Hemodialysis nurses, who left Hemodialysis because they were likely to be laid off from the area that they originally had chosen to work in.

It is recognized that utilization of these nurses will have an impact on ICU, and negotiations to that effect will need to be made. Although the transferred nurses are acquiring ICU skills and may not wish to have all of their work time be in delivery of Hemodialysis care, some hours of better utilization of specialized Hemodialysis expertise would seem to be a sensible approach and eliminate the risk of these staff becoming deskillled.

3.8 Communication

Communication is the sharing of information between two or more individuals or groups to reach a common understanding. The most important part of communication is that the information or ideas conveyed must be understood. Communication is essential for effective functioning in every part of every patient care unit as it increases staff effectiveness, efficiency, improves quality of patient care, and builds and sustains a foundation of trust within the workplace.

Recommendation 18: Implement Frequent and Consistent Patterns of Communication from all levels of management with the Staff, and from Staff with Management

From the prehearing submissions and discussion during the hearing the IAC learned that there was a need for dedicated agenda items on the Hospital Association Committee (HAC) to ensure that concerns were addressed in a timely fashion. Although there are minutes from the HAC, the IAC committee suggests that a format which includes the following elements be adopted to track issues, progress and resolution.

- Date
- Issue/concern
- Desired outcome
- Timeframe
  - Short term (up to 3 months)
  - Medium term (3-9 months)
  - Long term (9-12 months)
- Most responsible person(s)
- Milestones
- Progress to date (updated at each meeting)
- Activities to be completed (updated at each meeting)
- Indicator
  - Green (on track)
  - Yellow (one activity has missed one milestone)
  - Orange (one or more activities have missed one milestone)
  - Red (immediate intervention one activity has missed more than two milestones)

The IAC further recommends that this be a transparent document which is updated, shared and posted during each and every meeting for all of Hemodialysis to see.
Recommendation 19: Revitalize and effectively use methods of communication to ensure the form matches the intended outcome required.

During the tour there was a comment that a setting on more than one of the Hemodialysis machine was not in accordance with the setting stated in a recent e-mail – that is all machines are to be set to the revised number. The IAC Chair at that time commented that e-mail alone is usually ineffective in implementing a change of this magnitude – rather point of care visual cues like a sign on each machine indicating the new setting would serve to communicate the message at the time of need and shape the behavior. The IAC was pleased that both the Director and the Association representative were receptive to this suggestion and strongly recommend that the Hospital use the suggestions illustrated in Figure 3 to match communication to the intended outcome.

Figure 3: Matching Communication to the Intended Outcome

Recommendation 21: Develop a Hemodialysis Unit Specific Dashboard.

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

1. Recruitment and retention (Recommendation 13).
3. RNs who have successfully completed Charge Nurse education (Recommendation 25).
4. RNs who have successfully completed Mentorship education (Recommendation 9).
5. Patient Satisfaction results.

The white board currently used for Bullet Rounds will be utilized to convey the direction of key metrics.

The IAC takes this opportunity to reinforce the importance of achieving short-term “wins” when looking to achieve sustained change in the long term, on Hemodialysis Unit. Measuring progress, seeking feedback, and continuing to adjust and improve, are all important factors in evaluating the skill mix and workload.

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4 Sarah Fraser 2001
Recommendation 22: Ensure Adequate Staffing on the Hemodialysis Unit for the Near Term until an Evaluation is Undertaken Regarding the Impact of the RN/RPN skill mix

a) The IAC Strongly Recommends that the Hospital and Association work Together to Complete a Forecasting Model for the Hemodialysis Unit

b) The IAC Strongly Recommends that a permanent Scheduler Proceed for the Hemodialysis Unit Advance as a Priority

Since the commencement of the implementation of the RN/RPN skill mix there has continued to be turnover resulting in a continual need for ongoing orientation. Any amount of significant change in a unit or organization will naturally result in both challenges and opportunities.

It was evident in many of the professional responsibility complaints that there was not sufficient RN staff to meet the needs of the unit. Although the Hospital has made progress in reducing the number of holes a posted schedule would have, it was evident that the unit is not able to consistently replace sick calls and other short term staffing requirements. In 2010, the Central Staffing and Scheduling Office (CSSO) was developed at the Hospital. Assignment of Schedulers to clinical units has been a slow process. Unfortunately there are no immediate plans to support the Hemodialysis Unit with a permanent Scheduler.

The Hemodialysis Unit, unlike other areas of the Hospital, does not have an experienced pool of nurses to draw on when their full and part time staff are unable to fill ‘holes’ due to last minute emergencies, sick calls etc given the specialized nature of work within the unit (Recommendation 15).

It is very important that the Hospital consistently staff this unit to meet the patient needs over the near term given there remains a significant number of novice nurses (i.e. under two years of Hemodialysis experience). The significant turnover of staff has eroded trust and confidence in the Hospital and this must be rebuilt for the future (Recommendation 12).

Forecasting models in nursing human resources provide a predictive model to determine staffing requirements for the future. One such model is in the one published in the recently published toolkit - Building Capacity for Nursing Human Resource Planning: A Best Practice Resource for Nursing Managers.

The IAC strongly recommends that the Hospital and Association work together to complete a forecasting model for the Hemodialysis Unit in order to ensure that recruitment is structured to proactively support the ongoing needs of the unit as opposed to being reactive. Such a model serves to smooth the negative impacts associated with peaks and troughs of recruitment. The positive benefit to the Hemodialysis Unit would include:

- Significantly reduce/eliminate day to day issues of working short staffed;
- Assimilate new nurses proactively into anticipated vacancies;
- Avoid peak vacation times when preceptorship availability can be limited.

Recommendation 23: Education to the Hemodialysis unit from the College of Nurses of Ontario on the roles of RNs and RPNs and the three factor model, and how it applies to Hemodialysis

The IAC recognized that there was a dedicated session planned for the Hemodialysis Unit, however, this morphed into an organizational event. The IAC remains of the opinion that there is a definite need for a dedicated CNO session which will provide an opportunity for the staff to work through Hemodialysis specific examples.

Given the inherent tension regarding the assignment of ‘appropriate’ patients to RPNs within the Hemodialysis, the IAC strongly recommends that the Hospital work to engage the College of Nurses to incorporate appropriate aspects of the Conflict and Prevention Management Practice Guideline. The organization also needs to examine tools from organizations which have successfully integrated RPNs into the Hemodialysis skill mix (Appendix 8 – example: The Ottawa Hospital Model).
Recommendation 24: Site visit to one or more Hemodialysis Units upon the Appointment of a New Front-Line/Transitional Manager

The IAC strongly feels that the unit would benefit from having several staff members visit several other units outside of their Region. The purpose of the visit would serve to see firsthand other models of care (including an RPN skill mix) in their respective operational settings. The IAC suggests that the sites visited possess two or more of following characteristics:

- Low turnover
- Maintenance of indicators reflective of safe renal outcomes
- Mixed skill mix
- Positive staff and patient satisfaction surveys

The IAC also feels that while the Hospital had requested by e-mail, information from other dialysis units for a range of categories, they needed to build on this by making site visits. The review of information from other sites lacks the richness of the context in which their model of care, skill mix and processes are set.

Recommendation 25: Immediately Provide Education for RN Staff who Function in the Charge Nurse role

1. Provide additional leadership training for RNs who function in the Charge Nurse role to enable them to work effectively within the skill mix.
2. All RN staff who hold or assume the role of Charge Nurse to complete the leadership training within 3 months to facilitate functioning within their full scope of practice with respect to competencies such as leadership, resource the Hospital, coaching, critical thinking, conflict
3. An annual refresher should be developed and attended by all RN staff who regularly assume the role of Charge Nurse.

Following the implementation of the RN/RPN skill there was no evidence to support the fact that the RN staff who hold or assume the role of the Charge Nurse were provided with additional education which would equip them to undertake the assignment of appropriate patients to RPNs. Especially given the RPNs’ limited Hemodialysis experience. The educational material for the Charge Nurse and those RNs who routinely assume this role would serve to provide an opportunity to enhance their critical thinking, decision making, and leadership skills.

The development of Charge Nurses education by means of formal programs, are increasingly commonplace within organizations and are often supported with annual refreshers for both existing in addition to new RNs who become eligible to assume this role.

Recommendation 26: Assess the Work Load of the Charge Nurse with a View to Relieving the Role of ADMINISTRATIVE DUTIES to Free Up Time for Ongoing Assessment of Patients and Assistance for Activities such as the Reassignment of Staff.

The IAC received a short informal list of duties for the Charge Nurse. According to nursing staff, in the absence of a manager, the Charge Nurses are heavily involved in administrative duties - paper work, scheduling etc., and do not have time to do an in depth assessment of the patients before assigning the patients on admission to either an RN or RPN. The assignment is already made by the time the patient is in the chair and the assigned nurse does the first assessment. The assignment is rarely changed before the patient is in the chair. As the unit is currently functioning with both a primary nurse and a total patient care model it is expected that the Charge Nurses will receive accurate information about changes in the stability of chronic patients which could influence assignment.

It was unfortunate that neither Charge Nurse was available during the tour given their need to attend an off unit meeting on any of the three days of Hearings, as it would have been advantageous to
speak with them directly regarding the staff nurses concerns. However, the IAC feels that the staff nurses concerns are valid especially given the absence of a Manager (i.e. liaise with Director regarding staffing levels and since attendance of off unit meetings was validated at the time of the tour).

The IAC feels strongly that an assessment of their work load is imperative to ensure that administrative activities which can be undertaken by unit clerical staff are delegated. Having the Charge Nurse role relieved of unnecessary administrative duties would release valuable clinical expertise and time in support of the unit staff.

**Recommendation 27:**  *Immediately commence dedicated weekly Hemodialysis Unit Meetings for Nursing Staff for the Purpose of Sharing Information on both sides and Celebrating Success.*

The IAC understands that there are Hemodialysis Unit meetings; however, the dedicated time allowed for specific nursing issues/concerns appears to be limited. Therefore, the IAC strongly recommends that the Hospital immediately commence the scheduling of dedicated weekly Hemodialysis Unit meetings for nursing staff.

The IAC sees that as the measures and evaluation methodology takes shape that these meetings may objectively assist in addressing the RNs’ concerns, which include:

- The volume of appropriate RPN patients
- Clarity of the RPN scope of practice of RPN

Further to this, the IAC noticed that throughout the two and half days of the hearing, a striking absence of how the Hemodialysis Unit celebrate/recognizes staff achievements and success (Recommendation 27).

Current literature strongly supports the ongoing celebration/recognition of staff as an essential ingredient of a healthy workplace. The IAC sees this as a priority of the Hospital. As a starting point in addressing this need, consideration should be given to making this a standing item on the weekly meetings.

**Recommendation 29:**  *Immediately Clarify the Role of the Charge Nurse and Educator*

Throughout the hearing, the IAC identified a lack of common understanding of the role of the Charge, Nurse and Educator. The IAC acknowledges that in the absence of a dedicated manager some blurring of boundaries may have occurred. However, concurrent to the recruitment and appointment of a dedicated manager (Recommendation 1) there is an opportunity for clarification of the roles of the Charge, Nurse and Educator.

The Charge Nurse seems to have been required to assume a variety of administrative tasks in the absence of a dedicated manager which had decreased their availability to assist with the direct needs of the unit (Recommendation 1).

Staff expressed that clarity of the role of the Educator would be most beneficial. The Educator who is responsible for the orientation of new staff as well as corporate responsibilities seems to have decision making responsibilities and also seems to be involved in what has been perceived as disciplinary actions by some staff (Recommendation 34).

**Recommendation 30:**  *The IAC Recommends that the Hospital Build on the Sharing of the Orientation Binder, which the IAC and Association were given by making it Available to all the Staff on the Hemodialysis Unit.*

The IAC further recommends that the Hospital share the orientation binder in the context of a staff meeting, when the staff could be encouraged to read and also constructively comment. This would serve to ensure that collective knowledge of the unit is captured, clarified and update the orientation
binder. It is also recommended there be a formal process for the binder to be updated with new policies, processes and or directives as they are approved for use in the unit.

**Recommendation 31:** The Hospital Immediately Explore Opportunities for RNs and RPNs to take Specific Nephrology Course Certifications for Colleges or In-House Education through a Community College. In the Absence of Courses open to RPNs, the Hospital needs to Immediately Work with the Colleges and Universities to Advocate for Formal Programs to Support Nurses who want to Strengthen their Nephrology Specific Learning

The IAC strongly recommends that they commit to having two individuals undertake specific nephrology course certifications per year and concurrently be mentored by the Educator or a CAN certified nephrology nurse who has completed the mentorship program (Recommendation 9) within the coming fiscal year. It is also strongly recommended that throughout the annual budget process that the Hospital moves from its current allocation of zero (0) hours for the Hemodialysis Unit to accommodate the following educational recommendations, which will also serve to support recruitment and retention (Recommendation 13).

- Mentorship programs;
- Annual Charge Nurse refresher courses;
- Annual Nephrology Forum; and
- Others as identified through staff meetings.

**Recommendation 32:** Provide Education related to Leadership, Decision Making, Coaching and Conflict Resolution to all Hemodialysis Staff.

Continued leadership development for management staff is strongly supported by the IAC. The unrelenting nature of change in the health care sector places considerable expectation on all staff, but particularly formal leaders to be effective change agents. Professional development of the nursing staff as well as leadership will serve to support the implementation and imbedding the regeneration model of care into day to day practice; and continue to develop effective collaborative relationships between the staff and leadership.

**PATIENT SAFETY**

Since the era of Patient Safety started in the late 1990’s with the release of the Institute of Medicine’s report ‘To Err is Human’, 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.

**Recommendation 33:** The Hospital Immediately Address the Alarm System Associated with the Negative Pressure Room.

The alarm system has been subject to a number of unsuccessful attempts to resolve the ability to have the door open without the alarm being set off when the need for negative pressure is not required. According to both the Hospital and the Association this impacts patient safety as machine alarms are inaudible outside the room when the door is closed.

The Hospital needs to ensure that the manufacturer and facilities bring this ongoing issue to resolution to address patient safety and reduce any additional workload associated with increased observation and interventions as a result of the door being closed to prevent the activating of the alarm unnecessarily. The IAC considers it unacceptable that the manufacturer and facilities previous stance that ‘it cannot be fixed’, has been tolerated. There is potential for serious incident occurrence when alarms cannot be heard by the nurses and there is a clear workload implication.
Recommendation 34:  Provide Patient Safety Education to all the Hemodialysis Unit staff.

The IAC strongly believes that through the provision of Patient Safety education to the staff there would be a common understanding of what constitutes a preventable error, the importance of reporting a ‘near miss’ and ‘errors’ for the purpose of learning as opposed to the assignment of blame. The Hospital indicated that they are moving to a ‘just culture’ although the IAC found numerous examples of gaps in knowledge with respect to the essence of the principles of Patient Safety. The IAC also feels that this will serve to progress the Hospital’s shift to a ‘just’ culture.

Recommendation 35:  Immediately Move to Implement an Interim Solution to Eliminate the Two Chart System which serves Level 3 Hemodialysis Patients. As Part of this Process the Hospital undertake a Failure Mode and Effects Analysis (FMEA) of the Two Chart System for Level 3 Hemodialysis Patients.

The dialysis unit develops an extra chart for in-house patients as they have difficulty accessing the patients’ regular hospital chart. The second chart allows them to quickly access needed data for the patient. However, it increases the risk of missed orders which might be written on one or the other of the two chart system. This was further reinforced as during the explanation to the IAC, an error was revealed and corrected!

The IAC acknowledges that a computerized documentation system would alleviate the need for two charts.

However, given that there are no timelines for the implementation of a computerized documentation system the IAC strongly feels a Failure Mode and Effects Analysis (FMEA) be undertaken regarding the two chart system for Level 3 Hemodialysis patients (those who are inpatients). The FMEA will serve to identify all possible design failures with this process and therefore provide opportunities for improvement. Given that the IAC understands that the Renal Program will be preparing for Accreditation in the near future and that FMEA is an annual ‘Required Organizational Practice’ this would also serve to meet with future requirements. An example of a FMEA is provided in Appendix 9.

Recommendation 36:  Move as Quickly as Possible to a Preprinted Medication Administration Record

The Nursing staff within Hemodialysis Unit move as quickly as possible to a pre-printed medication administration record (MAR). Notwithstanding the amount of time a nurse spends copying information from one MAR to another, inherent in the process itself is the risk of human error which has the potentially to be eliminated by means of technology. Movement to a pre-printed MAR serves to strengthen the medication administration by means of a system process improvement.

Recommendation 37:  Move to Implement the Auditing of 10% of all Medication Administration Records and Treatment Sheets within the Next Three Months.

Within the Patient Safety literature there is overwhelming support for discovering what one doesn’t know. There is an underlying assumption that the MARs and Treatment Sheets when copied are correct. A 10% audit of these will confirm this or identify opportunities for improvement.

Recommendation 38:  Computerize the Documentation System as Quickly as Possible which will Assist in both the Reduction of Workload and Collection of Data.

During the hearing the IAC learned that there is an envelope of funding which has recently become available to support the implementation of a computerized documentation system.

While the IAC strongly encourages the Hospital to move quickly with computerizing the documentation system, it also acknowledges that the Hospital’s Hemodialysis Unit is part of a Regional Program and therefore there are other stakeholders involved which can impact the implementation date.
The IAC recognizes that more computers will be needed for the Hemodialysis Unit.

**Recommendation 39:** *Use the Professional Responsibility Workload Report Forms (PRWLFs) to Serve as a Source of Learning Needs.*

The IAC strongly recommends that the PRWLFs, when correctly completed by both the Association and Hospital, serve as a record of unit specific data which can identify opportunities for improvement and serve as a basis to develop, implement and evaluate plans to eliminate the reported issues from reoccurring.
SUMMARY and CONCLUSIONS

The IAC was requested to specifically address the identified workload issues and the work environment, which RNs within the Hemodialysis Unit have identified, make it difficult to provide safe quality patient care and practice safely in accordance with the professional standards set out by the College of Nurses, Ontario. The effect of the workload and the working environment on RNs relates to professional practice, patience acuity, fluctuating workload and fluctuating staffing. Attempts to resolve the workload issues that constitute professional practice concerns at HAC and the Hospital have been unproductive.

The IAC has made 38 recommendations following a comprehensive process involving review of written and oral submissions, focused discussion and clarification during the three (3) day hearing and extensive Committee analysis and discussion following the Hearing.

The 39 Recommendations address nursing leadership, change management, evaluation and measurement, staffing, professional development, communication, and patient safety. A significant number of the recommendations are highly interdependent and are therefore referenced accordingly.

The IAC strongly believes that the Hospital and Association have a tremendous opportunity for a “fresh start.” The IAC also strongly believes that the process of implementing these recommendations will have a very positive impact on building trust, a necessary foundational piece in creating a new relationship between the Hospital and the RN staff of the Hemodialysis Unit. The process will also improve the quality of the patient care, nursing workload, the RN staff working environment, the evaluation of the RN/RPN skill mix and patient safety.

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.

The IAC thanks you for the opportunity to assist you both in making a fresh start in the Hemodialysis Unit.
APPENDIX 1

Referral Letter to the Independent Assessment Committee
July 14, 2011

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

Dear Ms. Duesbury-Porter,

Re: Peterborough Regional Health Centre (PRHC) – Hemodialysis Unit, Professional Responsibility Complaint – Proceeding to an Independent Assessment Committee – Ontario Nurses’ Association (ONA) FILE # 201004944

In accordance with Article 8.01 of the Central Hospital Agreement set out between Ontario Nurses’ Association (ONA) and Peterborough Regional Health Centre (PRHC) the Labour Management Committee (LAC) has met on a number of occasions and exchanged letters of communication several times in attempt to bring resolution to workload issues causing RNs working in the Hemodialysis Unit to believe that they are being asked to perform more work than is consistent with proper patient care.

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

The RNs working in the Hemodialysis Unit at the PRHC have identified workload issues and the work environment to make it difficult to provide safe quality patient care and practice safely in accordance with the professional standards set out by the CNO for RNs. The effect of the workload and the working environment on RNs relates to professional practice, patient acuity, fluctuating workloads and fluctuating staffing.

Attempts towards working to resolve the workload issues that constitute professional practice concerns at the HAC with the Employer have been unproductive. The Employer is resolved to move forward to an IAC hearing to address the professional practice responsibility concerns presented to them. The Association has no other recourse at this time but to forward this matter to a hearing at the Independent Assessment Committee. To this effect ONA respectfully submits this Professional Responsibility Complaint to the IAC.

Provincial Office: Toronto
Regional Offices: Ottawa • Hamilton • Kingston • London
Orillia • Sudbury • Thunder Bay • Timmins • Windsor
ONA is preparing to name their nominee to forward to your attention along with their contact information. It is our expectation that the Employer will do the same. Once you have the information you require, it is our understanding that as the IAC Chair you will communicate with the two nominees to set up a date for the hearing that is agreeable to both parties, the Employer and ONA.

We thank you for your assistance in this matter.

Sincerely,

ONTARIO NURSES’ ASSOCIATION

Mariana Markovic
Professional Practice Specialist
Labour Relations Officer

C:  Jayne White, Chief Nursing Executive, PRHC
    Liz Hawthorne, Renal Program Director, PRHC
    Craig MacVicchie, Human Resource Program Support Partner, PRHC
    Jane Mark, Professional Practice Chair, ONA
    Janice Flynn, Bargaining Unit President, ONA
    Mathew Stout, Servicing LRO, ONA
    Doug Anderson, Manager PST, ONA
APPENDIX 2

Association's Letter Outlining Their Nominee and Contact Details
July 20, 2011

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

Dear Ms. Duesbury-Porter,

Re: Peterborough Regional Health Centre (PRHC) – Hemodialysis Unit, Professional Responsibility Complaint – Proceeding to an Independent Assessment Committee – Ontario Nurses’ Association (ONA) FILE # 20100944

Thank you for accepting to chair the independent Assessment Committee to investigate a professional practice complaint at PRHC, Hemodialysis Unit.

To date, the employer has been unable to propose sufficient measures to resolve the concerns and is not agreeable to continue to work with ONA in an ongoing effort towards resolution.

Timely resolution of the Professional Responsibility Workload Report Forms is vital to the RNs and the patients in the Hemodialysis Unit. In continuing the PRC process ONA is forwarding the name and contact information of Trudy Molke as ONA’s nominee to the Independent Assessment Committee and is forwarding the following contact information for your attention.

Trudy Molke
Trudy Molke Practice Consulting
46 Overbank Crescent
Toronto, ON M3A 1W2
Tel: 416-447-7738; trudy.molke@sympatico.ca

Please set up dates with nominees, who will confirm with their respective parties.

Sincerely,

ONTARIO NURSES’ ASSOCIATION

Mariana Markovic
Professional Practice Specialist
Labour Relations Officer

cc: Jayne White, Chief Nursing Executive, PRHC (By Email Only)
    Liz Hawthorne, Renal Program Director, PRHC (By Email Only)
    Craig McCutcheon, Manager Labour Relations, PRHC (By Email Only)
    Dale Dixon, Local Grievance Chair, ONA (By Email Only)
    Matthew Stout, Servicing LRO, ONA (By Email Only)
    Doug Anderson, Manager PST, ONA (By Email Only)
APPENDIX 3

Hospital’s Letter Outlining Their Nominee and Contact Details
August 19, 2011

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

Dear Ms Duesbury-Porter,

In the matter of the Hemodialysis continuing PRC process the Peterborough Regional Health Centre is forwarding the name and contact information of Diane Stephenson as the Health Centre’s nominee to the Independent Assessment Committee for your attention.

Diane Stephenson
Diane Stephenson Consulting
16 Bremer Street
Ottawa, ON K1K 3C5
Tel: 613-745-7424
stephenson@diane@gmail.com

Please contact our nominee at your convenience to confirm availability.

Sincerely,

Craig MacVicchie
Program Support Partner, Labour Relations Lead

Cc: Jayne White, CNO & Interim CNE
Liz Hawthorne, Director Women & Child and Ambulatory Care
Susan Hayden, Program Support Partner – Human Resources
Vicky Slatta, Emond-Hamden
Jane Mark, Workload Chair, ONA
Janice Flynn, ONA, Bargaining Unit President
Matthew Stout, Labour Relations Officer ONA
APPENDIX 4

Letter to the Hospital
Mr. Craig MacVicke  
Human Resources Program Support Partner  
Peterborough Regional Health Centre  

Monday August 29th 2011  

Dear Craig  

Re: Peterborough Regional Health Centre (PRHC) – Hemodialysis Unit, Professional Responsibility Complaint – Proceeding to an Independent Assessment Committee – Ontario Nurses’ Association (ONA) FILE # 201004944  

Thank you for your e-mail message dated August Friday August 26th 2011.  

Given e-mails exchanged on Friday July 29th 2011 which indicated that the Health Centre wished that this proceed in a timely manner it was disappointing to receive the dates put forth by the Health Centre. In that exchange of e-mails it was also suggested that the prehearing submission be concurrently compiled to avoid any further delays later on during the IAC process.  

The Health Centre has been aware of the need to prepare their pre-hearing submission since the Association’s letter to advance the PRHC process for RNs working in the Hemodialysis Unit, at the PRHC, to an IAC hearing dated July 14th 2011. Therefore it was felt that proposed submission date of September 30th 2011 provided ample lead time (11 weeks). In an e-mail dated Friday August 26th 2011 the Association stated that the Health Centre has cancelled meetings scheduled in July and August with them in order to prepare for the IAC.  

I spoke with the Health Centre’s nominee Diane Stephenson after having received your e-mail on Friday August 26th and she reaffirmed that the proposed dates below are ideal for her:  
- Pre Hearing Submission due date: Friday September 30th 2011  
- Hearing Dates: November 1st - 3rd 2011 (Tuesday-Thursday inclusive).  

In addition the above dates or dates within that week are acceptable to the Association, their nominee and the Chair.  

The dates proposed by the Health Centre on Friday July 29th unfortunately will not provide sufficient time for the IAC committee to be in receipt of the pre-hearing material, review and prepare for the hearing, given the IAC Chair was previously notified that the Health Centre’s nominee is to be out of the country from November 17th through the 28th 2011. It is assumed that the Health Centre is aware of this. Further to this it would prove difficult for the IAC Committee to comply with Article 8.01, (x) as the 45 days would extend into the annual holiday season in December/January.  

Therefore, reconsideration of the proposed meeting dates by the Health Centre would be truly appreciated. Other dates earlier in the fall would also be welcomed in order that the Peterborough Regional Health Centre (PRHC) – Hemodialysis Unit, Professional Responsibility Complaint – Proceeding to an Independent Assessment Committee – Ontario Nurses’ Association (ONA) FILE # 201004944 is undertaken in a timely manner.  

If you wish to discuss this rather than exchange further e-mails please feel free to call me on 416-344-6377.  

I look forward to hearing from you.  

Regards  

June Duesbury-Porter MScn, MBA  

Cc: Trudy Molke, Association Nominee  
Diane Stephenson, Hospital Nominee  
Mariana Markovic, Professional Practice Professional Practice Specialist, Labour Relations  
Officer
APPENDIX 5

Requesting The Hospital to Provide Selected Additional Information by the Close of the Hearing
Pharmacist
  • # of FT

Vacancy Information
  • # of vacant RN and their respective FTE
  • # of vacant RPN and their respective FTE

Allotted Support Staff – unit clerks and housekeeping etc. for the Dialysis Unit
  • Daily hours for weekdays and weekends of housekeeping coverage for unit
  • # of FT
  • # of Temp FT
  • # of PT
  • # of Temp PT

Actual Staffing (Headcount currently in place and in addition please also provide the FTE commitment of each PT person for RNs and RPNs)

RN
  • # of FT
  • # of PT

PD RNs
  • # of FT
  • # of PT

R1 RNs
  • # of FT
  • # of PT

Vascular Access RNs
  • # of FT
  • # of PT

RPNs
  • # of FT
  • # of PT

Assistants
  • # of FT
  • # of PT

Technologists
  • # of FT
  • # of PT

Dietitians
  • # of FT
  • # of PT

Pharmacist
  • # of FT

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 Monday November 14th 2011 and that the remainder be provided at the latest by Monday November 21st 2011.
Human Resource Indicators and Information
- Number of RNs, RPNs with 1-3 and greater than 3 years experience
- Sick time: sick rate/FTE for nursing within the Peterborough Health Centre and the Dialysis Unit
- Sick time for Dialysis Unit as a cumulative FTE for budget YTD
- Overtime: OT rate/FTE for nursing within the Peterborough Health Centre and the Dialysis Unit
- OT for Dialysis Unit as a cumulative FTE for budget YTD
- Banked hours as a cumulative FTE for budget YTD
- Turnover: RN rate/FTE for nursing within the Peterborough Health Centre and the Dialysis Unit
- Is there an annual performance review process? If yes, how frequently are they undertaken, if No, when is one expected to be implemented?
- Are exit interviews undertaken. If yes, themes, trends identified, if No, was this a practice which has been stopped or is it a practice which is under consideration
- Number of RNs and RPNs on the Dialysis Unit currently on any kind of leave (e.g. MLQA, personal, education); those expected back to work in the next year (please specify FT or PT)
- Number of RNs and RPNs expected to go on a leave in the next year, (please specify if FT or PT)
- Number of RNs and RPNs on the Dialysis Unit expected to retire in the next year
- Overview of recruitment efforts for a Dialysis Manager
- Page 20 of PHC submission indicated initiatives to develop positive relationships – please expand

Non-nursing duties
- A list of identified ‘non-nursing’ duties

Other Staffing Items
- Guidance for the assignment of patients when short staffed?

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

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

Patient Satisfaction
- Patient satisfaction data relating to Peterborough Health Centre and the Dialysis Unit

Staff Satisfaction
- Staff satisfaction/quality of worklife data to Peterborough Health Centre and the Dialysis Unit

Administrative Information
- Organizational chart for Peterborough Health Centre and the Dialysis Unit
  - Lines of accountability for operations and for professional nursing practice.
  - Medical leadership, site and program
  - Renal Program Director span of control

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 Monday November 14th 2011 and that the remainder be provided at the latest by Monday November 21st 2011.
Medical Leadership
- The IAC would find it beneficial to meet and speak with the Renal Program chief and or designated nephrologists

Medication Administration
- Medication administration policy (including independent double check)
- When will the MARs be preprinted?
- Schedule of pharmacy deliveries
- Process for locating/replacing lost/missing medication

Quality and Patient Safety
- Adverse and critical incidents in last 12 months
- Medication incidents and information regarding near-miss events, adverse events, and critical incidents
- Fistula complication rate for last 6 months
- Description of Quality/Continuous improvement projects over the past two years relating to nurses and/or nursing practice for the Dialysis Unit.
- Copy of the last Accreditation recommendations/comments/praise for the Renal Program
- Dialysis specific measures to evaluate the implementation of the RN/RPN skill mix

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 Monday November 14th 2011 and that the remainder be provided at the latest by Monday November 21st 2011.
APPENDIX 6

Hearing Agendas
## Independent Assessment Committee Hearing

**Ontario Nurses' Association and Peterborough Health Centre**

**Agenda**

**Monday November 14th 2011**

**Holiday Inn Waterfront, Peterborough**

<table>
<thead>
<tr>
<th>Time</th>
<th>Item</th>
<th>Participants</th>
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<tbody>
<tr>
<td>08:00 — 09:00</td>
<td>Pre-Tour meeting</td>
<td>IAC</td>
</tr>
<tr>
<td>09:00 — 09:45</td>
<td>Meet with Chief of Renal Program or designated Nephrologists</td>
<td>IAC and designated Physician</td>
</tr>
<tr>
<td>10:00 — 12:00</td>
<td>Tour of Dialysis</td>
<td>All</td>
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<tr>
<td>12:00 — 12:45</td>
<td>Observation of Dialysis Handover</td>
<td>IAC with PHC and ONA (one member each)</td>
</tr>
<tr>
<td>12:45 — 13:00</td>
<td>Travel to Hearing Venue</td>
<td>IAC</td>
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<tr>
<td>13:00 — 13:45</td>
<td>Lunch at Holiday Inn</td>
<td>IAC</td>
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<tr>
<td>13:45 — 14:00</td>
<td>Introduction and Review of Proceedings by Chairperson</td>
<td>IAC Chair</td>
</tr>
<tr>
<td>14:00 — 15:30</td>
<td>Ontario Nurses' Association Submission Presentation</td>
<td>All</td>
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<tr>
<td></td>
<td>Response to questions of clarification from:</td>
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<tr>
<td></td>
<td>• Independent Assessment Committee</td>
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<td></td>
<td>• Peterborough Health Centre</td>
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<tr>
<td>15:30 — 15:45</td>
<td>Break</td>
<td>All</td>
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<tr>
<td>15:45 — 17:15</td>
<td>Peterborough Health Centre Submission Presentation</td>
<td>All</td>
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<td>Response to questions of clarification from:</td>
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<tr>
<td></td>
<td>• Independent Assessment Committee</td>
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<tr>
<td></td>
<td>• Ontario Nurses' Association</td>
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<td>17:15 — 17:30</td>
<td>Review of Process for Tuesday November 15&lt;sup&gt;th&lt;/sup&gt; 2011</td>
<td>IAC Chair</td>
</tr>
<tr>
<td>17:30</td>
<td>Adjournment of Hearing</td>
<td>IAC Chair</td>
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</tbody>
</table>
## Independent Assessment Committee Hearing
### Ontario Nurses’ Association and Peterborough Health Centre
#### Agenda

**Tuesday November 15th 2011**
Holiday Inn Waterfront, Peterborough

<table>
<thead>
<tr>
<th>Time</th>
<th>Item</th>
<th>Participants</th>
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</thead>
</table>
| 09:00 — 12:00 | Peterborough Health Centre Response to Ontario Nurses’ Association Submission Response to questions from  
               - Independent Assessment Committee  
               - Ontario Nurses’ Association  
               - Discussion | All          |
| 10:30 — 10:50 | Break                                                              | All          |
| 10:50 — 12:00 | Peterborough Health Centre Response to Ontario Nurses’ Association Submission Response to questions from  
               - Independent Assessment Committee  
               - Ontario Nurses’ Association  
               - Discussion | All          |
| 12:00 — 13:00 | Lunch                                                              | All          |
| 13:00 — 14:30 | Ontario Nurses’ Association Response to Peterborough Health Centre Submission Response to questions from  
               - Independent Assessment Committee  
               - Peterborough Health Centre  
               - Discussion | All          |
| 14:30 — 14:50 | Break                                                              | All          |
| 14:50 — 16:00 | Ontario Nurses’ Association Response to Peterborough Health Centre Submission Response to questions from  
               - Independent Assessment Committee  
               - Peterborough Health Centre  
               - Discussion | All          |
| 16:00 — 16:15 | Review of Process for Wednesday April 6th 2011                  | IAC Chair    |
| 16:15       | Adjournment of Hearing                                           | IAC Chair    |
| 16:15 — 18:00 | Break and Dinner                                                | IAC          |
| 18:00 onwards | Independent Assessment Committee Meeting                      | IAC          |
Independent Assessment Committee Hearing  
Ontario Nurses’ Association and Peterborough Health Centre  
Agenda

Wednesday November 16th 2011  
Holiday Inn Waterfront, Peterborough

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<th>Time</th>
<th>Item</th>
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<tr>
<td>09:00 — 12:00</td>
<td>Questions to both Parties by Independent Assessment Committee</td>
<td>All</td>
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<tr>
<td>12:00 — 12:30</td>
<td>Closing Remarks and Identification of Next Steps by IAC Chair</td>
<td>IAC Chair</td>
</tr>
<tr>
<td>12:30</td>
<td>Closure of Hearing</td>
<td>IAC Chair</td>
</tr>
<tr>
<td>12:30 — 15:00</td>
<td>Lunch and Independent Assessment Committee Meeting</td>
<td>IAC</td>
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APPENDIX 7

Hearing Participants
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<tr>
<th>NAME</th>
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<tbody>
<tr>
<td>Anne Clark</td>
<td>Registered Nurse, VP Region 2</td>
<td>ONA</td>
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<tr>
<td>Cheryl Osborne</td>
<td>Registered Nurse, BUP</td>
<td>ONA</td>
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<tr>
<td>Colin Johnston</td>
<td>Litigation Team Leader</td>
<td>ONA</td>
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<td>Dale Dixon</td>
<td>Registered Nurse ICU, Grievance Chair</td>
<td>ONA</td>
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<tr>
<td>Jane Mark</td>
<td>Registered Nurse, Workload Chair</td>
<td>ONA</td>
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<tr>
<td>Julie Sanders</td>
<td>Registered Nurse</td>
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<tr>
<td>Karen McNeil</td>
<td>Registered Nurse, Unit Representative</td>
<td>ONA</td>
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<tr>
<td>Mariana Markovic</td>
<td>Prof. Practice Specialist, Labour Relations Officer</td>
<td>ONA</td>
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<tr>
<td>Matthew Stout</td>
<td>Labour Relations Officer</td>
<td>ONA</td>
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<tr>
<td>Cheryl Kenniphaas</td>
<td>Registered Nurse</td>
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<tr>
<td>Craig MacVichie</td>
<td>HR, Program Support Partner</td>
<td>PRHC</td>
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<td>Registered Nurse</td>
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<tr>
<td>Jane Parr</td>
<td>VP &amp; Chief HR Officer</td>
<td>PRHC</td>
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<tr>
<td>Vicky Satta</td>
<td>Legal Counsel</td>
<td>PRHC</td>
</tr>
<tr>
<td>NAME</td>
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<td>Leanne Hubble</td>
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<tr>
<td>Adele Churchill</td>
<td>LRA</td>
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<tr>
<td>Karen McNeil</td>
<td>Registered Nurse, Unit Representative</td>
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<tr>
<td>Linda Haslam-Stroud</td>
<td>President</td>
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<tr>
<td>Mariana Markovic</td>
<td>Prof. Practice Specialist, Labour Relations Officer</td>
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<tr>
<td>Vicky Satta</td>
<td>Legal Counsel</td>
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ONA, PRHC
APPENDIX 8

The Ottawa Hospital Model
Model of Nursing Clinical Practice (MoNCP)
RPN Generic Skills List

At TOH, the RPN is expected to assume responsibility for complex patients with less acute conditions, when outcomes are predictable and the care needs are well defined and established. The patient’s acuteness must be determined by an RN through an initial assessment.

In keeping with the parameters of practice from the College of Nurses of Ontario (CNO), a consensus of experts from TOH has determined that certain skills may be performed by RPNs at TOH and this decision is based upon the acuity of our patients, the dynamics of our environment, the resources available to the RPN, the frequency of performing a skill to maintain competency, the level of risk involved, as well as the ability of the RPN to manage the possible outcomes of the skill. (CNO Practice Guideline, 2009 Utilizing RPN’s and RPN’s)

It is expected that the RPN’s competency will be enhanced by increasing their basic education through several educational strategies including orientation, training, and practice opportunities in the clinical areas. (CNO June 2009, Entry to Practice Competencies for Ontario Registered Practical Nurses).

If the RPN does not feel comfortable to perform a skill permitted at TOH, they must make this known, so that appropriate resources may be found to manage the patient’s care, including re-assignment.

There are also program based lists wherein the RPN receives extensive education and has extra resources within the unit to support their practice. These lists as well as the generic list are approved on an annual basis at the Professional Leaders meeting in April. They are available on the specific units wherein the skill is performed.

Please note that the definition of “care for” in the skills list refers to all the steps related to the performance and care provided for a certain skill. An example would be the IV section i.e. Insert IV device would indicate that the site assessment, set up of equipment, dressing change if needed, etc are being performed. The exceptions to care are listed in the “DO NOT” column.
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<thead>
<tr>
<th></th>
<th><strong>DO</strong></th>
<th><strong>DO NOT</strong></th>
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</thead>
<tbody>
<tr>
<td><strong>INTRAVENOUS THERAPY (Peripheral)</strong></td>
<td>• Insert, care for, and remove IV device</td>
<td>• Care for patients with Central Venous Access Device (CVAD)</td>
</tr>
<tr>
<td></td>
<td>• Set up and operate IV infusion pump</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Regulate flow (drops/minute)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Convert primary IV to a saline lock</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Convert saline lock to primary infusion</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Initiate and change primary IV solution with PRE-MIXED/SUPPLIED</td>
<td>• Care for patients with Total Parenteral Nutrition (TPN) and verify TPN orders</td>
</tr>
<tr>
<td></td>
<td>1. Potassium Chloride solution up to 40 milli-equivalents (meq)</td>
<td>• Administer anything other than primary IV solution with PRE-MIXED/SUPPLIED</td>
</tr>
<tr>
<td></td>
<td>2. Multivitamins</td>
<td>1. Potassium chloride solution up to 40milli-equivalents (meq)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Multivitamins</td>
</tr>
<tr>
<td></td>
<td>• Blood products</td>
<td>• Initiate administration of blood product</td>
</tr>
<tr>
<td></td>
<td>• Verify and co-sign when RN hangs blood products</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Care for, and monitor patient and regulate drops once blood product is infusing and patient stability is established</td>
<td></td>
</tr>
<tr>
<td><strong>NARCOTICS</strong></td>
<td>• Administer:</td>
<td>• Initiate and administer continuous subcutaneous narcotic medication infusion</td>
</tr>
<tr>
<td></td>
<td>1. Intermittent subcutaneous injections</td>
<td>• Administer IV narcotics</td>
</tr>
<tr>
<td></td>
<td>2. Transdermal</td>
<td>• Care for, monitor, or remove pleural epidural/IV PCA (Patient Controlled Analgesia)/peripheral block catheters</td>
</tr>
<tr>
<td></td>
<td>3. Oral</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4. Rectal</td>
<td></td>
</tr>
<tr>
<td></td>
<td>5. Intramuscular</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Pick up narcotics from pharmacy.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Complete end of shift count</td>
<td></td>
</tr>
<tr>
<td><strong>WOUND CARE AND WOUND DRAINAGE SYSTEMS</strong></td>
<td>• Care for and monitor simple wounds</td>
<td>• Blunt Debridement</td>
</tr>
<tr>
<td></td>
<td>• Irrigate simple wounds</td>
<td>• Irrigate percutaneous catheters (i.e. nephrostomy tubes, chest tubes)</td>
</tr>
<tr>
<td></td>
<td>• Change simple dressings</td>
<td>• Care for patients with Vacuum Assisted Closure (VAC) dressings</td>
</tr>
<tr>
<td></td>
<td>• Remove sutures/caps</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Manage complex dressing (where the base of the wound is not visible) including removal of packing, repacking and irrigation</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Care for, monitor and remove wound drainage systems including, Jackson Pratt (JP), Hemovac, and Penrose drains</td>
<td></td>
</tr>
<tr>
<td><strong>NUTRITION</strong></td>
<td>• Care for and monitor enteral feeding tubes</td>
<td>• Insert Naso-enteric tubes.</td>
</tr>
<tr>
<td></td>
<td>• Remove Naso-enteric tubes</td>
<td>• Remove or replace gastrostomy tubes</td>
</tr>
<tr>
<td></td>
<td>• Insert Naso-enteric tubes.</td>
<td>• Insert/Remove tracheo-oesophageal (TE) tubes</td>
</tr>
<tr>
<td>MEDICATIONS</td>
<td></td>
<td></td>
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<tr>
<td>-------------</td>
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<td></td>
</tr>
<tr>
<td><strong>DO</strong></td>
<td><strong>DO NOT</strong></td>
<td></td>
</tr>
<tr>
<td>Administer:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Transdermal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Topical</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Oral and sublingual</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Rectal and vaginal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Inhalation and nebulized</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Intradermal, intramuscular and subcutaneous injections</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Enteric feeding tubes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Intermittent subcutaneous medication</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. IV secondary medication PREMIXED/SUPPLIED antibiotics and antiviral agents solution via a mini bag system above the drip chamber through a secondary infusion line as follows:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Verify drug compatibility with the primary IV solution.</td>
<td></td>
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<tr>
<td>• Administer and prepare according to the TOH Parenteral Manual.</td>
<td></td>
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</tr>
<tr>
<td>• Inject the contents of the PREMIXED/SUPPLIED antibiotics or antiviral agent syringe prepared by pharmacy into a mini bag and label the mini bag.</td>
<td></td>
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<tr>
<td>• Dispense medications as per delegation on specific units</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Order from night pharmacy</td>
<td></td>
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</tr>
<tr>
<td>• Administer anything other than IV secondary medication PREMIXED/SUPPLIED antibiotics and antiviral agents prepared by pharmacy.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Administer IV secondary medication antibiotics and antiviral agents below the drip chamber (IV DIRECT).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Initiate and administer continuous subcutaneous medication infusion</td>
<td></td>
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</tr>
<tr>
<td>• Care for, monitor, or remove pleural/pituitary/IV PCA/peripheral block catheters.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>ELIMINATION</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Perform disimpaction</td>
<td></td>
</tr>
<tr>
<td>• Care for ostomy/ileo conduit</td>
<td></td>
</tr>
<tr>
<td>• Insert, care for and remove indwelling urinary catheters (i.e., Teney catheter)</td>
<td></td>
</tr>
<tr>
<td>• Perform closed system bladder irrigation</td>
<td></td>
</tr>
<tr>
<td>• Perform manual bladder irrigation for non surgical or maintenance catheter patients</td>
<td></td>
</tr>
<tr>
<td>• Remove supra-pubic catheters</td>
<td></td>
</tr>
<tr>
<td>• Perform bladder irrigation with medicated solution</td>
<td></td>
</tr>
<tr>
<td>• Perform manual bladder irrigation for surgical patients</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MONITORING AND ASSESSMENT</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Perform all of the following:</td>
<td></td>
</tr>
<tr>
<td>• Basic Head to toe Physical assessment (i.e., respiratory, cardiovascular, neuro, abdominal)</td>
<td></td>
</tr>
<tr>
<td>• Vital signs, Neuro-vitals</td>
<td></td>
</tr>
<tr>
<td>• Oxygen saturation</td>
<td></td>
</tr>
<tr>
<td>• Oxygen Titratiion Protocol (OTP)</td>
<td></td>
</tr>
<tr>
<td>• Neurovascular status (NVS) (with or without Doppler)</td>
<td></td>
</tr>
<tr>
<td>• Apply/Remove Sequential Compression Device (SCD) sleeves</td>
<td></td>
</tr>
<tr>
<td>• All responsibilities related to glucose testing</td>
<td></td>
</tr>
<tr>
<td>• Pronounce death when death is expected</td>
<td></td>
</tr>
<tr>
<td>• Complete initial Admission Assessment</td>
<td></td>
</tr>
<tr>
<td>DO</td>
<td>DO NOT</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td><strong>VENTILATION AND RESPIRATION</strong></td>
<td></td>
</tr>
<tr>
<td>✦ Use an oro-pharyngeal/masal airway</td>
<td>✦ MIE (mechanical in-exsufflatior treatment)</td>
</tr>
<tr>
<td>✦ Perform suction via Oropharyngeal, nasopharyngeal and tracheal routes</td>
<td>✦ Perform ongoing tracheostomy cuff pressure verification</td>
</tr>
<tr>
<td>✦ Care for non acute, non emergent patients with Non Invasive Positive Pressure Ventilation (NIPPV)</td>
<td>✦ Perform initial artificial airway application of:</td>
</tr>
<tr>
<td>✦ Care for a tracheostomy/laryngectomy for a patient with a healed stoma</td>
<td>1. Passy-Muir Valve (PMV)</td>
</tr>
<tr>
<td></td>
<td>2. Corking</td>
</tr>
<tr>
<td><strong>CHEST TUBES</strong></td>
<td></td>
</tr>
<tr>
<td>✦ Monitor established chest tubes (small and large bore)</td>
<td>✦ Care for PleurX drainage catheter/systems</td>
</tr>
<tr>
<td></td>
<td>✦ Change chest drainage systems</td>
</tr>
<tr>
<td></td>
<td>✦ Irrigate/Instill medications via any chest drainage system</td>
</tr>
<tr>
<td><strong>SPECIMEN COLLECTION</strong></td>
<td></td>
</tr>
<tr>
<td>✦ Venti-puncture including blood cultures</td>
<td>✦ Blood procurement from a CVAD</td>
</tr>
<tr>
<td>✦ Urine</td>
<td></td>
</tr>
<tr>
<td>✦ Stool</td>
<td></td>
</tr>
<tr>
<td>✦ Wound</td>
<td></td>
</tr>
<tr>
<td>✦ Swabs</td>
<td></td>
</tr>
<tr>
<td><strong>DOCUMENTATION</strong></td>
<td></td>
</tr>
<tr>
<td>✦ Transcribe physician’s orders</td>
<td>✦ Complete initial patient plan of care</td>
</tr>
<tr>
<td>✦ Recopy the Medication Administration Record (MAR). Either an RN or RPN can verify the profile before it is first used</td>
<td>✦ Transcribe special order sheets i.e. TPN, IV PCA, epidural, chemotherapy.</td>
</tr>
<tr>
<td>✦ Complete Medication Reconciliation Order (MRO)</td>
<td></td>
</tr>
<tr>
<td>✦ Update the Interprofessional (IP) Kardex, Inter professional patient care plan (IPPCP), patient teaching record.</td>
<td></td>
</tr>
<tr>
<td>✦ Identify Nursing Diagnosis</td>
<td></td>
</tr>
<tr>
<td>✦ Take telephone orders</td>
<td></td>
</tr>
<tr>
<td>✦ Take verbal orders in an emergency situation only</td>
<td></td>
</tr>
<tr>
<td>✦ Initiate Clinical Pathway (CP) as ordered</td>
<td></td>
</tr>
<tr>
<td>✦ Initiate medical directives that include the RPN</td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX 9

FMEA
What is an FMEA?

Since the 1960's Failure Modes and Effects Analysis (FMEA) have been used in the nuclear, military, aviation, food and automotive industries.

FMEA (Failure Modes and Effects Analysis) as it is applied in healthcare is a proactive team oriented approach to risk reduction for the purpose improving patient safety by minimizing risk potential in high risk processes.

Failure Modes and Effects Analysis (FMEA) is a systematic, proactive method for evaluating a process to identify where and how it might fail, and to assess the relative impact of different failures in order to identify the parts of the process that are most in need of change.

As opposed to focusing on a problem after it has occurred. FMEA looks at what ‘could’ go wrong at each step in the process, the so-called ‘Failure Modes’, assigns a risk score to each of these possibilities, and provides for a team orientated approach to focus resources on priority issues.

Why use FMEAs in Healthcare?

The 1999 Institute of medicine (IOM) report, ‘To Err is Human: Building a Safer Health System’ stated that most medical errors do not result from ‘individual recklessness,’ by instead from ‘basic flaws’ in the way the healthcare system is organized.

The following pages within this Appendix provide additional information.¹

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Phases of a FMEA

FMEAs are developed in three distinct phases where actions can be determined. It is also imperative to do pre-work ahead of the FMEA to assure that the Robustness and past history are included in your analysis.

Step 1: Occurrence

In this step it is necessary to look at the cause of a failure mode and the number of times it occurs. This can be done by looking at similar products or processes and the failure modes that have been documented for them in the past. A failure cause is looked upon as a design weakness. All the potential causes for a failure mode should be identified and documented. Again this should be in technical terms. Examples of causes are: erroneous algorithms, excessive voltage or improper operating conditions. A failure mode is given an occurrence ranking (O), again 1–10. Actions need to be determined if the occurrence is high (meaning > 4 for non-safety failure modes and > 1 when the severity-number from step 1 is 1 or 0). This step is called the detailed development section of the FMEA process. Occurrence also can be defined as %. If a non-safety issue happened less than 1%, we can give 1 to it. It is based on your product and customer specification.

<table>
<thead>
<tr>
<th>Rating</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>No known occurrences on similar products or processes</td>
</tr>
<tr>
<td>2/3</td>
<td>Low (relatively few failures)</td>
</tr>
<tr>
<td>4/5/6</td>
<td>Moderate (occasional failures)</td>
</tr>
<tr>
<td>7/8</td>
<td>High (repeated failures)</td>
</tr>
<tr>
<td>9/10</td>
<td>Very high (failure is almost inevitable)</td>
</tr>
</tbody>
</table>

Step 2: Severity

Determine all failure modes based on the functional requirements and their effects. Examples of failure modes are: Electrical short-circuiting, corrosion or deformation. A failure mode in one component can lead to a failure mode in another component, therefore each failure mode should be listed in technical terms and for function. Hereafter the ultimate effect of each failure mode needs to be considered. A failure effect is defined as the result of a failure mode on the function of the system as perceived by the user. In this way it is convenient to write these effects down in terms of what the user might see or experience. Examples of failure effects are: degraded performance, noise or even injury to a user. Each effect is given a severity number (S) from 1 (no danger) to 10 (critical). These numbers help an engineer to prioritize the failure modes and their effects. If the sensitivity of an effect has a number 9 or 10, actions are considered to change the design by eliminating the failure mode, if possible, or protecting the user from the effect. A severity rating of 9 or 10 is generally reserved for those effects which would cause injury to a user or otherwise result in litigation.
<table>
<thead>
<tr>
<th>Rating</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>No effect</td>
</tr>
<tr>
<td>2</td>
<td>Very minor (only noticed by discriminating customers)</td>
</tr>
<tr>
<td>3</td>
<td>Minor (affects very little of the system, noticed by average customer)</td>
</tr>
<tr>
<td>4/5/6</td>
<td>Moderate (most customers are annoyed)</td>
</tr>
<tr>
<td>7/8</td>
<td>High (causes a loss of primary function; customers are dissatisfied)</td>
</tr>
<tr>
<td>9/10</td>
<td>Very high and hazardous (product becomes inoperative; customers angered; the failure may result unsafe operation and possible injury)</td>
</tr>
</tbody>
</table>

**Step 3: Detection**

When appropriate actions are determined, it is necessary to test their efficiency. In addition, design verification is needed. The proper inspection methods need to be chosen. First, an engineer should look at the current controls of the system, that prevent failure modes from occurring or which detect the failure before it reaches the customer. Hereafter one should identify testing, analysis, monitoring and other techniques that can be or have been used on similar systems to detect failures. From these controls an engineer can learn how likely it is for a failure to be identified or detected. Each combination from the previous 2 steps receives a *detection number* \( (D) \). This ranks the ability of planned tests and inspections to remove defects or detect failure modes in time. The assigned detection number measures the risk that the failure will escape detection. A high detection number indicates that the chances are high that the failure will escape detection, or in other words, that the chances of detection are low.

<table>
<thead>
<tr>
<th>Rating</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Certain - fault will be caught on test</td>
</tr>
<tr>
<td>2</td>
<td>Almost Certain</td>
</tr>
<tr>
<td>3</td>
<td>High</td>
</tr>
<tr>
<td>4/5/6</td>
<td>Moderate</td>
</tr>
<tr>
<td>7/8</td>
<td>Low</td>
</tr>
<tr>
<td>9/10</td>
<td>Fault will be passed to customer undetected</td>
</tr>
</tbody>
</table>

After these three basic steps, risk priority numbers (RPN) are calculated.
**Risk Priority Numbers (RPN)**

After each of these steps actions are developed. Next, **Risk Priority Numbers (RPN)** are calculated. Please note that RPN's are calculated after three possible action opportunities have occurred. Actions are not only determined based on RPN values. RPN threshold values do not play an important role in action development, only in action evaluation when completed.

Selecting an arbitrary RPN to fall below is both ineffective at driving change and foolhardy if the order of the improvement is not controlled (severity, occurrence, detection) steps 1,2,3 as described above.

In past years, setting an RPN would immediately be met with lower numbers without any real change or improvement. This is not preventing failure, but in fact driving bad behavior of the design and process teams required to perform the FMEA.

**Summary**

For further information, it is suggested that the Quality Healthcare Network of Ontario or the Canadian Patient Safety Institute (CPSI) be accessed.