Independent Assessment Committee Report

Constituted under Article 8.01 of the

Collective Agreement

between

Rouge Valley Health System

and

Ontario Nurses' Association

February 2014

Independent Assessment Committee

The Rouge Valley Health System
and
The Ontario Nurses' Association

Amelia McCutcheon
Vice President, Cardiac, Cancer & Critical Care
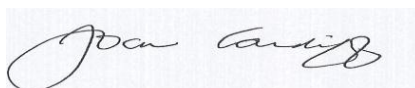Chief Nurse Executive
Rouge Valley Health System

Jo Anne Shannon
Professional Practice Specialist
Ontario Nurses' Association

The members of the Independent Assessment Committee Panel respectfully submit the attached Report with findings and recommendations regarding the Professional Development Complaint presented by the Registered Nurses working on 3 Margaret Birch Wing at the Centenary Site of the Rouge Valley Health System.

The Professional Responsibility Complaint was presented to the Independent Assessment Committee, in accordance with Article 8.01 of the Collective Agreement between the Rouge Valley Health System and the Ontario Nurses' Association, at a Hearing held January 7 – 9, 2014.

The Independent Assessment Committee Panel recognizes and appreciates the time, energy and thought given by representatives of the Rouge Valley Health System, the Ontario Nurses' Association and the Registered Nurses working on 3 Margaret Birch Wing to prepare and present information regarding the Professional Responsibility Complaint, and to respond to the Panel's questions. The attached Report contains unanimously supported recommendations which we hope will assist all parties to continue to work together, within the context of a quality practice environment that supports professional practice, to provide proper patient care to the patients residing on 3 Margaret Birch Wing.
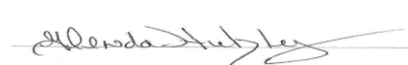
Respectfully submitted on February 14, 2014.

_____
Joan Cardiff, RN
Chairperson, Independent Assessment Committee

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Carol Anderson, RN   Glenda Hubley, RN
Rouge Valley Health System Nominee   Ontario Nurses' Association Nominee

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SECTION 1

INTRODUCTION

1.1   Organization of the Independent Assessment Committee Report

The Independent Assessment Committee (IAC) Report is presented in five sections.

Section I reviews the IAC's jurisdiction as outlined in the Collective Agreement between the Rouge Valley Health System ('the Hospital') and the Ontario Nurses' Association ('the Association'), reviews the process of referral of the Professional Responsibility Complaint ('the PRC') to the IAC, and presents the Pre-Hearing, Hearing and Post-Hearing processes.

Section II presents the IAC's understanding of the PRC, including the development of the PRC, referral of the PRC to the IAC, and activities undertaken between the IAC referral and IAC Hearing, and presents the IAC's understanding of the Association's and Hospital's perspectives regarding the PRC issues.

Section III presents the IAC's analysis and discussion of the issues relating to the PRC.

Section IV presents the IAC's conclusions and recommendations.

Section V contains the Appendices referenced throughout the IAC Report.

1.2   Jurisdiction of the Independent Assessment Committee

The IAC is governed under Article 8.01 of the Collective Agreement between the Hospital and the Association.

Article 8.01 (a) sets of the PRC process by which Registered Nurses (RNs) may raise their concerns regarding their perspective of being asked to perform more work than is consistent with proper patient care. Article 8.01 (a) also outlines the steps to be followed to address the RNs' concerns to the mutual satisfaction of the RNs, the Local Committee and the Hospital. Article 8.01 (b) identifies the logistics associated with selection and remuneration of the IAC Chairperson and Hospital and Association Nominees (*Appendix 1*).

The IAC's jurisdiction relates to whether RNs have cause to believe that they are being asked to perform more work than is consistent with proper patient care. As identified in the College of Nurses of Ontario (CNO) 'Three Factor Framework'[1], RN workload is impacted by the inter-relationship of:

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[1] College of Nurses of Ontario: Practice Guideline: *RN and RPN Practice: The Client, the Nurse and the Environment.* ISBN 978-1-897308-95-0, Publication # 41062, December 2011

- client factors (complexity of care needs, predictability of outcomes, risk of negative outcomes),
- nurse factors (knowledge, skill and judgement of the nurse in relation to direct practice, leadership, resource management and research), and
- environmental factors (practice supports, consultation resources, stability and predictability of the practice environment).

The IAC is responsible for examining the client, nurse and environmental 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, analysis and recommendations are intended to provide an independent and external perspective to assist the RNs, the Association and the Hospital to achieve a mutually satisfactory resolution to the PRC. The IAC is not an adjudicative panel, and its recommendations are non-binding.

1.3   Referral to the Independent Assessment Committee

The RNs on 3 Margaret Birch Wing at the Centenary site of the Rouge Valley Health System began to consistently document concerns regarding workload following the implementation of a Collaborative Care Model on the unit in October 2011 that included the introduction of Unregulated Care Providers (UCPs)[2]. A total of 103 Professional Responsibility Workload Report Forms (PRWRFs) were submitted between October 2011 and the time of the Hearing in January 2014.

Between 2011 and late 2013, the Association and the Hospital invested significant effort to address issues impacting the RNs' workload. This included discussion at regularly held Hospital Association Committee (HAC) meetings, program-specific Model of Care Working Group meetings, staff meetings, Unit Council meetings, provision of extensive education sessions relating to regulated/unregulated role responsibilities, education on assignments utilizing the "3 Factor Framework", and several Lean and Kaizen events. Although strategies were developed and implemented to address the key identified issues, these were constructive but insufficient to meet the RNs' key practice and workload concerns. The Association notified the Hospital of its referral of the PRC to an IAC on June 12, 2013 (*Appendix 2*).

1.4   Proceedings of the Independent Assessment Committee

1.4.1   Pre-Hearing

1.4.1.1   Nominee Selection

In accordance with Article 8.01 (a) (viii), the Association and the Hospital identified their Nominees to the IAC. The IAC Chairperson received notification of the Association's Nominee, Glenda Hubley, on July 17, 2013 (*Appendix 3*) and the Hospital's Nominee, Carol Anderson, on July 22, 2013 (*Appendix 4*).

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[2] Unregulated Care Provider (UCP) is a generic term used to differentiate regulated from unregulated care providers.

1.4.1.2   IAC Introductory Teleconference

The Chairperson contacted the Nominees on July 22, 2013. Due to the summer vacation logistics of the IAC Panel, the IAC held its introductory teleconference on August 22, 2013. The Chairperson reviewed the jurisdiction of the IAC within the Collective Agreement, discussed the role of the Nominees and Chairperson, reviewed the three phases of the IAC process, and discussed logistics associated with scheduling the Hearing and the process for review of the Hearing Briefs. Following the teleconference, the Nominees discussed potential dates for and location of the Hearing with their respective parties.

1.4.1.3   Hearing Confirmation and Hearing Brief Distribution

The date for the Hearing was confirmed on September 18, 2013, and the location was determined in early October. The IAC Chairperson wrote to the Hospital and the Association on October 4, 2013 to confirm the date and location of the Hearing and to provide the draft Hearing Agenda. Respecting the principle of full disclosure and to streamline the process of the Hearing by enabling the IAC to become familiar with the issues in advance, the IAC requested the Hospital and the Association to submit a Hearing Brief to the Chairperson by December 13, 2013 (*Appendix 5*).

The IAC Chairperson received and distributed the Hearing Briefs and supporting Exhibits as follows:
- Association Brief received December 13, 2013 and distributed to the IAC Panel and the Hospital on December 17, 2013;
- Hospital Brief received December 16, 2013 and distributed to the IAC Panel and the Association on December 17, 2013; and

The Hospital submitted additional information to supplement its Brief on December 30, 2013. This information was sent to all parties directly by email on December 30, 2013.

1.4.1.4   IAC Pre-Hearing Meeting

The IAC held a full-day Pre-Hearing meeting on January 6, 2014. The IAC reviewed the anticipated process of the Hearing, discussed the Hearing Briefs and identified key issues for exploration at the Hearing.

1.4.1.5   Confidentiality Issue

The Hospital and the Association met on the morning of January 7, 2014 to discuss the Hospital's request that all non-Hospital employees participating on the Site Tour sign a confidentiality agreement. This issue was resolved to the mutual satisfaction of the parties.

1.4.1.6   Site Visits: January 7, 2014 and January 8, 2014

On the morning of January 7, 2014, the IAC Panel conducted a Site Tour of 3 Margaret Birch Wing (3 MBW). In addition to the IAC Panel, the following individuals attended the Site Tour:
On behalf of the Hospital:
- Aaisha Savvas, Manager, 3 MBW
- Cheryl Williams, VP, Acute and Post-Acute Services
- Karl Wong: Director, Post-Acute Services & Allied Health

On behalf of the Association:
- Brenda Barnes, Unit Coordinator, 3MBW
- Mary Deli, ONA-RVHS Professional Responsibility Representative
- Meni Didimos-Bryant, ONA Professional Practice Specialist
- Sue Peschke, RN, 3 MBW
- Jo Anne Shannon, ONA Professional Practice Specialist

The Tour was led by Aaisha Savvas and included a comprehensive walk-through of all areas on the 3 West and 3 East areas of 3MBW. The Tour provided an opportunity to understand the context of practice regarding documentation, care planning and care provision, medication administration and intra-unit team communication, as well as an introduction to the geographical configuration of the two sides of the 3MBW unit.

On the morning of January 8, 2014, the IAC, accompanied by Brenda Barnes and Aaisha Savvas, observed the change of shift report between the outgoing night and incoming day staff on 3 East.

1.4.2   Hearing

1.4.2.1   Hearing Schedule

The Hearing convened at 1330 hours in the Dr. Bruce Johnston Conference Room at the Centenary Site of the Hospital. As indicated on the Hearing Agenda (*Appendix 6*), the Hearing was held over three days as follows:

January 7, 2014:   13:30 – 17:30 hours

January 8, 2014:   08:30 – 11:30 hours
                                    12:30 – 16:00 hours

January 9, 2014:   08:30 – 13:30 hours

The participants and observers who attended the Hearing are listed in *Appendix 7.*

1.4.2.2   Hearing Day 1: January 7, 2014

The IAC Chairperson opened the Hearing at 13:30 hours. Following introduction of the three IAC Panel members and round-table introduction of the Hospital and Association participants, the IAC Chairperson reviewed the following:
- the Hearing process, including anticipated flow and organization of each day;
- the jurisdictional scope of the IAC, including the purpose of the IAC and the nature of its non-binding recommendations;
- the role of Hearing participants, to promote clarity of understanding of the issues from their perspective; and
- the 'ground rules', to facilitate a respectful, constructive and non-adversarial environment.

The Association Brief, presented by Jo Anne Shannon, reviewed the Association's written Brief and 59 Exhibits of supporting/explanatory information, as well as copies of the PRWRFs submitted by RNs on 3 MBW between October 2011 and January 2014. Following the presentation, the Association responded to questions of clarification from the Hospital and the IAC.

A break was held between the Association and Hospital presentations.

The Hospital Brief, presented by Shane Smith, reviewed the Hospital's written Brief and 44 Exhibits of supporting/explanatory information. Following the presentation, the Hospital responded to questions of clarification from the Hospital and the IAC.

The Chairperson adjourned the Hearing at 17:30 hours.

1.4.2.3   Hearing Day 2: January 8, 2014

The IAC Chairperson opened the Hearing at 08:30 hours.

Shane Smith, supported by members of the Hospital Hearing team, provided the Hospital's response to the ONA Hearing Submission.   Following the lunch break, Jo Anne Shannon, supported by members of the Association Hearing team, provided the Association's response to the Hospital Hearing Submission. Following both presentations, members of both the Hospital and the Association teams participated in active discussion.

The Chairperson adjourned the Hearing at 16:00 hours.

1.4.2.4   IAC Intra-Hearing Meeting

The IAC met during the evening of January 8, 2014 and the morning of January 9, 2014 to review and synthesize the information presented through the written Briefs, supporting documents and discussion during the Hearing, and to identify questions to focus the Hearing discussions on January 9, 2014.

1.4.2.5   Hearing Day 3: January 9, 2014

The IAC Chairperson opened the Hearing at 08:30 hours.

The IAC focused discussion through a series of questions relating to staffing and scheduling, professional practice, shared governance, role clarity regarding regulated and unregulated practitioners, pharmacy and medication administration issues, unit processes, model of care and the Hospital bedmapping initiative. All Hearing participants actively participated in the discussion.

Shane Smith, on behalf of the Hospital, and Jo Anne Shannon, on behalf of the Association, provided final comments following the Question and Answer session.

The IAC Chairperson's closing comments referenced the following:
- appreciation for the time and effort given by both parties to prepare the Hearing submissions and additional requested information, and for the participants' engagement in and commitment to the Hearing process;
- reconfirmation that the IAC process is intended to provide an independent objective external perspective to aid in the resolution of outstanding issues, and that although the recommendations are non-binding, it is hoped that they will provide a foundation from which both parties can move forward constructively; and
- confirmation that the IAC Report would be submitted within the 45 calendar day timeframe stipulated in Article 8.01 (a) (viii) of the Collective Agreement.

The Chairperson closed the Hearing at 13:30 hours.

1.4.3   Post-Hearing

1.4.3.1   IAC Report Development

The IAC met once in person and five times by teleconference to draft the Report.

The IAC held a full-day face-to-face Post-Hearing Meeting on January 22, 2014, during which the Panel reviewed Draft 1 of the Report and discussed the IAC's analysis and proposed recommendations in depth. The IAC met by teleconference on January 24, 2014 to review Draft II, January 29, 2014 to review Draft III, February 3, 2014 to review Draft IV, February 11, 2014 to review Draft V and February 13, 2014 to review Draft VI. The IAC unanimously approved the Report by email on February 14, 2014.

1.4.3.2   IAC Report Submission

The IAC Report was submitted to the Association and the Hospital by email, in PDF format, on February 14, 2014.

SECTION II

PRESENTATION OF THE PROFESSIONAL RESPONSIBILITY COMPLAINT

2.1   Development of the Professional Responsibility Complaint

2.1.1   Events Prior to Referral of the Professional Development Complaint

The Post-Acute Program at the Hospital includes two inpatient care units at the Centenary Site: 3 Margaret Birch Wing and 4 Margaret Birch Wing, and two inpatient units at the Ajax Site: 2 North and 3 East.   In January 2011, as part of the Central East Local Health Integrated Network's (CE LHIN) *Aging at Home Strategy*, the Hospital implemented a Transitional Restorative Care Program (TRCP) on 2 North. In accordance with the CE LHIN funding model, the TRCP was based on a collaborative care model which utilized RNs, RPNs and UCPs as direct care providers.

In April 2011, the Hospital initiated a "Post-Acute Optimization Project" to realign the Post-Acute Program with the Hospital's strategic direction that "hospital is not the place to provide residential service when this is best provided in the community when patients are able to make that transition."[3] Building on the experience of implementation of the TRCP at the Ajax Site, the project plan indicated that 3 MBW would expand from 40 to 44 beds, and would move from a primary nursing model, with all care provided by RNs and RPNs, to a collaborative care model, with personal care provided by UCPs[4] under the direction and supervision of RNs and RPNs. Within the former primary nursing model, the regulated (RN or RPN) nurse : patient ratio was 1:5 during the day, 1:6 during the evening and 1:10 at night[5]. Following implementation of the collaborative care model, the total staff direct care provider (RN, RPN, UCP) to patient ratio on the unit moved to 1:4.8 on days, 1:5.5 on evenings and 1:11 on nights. The regulated (RN or RPN) nurse : patient ratio was 1:11 on days, evenings and nights, with the UCPs providing the majority of the personal care[6].

In preparation for moving to the collaborative care model, the Hospital announced the layoff of three full-time RNs from 3MBW in May 2011. An additional two full-time RN positions were eliminated in September as a result of the Manager being unable to create a workable master schedule with six full-time RNs. As a result, 3MBW was left with four full-time and eight part-time RNs, a FT:PT ratio of 33:67. UCP positions were posted in June 2011, and the successful candidates began a 2-week clinical

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[3] *Post-Acute Care Optimization* presentation by Hospital to ONA, CUPE, OPSEU in April 2011. (Exhibit 10: Hospital Brief)

[4] The individuals hired into the UCP positions at the Hospital were Personal Support Workers. The IAC is unclear what proportion of these individuals had previously completed a formal PSW Program, and what proportion transferred internally from other positions within the Hospital and received Hospital-based education only.

[5] Hospital Brief, pg. 15. This ratio relates to direct care providers only; the Unit Coordinator and Unit Clerk were not included in the calculation. The IAC believes that the regulated nurse : patient ratio was in fact 1:5.5 on days and evenings and 1:11 on nights.

[6] By November 2013, the total direct care provider staff to patient ratio had moved to 1:4.4 on days, 1:5.7 on evenings and 1:10 on nights. The regulated nurse : patient ratio was 1:8 on days, and 1:10 on evenings and nights.

orientation on 2 North followed by a one-month orientation on 3MBW in September 2011. Policies/tools to assist with the transition from a primary nursing to collaborative care model[7] on 3MBW, developed over the summer, formed the basis for this orientation period.

In September 2011, several RNs expressed concern regarding the roll-out of the collaborative care model; one wrote "I hear the new model of care will start on oct 6 (just an fyi). nothing is written and all info is second hand. Is there anything I should be asking for? Education was very minimal. everything is very up in the air"[8]. That month, the Association and the Hospital made a joint application to the MOH-LTC Quality Environment – Quality Patient Care Funding initiative. One of the eight requested projects was $34,305 funding for "Creating Culture of Staff Engagement during Transition to a multi-disciplinary Model of Care – RVC 3 East / 3 West, 2 North, 3 East TRCP. Assist with model change and develop systems to facilitate safe practice and patient care"[9]. The Hospital received funding for this request, which was implemented on 2 North but not 3MBW, due to staffing changes in the Unit Coordinator position between November 2011 and January 2012.

In September 2011, RNs began to document concerns regarding the RPN role on 3MBW. The collaborative care model was based on the expectation that RPNs would work at full scope including the administration of blood products, administration of IM, IV and oral medications, and provision of direction and supervision of UCPs. As many of the RPNs on 3MBW began practice before these competencies became part of the RPN role, additional education was required. During the period when RPNs were 'coming up to speed', the RNs were required to cover these responsibilities when the RPN was unable, or unwilling, to do so[10].

A Model of Care Working Group, involving staff from the inter-professional 3MBW team, was established in October 2011 to enable inter-disciplinary discussion regarding team functioning. Over the seven meetings held between October 2011 and February 2012, the group discussed communication issues and strategies, role clarity/role responsibilities of the UCPs, unit clerks and RNs/RPNs, unit routines, scheduling of patients for therapy (PT, OT and recreation therapy), and team building. Although the minutes indicate that discussion at these meetings was spirited, unresolved issues remained in each of these areas in February 2012, when the Working Group ceased meeting[11].

In January 2012, as part of the HAC process, specific meetings regarding 3MBW workload concerns were held in response to concern regarding the continually increasing number of PRWRFs submitted since October 2011. RNs were consistently documenting concerns relating to intra-team communication, late

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[7] Policy: Utilization of Personal Support Workers (Exhibit 11: Hospital Brief), Guidelines: Understanding the PSW Role – How does it Affect my Practice? (Exhibit 12: Hospital Brief) and Role Clarity Chart (Exhibit 14: Hospital Brief); Documentation: *Assessment and Routine Care Flowsheet* (Exhibit 13: Hospital Brief); PSW Orientation Evaluation Form (Exhibit 7: Association Brief).

[8] September 27, 2011 email from Carol Oates, Bargaining Unit President to Karl Wong, Director Post-Acute & Allied Health Services (Exhibit 14: Association Brief)

[9] September 9, 2011 submission (Exhibit 12: Association Brief).

[10] In January 2012, RPNs began attending an RPN Competency Skills Day on a voluntary basis. Uptake was slow. It was not until May to July 2013 that the Hospital monitored RPNs to ensure they could demonstrate the required competencies. The Hospital notified the Association at the July 30, 2013 HAC Meeting that all available RPN staff were competent, and acknowledged "it failed to effectively implement the new model of care by allowing the RPNs to delay full scope implementation" (#70, pg. 21, Hospital Brief)

[11] The minutes of the February 14, 2012 meeting state "Next Meeting: TBD". The IAC is unclear as to why the meetings ceased at that time.

medication administration, lack of required equipment, inappropriate patient assignments etc. These issues were confounded in the spring of 2012, when the follow-up investigation of a family complaint resulted in further erosion of the staff-leadership relationship. In an attempt to address the ongoing conflict within the 3MBW team, a series of half-day Team Building/Education Days were held in April and May 2012, to ensure a consistent understanding of important aspects of care and to solicit feedback on formalizing communication between staff. Over the summer, initiatives emanating from the Team Building sessions included a new change of shift report form, a new daily activity log for the UCPs, and a series of education sessions focusing on specific care elements (e.g. antimicrobial wound dressings, ceiling lifts, pneumococcal vaccines).

In July 2012, a Kaizen event was held to plan for the implementation of 4P Rounding (defined by the Hospital as "standardizing the rounding process to address the 4Ps of pain, position, personal care and presentation"[12]). The IAC understood that the decision to implement this structured form of assessment emanated from a review of the issues surrounding the March 2012 family complaint. In addition, a number of issues identified in the Kaizen event[13] were addressed prior to implementation of 4P Rounding in October 2012. Expectations for all staff (Unit Coordinator, RN, RPN, UCP, Unit Clerk, OT/PT, Rec Therapy and Social Work) were articulated in an "Hour by Hour Accountability" schedule of activity document, which specified that 4P Rounding was to be completed every hour on the day shift and every two hours on evenings and nights, with specific care providers assigned specific time slots.

In November 2012, the Association sent a Pre-Complaint letter to the Hospital, identifying ongoing concerns as evidenced in the PRWRFs and requesting that the Hospital agree to allow a Professional Practice Specialist to become actively involved to "work with the Employer to achieve resolution to member's concerns"[14]. The Hospital agreed, and a Professional Practice Specialist(s) began attending HAC meetings in March 2013.

In an ongoing effort to clarify role responsibilities, a number of education sessions were held. An Outreach Consultant from the College of Nurses of Ontario (CNO) presented *RN and RPN Practice in Acute Care: The Client, the Nurse and the Environment* in January 2013 and *Working Together: RN, RPN and UCP Collaboration* in May 2013, and in April 2013 the Hospital coordinated a one-day meeting for all Unit Coordinators to discuss patient flow and use of the 3 Factor Framework for creating patient assignments.

At the May 29, 2013 HAC Meeting, the Association notified the Hospital that the PRC was being referred to an IAC but that the Association wished to continue to work closely with the Hospital to resolve issues on 3MBW. At the meeting, the key issues of concern were noted as:
- the roles of RNs, RPNs and UCPs (the RPNs, now practising at full competency, were not capable of caring for patients with the high level of acuity on the unit, the UCPs were continuing to request assistance from the RNs for bedside care);

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[12] #54, Hospital Brief, pg. 18

[13] These included a 6S event (to clean and organize the supply room, hallways, utility room and nurses station), alteration of unit clerk hours to ensure coverage from 1530-1600 during change of shift, renovations and equipment purchase (team charting stations, new med carts, satellite supply carts, new computers, new commodes) to decrease staff time spent walking to and searching for supplies.

[14] November 19, 2012 letter from Steven Lobsinger, ONA Labour Relations Office to Susan Fyfe, RVHS Director Women's and Children's Program (Exhibit 25: Association Brief)

- patient assignment using the 3 Factor Framework; and
- inappropriate patients being admitted to the unit (insufficient skill mix to meet the complex care needs of the patient population)[15].

The Association submitted the formal notification of referral of the PRC to an IAC on June 12, 2013 (*Appendix 2*).

2.1.2   Events Following Referral of the Professional Responsibility Complaint

Following referral to the IAC, efforts continued to address the workload issues on 3MBW.   Between May and November 2013, RN, RPN and UCP staff participated in a 3-day Collaborative Care Training Event[16], which focused on understanding the 3 Factor Framework, how to collaborate effectively in a team environment, and how to have 'crucial conversations' with colleagues in instances of disagreement. In June 2013, an A3 (Lean Quality Improvement Exercise) was held to address communication and process issues. The issues identified[17] mirrored some of the concerns expressed by the RNs through PRWRFs submitted since the move to the collaborative care model of care delivery. A number of "quick wins" resulted, including the purchase of commode chairs and wireless phones, and placement of hard-copy policy binders at the nursing station. A second A3 was held in July to address diabetic management in Post-Acute Care.

In July 2013, the Hospital introduced a new Bed Map, in which 3MBW would move from 44 to 40 beds with a complex continuing care /restorative focus, and patients with complex medical and behavioural challenges would receive care on integrated units "better suited to meet their needs"[18] (i.e. not 3MBW). The 4 beds moved from 3MBW to 4MBW in August, resulting in a regulated nurse : patient ratio of 1:10 on days, evenings and nights, with the UCP continuing to provide the majority of personal care for the 10 patients within the dyad. As well, the decision was made to increase unit clerk hours from 5 to 14 shifts per week (providing 0800 – 1600 and 1200 – 1800 coverage) seven days per week[19].

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[15] Exhibit 4j, Association Brief, pg. 9; #63, pg. 19, Hospital Brief

[16] The IAC understood that at the time of the Hearing, the "majority" of staff had participated in the 3-day program, and that additional sessions were planned for January 2014.

[17] Table: Exhibit 29, pg. 153, Hospital Brief

		DIFFICULTY		
		Easy	Medium	Hard
I M P A C T	High	Equipment purchase	Medication administration	Communication on unit
			Blood sugar execution	Scheduling
				Documentation on unit
				TREAT/MDS
				MD follow-up
	Med	Maintenance and repairs	4P Rounding Execution	
			Policies – family education	
			Standard Work & Level Loading	
	Low			

[18] #67, pg. 20, Hospital Brief

[19] The 1200 – 2000 Monday-Friday shift was implemented in November 2013. At the time of the Hearing, interviews were underway for part-time unit clerks to provide the four shifts of weekend coverage.

As the time required for medication administration continued to be a key area of concern, Takt time[20] evaluations were conducted in October and November 2013. Multiple differences in practice among the RNs and RPNs were noted. In an effort to streamline the process, sharps containers were replaced by waste bins on the med carts, an electronic pill crusher was purchased, MAR books were established for each med cart, and a sign "no interruptions" was posted on each cart. As well, Bullet Rounds were changed from 0830 to 1100 to minimize interference with morning medication administration.

In August 2013, the 3MBW Unit Council was (re)established. Initially chaired by two UCPs, co-chairing responsibility moved to the Unit Coordinator and a UCP in October[21]. The Unit Council met five times between August and December 2013. As indicated by the minutes, the Council discussed the key issues identified through the PRWRFs, and Kaizen and A3 events, including 4P Rounding, medication administration, intra-team communication, and MDS completion[22].

In September 2013, the Hospital underwent a corporate restructuring, which resulted in the assignment of a different Manager to 3 MBW and a different Vice President for the Post-Acute Program. The new Manager is a Registered Physiotherapist; the new Vice President is an RN.

Two initiatives to improve intra-team communication were implemented in October 2013. A white board for each patient was installed in the patient rooms, to "support nursing to visually direct the personal care needs of patients"[23]. This initiative would support the UCP to provide appropriate personal care without needing to interrupt the RN/RPN, and would facilitate team-family communication. In addition, the change of shift process was revised to ensure report could be completed within 15 minutes.

Also in October, a "float RPN" position was trialed on the day shift, to assist with timely medication administration. In November, the "float RPN" position was changed to a "float RN", responsible for providing total patient care to two patients on each of 3 West and 3 East on the day shift[24], which altered the total direct care provider staff : patient ratio to 1:4.4 and the regulated nurse : patient ratio to 1:8[25]. The RN and RPN on 3 West and the two RPNs on 3 East continued to pair with a UCP within the collaborative care model, with each dyad now responsible for 9 patients on the day shift.

A second comprehensive (three-day) Kaizen event was held in late November 2013. A revised Hour by Hour Accountability schedule resulted, which altered 4P Rounding expectations (4P rounding to be completed every 2 hours by RN/RPN and UCP with 2P "Safety Checks" completed in-between). The outcome of the revision was "further role clarity, spreading the workload across days and evenings,

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[20] Takt time is the available production time per day divided by customer demand per day. Takt time provides the heartbeat of a Lean production system. First used as a production management tool by the German aircraft industry in the 1930s, it has been widely utilized by Toyota since the 1950's. http://www.lean.org/Common/LexiconTerm.aspx?termid=337 (accessed 14/01/2014)

[21] The IAC understood that the agreed plan is to replace with UCP co-chair with an RN co-chair, to enable the Unit Council to be chaired by regulated practitioners.

[22] Exhibit 31, Hospital Brief; Exhibit 49, Association Brief

[23] #78, pg. 23, Hospital Brief

[24] The IAC understood that the "float RN" is also responsible for completing outdated MDS assessments, but was unclear as to whether this expectation related to her four patients, or to all 40 patients on 3MBW.

[25] This ratio does not include the Unit Coordinator. With the Unit Coordinator included, the regulated nurse : patient ratio is 1:5.7.

standardizing breaks, and creating communication touch points within and between roles"[26]. At the time of the Hearing, the IAC understood that these changes were in the process of being implemented.

Notwithstanding the efforts and process initiatives undertaken since referral of the PRC to the IAC in June 2013, the Hearing proceeded as scheduled on January 7 – 9, 2014.

2.2   Ontario Nurses' Association and Rouge Valley Health System Perspectives

The Hearing was structured such that:
- On January 7, 2014, the Association and the Hospital each provided an oral Submission presentation highlighting the key elements of their previously submitted written Brief.
- On January 8, 2014, the Hospital and the Association each provided an oral Response presentation, which included an opportunity for each party to clarify / discuss / challenge / question the information provided by the other.
- On January 9, 2014, the IAC posted a number of questions, to both parties, to obtain a more comprehensive understanding of the issues. The questions related to:
    - staffing and scheduling (self-scheduling, innovative scheduling, orientation provided to the Staffing Resource Team (SRT) and agency staff, clerical hours, staff replacement processes),
    - professional practice,
    - shared governance,
    - role clarity (operationalization of the PSW Role Profile, embedding of collaborative care model into practice, outcome of the collaborative care education sessions, Standard Work documents),
    - pharmacy and medication issues (hand-written vs electronic documentation, committee structure, incident/adverse event review, administration standards and practices, polypharmacy),
    - unit processes (3 Factor Framework, accountability for patient assignment, change of shift report, documentation of patient care needs),
    - model of care, and
    - bed mapping.

From the Hearing Briefs and supporting Exhibits submitted prior to the Hearing, the presentations, discussion and response to Questions at the Hearing, and analysis of information following the Hearing, the IAC understands the Association's and Hospital's perspectives regarding the PRC on 3MBW to be the following.

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[26]#81, pg. 23, Hospital Brief

2.2.1   Ontario Nurses' Association

Accountability of RNs

The CNO *Professional Standards*[27] states that RNs are accountable to advocate on behalf of their clients, to provide, facilitate, advocate for and promote the best possible outcomes for clients, to seek assistance in a timely manner, and to take action in situations where client safety and well-being is compromised. The RNs on 3MBW are meeting their CNO accountabilities by notifying their leaders of their care and practice concerns through documenting on PRWRFs.

The CNO *Professional Standards* state that administrative nurses are accountable to ensure mechanisms allow for staffing decisions that are in the best interest of clients and professional practice, support the appropriate use, education and supervision of staff, advocate for a quality practice setting that supports nurses' ability to provide safe, effective and ethical care, articulate an evidence base for all decisions, ensure systems are in place to effectively reduce and manage conflict between staff members, and involve nursing staff in decisions that affect their practice.   While the nursing leadership has acknowledged issues and taken some actions, serious concerns relating to the nurses' inability to provide quality care remain unresolved.   As noted in the *Professional Standards*, a quality practice environment is central to the provision of care; the RNs on 3MBW are unable to meet the required standards of care due to excessive workloads and inappropriate staff mix.

Concerns regarding Process of Change from Primary Nursing to Collaborative Care Model

The Association believes that the change processes supporting the transition from a primary nursing to collaborative care model on 3MBW were inadequate to support the change, and thus negatively contributing to the current workload concerns.

- The Association first requested educational support for RNs in August 2011, believing that RNs needed support to understand the expected role and skill set of UCPs, and their role responsibilities in working with UCPs. The Association believes that the internal education sessions, team building sessions, A3 and Kaizen events and external CNO presentations that have occurred since October 2011 have not successfully addressed this concern, especially in relation to working with UCPs. The Association believes that role clarity remains an outstanding issue.
- The Association believes that if the Unit Coordinator on 3MBW had been able to participate in the MOH-LTC funded Quality Environment – Quality Patient Care Initiative in early 2012, the skill mix and model of care transition on 3MBW might have proceeded more smoothly.
- The Hospital's decision to decrease the full-time RN staff from nine to four positions has resulted in a full-time : part-time ratio of 33:66, which is significantly different than the provincial norm of 70:30, and has contributed to fractured continuity of patient care.
- The Association recognizes the Hospital's acknowledgement that the RPNs' development of practice competencies at full scope was inappropriately slow and hindered the transition to the collaborative care model. In addition, the Association believes that the requirement for RNs to provide education and assistance and/or cover the responsibilities for RPNs on a daily basis between October 2011 and July 2013 has contributed to the ongoing level of intra-team conflict currently existing.

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[27] College of Nurses of Ontario: Standard of Practice: *Professional Standards (Revised 2002)* ISBN 1-894557-33-6, Publication # 41006, August 2013

- The Association remains concerned that the process for competency evaluation of the UCPs is inconsistent and not effectively documented. The Association believes that UCPs can be safe and effective members of the care team in complex continuing care practice settings. However, the RNs (and RPNs) must have clarity regarding role expectations and confidence in the UCPs' role responsibilities and performance of these responsibilities.

Professional Responsibility Workload Report Forms

Over 100 PRWRFs were submitted by the nurses between October 2011, when the collaborative care model was implemented on 3MBW, and January 2014. The key issues identified on the PRWRFs relate to:
- Medication administration: Nurses are unable to complete medication administration in a timely manner in accordance with Hospital policy, and experience many interruptions resulting in errors and delays.
- Fragmented and delayed patient care: Frequent interruptions (especially during medication administration), the need to assist UCPs with direct care provision, and the need to perform a range of non-nursing duties resulted in competing priorities. Coupled with the very tightly scripted shift routines and 4P Rounding schedule, there were delays in documentation, medication administration, provision of treatments, and MDS assessments. Patients and families are frustrated with the lack of time RNs have to interact and address issues.
- Patient Factors: The high level of complexity of patient care needs, frequent changes in patient condition, the large number of patients with behavioural challenges and (until recently) the high levels of isolation do not balance with the times built into the Hour by Hour Accountability requirements. As a result, there are limited opportunities for the regulated staff to address alterations in patient condition in a fulsome manner.
- Model of Care: Insufficient base staffing levels for RNs and RPNs result in nurse : patient ratios that are unsafe, unmanaged and dangerous. The collaborative and consultative resources are insufficient for RNs to work effectively with RPNs and UCPs, which is complicated by ongoing concerns regarding role ambiguity and role conflict.
- Practice Environment: Substantial non-nursing duties relate to phone calls during evening and night shifts, transcribing MD orders in the absence of Unit Clerk assistance, housekeeping responsibilities.

Analysis and Recommendations

The Association identified 21 recommendations (*Appendix 8*) relating to RN/RPN practice, UCPs, model of care, staff nurse leadership, designated nursing authority and the *Excellent Care for All* Act. Key issues identified included the following:

RN/RPN Practice:
- The CNO 3 Factor Framework is intended to assist nurses and employers to make effective decisions regarding the required staff skill mix and daily patient assignment. A key element of the 3 Factor Framework is the ability of care providers to consult and collaborate with other members of the care team in situations where client safety is at risk. The current staff mix ratios of regulated to unregulated providers, and of RNs to RPNs, do not enable RNs (or RPNs) to collaborate as required by the 3 Factor Framework. This issue is exacerbated by the number of SRT and agency staff members on the unit, who are unfamiliar with the patients, the unit routines and the model of care.

UCPs:
- UCPs are not accountable to an external body or regulatory mechanism. They are responsible to provide personal care within the agreed upon plan of care, and to observe and report their findings to an RN/RPN. The RNs on 3MBW do not have sufficient time or resources to adequately assess the patient population, assign appropriately or supervise UCPs, and to evaluate their competencies to meet patient care needs. This low proportion of regulated staff makes it challenging for the RNs and RPNs to enact full scope, and in particular to ensure changes in patient condition are being appropriately communicated and documented by UCPs.

Model of Care:
- The collaborative care model has decreased RN and RPN staffing to a level more aligned with a long-term care facility than a complex continuing care setting. The RNs are very frustrated that the Hospital has not increased regulated staffing levels, in comparison to peer comparator ratios.
- The 4P Rounding process requires RNs to rely on scripts, rather than critical thinking. Although RNs are present at the bedside, 4P Rounding has stripped the RNs of their ability to use professional judgement and their ability to prioritize, plan, individualize, implement and evaluate patient care needs. This has resulted in a potential for poor patient outcomes and lower patient and nurse satisfaction.
- Increased RN workload associated with the collaborative care model has negatively impacted RN morale, resulting in the RNs feeling burned out, stressed and overwhelmed by their work.
- Interruptions and fragmentation of care have been exacerbated, rather than lessened, by the 4P Rounding and Hour by Hour Accountability requirements. Lack of clarity regarding role responsibilities between regulated and unregulated staff has resulted in a culture where interruption of the RN is an accepted practice.

Staff Nurse Leadership:
- RNs' current role responsibilities, as well as ongoing interpersonal conflict with UCPs prevent them from gaining an overall perspective of the unit and from fulfilling the leadership mandate as defined by the CNO.

Designated Nursing Authority:
- The RNs' concerns are escalating; they feel dissatisfied with the recognition they are receiving from the employer and believe that the current management structure does not enable nursing leadership support of nurses on a day-to-day basis.

Excellent Care for All Act:
- Quality improvement is the responsibility of everyone. This level of accountability should foster a culture of continuous improvement and make the Hospital more responsive to concerns being brought forward by the nursing staff.

<u>Summary</u>

Patient care is enhanced when concerns relating to patient acuity, roles and responsibilities, and workload are addressed. The Association believes that while there have been, and continue to be, significant challenges associated with the implementation of the collaborative care model, the key issue relates to the inadequate level of base staffing within the model. In addition, the support of the RNs, in

terms of respect for their concerns and opportunities for leadership development, has been insufficient. The Association is hopeful that with the development and fostering of a healthy practice environment, positive traction and momentum can be achieved.

2.2.2   Rouge Valley Health System

Context of Discussion at the IAC

When the collaborative care model for 3MBW was envisioned, the plan was based on the TRCP experience at the Ajax Site. The Hospital acknowledges that while implementation of the collaborative care model has been viewed as largely successful on 2 North, there are cultural, structural, process, support and other staffing differences between the Ajax and Centenary Sites which have impacted the implementation process on 3MBW. The Hospital acknowledges that comparison of the two experiences has not, in general, been helpful or supportive.

From a change management perspective, implementation of the collaborative care model on 3MBW has been very challenging. Although many strategies and actions were implemented in an attempt to address issues, the Hospital recognizes that there are a number of issues "still in play". It is acknowledged that there is a need to ensure that all staff members clearly understand the role responsibilities of themselves and each other, are supported to imbed these into day-to-day practice, and are able to participate in evaluation of their impact on practice and outcome on patient care. The Hospital acknowledges that further work to ensure the change is successful is required.

The Hospital is committed to moving forward to support the RNs to be the leaders on the unit. However, the Hospital does not believe that changes to the staffing complement or eliminating the 4P Rounding process are required for this goal to be achieved.

Initiatives to Support Implementation of the Collaborative Care Model

The introduction of UCPs into the patient care team on 3MBW not only impacted operational processes on the unit, but also substantially impacted the team dynamics and interpersonal relationships that existed on the unit (e.g. roles and relationships, and expectations for individual and team behaviour.) The Hospital was aware that the transition would be challenging, and between October 2011 and December 2013 the leadership team implemented 43 initiatives to facilitate a smooth transition and to assist in achieving the goal of a highly functioning unit under the new model of care. The Hospital summarized these as follows:

- The Hospital completed an *extensive benchmarking exercise*, including site visits to other hospitals providing a restorative care program (including Parkwood and Markham Stouffville) and long term care facilities (including The Village of Taunton Mills), external consultation with Extendicare (which provides oversight for complex continuing care in a number of facilities), and consideration of the factors influencing success of the TRCP at the Ajax site. The Hospital believes that the benchmarking exercise resulted in appropriate decisions regarding the staff mix based upon the expected patient mix on a restorative care unit.

- A *Model of Care Working Group* was constituted to provide an opportunity for interdisciplinary dialogue on group or team functioning. The Working Group met from October 2011 to February 2012, and identified interpersonal issues as an early challenge. In response, small-group sessions regarding *Respect in the Workplace* were provided. As well, a staffing algorithm was developed to provide clarity for unit staff on the triggers and process for 'up-staffing' as required by patient volume or acuity. Recently, the Unit Coordinator/Charge Nurse has been authorized to increase staffing without management pre-approval – a significant change made to address Association concerns.

- *Professional development work to assist the RPNs to move to full scope of practice* began in January 2012 and concluded in July 2013. The Hospital recognizes that this voluntary process should have been mandatory and should have proceeded more quickly, and that the delay had a negative impact on the workload of the RNs.

- *Unit dose medication delivery* was introduced on 3MBW in January 2012 in order to enhance the efficiency of medication administration by eliminating the need for 'pill pouring' by each individual nurse. Centralized MAR books (one per medication cart) were established in August 2013, in response to feedback from staff that it was too difficult to access the MARs kept in individual patient charts.

- *Team building sessions* were held in April and May 2012 in follow-up to the Hospital's investigation of a family complaint on 3MBW. The goals were team building and educating staff to ensure a consistent understanding of important aspects of care and to solicit feedback on formalizing intra-unit communication. Feedback from the team building sessions resulted in new tools and processes, including implementation of a Daily Activity Log for documentations by UCPs and a revised change of shift report.

- *Kaizen events* (undertaken to improve unit functioning by reducing waste and improving efficiency) were held in July 2012 and November 2013. The July 2012 Kaizen identified issues and activities required for the effective implementation of 4P Rounding (which occurred in October 2012), and resulted in a 6S event (to clean and organize the supply rooms), equipment purchase (medication carts, computers, commodes) and revised hours of unit clerk staffing (from 0730-1530 to 0800-1600 to ensure clerk coverage during team change of shift). The November 2013 Kaizen altered a number of unit processes, including change in the timing of Bullet Rounds from 0830-1100, the use of white boards in patient rooms, expansion of Unit Clerk shifts from 5 to 14 per week, and revised staff accountabilities as identified on the Hour by Hour Accountability schedule.

- *Lean / A3 / Takt initiatives*, involving RN staff, have been held to explore issues impacting quality care. An A3 in June 2013 focused on improving communication processes, and resulted in the purchase of additional commode chairs and wireless phones. An A3 in July 2013 was conducted on Diabetic Management in Post-Acute Care. Takt time monitoring of medication administration was completed in October and November 2013.

- Nursing staff attended a *wide range of clinical staff education sessions* between May 2012 and January 2013:
    - Anti-microbial wound care

- o Venous thromboembolism
- o Ceiling lifts
- o Intravenous pumps
- o Pneumococcal vaccines
- o 3M skin and wound care webinar
- o Central venous access device (CVAD)
- o Fall prevention
- o Least restraints
- o Introduction to Dementia Care
- o Gentle Persuasive Approach training
- o Montessori Methods

- *Education regarding the use of the 3 Factor Framework* for patient assignment was provided for all Unit Coordinators throughout the Hospital in April 2013. In May 2013, the CNO provided a presentation related to working with UCPs and ensuring the right care provider for the right patient. Discussion regarding the use of the 3 Factor Framework was also included in the 3-day Collaborative Care Training program attended by the majority of staff between May and November 2013. To ensure care delivery is grounded in evidence and to facilitate transparency of decision-making, patients are now identified as green, yellow or red on the patient assignment sheet and unit Patient Assignment Board, and patients flagged as 'yellow' are considered for transfer back to acute care in consultation with the Most Responsible Physician (MRP).

- In recognition that role conflict and interpersonal issues were continuing to impede effective team functioning, between May and November 2013, the majority of regulated and unregulated staff attended a 3-day *Collaborative Care Training program*. This session provided both education and role-playing experiences regarding effective functioning in a team environment and addressing interpersonal issues through crucial conversations. (Further sessions scheduled for January 2014).

- A comprehensive Hospital-wide *Bed Map has* is being implemented. In the revised Bed Map the patient population on 3MBW will shift to post-acute restorative care, and no longer include the current mix of patients with complex medical or behavioural issues. The Hospital recognizes that the current situation, in which the restorative population is integrated with patients with complex medical and complex behavioural issues, is both challenging for staff and not positive for patients and families. The first step in the process occurred in August 2013, with the transfer of 4 beds from 3MBW to 4MBW.

- *Strategies to support intra-team communication* have included regular staff meetings, implementation of an Ideas Board, changing the time for Bullet Rounds from 0830 to 1100, use of the white boards in patient rooms (though further staff education regarding responsibilities is required), support for use of crucial conversations, and posting of the Role Clarity document.

- *Leadership and engagement initiatives* have included the re-establishment of the Unit Council in August 2013, assignment of a new Manager and Vice President to 3MBW in September 2013 and registering of the Unit Coordinator to participate in a leadership development program sponsored by the CE LHIN in the winter of 2014. The Hospital is currently recruiting a Nurse Practitioner to enhance nursing leadership at the bedside and with the inter-professional team.

- *Staffing support* through increasing the number of full-time and part-time positions within the Staffing Resource Team (SRT) to enable more consistent assignment of SRT nurses to 3MBW with less reliance on agency nurse personnel.

- *Revisions to the Hospital isolation policy* regarding the management of ESBL-positive patients, implemented in December 2013, will decrease the number of patients requiring isolation, a significant driver of the high use of SRT and agency staff on the unit.

- The Hospital is planning to move from the provision of generic education sessions to *1:1 coaching with individual staff* regarding role clarity/responsibilities[28] and use of the 3 Factor Framework to 'close gaps' and support the imbedding of practice requirements/role expectations into daily practice.

Summary

The history of change on 3MBW is not out of step with change management strategies, initiated in other hospitals settings that have involved implementation of significant changes in unit staffing complements. A change such as this is an evolutionary process. Adjustments and changes will continue to be required, and interpersonal and inter-professional conflicts will continue to need to be addressed. The Hospital believes that the current staffing resources are appropriate to meet the needs of the 3MBW patient population, and that 4P Rounding, which has been adopted throughout the Hospital, is an effective strategy to support patient care. The Hospital believes that steps taken to date to address workload concerns, have resulted in significant progress, and that the ultimate path to success will require communication, collaboration and cooperation between, and among, staff and management. The Hospital is committed to working towards achieving a workplace with an appropriate and reasonable workload for all staff, with a highly-functioning team, amid good inter-personal relationships.

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[28] The Hospital believes that specific education for the UCPs regarding their clinical relationship with RNs/RPNs and nurses' accountability as leaders of the collaborative team, is required, as some of the UCPs are continuing to struggle with these concepts.

SECTION III

DISCUSSION AND ANALYSIS

3.1   Introduction

The IAC believes that the Panel has developed a comprehensive understanding of the professional responsibility concerns of the RNs working on 3MBW at the Centenary Site of the Hospital. This understanding was achieved through:
- review and analysis of the written submissions, exhibits, oral presentations and discussions at the Hearing,
- review of information provided by the Hospital, at the IAC's request, during the Hearing,
- review of literature available in the public domain regarding models of care and the practice of gerontology and rehabilitation nursing, and
- the IAC Panel's collective practice experience with similar issues.

3.2   Factors Impacting the Practice Environment

Discussion of professional responsibility within a complex continuing care setting such as 3MBW must be considered within the context of the practice environment. The IAC's analysis and recommendations are based on assumptions regarding:

- Scarborough Facilitated Integration Initiative,
- Health Based Allocation Model (HBAM) funding
- 3MBW geographical configuration,
- 3MBW patient population,
- 3MBW use of external staffing resources,
- Nursing standards of practice, and
- Use of UCPs.

3.2.1   Scarborough Facilitated Integration Initiative

In March 2013, the CE LHIN Board directed the Scarborough Hospital to partner with the Rouge Valley Health System to design and implement a Scarborough Cluster hospital services delivery model through integration of front-line services, back office functions and leadership and/or governance. At the time of the Hearing, the Boards of Directors of both hospitals had supported moving forward with the merger, believing that "the benefits of a merger would especially be realized in the longer-term as the hospitals position themselves to better serve their communities, create a shared vision for a transformed local health care system, address fiscal challenges together, and take advantage of the fast changing health

care environment."[29] Rouge Valley Health System and the Scarborough Hospital submitted the Pre-Capital Planning Document to the CE LHIN on January 23, 2014. If approved by the CE LHIN Board, the merger proposal will be forwarded to the Minister of Health and Long-Term Care for consideration. The goal is for the merger to take effect early within the 2014-15 fiscal year.

While the merger, if it is implemented, will have health human resource implications, the IAC believes that these will be at a high level. The IAC does not believe that the merger will have a direct impact on the specifics of the Post-Acute Care Program at the Hospital.

3.2.2   Health Based Allocation Model (HBAM) Funding

The IAC understood that under the HBAM formula, the Hospital experienced negative funding in 2013/14. Notwithstanding the Health Services Funding Reform currently occurring within Ontario, the IAC is assuming that the Hospital will not receive any funding increases in 2014/15, and that the budget for the Post-Acute Program will remain constant at a defined cost per day as weighted by the CMI.

The IAC understands that there are no parameters, within the HBAM funding for complex continuing care, that specify or restrict skill mix or staffing levels, and that the Hospital is amenable to staffing alterations within the budget window. The IAC has based its recommendations regarding staffing and model of care on this basis.

3.2.3   3MBW Geographical Configuration

3MBW is comprised of two separate 20-bed (with the capacity to surge to 26 beds) wings, separated by a large elevator lobby. 3 East is locked, with a swipe card entrance. 3 West is open to the elevator lobby.

3MBW was purpose-built for geriatric care, and has wide hallways, accessible bathrooms, large patient rooms, and extensive light from large windows. A pleasant family lounge is located off the elevator lobby, in addition to a small lounge on each of 3 West and 3 East.   3 West contains a large physiotherapy rehabilitation room (shared by both 3 West and 3 East), an equipment room (containing beds, wheelchairs etc.) and a congregate dining room with direct kitchen access. Each of 3 East and 3 West has a code-access clean supply room, a large nursing station with an adjoining conference room and small medication room.   The Patient Assignment board is located directly across from the nursing station on both 3 West and 3 East, as are the medication carts (two carts on each wing).   Satellite supply carts are located in all hallways.   An Ideas Board is located close to the nursing station on 3 West, and the unit's Balanced Scorecard data are posted on a bulletin board on the entrance hallway on 3 East.

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[29] http://www.tsh.to/leadingforpatients/ (accessed 20/01/2014);
http://www.leadingforpatients.ca/wp-content/uploads/2013/10/Workbook_Post-Acute-Care_September-27_2013.pdf (accessed 23/01/14)

The IAC noted distinct positive and negative elements of the 3MBW configuration. The positive relates to the unit's purpose-built features which support geriatric and rehabilitation care. The negative relates to the fact that that 3MBW is, in practice, two very separate units. The nurse call system and telecommunications infrastructure is separated on each side, and staff working on 3 West are unaware of care provision issues on 3 East and vice versa. The IAC understood that while 3MBW is considered to be "one unit" for management purposes (budgeting, scheduling etc.) from a practice viewpoint, the two sides operate independently over the course of a shift. Staff who have responsibilities on both sides (the Unit Coordinator, Unit Clerk, the 'float' RN position on days and the 'float' PSW position on evenings) are not easily accessible to one side when working on the other, and must walk long distances to provide care on both sides.

The IAC understands that the Hospital has commissioned architectural drawings to create a central nursing station 'to enhance sense of team'. The drawings are in development and have not yet been costed, but the issue has been discussed at the senior management and Board levels. As specific information regarding the possible location and configuration of a central nursing station was unknown at the time of the Hearing, the IAC's analysis and recommendations are based on the current nursing station(s) configuration.

3.2.4   3MBW Patient Population

As identified in Table 1, in October 2011 when the Collaborative Care Model was implemented, three groups of patients received care within the 44 beds on 3MBW: geriatric treatment and assessment (GATU), complex general (CG)[30] and alternate level of care (ALC)[31]. The unit had the capacity to surge to 48 beds, which the IAC understood occurred frequently during 2012 and 2013. Although ineligibility criteria were identified for each of the patient groups, the IAC understood that these were not always adhered to, resulting in patients with resource-intense care needs being admitted to the unit.

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[30] The IAC understood that the Hospital uses the terms 'complex general' and 'medically complex' interchangeably. The IAC has used the term 'medically complex' throughout the Report, believing that this term provides a better description of the patient population.
[31] Post Acute Care Program chart, Exhibit 9 Hospital Brief

	Geriatric Assessment and Treatment (GATU)	Complex General (CG) / Medically Complex (MC)	Alternate Level of Care (ALC)
# Beds (Total 44)	3 East: 19 beds: 43%	3 West: 3 beds: 7%	3rd Floor: 22 beds: 50%
Focus	•Comprehensive geriatric assessment and intervention by interdisciplinary team members to assist frail elderly patients who have sustained significant illness or injury.	•Complex care for patients with chronic conditions or multi-system disease processes such as diabetes, cardio vascular conditions and stroke. •Patients may be receiving IV therapy and are dependent on technology-based continuing or intermittent care or have complex wound management issues.	•Maintenance care for ALC patients who have finished the acute care phase of treatment. •Admission priority given to eligible patients awaiting placement in long-term care facilities.
Goals	•Establish specific patient goals in partnership with patients and families. •Ongoing evaluation of patient's status against established goals •Develop a personal discharge plan (including educational support for family members and links with community resources as required).	•Provide frequent ongoing professional assessment / interventions with a goal to decrease the overall level of care needs thereby increasing potential for D/C to a lower level of care.	•To optimize cognitive and functional level allowing for D/C to most appropriate level of care, e.g. nursing home or lesser level of care and to provide maintenance care for those awaiting placement. •Completion of discharge planning in collaboration with Scarborough CE-CCAC.
Admission Criteria	•Primarily frail elderly adults ≥ 65 years with complex medical and functional conditions: multiple pathologies, polypharmacy, high risk for readmission, symptom complexities such as incontinence, confusion etc. •Must be willing and able to participate in PT x 3/wk, OT x 2/wk	•Patients with specialized medical needs such as care of G/J tubes and feeds, tracheostomy care •Assistance required with all or most activities of daily living •May have skin ulcers – all stages	•Patients designated as 'ALC' by the most responsible MD (MRP) •plan for permanent placement must be in place and documented as agreed upon by patient/SDM •Limited therapeutic services required •Stable neoplastic diagnosis •Must be able and willing to participate in PT x 2/w and OT ad hoc
Ineligibility	•Significant cognitive impairment preventing assessment / intervention	•Need for suctioning more frequently than q2h	•Patients requiring ongoing treatment intervention and/or complex symptom management and monitoring

With the transfer from 44 to 40 beds in August 2013, the IAC understood that the category breakdown moved to:
- GATU: 15 patients (37.5% of the 40 beds)
- MC: 5 patients   (12.5% of the 40 beds), and
- ALC: 20 patients (50% of the 40 beds.

At the time of the Hearing, the breakdown of patient category types was:
- GATU: 13 patients (32.5% of the 40 beds),
- MC 2 patients (5% of the 40 beds), and
- ALC: 25 patients (62.5% of the 40 beds).

In July 2013, the Hospital announced the implementation of a Bed Mapping Exercise to improve access, quality/safety and HBAM cost performance. The IAC understood that the anticipated outcomes of the initiative were to create patient streams (grouping like patients together along the continuum) that would improve overall patient flow by minimizing the transfer of patients between services/patient care units. This will result in a reduction in the number of ALC transitions and essentially improve the overall operation of the Emergency Department.

Within the Bed Map, 3MBW is designated as a 40-bed Complex Continuing Care (CCC) / Restorative unit[32]. The IAC understood that the plan is to create a complex medical unit at both the Ajax and Centenary sites and a complex behavioural unit at the Ajax site, and that patients requiring complex medical and behavioural care will transfer from 3MBW to these new units. 3MBW will focus on restorative "slow stream rehab" care (recognizing that a residual number of patients, who have 'failed' rehab, will remain as ALC patients until long-term care placement is found.) The IAC understood that the Hospital considers 'restorative' to mean that, based on clinical expertise and evidence in the literature, the patient's condition is likely to undergo functional improvement and benefit from rehabilitative care, taking into consideration his/her premorbid level of functioning, medical diagnosis/prognosis and ability to participate in and benefit from rehabilitative care within the context of his/her specific functional goals[33].

As indicated in the Post-Acute Scorecard for 2011/12 and 2012/13[34], the Case Mix Index (CMI) for 3MBW was 1.04 to 1.06. The Hospital stated at the Hearing that it anticipates the CMI for the CCC/Restorative Unit will be 1.03 to 1.06. In light of the different patient population after implementation of the Bed Map (less complex care needs, such as PICC lines, tracheostomies, complex wound care etc.), the IAC understood that the CMI level is expected to be similar as a result of the needs of the restorative care population receiving additional therapy interventions (increased minutes of physiotherapy and occupational therapy), and that the key driver of the anticipated future CMI will be therapy requirements, not an expanded nursing workload.

The IAC believes that the new Bed Map will be implemented within the 2014/15 fiscal year, and has based its analysis and recommendations on the assumption that 3MBW will be a CCC/Restorative Care unit.

3.2.5   3MBW Use of External Staffing Resources

During the fiscal years 2011/12 and 2012/13, 3MBW extensively augmented the core (i.e. unit-based) RN, RPN and UCP staff with staff from the SRT and external agencies[35]. When core part-time staff was unavailable, external staffing resources were used to meet base-line staffing allocations, 'upstaff' in response to acuity and workload (including isolation) needs, and provide replacement for unanticipated

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[32] Four (4) beds moved to form part of a newly integrated Care of the Elderly unit on 4MBW in August 2013. #71, pg 21, Hospital Brief; Exhibit 58, Association Brief.

[33] "Restorative Potential" definition document distributed by the Hospital at the Hearing. The IAC believes this definition to be consistent with that identified by the Rehabilitative Care Alliance.

[34] RVHS Post-Acute Scorecard distributed by the Hospital at the Hearing.

[35] Statistics provided by the Hospital at the Hearing

(sick time, bereavement leave etc.) and anticipated (vacation, stat holidays, maternity leave etc.) vacancies.

<div align="center">Table 2: 3MBW: Use of External Staffing Resources</div>

Category	2011/12 \# shifts		2012/13 \# shifts		2013/14 YTD Nov \# shifts		2013/14 YTD Nov Annualized		2013/14 YTD Nov % Budgeted Shifts		
	SRT	Agency	SRT	Agency	SRT	Agency	SRT	Agency	SRT	Agency	Total
RN	56	3	57	38	108	85	162	128	7%	6%	13%
RPN	40	2	18	37	40	65	60	98	3%	4%	7%
UCP	3	578	19	1,648	31	747	47	1,121	2%	51%	53%
Total # Shifts	99	583	94	1,723	179	897	269	1,347			
	682		1,817		1,076		1,616				

As indicated in Table 2, the annualized figures for the 2013/14 fiscal year indicate that
- 13% of the total number of budgeted RN shifts,
- 7% of the total number of budgeted RPN shifts, and
- 53% of the total number of budgeted UCP shifts

will be filled by non-core staff. In the case of UCPs, the vast majority of these shifts will be filled by UCPs from an external agency.   This is substantially contributing to continued staffing instability.

The IAC understood that since July 2013, focused efforts have been made to expand the SRT pool, in all categories, and that an orientation to post-acute care, including shadowing and a preceptor experience, is provided. Most nurses on the SRT have transferred internally, and are therefore comfortable with the Meditech system, medication administration system, Point-of-Care-Testing (POCT) etc.

The IAC understood that the Hospital uses one specific external staffing agency, and that agency nurses who have been regularly scheduled to work at the Hospital have attended a four-hour orientation to Meditech codes. However, as non-Hospital employees, they do not have code-access to the supply room, and cannot perform POCT (responsibility for which therefore falls to the core RN or RPN).
The IAC has based its analysis and recommendations regarding staffing resources on the assumption that the extensive instability created by the very high use of external agency staff will not continue, due to the expansion of the SRT resources, the decreased need for isolation due to the December 2013 isolation policy revision, and the adherence to the 'no surge capacity' (beyond 40 beds) included within the new Bed Map.

3.2.6   Nursing Standards of Practice

The Canadian Gerontological Nurses Association published *Gerontological Nursing Competencies and Standards of Practice* in 2010[36], which describe the appropriate therapeutic health promotion, prevention, maintenance, rehabilitation, or palliation activities of gerontological nurses to facilitate client health. Six standards are identified: physiological health, optimizing functional health, responsive care, relationship care, health system and safety and security.

The Canadian Nurses Association (CNA) has identified eight competency categories for certification for the gerontological nurse[37]. These relate to:
- culture and human diversity,
- assessment of the older adult,
- health promotion and risk reduction,
- illness and disease management,
- ethical and legal issues
- health care systems and policy
- professional development, and
- information and health-care technologies.

The IAC considers competence in gerontological nursing practice standards to be an expectation for nurses working on 3MBW.

The philosophy and practice of restorative nursing bridges both gerontological and rehabilitation nursing. Although there are no defined standards of practice for restorative nursing in Canada, the tenets underpinning restorative care (total enablement, enhancement of independence, support for living with informed risk etc.) are consistent with both the practice competencies for a gerontological nurse and the competencies identified for Rehabilitation Nursing (CNA 2011) and are philosophically different from those supporting the complex continuing client care. As the 3MBW patient population changes, the IAC expects that nurses' knowledge, upon which critical thinking is based, will be required to expand to incorporate a restorative nursing care philosophy.

3.2.7   Use of UCPs

In their written Briefs and throughout discussion at the Hearing, both the Hospital and the Association indicated support for the ongoing involvement of UCPs in the provision of personal care on 3MBW. The IAC has based its analysis and recommendations on the assumption that UCPs will continue to provide personal care to the 3MBW patients, and that they will practice in accordance with the role profile and competencies established by the Hospital.

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[36] http://www.cgna.net/uploads/CGNAStandardsOfPractice_English.pdf (accessed 23/01/2014)
[37] http://www.nurseone.ca/Default.aspx?portlet=StaticHtmlViewerPortlet&plang=1&ptdi=583 (accessed 23/01/2014)

3.3   Analysis and Discussion

3.3.1   Introduction

The IAC was requested to examine whether the current RN staffing resources support proper patient care on 3MBW. The IAC has based its analysis on careful review of the information provided by the Association and the Hospital prior to, during and following the Hearing, as well as the contextual information referenced in Section 3.2.

The IAC believes that this PRC must be considered within two contexts, the past and the future.   The past context includes the implementation experience of the Collaborative Care Model within the former 44-bed 3MBW, and associated the resources required to effectively provide care to a combination of complex medical, complex behavioural, ALC and GATU patients. The future context relates to ongoing implementation of the Collaborative Care Model within the new 40-bed configuration, and the resources required to meet the needs of a transitional restorative care patient population.   While the IAC's analysis encompasses both contexts, its recommendations are focused on the future.

From the IAC's perspective, the Hospital 'lost focus' with regards to the initiatives undertaken to support the implementation of the Collaborative Care Model.

- With a heavy focus on clinical education and addressing the implications of integrating UCPs into a formerly regulated care provider environment, it appeared to the IAC that the Hospital failed to recognize and acknowledge the impact of removing 55% of the full-time RN positions. Not only was there a significant impact on the team interpersonal dynamics, the RNs' workload was accentuated by the fact that RPNs were not required to practice at full scope for a full 18 months following the Collaborative Care Model implementation.

- The Post-Acute Program leadership team devoted significant time, energy and effort to articulating expectations regarding role performance and intra-team communication strategies. However, it appeared to the IAC that focused follow-up was not provided to ensure that these expectations were operationalized into day-to-day practice on the unit.

- The IAC believes that many of the challenges associated with the UCPs' understanding of their role in relation to the regulated staff related to the astoundingly high use of agency UCP staff. With more than 50% of the budgeted UCP shifts filled with individuals from an external agency, it is not surprising that communication breakdowns and lack of understanding regarding role expectations were rampant. The IAC would have expected the leadership team to have acknowledged this challenge and to have taken action 'on the ground' to ensure an effective orientation to the 3MBW care delivery model and to have provided timely follow-up when issues arose. Rather, the approach appeared to the IAC to be high level implementation of tools, processes and schedules, leaving the RNs to cope with the operational challenges on their own.

- The wide range of clinical education provided throughout 2012 and 2013 suggested to the IAC that the RNs were inundated with generic education. Although potentially clinically relevant, this focus was not appropriate in light of the immediate issues that were occurring on the unit. The RNs were

struggling to meet their own practice expectations related to supervision of UCPs and overall clinical leadership on the unit. In addition, the pace of implementation of quality improvement initiatives did not allow the RNs (or any of the staff) to meaningfully adopt one new process into their daily practice before another was implemented.

Having said this, the IAC believes that while the past can inform the future, it does not need to predict the future. The IAC believes that the Hospital leadership team, at both the front-line and senior levels, sincerely wishes to create a quality work environment that will support both professional practice and patient care, and that the 3MBW RNs are equally committed to the provision of quality patient care. The IAC is hopeful that the opportunity to openly express concerns and perspectives at the Hearing, together with the external objective analysis and associated recommendations provided by the IAC, will assist both the RNs and the leadership team to find common ground on which to move forward.

In a Joint Position Statement *Practice Environments: Maximizing Client, Nurse and System Outcomes,* the Canadian Nurses' Association (CNA) and Canadian Federation of Nurses Unions (CFNU) believe that quality practice environments maximize outcomes for clients, nurses and systems[38]. They state that quality practice environments demonstrate seven sentinel characteristics[39]:

1. Communication and collaboration: Effective communication is promoted throughout the system: among nurses, between nurses and clients, between nurses and other health and non-health professionals, between nurses and unregulated workers, and between nurses and system managers and employers.

2. Responsibility and accountability: As professionals, nurses are responsible and accountable for their practice. Within the practice environment, nurses must be supported to participate in decision-making that affects their work, including developing policies, allocating resources and providing client care.

3. Realistic workload: Quality practice environments support continuity of care and enable nurses to maintain competence, develop holistic therapeutic relationships and create work-life balance. There must be sufficient nurses to provide safe, competent and ethical care.

4. Leadership: Effective leadership is important in all nursing roles and is an essential element for quality practice environments. Nurses who are employers have a direct impact on nurses' work environments, but nurses who act as collaborators, communicators, mentors, role models, visionaries and advocates for quality care also play a leadership role.

5. Support for information and knowledge management: Enabling technologies to support optimal information and knowledge management as well as critical thinking (e.g. electronic health records and decision support tools) are required. Adequate time for nurses to access these technologies is important.

6. Professional development: Adequate funding to enable nurses to access professional development opportunities, including continuing education, formal education, online learning and mentoring, are required to support nurses to maintain competence.

7. Workplace culture: A workplace culture that values well-being of clients and employees is important. Contributions to a positive workplace culture include, but are not limited to, policies that address ethical issues, support safety, promote employee recognition and ensure adequate resources.

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[38] Joint Canadian Nurses Association/Canadian Federation of Nurses Unions Position Statement: *Practice Environments: Maximizing Client, Nurse and System Outcomes.* 2006 http://www2.cna-aiic.ca/CNA/documents/pdf/publications/PS88-Practice-Environments-e.pdf (accessed 25/01/2014)
[39] Ibid

The IAC believes that elements of all of these characteristics are currently missing on 3MBW. The IAC has focused its analysis and recommendations on the areas of leadership and governance, nursing care delivery model and associated staffing, and clinical practice/unit processes. The IAC believes that action within each of these areas will assist 3MBW to become a quality practice environment demonstrating the above sentinel characteristics.

3.3.2   Leadership and Governance

The Registered Nurses Association of Ontario (RNAO) Best Practice Guideline *Developing and Sustaining Nursing Leadership* identifies five evidence-based transformational leadership practices which are fundamental for transforming nurses' work settings into healthy work environments. These transformational practices, which apply to all roles and levels of leadership, including nurses providing direct care are[40]:

- Building relationships and trust is a critical leadership practice, the foundation on which the other practices rest. Relationships include those formed between individual nurses, on teams and in internal and external partnerships.

- Creating an empowering work environment depends on respectful, trusting relationships among people in a work setting. An empowered work environment has access to information, support, resources, and opportunities to learn and grow, in a setting that supports professional autonomy and strong networks of collegial support.

- Creating a culture that supports knowledge and development and integration involves fostering both the development and dissemination of new knowledge and instilling a continuous-inquiry approach to practice, where knowledge is used to continuously improve clinical and organizational processes and outcomes.

- Leading and sustaining change involves the active and participative implementation of change, resulting in improved clinical and organizational processes and outcomes.

- Balancing the complexities of the system, managing competing values and priorities entails advocating for the nursing resources necessary for high-quality patient care, while recognizing the multiple demands and complex issues that share organizational decisions. Proper use of evidence is key.

The IAC believes that these transformational practices must be incorporated into the operational, clinical and point-of-care leadership positions on 3MBW.

3.3.2.1   Operational Leadership

Operational leadership for 3MBW is encompassed in the Manager and Program Director roles. The Program Director, a Registered Physiotherapist, has held the role since prior to the October 2011 Collaborative Care Model implementation. The Manager, also a Registered Physiotherapist, assumed the position in September 2013, and is also responsible for Outpatient Rehab Services. 3MBW is the

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[40] RNAO Healthy Work Environments: International Affairs and Best Practice Guideline *Developing and Sustaining Nursing Leadership*, 2nd edition, 2013, pg. 17

only in-patient unit at the Hospital where both the Manager and Program Director have a non-nursing background.

The IAC believes that effective leadership of an inpatient unit with the magnitude of concerns that 3MBW is experiencing requires expert competencies in management coupled with strong nursing practice leadership. While these skills are often combined within one individual, the IAC believes that operational and clinical leadership can be as equally effectively provided by two individuals, and is therefore not concerned that the current Manager, providing operational leadership, is not a nurse.

However, given the magnitude of the issues on 3MBW, the IAC believes that this is not a 'learning curve' management position. The inconsistencies in clinical practice, the non-constructive communication patterns which appeared to the IAC to be, if not an accepted norm, at least accepted practice, and the lack of adherence to practice standards, such as those surrounding change of shift report, require a day-to-day presence of solid decision-making, problem-solving and action-taking to set standards and effect change. An experienced manager is able to give staff a voice vs. doing him/herself, to differentiate when coaching vs. discipline is required, to recognize when an issue requires immediate action vs. longer term follow-up, and to identify what are and are not appropriate and/or feasible role expectations. The IAC was concerned that while the current Manager is well liked by the staff, who referred to her at the Hearing as "an angel", she appeared to be relating to the staff as an equal, rather than as a leader able to take decisive action when required, and to be relying, through no fault of her own, on LEAN/quality improvement tips and tools rather than years of experience and intuition. For example, when asked at the Hearing what action would be taken when a regulated staff member was noted to not be providing any form of direction to the UCP, the response was "I would try to have them have that conversation". While this approach is gentle and does not ruffle feathers, the scope of issues in the current practice environment require a more overt and directive strategy.

The Manager and Program Director are regulated professionals who understand the concepts underlying self-regulated practice. To augment their understanding of nursing practice, the IAC understood that the Hospital has implemented a formal "pairing" relationship between nursing and non-nursing managers, and that the 3MBW Manager collaborates with the 2 North Manager (at the Ajax site) for CNO-related questions and issues. While this is beneficial and should continue, the IAC believes that mentorship with another manager regarding standards of practice is insufficient. The IAC believes that in order to provide effective transformational leadership that supports a quality practice environment, the Manager should receive skills development support through focused mentoring from an expert leader outside the organization, and attendance at a recognized Leadership Development Program such as the *Hospital Leadership and Healthcare Executives: Resilience, Agility and Presence* co-sponsored by the Ontario Hospital Association.

The IAC recognizes that the Manager's current portfolio, encompassing a 40-bed inpatient unit and an outpatient program, is well within industry standards for a front-line leadership position. However, in light of the novice manager practice competencies of the current Manager, the need for an 'on the ground' daily presence to address issues as they arise, and the current level of instability of 3MBW, the IAC believes that an assignment of the Manager to 3MBW on a full-time basis for a six month period, or until the Advanced Practice Nurse is hired, would be beneficial. In making this recommendation, the IAC does not wish to invite instability within the Outpatient Rehab Services program, but believes the current crisis situation on 3MBW requires full-time operational leadership until enhanced stability is achieved

Recommendations:

1. *The 3MBW Manager be responsible for 3MBW only, on a 1.0 FTE basis, for a six-month period.*

2. *The Vice President accountable for Post-Acute Care Program organize and implement a formal management mentorship relationship for the 3MBW Manager with an external expert leader.*

3. *The 3MBW Manager successfully complete a comprehensive Leadership Development Program.*

3.3.2.2   Clinical Leadership

3.3.2.2.1   Advanced Nursing Practice Roles

Clinical nursing leadership within the Post-Acute Care Program is provided by the Clinical Practice Leader (CPL) and the Nurse Practitioner.

The IAC understood that the Hospital has both corporate and program-based CPL positions. The IAC understood that corporate education programs, such as the Collaborative Care Workshop or the 3 Factor Framework Training sessions, are provided by the corporate CPLs. The Post-Acute Care Program CPL provides education support to 3MBW as well as 4MBW, and 2 North, 3 East and the TRCP at the Ajax site. She therefore has a 0.2 FTE, or one day per week, involvement on 3MBW.

The IAC understood that the 3MBW CPL is responsible for coordinating the unit-based orientation, providing leadership for A3 initiatives such as that held regarding diabetic management, participating in discussions regarding practice issues at the Unit Council and Program Council, and bringing professional practice concerns forward to the Professional Practice Leadership and Medication Safety Committees. The IAC's sense was the CPL role is not "hands-on-at-the-bedside" focused, and that while the CPL's role is program-based on paper, in reality, many of her day-to-day responsibilities take her away from the unit. She is therefore not able to provide consistent, day-to-day, on-the-spot leadership regarding clinical practice issues or gerontological nursing practice standards.

In light of the need to augment the core UCP staffing to decrease reliance on external agency personnel (see Recommendation 22), a significant time commitment will be required to ensure that these newly hired UCPs clearly understand how their role responsibilities are to be operationalized in the 3MBW practice environment. The addition, the Hospital has recognized the need to help current UCPs understand the clinical relationship and accountability of nurses as leaders of the collaborative care team. The IAC believes that the Post-Acute Program CPL will need to focus energy and attention on the support of these activities over the coming months, until core staffing stability and clarity of role expectations among the UCPs is achieved.

Two advanced practice nursing roles are recognized in Canada: the clinical nurse specialist and the nurse practitioner[41]:

- Clinical nurse specialists (CNS) provide expert nursing care and play a leading role in the development of clinical guidelines and protocols. They promote the use of evidence, provide expert support and consultation, and facilitate system change.

- Nurse practitioners (RN(EC))[42] provide direct care, focusing on health promotion and the treatment and management of health conditions. They have an expanded scope of practice and can diagnose, order and interpret diagnostic tests. They can also prescribe medications and perform certain procedures.

The IAC understood that implementation of a Nurse Practitioner position was one of the recommendations of Extendicare, and that the position was filled for a short time in 2012. The position was reposted in April and September 2013, but at the time of the Hearing, had not been filled. The IAC also understood that the Hospital's goal was for the Nurse Practitioner to provide 'advanced medical and nursing consultation' and 'nursing leadership at the bedside and with the inter-professional team'[43].

The IAC believes that implementation of an Advanced Practice Nurse CNS role, rather than an RN(EC) role, will better meet the needs of 3MBW. Given that neither the Manager nor Program Director are nurses and the CPL has responsibilities beyond 3MBW, the IAC believes that strong clinical nursing leadership is required from another member of the unit leadership team. In addition, with the move to a transitional CCC/restorative care focus, the staff will require support to integrate the tenets underlying restorative care/best practices into their daily practice. The IAC believes that such clinical support will be much more effectively provided by a CNS than an RN(EC)[44], and strongly encourages the Hospital to fill the position in the immediate future.

Recommendation:

4. ***The Post-Acute Program replace the budgeted RN(EC) position with an Advanced Practice Nurse CNS position, and take action to hire this position as soon as possible.***

3.3.2.2.2   Unit Coordinator Role

The IAC believes that the Unit Coordinator (UC) is responsible for making clinical decisions and exercising judgement to ensure the best possible nursing care is provided within available resources. Under this umbrella, the UC works with the members of the health care team to:
- facilitate timely communication within the health care team, with external care providers, and with patients and families;
- ensure patients receive care from the most appropriate care provider on the team;
- participate in ongoing quality improvement and risk management activities; and
- ensure patient flow on the unit is timely and appropriate.

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[41] http://www.cna-aiic.ca/en/professional-development/nurse-practitioner-and-clinical-specialists (accessed 25/01/2014)

[42] Nurse Practitioners are regulated as Registered Nurse Extended Care: RN(EC) in Ontario.

[43] Hospital Response document, provided at the Hearing

[44] The IAC notes that an RN(EC) would likely not have an autonomous role, in light of the consistent physician coverage currently available on the unit. (This may have contributed to the short tenure of the RN(EC) in 2012).

The UC is the 'oil' that enables smooth functioning of the unit.

The IAC understood that the Standard Work document for the UC, reviewed at the Hearing, was developed in conjunction with the revised Hour by Hour Accountability schedule following the November 2013 Kaizen event. The IAC believes that the prescriptive nature of this document (X to be done at 0800, Y to be done at 0930) does not recognize the normal ebb-and-flow of activity on an inpatient hospital unit. The strict time expectations preclude the UC from being able to effectively problem-solve patient and staff issues in a timely fashion as they arise. In addition, the Standard Work document includes a number of non-nursing duties which the IAC believes would be better performed by the Personal Support Representative (PSR), as well as nursing responsibilities, such as ensuring care plans are up to date, which are the responsibility of the RNs and RPNs providing direct care. While the IAC understands the value of Standard Work for staff who have distinct time-related accountabilities (such responsibility to clean a washroom every X hours), use of such a tool for autonomous professionals is not encouraged.

The IAC supports the Hospital's recent revision of the staffing algorithm to enable UCs to implement needed adjustments to base staffing without prior managerial approval.. The IAC believes that the UC should lead the daily Bullet Rounds, assess eligibility of patient transfer to 3MBW, determine staffing requirements for the upcoming shift(s) and determine the associated patient assignment, and assist with problem-solving patient care issues   As an expert nurse, the UC provides integral mentorship, learning and evaluative support to staff who are unfamiliar with the unit. In addition, the UC needs to be readily available to step in in clinical situations when her expertise is required to ensure patient and staff safety.

Recommendations:

5. *Discontinue the current Standard of Work document for the UC.*

6. *Implement a Unit Coordinator role profile which identifies the key elements supporting the smooth functioning of 3MBW, including:*
     timely problem-solving of patient and staff issues;
     assessing patient eligibility for transfer to 3MBW;
     determining staffing requirements in advance;
     providing mentorship, learning and evaluative support to new and/or temporary unit staff; and
     leading the Bullet Discharge Planning Rounds.

3.3.2.2.3   RN Point-of-Care Leadership Role

Both the Association and the Hospital recognize that the RNs on 3MBW are not providing appropriate consultative support to RPNs or clinical leadership and direction to UCPs. The Association believes that as a result of inadequate RN staffing levels, RNs "do not have the time and resources to consistently have an overall perspective of what is happening on the unit due to multiple conflicting priorities competing for insufficient resources."[45]   The Hospital believes that the lack of role clarity and ongoing

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[45] Pg. 59, Association Brief

role conflict within the team have contributed to the RNs' inability to provide effective clinical leadership.

The IAC believes responsibility for the current situation lies with both the management team and the RNs on 3MBW. A key challenge has been the manner in which role expectations have been articulated by the management team and the failure to ensure integration of these expectations into the practice environment. The Hour by Hour Accountability schedule has placed all members of the inter-professional team on an equal footing, with no-one person defined as having the accountability for the supervision, direction or leadership of the team. Although the role profile documents state that the UCP works under the supervision of the RN or RPN, RPNs and in particular RNs have not been held accountable to provide such leadership. The management team has allowed unintegrated practice (i.e. the UCP and RN/RPN working in parallel beside each other, rather than with each other) within the team dyad to occur, and this has become the cultural norm. Rather than standing up for what they know is their professional accountability to direct and supervise UCP practice, in light of workload pressures the RNs (and it appears also the RPNs) have accepted this norm. The combination of RNs wanting to provide leadership but not wanting to take autonomous action to achieve this, coupled with the UCPs' apparent lack of interest in (or willingness to) acknowledge such leadership, has resulted in resentment and frustration on the part of everyone …. a very negative cycle that must be broken.

The IAC believes that RN point-of-care leadership on 3MBW needs to focus on the skills required to provide clinical direction to and supervision of UCPs, and collaborative consultation with RPNs. A model of care that clearly delineates this leadership role vis-à-vis the other members of the care team would be advantageous. Additional education programs outlining effective strategies for communication, collaboration, mentoring and direct supervision, with the type of role-playing opportunities included in the 3-day Collaborative Care workshop, are needed. Clear expectations for how clinical direction/consultation are to be enacted need to be developed (e.g. what behaviours on the part of the RN, RPN and UCP are expected at change of shift report), and supportive but constructive action needs to be taken to ensure that all staff (regulated and unregulated) are practising accordingly. In addition, the responsibility of the RN to determine that the patient assignment is appropriately updated at the beginning of every shift needs to be articulated[46].

Recommendation

7. *Develop and implement a role profile for the RN working in a leveled practice environment that clearly articulates her/his leadership practice expectations, including (but not limited to):*
   - *meet with the dyad team at the beginning of each shift to discuss and coordinate care provision;*
   - *update client Care Plans / Kardex as required to ensure content is correct and comprehensive; and*
   - *oversee the care provided by UCPs.*

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[46] The IAC believes that if an intra-team conflict arises regarding the assignment, the final decision is to be made by the UC, or in her absence, the Charge Nurse. Situations of conflict need to be forwarded to the Manager to enable timely follow-up.

3.3.2.3   Shared Governance Structures

Shared governance is defined as "a dynamic staff-leader partnership that promotes collaboration, shared decision-making and accountability for improving quality of care, safety and enhancing work life."[47]   Shared governance models which enable staff nurses to collaborate on decisions that impact patient care, quality improvement and nursing practice at the unit and/or program level have been found to be an effective way to improve the quality of the workplace environment[48].   The outcome of an effective shared governance model is the sense of empowerment that comes from participating in decisions that directly impact one's practice and the practice environment.   The IAC believes that shared governance models provide RNs with the opportunity to bring forth thoughts / suggestions / recommendations / ideas regarding unit/program practice, while at the same time explicitly reinforces that staff assume shared accountability for problem identification and constructive decision-making. Effective shared governance requires involvement and accountability from both management and staff.

Successful shared governance bodies integrate a number of specific elements[49]:
- a charter or terms of reference, which outline the boundaries of decision-making;
- collaboration between staff co-chairs and the area manager;
- regular meetings with a formal means of communication to all staff;
- mutually planned agendas (co-chairs and manager) distributed before the meeting;
- ground rules of how to work together, in both in-person and on-line meetings; and
- striving for consensus decisions, meaning that everyone agrees to support them after having discussed the options.

The IAC believes that the management team is trying to implement a shared governance approach through use of LEAN / A3 / Kaizen events, which have included front-line staff in discussion regarding unit/program processes and functioning. However, the IAC sensed that these events were resulting in staff feeling that they had not been 'heard nor included in decisions impacting their practice'. Following the November 2013 Kaizen in particular, the IAC understood that while the staff felt that the defined expectations (relating to the Hour by Hour Accountability schedule) were impossible to meet, they felt pressured by the management team to 'make it work'.

The IAC also believes that the 3MBW team needs to clearly articulate the mechanisms for which shared governance is enacted on the unit.   The Unit Council was resurrected in principle in August 2013 (which the IAC commends). However, the Unit Council does not appear to have been embraced as a decision-making mechanism for the unit. Throughout the fall of 2013 the mechanism for decision-making regarding practice issues and unit operations appeared to have continued to be primarily the management team utilizing Kaizen and other LEAN events. The IAC believes that this has likely contributed to a sense of learned helplessness and lack of engagement by the unit staff members, who feel that management continues to make all of the decisions.

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[47] http://www.mc.vanderbilt.eud/root/vunc.php?site=Shared%20Governance&doc=23722 (accessed 25/01/2014)

[48] Joint Canadian Nurses Association/Canadian Federation of Nurses Unions Position Statement: *Practice Environments: Maximizing Client, Nurse and System Outcomes.* 2006 http://www2.cna-aiic.ca/CNA/documents/pdf/publications/PS88-Practice-Environments-e.pdf (accessed 25/01/2014)

[49] http://www.mc.vanderbilt.eud/root/vunc.php?site=Shared%20Governance&doc=23722 (accessed 26/01/2014)

The IAC recognizes that the Hospital has embraced a LEAN philosophy, and that the 3MBW management team is very comfortable with this approach. The IAC believes that a LEAN event, such as an A3 or Kaizen, is appropriate if it is clearly sponsored by one of the shared governance structures and if the outcomes of the event are discussed by the sponsoring shared governance structure. In this governance model, the Unit Council would assume shared accountability for decisions regarding changes in policy or practice and would be active participants in the evaluation of interventions in the practice environment. The IAC believes that effective shared governance structures on 3MBW are the Unit Council and the Program Council.

3.3.2.3.1   3MBW Unit Council

In the Hospital Response document circulated at the Hearing, the Hospital stated that "A Unit Council has been established to give voice to staff to engage in quality improvement that will improve team functioning and quality of care. This is a forum that will be utilized to explore and review new and existing practice guidelines that reflect evidence-based nursing and interdisciplinary research and LEAN principles".   The IAC supports this statement, and believes that in addition, the Unit Council needs to integrate 'best practices' into their clinical practice and work environment. The IAC believes that to be effective, the Unit Council must have authority to make decisions within the scope defined in the Terms of Reference, which are then embraced and supported by the management team.   The IAC believes that the purpose of the Unit Council is to work collaboratively on decision-making relating to practice and procedures that enhance the quality of patient care, best practices, work environment and relationships among staff.

The IAC believes that the August 27, 2013 Complex Continuing Care Unit Council Terms of Reference need to be amended to address the elements identified in Section 3.3.3.1 above. In particular, the Terms of Reference need to specify the following:
- Co-chaired by two regulated staff members, one of whom is the UC
- Defined membership with a term of two years:
  - specific number of RNs, RPNs, UCPs and other members of the allied health care team who are selected by their peers through a nomination process, and
  - specific positions (UC, CPL, CNS and Manager, but not Program Director);
- mechanism by which agenda items will be identified;
- boundaries of decision-making (clinical and operational);
- ground rules for behaviour during and following the meeting; and
- reporting relationship (to the Post-Acute Care Program Council).

The IAC also believes that the Unit Council needs to be appropriately resourced, in order for it to develop as a key decision-maker on the unit. This should include paid time for the staff to attend (either paid at straight time to come in on a day off, or relieved of patient care responsibilities if working), clerical assistance, and professional practice mentorship. The IAC believes that meetings need to provide sufficient time for in-depth discussion, lasting two to three hours.

The IAC notes that the Unit Staff meeting is chaired by the Manager, and provides an opportunity for information sharing and dissemination. The Staff Meeting is not, and should not be used as, an

opportunity for discussion / debate / development of consensus on issues such as practice standards, model of care or unit operations. These are the purview of the Unit Council.

Recommendations:

8. *The Unit Council revise the Terms of Reference to specify chairmanship, membership, boundaries of decision-making and ground rules for action during and following meetings.*

9. *The Hospital provide appropriate resourcing of the Unit Council, to enable effective discussion and decision-making.*

10. *The Hospital provide clerical assistance to ensure agenda and minutes are developed and circulated in a timely fashion.*

11. *Professional Practice mentorship be provided by the ONA RVHS Professional Responsibility Representative and the 3MBW CNS.*

3.3.2.3.2   Post-Acute Care Program Council

The Post-Acute Care Program Council, chaired by the Program Director, meets monthly to address operational issues within the Program, including budget, balanced scorecard data, staffing, patient safety and quality, education, equipment purchase etc. From review of the minutes, the IAC believes that the Program Council is functioning effectively.

However, the IAC noted that the connection between discussions and decisions regarding practice at the Unit Council and discussion and decisions regarding operations at the Program Council lies with the CPL, Manager and Program Director, who sit on both Councils. There is no unit nursing representative from 3MBW (or from any of the other three units within the Program). The IAC believes that participation of front-line care providers in Program Council discussions has a two-fold benefit. Participation enables front-line providers to gain an understanding of the context of decision-making within which the Program operates, that is, they can gain an understanding of the broader operational and hospital processes. In addition, staff can participate in discussions about practice and processes, thereby informing non-direct care providers of the operational implications of decisions at the provider-client interface.

The IAC understood that Program Councils elsewhere in the Hospital include front-line staff, and believes that the Post-Acute Program Council membership requires amendment to include the UC from each of the four inpatient units within the Program.

Recommendations:

12. *The Unit Coordinator from each of the four inpatient units within the Post-Acute Program sit as a decision-making member of the Post-Acute Program Council.*

13. *A front-line staff member from the Unit Council (in addition to the Unit Coordinator) participate on the Program Council.*

3.3.2.3.3   Professional Practice Governance Model

The IAC was very confused by the Professional Practice (Nursing and Allied Health) Governance chart provided by the Hospital at the Hearing. While this is beyond the scope of the current PRC, the IAC noted that there do not appear to be opportunities to advance collective nursing practice issues within the organization, and in particular, no avenue for front-line nurses to bring issues forward as they are not part of the Professional Nursing Practice or Professional Nursing Standards Committees.   'Up and down' communication appears to depend on the CPL, who has an educational leadership focus and should not be the voice of nursing practice.   In addition, there does not appear to be a clear reporting relationship between the committee levels. The IAC encourages the Hospital to consider this issue.

3.3.2.4   Unit Culture

The IAC noted two areas of concern relating to unit culture: staff behaviour and demonstration of evidence-based practice.

The IAC noted a number of concerning behaviours during the Site Tour and shift change observation. These behaviours included a staff member who grunted but did not acknowledge the UC's greeting, another staff member talking on the phone during change of shift report, and a staff member who got up and walked away from a conversation.   The IAC believes that these behaviours were the 'tip of the iceberg' with respect to what is occurring on the unit and that they indicate a lack of courtesy and respect for colleagues. These behaviours need to be addressed forthwith. The IAC recognizes that the Hospital is fully aware of this issue, and has held a number of education/training/support sessions. In light of the reality that issues are still occurring, the IAC believes that team-building support from a source external to the unit, such as an Organizational Effectiveness expert, is required.

The IAC was extremely concerned with the anecdotal reports, from both the Hospital and the Association, of unprofessional staff interactions on 3MBW.   Yelling and screaming between health care team members is inappropriate; when it occurs within the hearing of patients and families, it is absolutely unacceptable and cannot be tolerated. Staff members are expected to demonstrate the values of the organization. Staff members who are violating the code of conduct of the Hospital and/or who are not upholding the values articulated in the Hospital Mission Statement[50] require direct action, up to and including discipline. In these situations, mentoring and/or coaching on how to have a crucial conversation is both insufficient and inappropriate.

The IAC noted that a culture of evidence-based practice appeared to be missing on 3MBW. Continuous quality improvement did not appear to be part of the practice culture. It appeared to the IAC that changes in practice (such as use of the white boards in patient rooms) were implemented and revised on an ad hoc basis, sometimes on the basis of one individual's opinion, without any form of review or evaluation.

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[50] The Hospital Values, as indicated on the Hospital website are: accountable for our resources, our services and our behaviours; responsive, respectful and caring to our patients, colleagues and community; value the diversity of our organization and community; honest and trustworthy; strive for innovation and high performance and committed to continuous learning http://www.rougevalley.ca/mission-vision-values (accessed 26/01/2014)

In addition, the IAC noted, from discussion throughout the Hearing, that RNs did not appear to demonstrate competencies in relation to current gerontological nursing practice. For example, at the Hearing the RNs appeared unconcerned that the practice of polypharmacy was the norm on the unit or that a patient was concurrently receiving three anti-psychotic medications[51]. As 3MBW moves away from custodial care and evolves towards reactivation / restorative care / enablement, the RNs (and RPNs) will need to develop additional competencies in relation to gerontological and rehabilitative care.

The IAC believes that 3MBW would benefit from a partnership with a local Community College or the Metro Toronto Regional Geriatric Program (RGP) to provide a curriculum associated with gerontological and rehabilitation nursing practice. Resources such as the Senior Friendly Hospital Toolkit[52] would, in the meantime, provide a supportive resource to the CPL. In addition, the IAC believes that support for several RNs to obtain CNA Certification in Gerontology and/or Rehabilitation Nursing would be very beneficial, both to provide point-of-care clinical leadership and assist with a cultural shift towards evidence-based practice.

Recommendations:

14. *The Hospital engage an external expert (such as an Organizational Effectiveness specialist) to facilitate the development of a unit culture that is founded on the principles that underpin the Hospital's code of conduct. This should include team-building, conflict resolution and communication activities involving active staff participation.*

15. *The Hospital take direct action, up to and including discipline, in instances where staff members violate the Hospital Code of Conduct and Values. This will require the consistent presence and observation by the Manager in the short term.*

16. *The Hospital engage in a partnership with an external body (community college, Regional Geriatric Program etc.) to develop and provide a curriculum for the 3MBW staff that will assist with the transfer to a restorative care / enablement philosophy, the development of rehabilitation and gerontological nursing competencies and implementation of senior-friendly best practices on the unit.*

17. *The CPL implement a support group to assist RNs to explore preparation for CNA Certification in Gerontology or Rehabilitation Nursing.*

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[51] Noted by the IAC during review of a MAR during the Site Tour.
[52] http://seniorfriendlyhospitals.ca/senior-friendly-hospital-toolkit (accessed 26/01/2014)

3.3.3 Nursing Care Delivery Model and Associated Staffing

3.3.3.1   Nursing Care Delivery Model

A nursing care delivery model is "a structured approach for organizing and providing nursing care to clients, informed by values and beliefs[53].   The goal of a nursing care delivery model is to:
- provide safe, competent, quality care that meets client needs and maximizes client outcomes across the continuum of care;
- utilize health-care providers effectively; and
- ensure meaningful work for health-care providers, thereby instilling in them a sense that their contributions are important[54].

In addition, nursing care delivery models provide structure, role clarity and a clear articulation of operational processes supporting nursing practice. Nursing care delivery models can be used to meet organizational needs, in terms of budget and financial management, accreditation standards and patient satisfaction while ensuring roles and accountabilities are clear.

A nursing care delivery model details assignments, responsibility and authority to accomplish patient care, clearly identifies who is going to perform what care, who is responsible and who makes decisions, and matches the number and type of caregivers to patient care needs.   The classic nursing care delivery models are total patient care, functional nursing, team nursing and primary nursing. Other care delivery models that have evolved from these are considered 'hybrid' models. For example, Modular Nursing is considered to be a hybrid of primary and team nursing.

When the Hospital made the staff mix change to include UCPs in October 2011, they referred to the care delivery model as a Collaborative Care Model. The term 'collaborative' reflects the interaction between the RN, RPN and UCP, but it is not, in itself, a care delivery model.   The Hospital identified five principles on which it based the Collaborative Care Model[55]:

- Leverage successful models: Transitional Care Model used successfully in TRCP could become the catalyst for change in Post-Acute Care (including IP and OP rehab healthcare professionals);
- Optimized Staff Mix: Use of regulated and unregulated workers to their scope of practice and with a focus on restoration and functional enhancement including OTA and PTA and new roles, such as the Nurse Practitioner;
- Efficiency: Standardization of policy and procedures at both sites, like infection control, metrics (LOS reduction in ALC patients awaiting LTC) etc.;
- Effectiveness: Patient population drives model of care, staffing patterns, patient safety and access/flow; and
- Strategic: Align with Plan-on-a-Page: geriatric specialization in the context of a hospital-wide senior friendly environment.

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[53] Invitational Round Table: Nursing Care Delivery Models and Staff Mix: Using Evidence in Decision-Making, pg. 1, Canadian Nurses Association, ISBN 978-1-55199-345-8, February 2011

[54] Nursing Care Delivery Models: Canadian Consensus on Guiding Principles, pg. 3, Canadian Nurses Association, ISBN 978-1-55119-376-2, March 2012

[55] Model of Care document, provided by the Hospital at the Hearing

The IAC understood the principles, but did not believe that these articulated a care delivery model. At the Hearing, the care delivery model on 3MBW was described by the Hospital as 'modified primary functional', and that while the vision was a team nursing concept, implementation has been an independent functional approach.

- A functional nursing care delivery model, which emerged during WWII due to a shortage of nurses, divides nursing care into a series of tasks, with each staff member assigned to perform one or two tasks for all patients in the unit. Although this model, in comparison to others, requires less RNs, care is fragmented across a range of providers and there is a potential for communication breakdown. In addition, 'neglecting the humanity of the patient and the individual needs of the patient will be lost in an effort to get the work done'[56].

- Team nursing, which evolved in the 1950's to reduce fragmented care, binds team members (who may be a combination of regulated and/or unregulated) into small teams. An RN, as team leader, coordinates care for a group of patients. Team nursing allows for efficient utilization of staff through direct supervision, guidance and teaching by RNs. Team nursing becomes less effective when variation in team assignments impact continuity, the team leader lacks leadership skills or insufficient time is provided for intra-team planning and communication[57].

The IAC is unclear regarding the meaning of 'modified primary functional', but does agree that the vision of team nursing has evolved to a functional care delivery model, with the UCPs responsible for providing personal care and the RN and RPN (equally, it appeared to the IAC) responsible for administering medications and providing treatments. The RN in the role of team leader was not evident. The care delivery model has been further confounded by the current trial of a "float RN" on the day shift, who provides total patient care[58] to two patients on each of 3 West and 3 East. The IAC believes that it is not surprising that role clarity, in terms of understanding of "who is on first" for care provision, care planning, and care documentation, has been cloudy.

The IAC believes that a model of care which maximizes the leadership capabilities and responsibilities of the RN, enables the RPN to work at full scope, and provides a mechanism to monitor and supervise the UCP, is required. The IAC believes that, in light of the context of 3MBW relating to the geographic 'two-units-within-one' situation, and the anticipated transitional restorative care patient population who will be more active in self-determination and have a relatively long length of stay, a modular nursing care delivery model will best meet the needs of the patients, staff and organization.

- Modular nursing is a modification of team and primary nursing, in which the patient care unit is divided into modules. Regulated and non-regulated staff co-operate in caring for patients under the leadership of an RN. The same team of caregivers is assigned as consistently as possible to same geographic area, thus enhancing continuity. As team leader, the RN is actively involved in planning and coordinating care[59].

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[56] http://faculty.ksu.edu.sa/Hanan_Alkorashy/Nursing%20management%20489NUR/10._Patient_Care_Delivery_System.pdf. (accessed 26/01/2014)
[57] Ibid
[58] In a Total Patient Care model, one nurse is responsible for planning, organizing and providing all care to a patient.
[59] http://faculty.ksu.edu.sa/Hanan_Alkorashy/Nursing%20management%20489NUR/10._Patient_Care_Delivery_System.pdf. (accessed 26/01/2014)

In recommending a modular nursing care delivery model, the IAC believes the structure should include the following:

- Each of 3 West and 3 East contain two modules, with 10 patients in each module. The modules be geographically determined (i.e. the room configuration that makes the most sense). Once the module configuration has been determined, it will be consistently maintained.
- The UC will continue in her present role with 3 West and 3 East.
- The 3MBW direct care staffing allocation (Table 3) will alter slightly to enable balanced RPN-UCP dyads in each module (Table 4).

Table 3: Current 3MBW Staffing Allocation

	Days	Evenings	Nights
RN	2	2	2
RPN	3	2	2
UCP	4	3	-

Table 4: Proposed 3MBW Staffing Allocation

	Days	**Evenings**	**Nights**
RN	2	2	2
RPN	4	2	2
UCP	4	2	-

The IAC believes that the proposed 3MBW staffing allocation can be achieved in a cost-neutral manner. At the time of the Hearing, the staffing allocation for 3MBW was as identified in Table 4. The IAC believes that reallocation of the funding for the 3rd UCP on evenings and for weekend Unit Clerk coverage (see Recommendation 19), will cover the cost of a 4th RPN on days.

- The modular staffing for each 10 bed module involve the following:
    - All staff receive report together;
    - The staff within the modular team work together as a team to provide patient care for patients in the module (shared ownership). As much as possible, consistency of assignments is maintained to facilitate continuity of care provider;
    - Assignment of patients within the module is dependent on the complexity of the patient care needs and provider competencies;

- The RN is responsible for overall leadership of the team, care planning, and managing family issues, complex discharges, and new admissions. She/he transfers accountability for the modules under her/his responsibility to the incoming RN at change of shift. She/he functions as a resource to the RPN and UCP dyad;
- The specific responsibilities of the RN and RPN will vary in response to the patient care needs[60], and will be discussed and determined at the beginning of each shift.
- The RN on days does not have a regular direct care patient assignment. However, in light of patient care needs within the module, she/he may choose to provide direct care to a complex patient to better understand patient/family care needs, or assume care for a newly admitted patient in order to comprehensively develop the care plan.

- Day shift: 1 RN responsible for 20 patients (two modules), with two RPN/UCP dyads each responsible for 10 patients
  - RPN provides total patient care, including all medications and treatments to her/his assigned patients, access consultative support from the RN as required;
  - UCP provides personal care to her/his assigned patients
  - RN and RPN support the UCP by providing nursing assessment, medications and treatments (allocation of which determined at the beginning of the shift).
- Evening shift: 1 RN, 1 RPN and 1 UCP responsible for 20 patients
  - RPN and UCP have an assignment but work as team to provide personal care to patients in the module;
  - RN and RPN determine allocation of assignment for documentation, assessment, medications/treatments etc. at the beginning of the shift.
- Night shift: 1 RN and 1 RPN, each responsible for 10 patients
  - Each of the regulated staff is responsible for providing all care needs of the 10 patients within the module
  - RN assumes overall leadership for both modules, and functions as a resource to the RPN.

- The modular teams will be as consistent as possible (i.e. a defined group of RNs, RPNs and UCPs will be assigned to each module, to enhance continuity of patient care, and enhance development of confidence and competence in staff team dynamics.
- Agreed unit admission criteria will be consistently applied to ensure that 3MBW maintains the anticipated restorative care patient population.

Modular nursing is premised on teamwork. The IAC recognizes that successful transition to a modular care delivery model will require effective teamwork between the three categories of care providers, RNs, RPNs, and UCPs, and effective point-of-care leadership by the RNs.

Given the current unit culture, and in light of the implementation challenges experienced since October 2011, the IAC strongly encourages the Hospital to ensure that the tools and resources outlining role

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[60] As evaluated in the 3 Factor Framework

expectations, standards of care, intra-team communication, documentation etc. are firmly in place and clearly understood by everyone before the modular nursing model is implemented. The IAC believes that in the absence of a CNS, assigning an RN as Professional Practice Project Lead will be necessary.   In addition, the team-building development, referenced in Recommendation 14 will be sentinel to the success of any model that is contingent on team work and professional communication. Consistent staffing with core (unit-based staff) (Recommendation 22) will also be necessary to ensure success.

Recommendations:

18. **3MBW implement an even staff allocation across all shifts to enable balanced regulated/unregulated care teams. The allocation be:**
    - **day shift: 2 RNs, 4 RPNs, 4 UCPs**
    - **evening shift: 2 RNs, 2 RPNs, 2 UCPs**
    - **night shift: 2 RNs, 2 RPNs.**

19. **Reallocate current budget from the third UCP on evenings and the weekend Unit Clerk coverage to support the creation of a fourth RPN position on the day shift.**

20. **Implement a professional nursing care delivery model, preferably modular nursing, that is based upon teamwork, geographic distribution of patients, shared accountability, continuity of patient care provider and maximizes utilization of the scope of practice of RNs, RPNs and UCPs.**

21. **Until modular nursing is implemented, assign one RN to each of 3 West and 3 East on the day shift (i.e. discontinue the current 'float' role).**

3.3.3.2   Staffing

The IAC believes that the key staffing issues on 3MBW result from the current balance of full-time and part-time staff, the self-scheduling guidelines currently in use for the RNs, and the high use of SRT and agency staff. In addition, the IAC believes that revisions to Unit Clerk staffing would be beneficial.

3.3.3.2.1   3MBW Staff Balance

3MBW has moved from 9 to 4 full-time RNs since implementation of the Collaborative Care Model in October 2011. As of January 14, 2014, 3MBW has:
- 4 full-time RNs, 8 part-time RNs, and 2 casual RNs;
- 4 full-time, RPNs, 6 part-time RPNs, and 4 casual RPNs;
- 7 full-time UCPs, 9 part-time UCPs, and 2 casual UCPS.

At the time of the Hearing, the Hospital was in the process of hiring a 7th part-time RPN. The 3MBW nursing staffing also includes the UC and Advanced Practice Nurse positions.

The IAC was amazed by the low number of full-time positions across each category of care provider, and believes that this is significantly contributing to the staffing instability being experienced by 3MBW.

The IAC reviewed the January 15 – February 25, 2014 RN and RPN schedules. The IAC noted that in order to fill the RN base-line schedule (of 2 RNs on each of the day, evening and night shifts), the part-time staff were virtually booked to their commitment hours. This means that when an unanticipated (i.e. sick call, bereavement leave etc.) or an anticipated (vacation, MLOA etc.) vacancy occurs, or when additional staff are required to meet patient care requirements, the unit may be in the situation of having no internal RN resources to call upon, as all the part-time RNs are pre-scheduled to their commitment.

The staffing situation appeared to be even more challenging for the RPNs: all of the part-time staff are working a minimum of 45 hours in a 2-week period (some as high as 60 or 67.5 hours, and one part-time has moved to a temporary full-time position). The RPN base-line schedule (3 RPNs on days, 2 RPNs on evenings and nights) has many gaps which will have to be covered from the SRT pool or an external agency. The IAC did not review the UCP schedule, but is confident that 7 full-time and 9 part-time staff cannot possibly cover the base-line schedule (4 UCPs on days, 3 UCPs on evenings), which is resulting in a high percentage of the budgeted shifts being covered by SRT or external agency staff.

The IAC believes that the most effective staffing approach is to cover a majority of the base-line schedule with full-time staff. This approach, which enables inclusion of a proportion of part-time staff's commitment to be integrated into the baseline schedule[61], means that part-time (and casual) staff are available to cover unanticipated and anticipated vacancies, as well as to provide 'upstaffing' support when staffing resources above the base-line are required.   In addition, consistency of staff results in enhanced continuity of patient care with consequent lower likelihood of risk and patient/family dissatisfaction issues.

With respect to the RN staffing requirements, the IAC believes that the current baseline of six (6) 7.5 hour tours per day requires 8.4 FTE positions, which can be most optimally filled by six (6) or seven (7) full-time RNs, with the remaining FTEs covered by part-time RNs.   A move to a 11.25 hour tour schedule, which would be very possible in light of the consistent number of RNs on all shifts over all seven days, would also require 8.4 FTE positions.

Recommendation:

> 22. **The Hospital increase the number of full-time RN, RPN and UCP positions to enable better coverage of the base-line schedule with full-time staff.**

3.3.3.2.2   Self-Scheduling

The IAC understood that the Hospital currently utilizes an on-line web-based scheduling system which can be accessed remotely, and that the Hospital has recently obtained approval to purchase an

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[61] The IAC believes that in a 'perfect world', 100% of the baseline schedule would be covered by full-time staff. However, in a competitive human resources environment (such as metro Toronto), the IAC believes integrating a proportion of the part-time staff member's committed hours into the baseline schedule facilitates her/his ongoing commitment to the unit, while still enabling availability for short-notice requests. The IAC anticipates that part-time staff whose committed hours are filled exclusively with short notice requests will choose to leave to work elsewhere.

electronic scheduling system. This new system will be rules-based, which will require staff to book themselves in accordance with their Collective Agreement commitments.

The IAC understood that the 3MBW RNs have utilized a self-scheduling system for a number of years. The Hospital Local Collective Agreement states "Self-scheduling is scheduling by nurses in order to promote more flexible schedules that meet the needs of the nurses and the patient care needs of the unit. Self-scheduling will not result in additional costs to the employer."[62] The IAC believes that self-scheduling as it has been practised on 3MBW has, in fact, been an 'additional cost' to the employer. Until recently, there were many gaps in the base-line schedule because the part-time staff members were not scheduling themselves to their committed hours. This has recently improved following intervention from the Manager, but did result in the 6% of the budgeted RN hours being provided by external agency staff, at a substantially increased hourly cost.

The IAC noted that the 3MBW Self-Scheduling Guidelines, most recently approved by the self-scheduling Monitors in September 2012, lack clear process-driven language that support all articles in the Local Collective Agreement. In addition, the IAC understood that, in fact, the "Monitors" are one RN who monitors the self-scheduling process, and that there is neither a unit-based or corporate Self-Scheduling Committee. The IAC is not surprised that scheduling has been a challenging issue.

The IAC believes that 3MBW will be best served by a master rotation. This will support staffing consistency within the recommended modular nursing care delivery model. A master rotation will enable a consistent group of RNs, RPNs and UCPs to work together in a team environment to provide care to patients within their defined module. The IAC recognizes that the autonomy provided by self-scheduling is important to the RNs, but noted that both the full-time and part-time RNs have chosen to work a relatively consistent shift pattern, including permanent shifts[63], which could be easily supported in a master rotation. The IAC believes that, as per Innovative Unit Scheduling Article 13.03 (d), opportunities to meld elements of scheduling autonomy with scheduling consistency are available. The IAC has developed several innovative draft master schedules, based on 7.5 hour tours (*Appendix 10*), 11.25 hour tours (*Appendix 11*), and a combination of 7.5 and 11.25 hour tours (hybrid) (*Appendix 12*) including a weekend worker line (*Appendix 13*) to demonstrate the range of possibilities.

In concert with the move to an electronic scheduling system, the IAC believes the Hospital will benefit from implementation of a corporate Scheduling Committee. This Committee, with representatives from both the Hospital and the Association, would be responsible to review all master schedules annually and prior to any revision, and to identify any potential scheduling issues in advance of their becoming a problem. The IAC believes this would provide a mechanism to assist units, staff and management to address challenging scheduling issues and would support the creation of innovative master schedules through developing collaborative options.

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[62] Rouge Valley Health System Local Collective Agreement: Article J.3

[63] During the six week period January 15-February 25, 2014,, one full-time RN is working permanent days, one full-time RN permanent nights, one full-time RN 72% evenings, 28% days, and one full-time RN 80% evenings 20% days.. The part-time RNs have an equally consistent pattern. The 3MBW Self-Scheduling Guidelines state in #1: "May opt to work more alternate shift if unit needs permit."

Recommendations:

23. ***Create a master schedule that covers the base-line staffing with full-time RNs, working 7.5 hour and/or 11.25 hour tours, with the potential for permanent shift assignment. Develop, as indicated in Article 13.03, a Letter of Agreement(s) to protect current the permanent shift schedules permitted under the 3MBW Self-Scheduling Guidelines.***

24. ***Implement a corporate Scheduling Committee which will be responsible to annually review (a) all unit master schedules to ensure compliance with the Collective Agreement and (b) all new or revised unit master schedules prior to implementation and to provide guidance and advice regarding challenging scheduling issues and innovative schedules.***

3.3.3.2.3   SRT and Agency

The IAC believes that with
- implementation of the above recommendations regarding increase in the number of full-time RN, RPN and UCP positions and
- implementation of a master rotation for RNs (and optimally RPNs and UCPs)[64],

together with
- the recently revised isolation policy for ESBL-positive patients, and
- the transition to a restorative care patient population,

the use of external agency staff will decrease substantially. The IAC believes this will beneficially impact the quality of patient care, and staff satisfaction/morale, and will enable better control of staffing costs.

The IAC supports the Hospital's decision to augment the SRT resources and noted that at the time of the Hearing, the SRT contained 37 RNs (29 full-time and 8 part-time) and 14 RPNs (11 full-time and 3 part—time).   The IAC believes that, in light of the care delivery model expectations on 3MBW which differ significantly from other units in the Hospital, all SRT RNs, RPNs and UCPs need to participate in a day-long orientation to 3MBW before being assigned there. In addition, the IAC believes that an Orientation to the Unit document, which was referenced at the Hearing as being under consideration, needs to be developed, and that all orienting staff must demonstrate understanding of its contents through discussion with the CPL at the completion of their orientation shift.

The IAC noted that ten (10) of the 37 SRT RNs are Nursing Graduate Guarantee (NGG)[65] positions. These NGG RNs, at the beginning of their career, will have less confidence and competence in the point-of-care leadership and direction and supervision of UCPs required for the RN role on 3MBW. The IAC believes that the SRT RN orientation to 3MBW needs to include the opportunity to shadow an experienced 3MBW RN, before being assigned to the unit.

The IAC believes that providing an identified 'home base' for the SRT staff rather than a corporate resource pool is an approach the Hospital may wish to consider.   The IAC understood that the Staffing Office, which currently manages the assignment of the SRT pool, is not open between 2100 and 0500

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[64] The IAC recognizes that it has no jurisdiction regarding RPN or UCP staffing or scheduling parameters or practices.

[65] The Nursing Graduate Guarantee (NGG) is an initiative of the Ontario Ministry of Health and Long-Term Care aimed at ensuring that every new nursing graduate (RN and RPN) who wishes to work full time in Ontario will have that opportunity.

during the week or at all during the weekend. Assigning the SRT staff to specific units, where their schedule would be posted, would support the recently granted authority for UCs/Charge Nurses to call in additional staff when required. (That is, if additional staffing resources were required and the SRT staff members assigned to 3MBW were not available (i.e. on a day off, or already scheduled), the UC/Charge Nurse could call other units to directly access an available SRT staff).

The IAC recognizes that the accepted belief within the hospital environment is that external agency nurses should not, if at all possible, be assigned to high acuity areas, but that assignment in less acute areas, such as post-acute care, is "OK". The IAC believes that in light of the current issues on 3MBW, external agency resources should be used as minimally as possible.

Recommendations:

25. ***Provide all SRT pool staff (RN, RPN and UCP) with a one-shift orientation to 3MBW prior to being assigned. The RN orientation include shadowing with an experienced 3MBW RN to enable understanding of the RN's responsibilities for direction and supervision of UCPs within the 3MBW model of care.***

26. ***The 3MBW Manager, CPL and UC develop an Orientation to 3MBW document, for use during SRT staff orientation and to enable evaluation of understanding of the 3MBW care delivery model by non-core staff.***

3.3.3.2.4   Unit Clerk

The IAC understood that prior to October 2011, 3MBW had one Unit Clerk on each side from 0730 – 1530[66]. Between October 2011 and November 2013, this was reduced to one Unit Clerk who floated between the two sides. The Unit Clerk's hours were changed in July 2012 from 0730 – 1530 to 0800 – 1600, to ensure Unit Clerk coverage during team change of shift. Comments at the Hearing indicated that this level of clerical coverage had a large impact on nursing, resulting in missed MD orders and transcription errors (e.g. orders transcribed but not flagged for the nurse to co-sign).

The IAC understood that the decision to increase Unit Clerk coverage from 5 to 14 shifts per week was made following the November 2013 Kaizen event, in recognition of the physical side configuration of the unit, and the clerical responsibilities being downloaded to nurses. The Hospital noted at the Hearing that because of the long stay nature of the 3MBW patient population, the clerical staff also provide an initial point of contact with families, assist with way-finding and participate in discussions with families.

At the time of the Hearing, one Unit Clerk worked 0800 – 1600 on 3 East Monday to Friday, and one Unit Clerk worked on 3 West 1200 – 2000 Monday to Friday. During the 0800 – 1200 and 1600 – 2000 hours period when only one Unit Clerk was present, he he/she floated to the other side for 30-45 minutes at a time to assist with phone calls, admissions, orders etc. The IAC does not support "float" positions on 3MBW due to the two-side configuration.

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[66] The IAC understood this from discussion at the Hearing.

At the time of the Hearing, interviews to hire part-time Unit Clerks to provide weekend coverage were in process. The IAC understood that the decision to implement consistent clerical coverage seven days per week was based on the belief that the level of work on the weekend alters only in terms of therapy (PT, OT, recreation) support, and that 3MBW is a seven-day-a-week operation, with orders and possible admissions.

The IAC believes that the majority of phone calls, orders, admissions and interactions with other Departments occur during the day shift Monday to Friday, when other Departments, CCAC etc. are functioning, and consequently believes that the Unit Clerk coverage needs to consistently cover these hours on both sides of the Unit. During the busy morning period between 0800 and 1200, it is essential that an individual be available to answer the phone, so that team members providing patient care are not interrupted and the UC is not functioning in a clerical role. While this can be achieved by forwarding the telephones and implementing a telecommunication structure functional across both sides, the IAC also believes that it is important that all new orders be transcribed and flagged for review by the RN module team leader before the end of the day shift. The IAC was concerned that orders written in the morning on 3 West may not be transcribed until the afternoon, resulting in potential delays in care and/or potential delay in problem-solving problematic issues.

In addition, the IAC believes that the budget allocated for weekend clerical coverage would be more effective if applied to direct care provision, to enable base-line scheduling of four (4) rather than three (3) RPNs on the day shift (See Recommendation 18)

Recommendations:

> **27. Provide Unit Clerk coverage from 0800 – 1600 Monday to Friday on each of 3 West and 3 East.**

> **28. Re-allocate budget for weekend clerical coverage to direct care (RPN on day shift).**

3.3.4   Clinical Practice / Unit Processes

The IAC believes that the workload of the RNs (and other staff) has been negatively impacted by the use of a number of practices and processes on 3MBW, and that, altering these will streamline and/or decrease workload responsibilities of the RNs. The IAC believes that the key practices / processes impacting workload relate to medication administration, transfer of accountability at change of shift, use of the 3 Factor Framework for staff/patient assignment, Bullet Rounds and 4P rounding expectations, and documentation.

3.3.4.1   Medication Administration

A variety of concerns associated with the administration of medications were identified by both the Association and the Hospital prior to and throughout the Hearing.

3.3.4.1.1   Medication Administration Record (MAR)

The IAC was taken aback by the lack of electronic support for the medication administration process. Transcribing orders by hand onto MAR sheets is antiquated, extremely time-consuming, and fraught with potential for error.   During the Site Tour, the IAC noted that the standards for MAR documentation[67] did not appear to be consistently adhered to by either the Unit Clerk transcribing or the RN/RPN checking the order, with significant variations/errors noted on the MARs the IAC reviewed.

The IAC understood that hand-written medication order transcription is recognized by the Hospital as an issue. A Working Group spearheaded by the Chief of Staff has been struck to select a vendor to provide a platform which will work in concert with the Meditech framework. The IAC strongly recommends that implementation of an electronic MAR be a key corporate priority and that implementation be achieved in the near future.

The IAC noted that MAR books, one for each medication cart, were implemented in August 2013, and that MARs are no longer kept in the patient's health record.   The IAC supports the use of MAR books as an effective tool to assist with medication administration.

Recommendations:

29. ***The Hospital implement an electronic Medication Administration Record as soon as possible.***

30. ***3MBW Manager ensure that the Unit Clerks meet the minimum qualifications to support the transcription of physician orders (e.g. a Medical Terminology course) and attend a unit in-service to reinforce medication transcriptions standards as indicated in Hospital Policy M-0120.   The 3MBW Manager must continuously monitor these practices to ensure competency.***

3.3.4.1.2   Medication Incident Reporting

The IAC understood that, due to time constraints (and, the IAC believes, unit cultural norms), IRIS[68] forms are not consistently completed when a transcription or administration error is discovered.   The IAC recognizes that when incident reports are not completed, management follow-up is difficult and trending of ongoing issues for the purposes of quality improvement is not possible. The IAC was very concerned about the apparent tolerance for inconsistent medication incident reporting. The IAC notes that all regulated staff, as identified in the CNO *Medication Standard*, have a responsibility to report all errors and near misses using formal practice-setting communication mechanisms[69].   Safe medication administration practice must be a joint initiative between staff and management.

The IAC understood that following review by the Manager, a list of medication errors and issues are compiled by the Pharmacy Department for review by the Medication Safety Committee, and subsequently the Quality and Safety Committee. While this process appears robust, the IAC believes that it will have little value if incidents are not noted at the time they are identified. In addition, the IAC

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[67] *Preparation, Administration and Documentation of Medication*, RVHS Policy M-0120, Revised October 2012
[68] Incident Reporting Information System
[69] College of Nurses of Ontario: Standard: *Medication* ., pg 8 ISBN 978-1-77116-007-0 Publication # 41007, Revised 2014

noted the lack of front-line nursing representation on the Medication Safety Committee; while this is an issue beyond the scope of the 3MBW PRC, the IAC encourages the Hospital to reconsider the membership.

Recommendation:

31. ***Regulated staff self-monitor to ensure adherence to CNO "Medication" standards of practice and Hospital policy "Preparation, Administration and Documentation of Medication" with respect to IRIS reporting.***

3.3.4.1.3   Medication Administration Practices

Workload associated with medication administration was clearly identified as a significant component of the PRC.   From review of the Takt time medication analyses completed in October and November 2013, and from discussion during the Site Tour and the Hearing, the IAC concluded that significant variation exists among the RNs and RPNs on 3MBW in terms of medication administration practices. Some nurses pour all medications in the med room and then walk to each individual patient's room to administer. Some nurses bring the med cart to the patient's room, pour the medications in the room, and administer. Some nurses pour all medications at once, place on the top of the med cart, and take the cart to each patient's room to administer. Some nurses use the MAR as a guide, while others check the MAR against the original order in the chart for each medication administered. Some nurses bring the charts in the chart rack with the medication cart to the patient's room, some walk back and forth to the nursing station.

The IAC understood that the Manager and the CPL have watched each nurse's medication administration practice, and have provided on-line feedback in relation to adherence to Hospital policy and regulatory standards. The IAC also understood that the Professional Practice Director has suggested that the Hospital move towards a systematic method of administering medications, but that this has not occurred.   However, wide variations in medication administration practice on 3MBW are continuing to occur, resulting in wide variation in the time required to administer medications.

The IAC recognizes the importance of professional autonomy. However, use of time-consuming practices, with which an individual nurse feels comfortable but which are inappropriate or unnecessary, must cease. The IAC believes that consistent parameters for medication administration practice, which support CNO standards and Hospital policy, need to be identified and followed. The IAC does not support variation in practice in this area: the IAC believes that the Hospital has the right to mandate uniform processes for high risk procedures, and that regulated professionals are accountable to practice in accordance with them.

The IAC recognizes the importance of appropriate tools and resources to provide timely and effective care.   The IAC commends the Hospital for the actions taken to date (medication carts, electronic pill splitter, wastebaskets on each cart etc.). The IAC believes that implementation of a modular nursing care delivery model will require the purchase of additional medication carts, to ensure that each RN and RPN within the module has her/his own cart and that sharing of a medication cart is not required. This will support point-of-care medication administration and compliance with the client identification requirements set out by Accreditation Canada.

Implementation of Unit Dose medication delivery, which the Hospital expected would ease the administration process, has in fact complicated medication administration due to the large number of medications in similar looking packages which the nurse must sort through each time medications are administered. The IAC understood that the Hospital is exploring some form of unit dose 'bundling' (i.e. 0800 medications bundled together in one package), and is hopeful that this can be achieved, as it will significantly facilitate more timely and efficient medication administration.

Finally, the IAC was concerned by the large number of standing medications (upwards of 20 in some cases) noted on the MARs reviewed during the Site Tour.   The IAC believes that the Pharmacy and Therapeutics Committee may wish to consider accessing gerontological pharmacy support to facilitate a corporate medication review process to decrease the number of standing medications for elderly patients as part of a Senior Friendly Hospital standard. Aside from patient quality of care, the number of standing and PRN medications has a significant workload impact. The IAC believes that consistent implementation of standardized medication administration times, which the IAC understood is in place on paper but not in practice on 3MBW due to physician preference, will be beneficial in the short term.

Recommendations:

> ### *32. The Professional Practice Committee establish, articulate and implement clear parameters for practice regarding medication administration.*
>
> ### *33. All RNs and RPNs on 3MBW adhere to the medication administration parameters identified by the Professional Practice Committee, with managerial follow-up as required.*
>
> ### *34. The Unit Council and the 3MBW management team jointly identify tools and resources that will assist in timely and efficient medication administration, included but not limited to additional medication carts, unit dose bundling and implementation of standard medication administration times.*

3.3.4.2   Change of Shift Report

The IAC had the opportunity to observe a change of shift report from the night shift to the day shift on 3 East on the morning of January 8, 2014. This experience, together with discussion at the Hearing, have led the IAC believe that there are significant risk issues association with the current mechanism being used for transfer of accountability at shift change.

During the observation experience, the IAC noted the following:
- There was no verbal report or direct interaction between the outgoing or incoming staff;
- A "Change of Shift Report" sheet is used for each patient to document relevant information;
  - Some nurses use a Charting-by-Exception approach, while others provide more comprehensive information regarding what has occurred during their shift; there did not appear to be a standard.
  - There is no methodological approach to the manner in which information is reviewed. One nurse presented all the written information on the Change of Shift report for each

of 10 patients, while another reviewed only the elements she considered pertinent for the 10 patients.

- The Change of Shift Report is used in lieu of the Care Plan / Kardex, which was not used or referred to at all.
- There was minimal to no communication between the regulated and unregulated staff within the 2-person dyad regarding patient care needs or plan for the shift, though the Charge Nurse did provide clear direction to an agency RPN regarding pain assessment.
- The Bullet Rounds Board, which the IAC noted was not current and contained inaccurate information, was used as a reference to guide care.
- The UCP Daily Activity Log, intended to be used to note patient care requirements, was not used at all by one of the UCPs, who arrived after report had started and stood at the door. A second UCP had written on her Daily Activity Log before Report started, and did not add to it during Report.

The IAC understood that a key driver of the current change of shift report mechanism is the requirement that report be completed within 15 minutes (on each of 3 West and 3 East), as per the Hour by Hour Accountability schedule.

- The IAC believes that the pressure to rush through precludes effective discussion between the RN (or RPN) and UCP dyad regarding care needs of, and care priorities for, each patient, and the team plan for the shift. This lack of 'team focus' has contributed to the unintegrated manner in which the regulated and unregulated staff are practising within the dyad.
- In terms of a modular care delivery model, the IAC believes that once the modular team (RN, 2 RPNs and 2 UCPs on day shift) has received report from the outgoing RN, the team should discuss patient care needs and determine the specific assignment within the module. Patient care is thus planned as a team, and staff assignment, that is ensuring the right care provider is assigned to the right patient, is determined once the care needs are understood. While this discussion needs to be completed in a timely manner, the IAC believes that setting the framework for the shift is important and will enable more efficient practice throughout the shift.

Following the change of shift report, the IAC noted that the dyad teams immediately conducted a 4P round on their 10 patients. While the IAC does not believe that 4P Rounding in its current form should continue (see Recommendation 44), the IAC strongly supports the concept of a beginning-of-shift assessment conducted jointly by the dyad or module team.

The IAC believes that transfer of accountability report needs to reflect standardized requirements for patient information that is transferred from shift to shift. Multiple tools exist in the literature, such as the Mosby Nursing Skills *Nursing Report*[70]. Effective transfer of accountability requires the nurse/team from the previous shift to provide information directly to the incoming nurse/team in order to ensure an opportunity to discuss and clarify patient care information. The IAC understood that a nurse-to-nurse transfer of accountability format is currently in use on the 9th floor of the Hospital. The IAC does not support the use of a written document, on which inconsistently completed information is transferred to the incoming nurse/team by a third party (the UC/Charge Nurse).

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[70] http://mns.elsevierperformancemanager.com/NursingSkiills/Cont

Both 3 West and 3 East have a large Patient Assignment Board opposite the nursing station.   The IAC understood that the Unit Clerk updates the 3 East Board with the day shift assignment, and tries to go over to 3 West to update the Patient Assignment Board by 0830. The IAC noted that during the Site Tour, which was held between 1030 -1230, the Patient Assignment Board on 3 West still reflected information from the previous day. The Patient Assignment Boards are not updated to reflect the evening or night shift assignments. Attempts have been made to colour-code the category of care provider (i.e. RN in one colour, RPN in another, UCP in a third) but this has not been consistently applied and the category colours are different on each side. The IAC questioned the value of the Patient Assignment Board in terms of assisting family members to know who their family member's care provider is, given that many families visit during the evening when the content of the Board is not current, and that the care providers' names are listed on the white boards in the patient rooms.

Recommendations:

35. ***Remove the requirement that change of shift report for 20 patients be completed within 15 minutes.***

36. ***Discontinue use of the Change of Shift Report sheet. Implement a change of shift report process whereby the outgoing nurse (RN or RPN) provides report for the 10 patients within her/his dyad[71] in accordance with a standardized format, and using the Care Plan / Kardex as the base.***

37. ***The Unit Council develop a standardized reporting format tool, which identifies the key information to be provided, in concert with the care plan as identified in the Care Plan / Kardex.***

38. ***Discontinue the use of the Patient Assignment Board. Post the daily staff assignment at the nursing station for access by the multi-disciplinary team.***

3.3.4.3   3 Factor Framework and Patient Assignment

The IAC understood that the Hospital has invested significant time and energy in operationalizing the CNO 3 Factor Framework (3FF) across the organization. The Hospital has developed a *3FF Decision Guide* and has recently implemented a policy specifying that "the UC/Charge RN/designate will record colour designation of each patient on the census assignment/report sheet by indicating a "G" for green, "Y" for yellow and "R" for red. This information will be retained as part of the Department record."[72]

The IAC strongly supports the concepts that are inherent in the 3FF, in terms of the inter-relationship of client, nurse and environmental factors on regulated staff mix determination. However, the IAC believes there are challenges in the manner in which the 3FF is being used to make day-to-day staffing assignment decisions on 3MBW.

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[71] Following implementation of a modular care delivery model, the outgoing RN will provide report for the 10 patients within the module to the incoming module team.
[72] 3 Factor Framework Decision Guide; Exhibit 33, Hospital Brief

There is no question that the UC/Charge Nurse should consider the patient's care needs in terms of complexity, predictability and risk of negative outcomes, the availability of supports and resources in the practice environment, and the skills and competence of the care provider when making staff/patient assignments. However, the patients themselves are not green, yellow or red: the colour is the outcome when all three factors (client, nurse and environment) considered in determining patient assignments. The IAC was thus confused by the practice of colour-coding patients. The IAC assumed, therefore, that the colour dot is intended to indicate whether the patient requires care from an RN (red dot), from an RPN with consultative support from an RN (yellow dot), or from an unregulated care provider under the direction of a regulated staff member (green dot).

In the 3MBW practice environment, the use of the 3FF is confusing in light of the regulated / unregulated staff mix, which the IAC believes was not integrated into the design of the 3FF by the CNO. The IAC noted that over the three days of the Hearing, almost all the patients on 3MBW were categorized as 'yellow', suggesting that patients could be cared for by an RPN, as long as RN consultative support was readily available. However, on 3 East all patients were receiving personal care from a UCP who was paired with an RPN. The only available RN carried a patient assignment across the two sides and did not receive report on any of the RPN/UCP dyad patients. The IAC questioned the extent to which she would be able to provide effective, timely and knowledgeable consultative support.

The IAC recommends that on 3MBW, in light of the regulated/unregulated staff mix, the 'green-yellow-red colour dot' allocation be eliminated and be replaced by RN nursing judgement on a shift by shift basis to determine the most appropriate care provider. Once a modular care delivery model is implemented, the RN team leader will be able to determine the staff assignment within the module, using the 3FF as a guide. In this model, the RN will gain an understanding of the skills and competencies of the staff working in the module and will be able to utilize this (nurse/care provider) factor when making assignment decisions. The RN will also be available to provide direction/supervision and consultative support, and will be able to provide direct patient care to any patients whose condition is not known (e.g. newly admitted) or unexpectedly deteriorating.

In addition, the IAC would like to identify that the colour dot system is currently utilized as a patient flow tool (stemming from the early work of the provincial Patient Flo Collaborative) in the majority of hospitals across the province. The colours indicate discharge readiness (green – discharge within 24 hours; yellow – discharge within 24-72 hours; red – discharge more than 72 hours) with some hospitals utilizing blue to indicate ALC status.

Recommendation

39. ***Continue to utilize the 3FF philosophy when making staff : patient assignment decisions, but discontinue the practice of colour-coding patients on the patient assignment sheet.***

3.3.4.4   Patient Care Rounds

The IAC noted three formal rounds processes that occur on 3MBW: Bullet Rounds, 4P Rounding and inter-professional rounds. The IAC believes that Bullet Rounds and 4P Rounding are currently impacting RN workload on 3MBW.

3.3.4.4.1   Bullet Rounds

The IAC understood that Bullet Rounds are conducted on each of 3 West and 3 East Monday to Friday in the conference room adjacent to the nursing station. The time of Bullet Rounds has been recently adjusted to occur between 1100 and 1130 in order to minimize conflict with medication administration and 4P Rounding times. The IAC understood that Bullet Rounds are attended by the UC, RNs, RPNs and UCPs, as well as the members of the inter-disciplinary team, including the CCAC Case Manager, physiotherapist, occupational therapist, recreational therapist, social worker and physician(s)[73].

As identified in the literature, the purpose of Bullet Rounds is to discuss each patient's case with the team, and to trouble-shoot any challenge(s) the patient may be facing that will impact on discharge. Specifically, Bullet Rounds provide the opportunity to
- identify, within 24-48 hours of admission, an estimated date of discharge and provisional discharge destination,
- screen patients for risk factors that may delay transition to subsequent care destinations and develop a plan for managing identified risks, and
- facilitate organized and regular communication within the inter-disciplinary team.

A Bullet Rounds Board provides visual triggers that clearly identify discharge status and required discharge planning activities for each patient on the unit[74].

The IAC understood that on 3MBW, Bullet Rounds are multi-purpose, and include an opportunity to discuss and update patient care needs (e.g. code status, Braden score etc.). This differs from the IAC's experience with Bullet Rounds as a patient flow tool to discuss discharge barriers as a team early in the day (in order to facilitate movement of patients out of the ER).

The IAC noted the Bullet Rounds Board in each of the conference rooms during the Site Tour, and during the change of shift reporting observation on 3 East. While the Board contains information regarding a number of discharge barriers, this was not the focus. In fact, the Board contained a range of other information as well, including code status, pressure ulcer status, fall incidents, and upcoming appointments, at least some of which was outdated or inaccurate. While the Board is written in a range of black, blue, red and green marker, the colours do not correspond to the industry-standard of green, yellow and red for anticipated discharge date, but rather reflect whatever marker happened to be closest at hand. The IAC noted that the staff referred to the Bullet Rounds Board frequently during change of shift report, using it as a patient care needs tool. This was disconcerting to the IAC, given the inherent risk associated with delivering patient care based upon inaccurate information.   The IAC also understands that it is 'everyone's' accountability to update and maintain the Board; the UC updates it during the Bullet Round, but the IAC observed other staff members changing information they believed to be incorrect.

The IAC recognizes the 3MBW management team's belief that inclusion of all staff involved with the care of a patient in the Bullet Rounds discussion can enrich the process. However, the IAC does not agree that it is either appropriate, or a good use of time, for UCPs to attend the Round. The focus of the Bullet Rounds is discharge: it is an opportunity for members of the inter-professional team to discuss factors impacting and strategies supporting discharge. The IAC believes that Bullet Rounds should not

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[73] The IAC was not clear regarding the extent of physician participation in the 3MBW Bullet Rounds.
[74] http://www.nelhin.on.ca/assets/0/16/2100/4860/4862/5cfab81e-a87b-4f1d-8db2-4b7b8f0b8eeb.pdf (accessed 30/01/2014)

be a forum for a general status update or care planning, and that information regarding current patient status, as required for discharge planning, can be provided by the modular leader.

Recommendations:

40. *Participation in the 3 East and 3 West Bullet Rounds include the UC, two RNs leading the modular care team and the allied health team members only.*

41. *The UC be exclusively responsible for maintaining the Bullet Rounds Board, and in so doing, use the green/yellow/red system (marker or magnet) to correspond with the patient's anticipated discharge status.*

42. *Limit the Bullet Rounds Board information to that required to facilitate discharge, such as room, patient name, diagnosis, service, admission date, discharge location, estimated discharge date and barriers to discharge.*

3.3.4.4.2   4P Rounding

The IAC was taken aback by the passion surrounding discussion of 4P Rounding[75], on the part of both the Association and the Hospital, at the Hearing. The IAC sensed that both sides feel entrenched in their position regarding the value (or lack thereof) of organized and scheduled patient rounding.

The IAC understood that when 4P Rounding was instituted on 3MBW in October 2012, the expectation was that a 'patient round' would be completed every hour during the day and every two hours on evenings and nights to assess, and address patients and meet their needs in an anticipatory fashion, thus reducing call bells and unnecessary interruptions.   In follow-up to the November 2013 Kaizen event, the Hospital implemented a 4P Refresh, which changed the expectation for 4P rounding by the RN/RPN/UCP to every two hours around the clock, and assigned 'visual safety checks' (assessing pain and presentation only) to allied health team members (e.g. the rec therapist at 0900, the OTA/PTA at 1445) in the interim. The IAC understood that 4P Rounds and safety checks are documented with a 'tick mark' on a laminated card located on the patient room door. The IAC was not clear whether the tick indicated that the patient had been seen, or that any identified issues had been addressed, or both. The laminated cards are not maintained as a permanent record of patient care, as the documentation on the cards is erased by the next shift.

The IAC understood from discussion at the Hearing that completion of the 4P Rounds varies significantly, with the exception of the morning round, which is completed by the regulated/unregulated staff dyad immediately following change of shift report.   The IAC noted during the Site Tour that documentation on the laminated cards also varies significantly.

The IAC is familiar with the theory underpinning the 4P Rounding concept, and has studied the reference material provided by the Hospital in depth. The IAC understood that the Hospital implemented 4P Rounding to provide assurance that patients would be assessed in a timely fashion, and that, when possible, patient care needs would be anticipated and interventions provided before the care need

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[75] The 4Ps stand for pain, personal needs, positioning and presentation.

became an issue. The IAC understands the value of structured rounding as a mechanism to ensure that UCPs are visualizing their patients on a regular basis and bringing issues forward to the regulated staff as appropriate.

However, the IAC is concerned that a structured, scheduled rounding requirement is dissonant with the expectation that regulated health care professionals use their knowledge, skill and judgement to determine when assessment and intervention are required. Some patients require regular and frequent monitoring of very specific health needs while others may require less specific intervention/observation only, as they are independent and can direct their own care. Regulated nursing professionals are expected to assess and plan for the care of their patients based upon their clinical judgement and critical thinking. Ultimately, RNs are responsible to direct UCPs in this regard after they have assessed the patients that they are accountable for.

The IAC is also concerned with the expansion of rounding responsibilities to other members of the inter-professional team, who are not directly involved in provision of direct patient care.   Inter-professional practice is not the same as trans-professional practice: while members of the inter-professional team are working towards the same goals regarding patient outcomes, they do not do each other's work. The IAC assumes that if the rec therapist believes the patient to be in pain, he/she will bring this issue to the RN or RPN for follow-up; the IAC is thus not sure how this approach 'saves' nursing time. In addition, the other team members lack the nursing knowledge, skill and judgement that the nurse brings to each patient encounter as she/he assesses the patient and the response to interventions through clinical observation.

The IAC believes that clearly written standards of care for 3MBW are required. These standards would be executed by regulated professionals who use their autonomy and judgement to implement. These standards, together with RN point-of-care leadership, supervision of UCP activities and appropriate performance evaluation, will effectively replace the need for an overly-structured 4P Rounding approach. For example, if a patient has been experiencing pain on the shift prior, assessment of that patient's pain level is a high priority during the current shift; discussion among the team will determine by whom and how often pain assessment will be required over the shift. The RN will be responsible to ensure that the assessments and associated interventions are completed as required. Similarly, a patient suffering from dementia may require very different prioritized personal needs (aka prompted voiding), just as a GATU patient admitted to gain strength in preparation for discharge home would have different care priorities. Each patient is unique, and requires assessment and intervention that is tailored to her/his specific situation.

To be clear, the IAC believes that the concept of 4P Rounding is appropriate, in that the four elements are appropriate.   The IAC believes that implementation of 4P Rounding in other facilities has been successful as it has been based on the regulated staff member's judgement[76] as to the frequency with which assessment and intervention are required. It is the concept of mandated scheduling of nursing activities that the IAC disagrees strongly with.

Similarly, the IAC does not believe that an Hour by Hour Accountability schedule is appropriate in an environment where the activity is unpredictable. Patient care needs can and do change over the course

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[76] There was considerable discussion at the Hearing regarding the requirement for use of a mandated script during the 4P Rounds process. The IAC does not believe that the Hospital expected that a mandated script be used, but believes that this may not have been clear to the 3MBW staff.

of a shift. The IAC is concerned that rigid adherence to a Rounding schedule can in fact open the Hospital to further risk.   For example, the IAC witnessed two staff members trying to fit in 4P Rounding because it was a scheduled task to be completed, and as a result, failed to review the Care Plan / Kardex for, or discuss the actual needs of a patient who had deteriorated significantly over the previous night shift. They were in and out of the room, placing a tick mark on the Rounding Log, very quickly, without demonstrating evidence of understanding of the patient's worsening condition. Similarly, assigning non-nursing staff to 'assess' patients for pain and presentation assumes that these staff have the knowledge, skill and judgement to recognize deviations from normal and/or issues arising with the clinical presentation of a patient. Both of these situations could result in delayed action when nursing intervention is required.

Recommendations:

43. **Discontinue use of the Hour by Hour Accountability Schedule.**

44. **Discontinue the formal 4P Rounding approach, including use of the laminated Rounding Log.**

45. **Each RN assume accountability to ensure that patients within her/his module are assessed at the beginning of each shift by the modular team, and that assessments and interventions are completed as required by the patient's care needs and by the minimum unit standard for patient observation.**

46. **Develop Standards of Care that outline the minimum expectations for the provision of patient care unique to this unit, team functioning, including regular patient assessment, intervention as required, and documentation of care provided.**

3.3.4.5   Patient Care Documentation

3.3.4.5.1   Care Plan / Kardex

The IAC noted that the blue care plan / Kardex did not appear to be considered a value-add document by the nursing staff. While the Kardexes were located in the Report Binder, they were not referred to during the change of shift report observed by the IAC. The IAC understood, from discussion at the Hearing, that because the Kardex is hard to read and cannot be relied upon to contain current information, it is of little use as a tool to guide the transfer of accountability at change of shift, or set care priorities during a shift.   The IAC believes that as a result of the manner in which the Collaborative Care Model has been implemented (by placing an equal 'accountability on everyone for everything'), in fact no-one is taking leadership to ensure the care plan is valid and current. The IAC also believes that the practice of documenting elements of the care plan in other locations (such as the patient room white board and Bullet Round Board) has diluted the efficacy of the Kardex as the 'go to' resource for patient care.

While understanding the challenges that have ensued with the care delivery model, the IAC believes that RNs and RPNs have clear accountability to ensure that their patient's plan of care is current and correct.   The IAC firmly believes that the care plan / Kardex should be the sole document providing

direction for patient care activities and that it is driven by interventions documented in the permanent health record.

Recommendation:

> **47. In concert with Recommendation 42, RNs and RPNs self-monitor accountability to update their patients' Care Plan / Kardex on a regular basis to ensure currency with the patient health record. In the short term, until it has become standard practice, Care Plans / Kardexes should be monitored by the Manager to ensure validity and currency.**

3.3.4.5.2   Patient Room White Boards

The IAC understood that erasable white boards, located in each patient's room, were originally introduced as part of the Hospital's examination of patient flow issues. The IAC understood that the original goal of the white boards was to enhance communication between the patient/family and the health care team, and that the boards were intended to include the current date, the names of the care providers (including allied health) on that shift, and the anticipated discharge date. The IAC supports such a board as a valuable two-way communication tool between patient/family members and health care team members[77].

It appeared to the IAC, however, that the white boards have transformed into a mini care-plan, that includes a range of additional information, such as whether the patient requires a one or two-person transfer. The IAC understood that the management team believed that documentation of specific care needs on the white boards would facilitate intra-team communication, and in particular, would decrease the need for the UCP to interrupt the RN/RPN with a practice question. The IAC also understood that at the time of the Hearing, staff members on 3MBW were making recommendations to add even more clinical information to the white board.

The IAC noted a wide variation in the quality and content of documentation on the white boards during the Site Tour. Some boards were up to date with the correct staff names, others were not. Most concerning was the apparent expectation that anyone, and everyone, could update the board at will and that UCPs and agency/SRT staff would refer to these boards to direct patient care. During the Site Tour, one of the unit staff noted information she believed to be incorrect, and wiped it off with her finger. There did not appear to be any requirement that the information on the white board be validated against the current care plan, or signed by the person documenting.

As noted in Section 3.3.4.5.1 above, the IAC believes that documentation of patient care information should be in one location: the care plan. The IAC believes that the practice of documenting elements of the patient care plan in a number of places (white board, Bullet Rounds Board) has diluted the efficacy of the care plan / Kardex as THE document guiding care ("one version of the truth"). The risk of providing incorrect patient care as a result of being guided by incorrect information is very high when documentation of care needs is duplicated in multiple locations. The IAC also believes that duplication adds unnecessary workload.

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[77] For example, the white board may be used to notify family members that a team member needs to discuss something with them, or vice versa.

Recommendation:

> **48. Utilize the patient room white boards as a communication tool with patients/families by including the date, name of current care providers on that shift, and estimated discharge date only.**

> **49. Update the white board during the modular team round immediately after change of shift report.**

3.3.4.5.3   Code Status

The IAC was pleased to note that the Hospital is working towards a seamless process for health record transition for patients moving from one service/facility to another, while recognizing legislative requirements. The IAC notes that standard expectations for patient re-assessment and patient/family communication upon admission to the unit will need to be articulated in the 3MBW standards of care.

The IAC was concerned with the translation of this seamless approach in relation to identification of patient's wishes for life sustaining treatment (including code status). The IAC understood that a new process, requiring the physician to discuss code status with the family within 24 hours of admission, has replaced the previous practice of transferring the code status noted in the acute health record to the post-acute care plan and validating this with the family. The IAC supports the need for timely discussion with the patient/family and agrees that direction regarding life-sustaining treatment should not be automatically transferred. In the interim until such discussion occurs, the IAC understood that patients are considered 'full code' until the physician orders otherwise.

It was apparent to the IAC that the required discussions with patients/families are not happening in a timely manner. During the Site Tour, the IAC noted a large number of patients listed as 'full code' on the Bullet Rounds Board. During change of shift report, a number of patients on 3 East, including a 95-year old with a 'huge tumour', were identified as 'full code' because there had been no conversation with the patient/family.   The IAC recognizes that these discussions are difficult, but the impact on both patients and nursing staff, if a full code is enacted because it is the default option, is unacceptable. While direction of medical practice is beyond the jurisdiction of the IAC, the IAC encourages the Hospital leadership team to take action to ensure that all members of the health care team are adhering to the standards of care.

3.3.4.5.4   *Assessment and Routine Care Flowsheet*

The IAC understood that the *Assessment and Routine Care Flowsheet* is used by all care providers, including RNs, RPNs and UCPs, to document care. The IAC understood that this is a generic form, utilized throughout the Hospital, and that the Hospital standard is that a separate signature sheet, located at the front of the health record, is signed by all staff on the unit.

The IAC was not clear regarding the overlapping responsibilities of the UCP and regulated staff member to document care provision on the *Flowsheet*. The Hospital Policy D-8[78] was most recently revised in 2009, prior to implementation of the Collaborative Care model on 3MBW. Policy D-8 states that 'the nurse, providing the care, will complete all documentation in permanent ink'. However, the Utilization of Personal Support Workers Policy[79] indicates that the UCP is expected to document specific items on the *Assessment and Routine Care Flowsheet.* These include date, time, psychosocial support, activity/mobility, personal/self-care, nutrition, bowel movement (number) and bowel care.

The IAC was not clear exactly what the UCP is expected to document, as the areas listed in Policy ADMIN-PT-340 do not directly correspond to the categories listed on the *Flowsheet*. In addition, given that the UCP is responsible for providing personal care, the IAC was unclear as to why the UCP is not documenting all elements of personal care, including, for example, bladder care. In addition, during a quick review of several health records during the Site Tour, it appeared to the IAC that both regulated and unregulated staff could (and did) document in the same column, and that differentiation between care provided by an unregulated vs. regulated staff member was unclear.

Recommendation

50. ***Review and revise policies regarding Documentation to ensure compatibility with the care delivery model on 3MBW.***

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[78] Documentation of *Assessment and Routine Care Flowsheet*, Hospital Policy D-8, revised February 2009, was distributed by the Hospital at the Hearing.
[79] Utilization of Personal Support Workers, Hospital Policy ADMIN-PT-340, revised October 2013, was distributed by the Hospital at the Hearing.

CONCLUSION AND SUMMARY OF RECOMMENDATIONS

4.1   Conclusion

Article 8.01 of the Collective Agreement between the Ontario Nurses' Association and the Rouge Valley Health System requests the Independent Assessment Committee to specifically address the issue of whether or not RNs are being requested to perform more work than is consistent with proper patient care. This IAC addressed this issue in relation to RNs on 3MBW.

The IAC Panel completed a thorough analysis, which included an in-depth review of information received prior to and during the Hearing in relation to the literature relating to gerontological and rehabilitation nursing, and restorative care, consideration of factors impacting the 3MBW practice environment, and integration of the Panel's cumulative practice experience.

The IAC Panel concluded that while the current number of RNs assigned over a 24-hour period is appropriate, the manner in which the care delivery model and associated staffing and unit processes have been implemented has resulted in the RNs being unable to provide proper patient care. This has been accentuated by a number of clinical unit practices which have not supported effective care provision.

A 'workload consistent with proper patient care' requires an environment that supports quality practice. Robust existence of the seven sentinel characteristics of a quality practice environment identified by the CNU and CNFU[80] are required. The IAC believes that addressing issues relating to leadership and shared governance, model of care delivery and associated staffing and clinical practice / unit processes will enable 3MBW to become a quality practice environment and all staff, including the RNs, to experience a workload that supports proper patient care.

4.2   Summary of Recommendations

The IAC identified 50 recommendations, in the areas of leadership and shared governance, nursing delivery model of care and associated staffing, and clinical practices / unit processes, to address the issue of RN workload on 3MBW.

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[80] Joint Canadian Nurses Association/Canadian Federation of Nurses Unions Position Statement: *Practice Environments: Maximizing Client, Nurse and System Outcomes.* 2006 http://www2.cna-aiic.ca/CNA/documents/pdf/publications/PS88-Practice-Environments-e.pdf (accessed 25/01/2014)

4.2.1   Leadership and Shared Governance

A quality practice setting requires effective <u>operational, clinical and point-of-care leadership</u>.

The 3MBW Manager is a novice leader, and requires mentoring support and skills development to provide effective leadership in light of the current instability on 3MBW. Assignment to 3MBW on a full-time basis, for a defined period, will be of benefit.

1. *The 3MBW Manager be responsible for 3MBW only, on a 1.0 FTE basis, for a six-month period.*

2. *The Vice President accountable for Post-Acute Care Program organize and implement a formal management mentorship relationship for the 3MBW Manager with an external expert leader.*

3. *The 3MBW Manager successfully complete a comprehensive Leadership Development Program.*

Clinical leadership will be more optimally provided by a Clinical Nurse Specialist (CNS) than an Nurse Practitioner (RN(EC)). The Advanced Practice Nurse in a CNS role is more suited to provide clinical leadership with respect to practice standards and competencies than is the RN(EC) role, which is more oriented to provision of patient care.

4. *The Post-Acute Program replace the budgeted RN(EC) position with an Advanced Practice Nurse CNS position, and take action to hire this position as soon as possible.*

The Unit Coordinator is the 'oil' that enables smooth functioning of an inpatient unit, and as such, requires flexibility to address issues impacting staffing and patient care.

5. *Discontinue the current Standard of Work document for the UC.*

6. *Implement a Unit Coordinator role profile which identifies the key elements supporting the smooth functioning of 3MBW, including:*
    - *timely problem-solving of patient and staff issues;*
    - *assessing patient eligibility for transfer to 3MBW;*
    - *determining staffing requirements in advance;*
    - *providing mentorship, learning and evaluative support to new and/or temporary unit staff; and*
    - *leading the Bullet Discharge Planning Rounds..*

College of Nurses of Ontario (CNO) regulatory standards include the requirement for RNs to assume a leadership role in the provision of patient care. The current care delivery model has been implemented in a manner which has not supported or facilitated RN leadership.

7. *Develop and implement a role profile for the RN working in a leveled practice environment that clearly articulates her/his leadership practice expectations, including (but not limited to):*
    - *meet with the dyad team at the beginning of each shift to discuss and coordinate care provision;*
    - *update client care plans (Kardex) as required to ensure content is correct and*

comprehensive;
✦*oversee the care provided by UCPs.*

Effectively implemented <u>shared governance models</u> provide staff at all levels with a sense of empowerment resulting from participating in decisions that directly impact professional practice and one's practice environment. Although 3MBW has resurrected the Unit Council, front-line staff members do not participate in the Program Council, and the accepted mechanism for decision-making has remained with the leadership team. Clarity regarding responsibility for decision-making regarding unit operational processes and clinical practices is required.

8. *The Unit Council revise the Terms of Reference to specify chairmanship, membership, boundaries of decision-making and ground rules for action during and following meetings.*

9. *The Hospital provide appropriate resourcing of the Unit Council, to enable effective discussion and decision-making.*

10. *The Hospital provide clerical assistance to ensure agenda and minutes are developed and circulated in a timely fashion.*

11. *Professional Practice mentorship be provided by the ONA RVHS Professional Responsibility Representative and the 3MBW CNS.*

12. *The Unit Coordinator from each of the four inpatient units within the Post-Acute Program sit as a decision-making member of the Post-Acute Program Council.*

13. *Front-line staff members from the Unit Council (in addition to the Unit Coordinator) participate on the Program Council.*

<u>Unit culture</u> impacts intra-team communication, collaboration and beliefs about practice. The 3MBW culture of tolerance for a lack of inter-collegial respect and unprofessional behaviour has not been effectively addressed, leaving issues to fester. The 3MBW practice culture does not embrace evidence-based practice.

14. *The Hospital engage an external expert (such as an Organizational Effectiveness specialist) to facilitate the development of a unit culture that is founded on the principles that underpin the Hospital's code of conduct. This should include team-building, conflict resolution and communication activities involving active staff participation.*

15. *The Hospital take direct action, up to and including discipline, in instances where staff members violate the Hospital Code of Conduct and Values. This will require the consistent presence and observation by the Manager in the short term.*

16. *The Hospital engage in a partnership with an external body (community college, Regional Geriatric Program etc.) to develop and provide a curriculum for the 3MBW staff that will assist with the transfer to a restorative care / enablement philosophy, the development of*

rehabilitation and gerontological nursing competencies and implementation of senior-friendly best practices on the unit.

17. *The CPL implement a support group to assist RNs to explore preparation for CNA Certification in Gerontology or Rehabilitation Nursing.*

4.2.2   Nursing Care Delivery Model and Associated Staffing

Although a team nursing care delivery model was envisioned when the collaborative care approach was implemented, this quickly evolved to a functional care delivery model.   A move to a modular nursing model of care will maximize the leadership capabilities and responsibilities of the RN, enable the RPN to work at full scope, and provide a mechanism to monitor and supervise the UCP.

18. *3MBW implement an even staff allocation across all shifts to enable balanced regulated/unregulated care teams. The allocation be:*
    * *day shift: 2 RNs, 4 RPNs, 4 UCPs*
    * *evening shift: 2 RNs, 2 RPNs, 2 UCPs*
    * *night shift: 2 RNs, 2 RPNs.*

19. *Reallocate current budget from the third UCP on evenings and the weekend Unit Clerk coverage to support the creation of a fourth RPN position on the day shift.*

20. *Implement a professional nursing care delivery model, preferably modular nursing, that is based upon teamwork, geographic distribution of patients, shared accountability, continuity of patient care provider and maximizes utilization of the scope of practice of RNs, RPNs and UCPs.*

21. *Until modular nursing is implemented, assign one RN to each of 3 West and 3 East on the day shift (i.e. discontinue the current 'float' role).*

3MBW has suffered significantly from a low number of full-time unit-based RN, RPN and UCP staff. The consequent assignment of part-time staff to their committed hours to meet baseline schedule needs has resulted in a heavy reliance on the SRT pool and external agency resources to cover unanticipated and anticipated vacancies and 'up-staffing' in response to patient care needs.   This has, in turn, had a negative impact on continuity of patient care, effective point-of-care leadership (and followership), and cost. An increase in the proportion of full-time to part-time staff is required.

22. *The Hospital increase the number of full-time RN, RPN and UCP positions to enable better coverage of the base-line schedule with full-time staff.*

Although the 3MBW RNs have utilized a self-scheduling system for a number of years, the majority of RNs self-schedule into a regular schedule and/or permanent shifts. Opportunities are available to meld scheduling autonomy with the scheduling consistency available through implementation of a master rotation.

23. *Create a master schedule that covers the base-line staffing with full-time RNs, working 7.5 hour and/or 11.25 hour tours, with the potential for permanent shift assignment. Develop, as indicated in Article 13.03, a Letter of Agreement(s) to protect current the permanent shift schedules permitted under the 3MBW Self-Scheduling Guidelines.*

24. *Implement a corporate Scheduling Committee which will be responsible to annually review (a) all unit master schedules to ensure compliance with the Collective Agreement and (b) all new or revised unit master schedules prior to implementation and to provide guidance and advice regarding challenging scheduling issues and innovative schedules.*

The SRT pool provides an important resource to meet short-notice staffing requirements.   To function as an effective team member within the 3MBW care delivery model, SRT staff members require an orientation to the 3MBW care delivery model prior to assignment to the unit. Assigning SRT staff to a home unit, rather than a corporate resource pool, will assist with this integration.

25. *Provide all SRT pool staff (RN, RPN and UCP) with a one-shift orientation to 3MBW prior to being assigned. The RN orientation include shadowing with an experienced 3MBW RN to enable understanding of the RN's responsibilities for direction and supervision of UCPs within the 3MBW model of care.*

26. *The 3MBW Manager, CPL and UC develop an Orientation to 3MBW document, for use during SRT staff orientation and to enable evaluation of understanding of the 3MBW care delivery model by non-core staff.*

Unit Clerk coverage is required on a consistent basis during the day shift on both 3 West and 3 East. The funding currently allocated for weekend Unit Clerk coverage would be better applied to support direct care provision by a regulated provider (RPN).

27. *Provide Unit Clerk coverage from 0800 – 1600 Monday to Friday on each of 3 West and 3 East.*

28. *Re-allocate budget for weekend clerical coverage to direct care (RPN on day shift).*

4.2.3   Clinical Practice / Unit Processes

The workload of the RNs (and other staff) on 3MBW has been impacted by a number of clinical practices and unit processes relating to medication administration, transfer of accountability at change of shift, use of the 3 Factor Framework for staff/patient assignment, Bullet Rounds and 4P rounding expectations, and documentation.

The time required for medication administration will be eased when an electronic Medication Administration Record is implemented, medication transcription incidents are addressed at the time they are identified, and medication administration practices are standardized and adhered to by all staff.

29. *The Hospital implement an electronic Medication Administration Record as soon as possible.*

30. *3MBW Manager ensure that the Unit Clerks meet the minimum qualifications to support the transcription of physician orders (e.g. a Medical Terminology course) and attend a unit in-service to reinforce medication transcriptions standards as indicated in Hospital Policy M-0120. The 3MBW Manager must continuously monitor these practices to ensure competency.*

31. *Regulated staff self-monitor to ensure adherence to CNO "Medication" standards of practice and Hospital policy "Preparation, Administration and Documentation of Medication" with respect to IRIS reporting.*

32. *The Professional Practice Committee establish, articulate and implement clear parameters for practice regarding medication administration.*

33. *All RNs and RPNs on 3MBW adhere to the medication administration parameters identified by the Professional Practice Committee, with managerial follow-up as required.*

34. *The Unit Council and the 3MBW management team jointly identify tools and resources that will assist in timely and efficient medication administration, included but not limited to additional medication carts, unit dose bundling and implementation of standard medication administration times.*

The requirements for professional staff to <u>transfer accountability for patient care at change of shift</u> report are unclear and inconsistent. There is no direct interaction between the outgoing and incoming staff, and no standardized expectations for patient information transferred from shift to shift, both of which are required. Information on the Patient Assignment Board is not consistently updated throughout the day, limiting its utility.

35. *Remove the requirement that change of shift report for 20 patients be completed within 15 minutes.*

36. *Discontinue use of the Change of Shift Report sheet. Implement a change of shift report process whereby the outgoing nurse (RN or RPN) provides report for the 10 patients within her/his dyad[81] in accordance with a standardized format, and using the Care Plan / Kardex as the base.*

37. *The Unit Council develop a standardized reporting format tool, which identifies the key information to be provided, in concert with the care plan as identified in the Kardex.*

38. *Discontinue the use of the Patient Assignment Board. Post the daily staff assignment at the nursing station for access by the multi-disciplinary team.*

The current approach of using the <u>3 Factor Framework</u> to colour-code a patient as green, yellow or red is inappropriate, as it is the triangulation of the patient, nurse and environment factors, not the patient, which leads to the green/yellow/red colour allocation. Replacement of the colour coding of patients

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[81] Following implementation of a modular care delivery model, the outgoing RN will provide report for the 10 patients within the module to the incoming module team.

with RN nursing judgement on a shift-by-shift basis to determine the most appropriate care provider will be beneficial.

39. *Continue to utilize the 3FF philosophy when making staff : patient assignment decisions, but discontinue the practice of colour-coding patients on the patient assignment sheet..*

Patient care rounds on 3MBW include inter-professional rounds, Bullet Rounds, held in the morning Monday to Friday, and 4P Rounding, held throughout the 24-hour day. Bullet Rounds currently involve all members of the care team (RN, RPN and UCP) as well as the UC and allied health staff, and appear to provide a general status update on each patient, rather than a focus on factors impacting discharge.

40. *Participation in the 3 East and 3 West Bullet Rounds include the UC, two RNs leading the modular care team and the allied health team members only.*

41. *The UC be exclusively responsible for maintaining the Bullet Rounds Board, and in so doing, use the green/yellow/red system (marker or magnet) to correspond with the patient's anticipated discharge status.*

42. *Limit the Bullet Rounds Board information to that required to facilitate discharge, such as room, patient name, diagnosis, service, admission date, discharge location, estimated discharge date and barriers to discharge.*

The current mandated schedule for 4P Rounding ensures that all patients are seen on a regular basis, but does not allow for individual accommodation of patient needs. While the concept of 4P Rounding is appropriate, successful implementation will require the regulated staff member's judgement regarding the frequency with which assessment and intervention are required for each patient. Rounding expectations must recognize that each patient is unique, and requires assessment and/or intervention tailored to his/her specific situation.

43. *Discontinue use of the Hour by Hour Accountability Schedule.*

44. *Discontinue the formal 4P Rounding approach, including use of the laminated Rounding Log.*

45. *Each RN assume accountability to ensure that patients within her/his module are assessed at the beginning of each shift by the modular team, and that assessments are interventions are completed as required by the patient's care needs and by the minimum unit standard for patient observation.*

46. *Develop Standards of Care that outline the minimum expectations for the provision of patient care unique to this unit, team functioning, including regular patient assessment, intervention as required, and documentation of care provided.*

Documentation of patient care needs is currently referenced in the Care Plan / Kardex, on the Bullet Rounds Board, and on the white boards in patient rooms. This approach has diluted the efficacy of the care plan / Kardex as "the" go-to resource, and has increased the risk of incorrect patient care being

provided. This risk is increased when documentation of care needs are duplicated in multiple locations. The patient room white board should be reserved for communication between the patient/family and the health care team.

47. *In concert with Recommendation 42, RNs and RPNs self-monitor accountability to update their patients' Care Plan / Kardex on a regular basis to ensure currency with the patient health record. In the short term, until it has become standard practice, Care Plans / Kardexes should be monitored by the Manager to ensure validity and currency.*

48. *Utilize the patient room white boards as a communication tool with patients/families by including the date, name of current care providers on that shift, and estimated discharge date only.*

49. *Update the white board during the modular team round immediately after change of shift report.*

Accountability for <u>documentation of patient care provision</u> on the *Assessment and Routine Care Flowsheet* requires clarification, to ensure that UCPs are providing comprehensive documentation of personal care provided, and that differentiation between care provided by regulated vs unregulated staff members is evident.

50. *Review and revise policies regarding Documentation to ensure compatability with the care delivery model on 3MBW.*

2011 – 2014 Collective Agreement between the Hospital and the Association

Article 8.01: Professional Responsibility

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

(a)   *i)*   *At the time the workload issue occurs, discuss the issue within the unit/program to develop strategies to meet patient care needs using current resources.*

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

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

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

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

   vi)   *Prior to the issue(s) being forwarded to the Independent Assessment Committee, the Union may forward a written report outlining the issue(s) and recommendations to the appropriate senior executive as designated by the Hospital.*

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

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

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

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

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

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

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

xii)   *The Chief Nursing Executive, Bargaining Unit President and the Hospital-Association Committee will jointly review the recommendations of the Independent Assessment Committee and develop an implementation plan for mutually agreed changes.*

(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 on 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.

ii)   *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*

ONA

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Ontario Nurses' Association

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June 12, 2013

Amelia McCutcheon
Vice President Cardiac, Cancer and Critical Care, Chief Nursing Executive
Rouge Valley Health System
2867 Ellesmere Rd
Toronto, ON, M1E 4B9

Dear Ms. McCutcheon

Re: Professional Responsibility Complaint 3 Margaret Birch Wing; Rouge Valley Health
    System (ONA File # 201300678)

The Registered Nurses (RNs) working in the 3 Margaret Birch Wing (3 MBW) at Rouge Valley
Health System have consistently identified ongoing serious practice and workload concerns as
evidenced by the data submitted on numerous Professional Responsibility Workload Report
Forms (PRWRFs) from September 2011 to today's date.

The RNs working in the 3 MBW have documented that the current practice, patient care, and
workload environment does not allow them to meet *College of Nurses of Ontario (CNO)
Standards and Practice Guidelines*, and they believe they are being asked to perform more
work than is consistent with proper patient care. Effective staffing patterns, skill mix and practice
supports have not been provided to respond to professional practice, patient acuity, fluctuating
workloads and fluctuating staffing.

The parties have been meeting regularly to attempt to resolve the issues. Despite this, the
Hospital has not put in place sufficient measures to resolve the very serious practice and
workload concerns identified by ONA members.

The Union is seeking resolution of the concerns on behalf of our members and the patients that
they care for, and remains very concerned regarding the risks to patient safety and the real
potential for negative patient outcomes.

Timely and effective resolution of the Professional Responsibility Complaint is vital to allow the
RNs working on 3 MBW to deliver safe, effective and ethical patient care. Accordingly, the
Union is forwarding the complaint to an Independent Assessment Committee as per Article 8 of
the collective agreement.

Joan Cardiff will be invited to Chair the Independent Assessment Committee as per the rotation
in Appendix 2 as confirmed with Stephen Green of the Ontario Hospital Association.

Please provide written confirmation concerning the name, mailing address, home or cell and
office phone numbers, fax number and e-mail address of your nominee. We will be providing
the information related to the Union nominee shortly.

Provincial Office: Toronto
Regional Offices: Ottawa · Hamilton · Kingston · London
Orillia · Sudbury · Thunder Bay · Timmins · Windsor

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

Sincerely,

ONTARIO NURSES' ASSOCIATION

Jo Anne Shannon
Professional Practice Specialist

Ja/kb

C: Linda Haslam-Stroud, President, Ontario Nurses' Association (ONA)
        Carol Oates, Bargaining Unit President (ONA)
        Dianne Brunton, Local Coordinator (ONA)
        Moni Diclimos Bryant, Professional Practice Specialist (ONA)
        Andrea Kay, Labour Relations Officer (ONA)
        Rik Ganderton, President & CEO (RVHS)
        Cheryl Williams, VP Acute Care Services (RVHS)
        Kathy Gooding, VP Human Resources (RVHS)
        John Aldis, Vice President Corporate and Post Acute Services and CFO (RVHS)
        Susan Fyfe, Director Children and Women Health (RVHS)
        Chris Jones, Director Emergency and Medicine (RVHS)
        Karl Wong, Director Post Acute Services (RVHS)
        Samantha Thomson, Manager 3 MBW
        Dr. Naresh Mohan, Chief of Staff (RVHS)
        Dr. Henry Huang, President, Medical Staff Society (RVHS)
        Dr. Ari Bay, Vice-President, Medical Staff Society (RVHS)
        Judith Barker, Chair, RVHS Foundation
        Nancy Maxwell, Alternate representative of the RVHS Foundation
        Joan Wideman, Chair, RVHS Board of Directors
        Fred Clifford, Vice-chair & Treasurer, RVH Board of Directors
        Tom Atkins, RVHS Board of Directors
        David Barlow, RVHS Board of Directors
        Yazdi Bharucha, RVHS Board of Directors
        Janet L. Ecker, RVHS Board of Directors
        Dave Goulding, RVHS Board of Directors
        Rhonda Lawson, RVHS Board of Directors
        Lisa Mattam, RVHS Board of Directors

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Professional Responsibility Complaint - 3 Margaret Birch Wing; Rouge Valley Health System

        Graeme McKay, RVHS Board of Directors
        Terri McKinnon, RVHS Board of Directors
        Lynda Mungall, RVHS Board of Directors
        John Rowinski, RVHS Board of Directors
        Jay Kaufman, RVHS Board of Directors
        Deborah Hammons, CEO, Central East LHIN
        Wayne Gladstone, Chair of the Board of Directors, CE LHIN
        David Sudbury, Vice Chair, CE LHIN
        Samantha Singh, Member, CE LHIN (Toronto)
        Stephen Green, Director, Hospital Employee Relations Services, OHA

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July 17, 2013

Joan Cardiff
416 Lakeshore Road
RR#2
White Lake, ON, K0A 3L0

Dear Ms. Cardiff:

RE: Professional Responsibility Complaint 3 Margaret Birch Wing; Rouge Valley
        Health System (ONA File# 201300678)

Thank you for accepting the nomination to Chair an Independent Assessment Committee (IAC) investigating a Professional Responsibility Complaint arising in the 3 Margaret Birch Wing; Rouge Valley Health System (ONA File# 201300678)

I have spoken with Mr. Stephen Green at the Ontario Hospital Association, and both parties have agreed to you chairing this IAC.

The attached letter was provided to the employer on June 12, 2013. In accordance with the collective agreement, both parties are required to appoint a nominee no later than July 27, 2013.

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

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

The Hospital will forward their nomination letter to you. Please set up dates with the nominees, who will confirm with their respective parties.

Sincerely,

ONTARIO NURSES' ASSOCIATION

Jo Anne Shannon

Jo Anne Shannon
Professional Practice Specialist

Provincial Office: Toronto
Regional Offices: Ottawa · Hamilton · Kingston · London
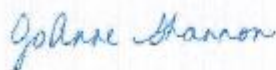Orillia · Sudbury · Thunder Bay · Timmins · Windsor

Owner/drafter/editor

Encl.

C: Linda Haslam-Stroud, President, Ontario Nurses' Association (ONA)
           Dianne Brunton, Local Coordinator, ONA
           Carol Oates, Bargaining Unit President, ONA
           Andrea Kay, Labour Relations Officer, ONA
           Meni Didimos-Bryant, Professional Practice Specialist, ONA
           Glenda Hubley, ONA Nominee
           Rik Ganderton, President and CEO, Rouge Valley Health System (RVHS)
           Amelia McCutcheon, Vice President Cardiac, Cancer and Critical Care, Chief Nursing
           Executive, RVHS
           Cheryl Williams, Vice President Acute Care Services, RVHS
           Kathy Gooding, Vice-President, Human Resources, RVHS
           Stephen Green, Director, Hospital Employee Relations Services, Ontario Hospital
           Association

Professional Responsibility Complaint 3 Margaret Birch Wing; Rouge Valley Health System (ONA File# 201300678)

Kearsey, Jessica [jkearsey@rougevalley.ca]

Sent: July-22-13 3:16 PM

To: Cardiff, Joan; canderson@baycrest.org

Cc: KateB@ona.org; McCutcheon, Amelia [amccutcheon@rougevalley.ca]; dmccoy@oha.com

Ms. Cardiff:

I am responding on behalf of Amelia McCutcheon to confirm the contact information for the Hospital's nominee, Ms. Carol Anderson:

Carol Anderson
Vice President, Clinical Programs and Chief Nursing Executive
Baycrest
3560 Bathurst St Toronto, ON M6A 2E1, Canada
Email: canderson@baycrest.org
Phone: 416-785-2500 x2761

Best regards,
Jessica

Jessica Kearsey, LLB

Joint Legal Counsel
Rouge Valley Health System/ Lakeridge Health
cell: 905.999.0627
email: jkearsey@rougevalley.ca

The contents of this message may be subject to solicitor-client privilege. Please notify the sender if you have received this message in error.

https://webmail.chco.on.ca/owa/?ae=Item&t=IPM.Note&id=RgAAAABnOWiRoJ15RJC... 23/07/2013

October 4, 2013

416 Lakeshore Road
White Lake, Ontario
K0A 3L0

Jo Anne Shannon
Professional Practice Specialist
Ontario Nurses' Association
85 Grenville Street, Suite 400
Toronto, Ontario
M5S 3A2

Dear Ms. Shannon:

> **Re: Rouge Valley Health System (RVHS) and Ontario Nurses' Association (ONA):**
> **Professional Responsibility Complaint: 3 Margaret Birch Wing – Independent Assessment**
> **Committee Hearing**

I am writing to confirm the plans for the Independent Assessment Committee Hearing regarding the Professional Responsibility Complaint between the Rouge Valley Health System 3 Margaret Birch Wing and the Ontario Nurses' Association.

The Independent Assessment Committee (IAC) Hearing will be held on *Tuesday January 7th, Wednesday January 8th and Thursday January 9th, 2014* at the Centenary Site of the Rouge Valley Health System.

On Tuesday January 7th, the IAC would like to tour 3 Margaret Birch in the morning, prior to the Hearing. Please work with the RVHS to arrange for the Tour to begin at 1000 hours, and jointly decide:
- how many ONA and RVHS representatives will accompany the three IAC members on the tour, and who these representatives will be;
- if areas in addition to 3 Margaret Birch need to be included in order for the IAC to have a comprehensive understanding of the issues, and if so, which these will be; and
- who will lead the tour.

Please provide this information by Monday December 16, 2013.

The Hearing will begin at 1300 hours on Tuesday January 7th, 2014. As indicated on the draft Hearing Agenda, each of the ONA and the SAH will have one and one half (1-1/2) hours to present their submission. The Hearing will adjourn for the day following presentation of both submissions, in order to enable each party to prepare their Response.

The Hearing will commence at 0900 hours on Wednesday January 8th, with the Response from RVHS, followed by the Response from ONA. The Hearing will adjourn for the day following presentation of both Response submissions; the time of adjournment will depend on the extent of discussion required.

The IAC will meet following the day's adjournment to determine areas/issues requiring further clarification.

The Hearing will recommence at 0830 hours on Thursday January 9th, 2014, with Questions to both ONA and RVHS by the IAC. The Hearing will close at 1300 hours; if additional time is required, arrangements will be made at that time for continuation of the Hearing at a mutually convenient date.

In order to support the principle of full disclosure, and to enable the IAC to effectively prepare for the Hearing, the IAC requests that individual, independent written submissions be provided by *Friday December 13th, 2013.* Please submit five copies of your submission and attachments/supporting documents in hard copy to my address. Please note that this is a rural address, with courier service only once daily. As Chair of the IAC, I will retain one (1) copy of each submission, and will distribute the remaining four (4) submissions with attachments/supporting documents by courier on Monday December 16th, 2013 as follows:

- One (1) copy of the RVHS submission and one (1) copy of the ONA submission to each of Carol Anderson (RVHS Nominee) and Glenda Hubley (ONA Nominee);
- Two (2) copies of the RVHS submission to the ONA (attention Jo Anne Shannon);
- Two (2) copies of the ONA submission to the RVHS (attention Amelia McCutcheon).

In the event that ONA wishes to provide supplemental information after December 16th, 2013, this will be accepted until Monday December 30th, 2013 and will be distributed as above. Supplemental information may be sent by email, with hard copy to follow. Please note that supplemental information is information to support/clarify ONA's submission; it is not information to respond to the RVHS submission.

The IAC will hold a Pre-Hearing Meeting on Monday January 6th, 2014, to review the submissions in detail. If the IAC requires additional information in order to understand the key issues prior to the Hearing, this will be requested immediately following the Pre-Hearing Meeting.

It is understood that ONA will be in contact with the Nominee, Glenda Hubley, prior to the Hearing. In order to ensure integrity of the IAC process, following completion of the Hearing the Nominee will not discuss development of the draft IAC Report with, or seek feedback, comments or input from ONA while the Report is being developed, and will not share draft copies of the Report.

The IAC looks forward to working with ONA and the 3Margaret Birch RNs to address professional responsibility issues of concern. If you have any questions, please contact me by phone at 613-622-7743 or by email at jcardiff@cheo.on.ca.

Sincerely

Joan Cardiff

cc.   Carol Anderson, RVHS Nominee
        Glenda Hubley, ONA Nominee
        Amelia McCutcheon, VP Cardiac, Cancer and Critical Care, Chief Nursing Executive, RVHS

October 4, 2013   *Appendix 5*

416 Lakeshore Road
White Lake, Ontario
K0A 3L0

Amelia McCutcheon
Vice President Cardiac, Cancer and Critical Care
Chief Nursing Executive
Rouge Valley Health System
2867 Ellesmere Road
Toronto, Ontario
M1E 4B9

Dear Ms. McCutcheon:

**Re: Rouge Valley Health System (RVHS) and Ontario Nurses' Association (ONA):
Professional Responsibility Complaint: 3 Margaret Birch Wing – Independent Assessment
Committee Hearing**

I am writing to confirm the plans for the Independent Assessment Committee Hearing regarding the Professional Responsibility Complaint between the Rouge Valley Health System 3 Margaret Birch Wing and the Ontario Nurses' Association.

The Independent Assessment Committee (IAC) Hearing will be held on *Tuesday January 7th, Wednesday January 8th and Thursday January 9th, 2014* at the Centenary Site of the Rouge Valley Health System.

On Tuesday January 7th, the IAC would like to tour the 3 Margaret Birch Wing in the morning, prior to the Hearing. Please work with ONA to arrange for the Tour to begin at 1000 hours, and jointly decide:

- how many RVHS and ONA representatives will accompany the three IAC members on the tour, and who these representatives will be;
- if areas in addition to the 3 Margaret Birch Wing need to be included in order for the IAC to have a comprehensive understanding of the issues, and if so, which these will be; and
- who will lead the tour.

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both Response submissions; the time of adjournment will depend on the extent of discussion required. The IAC will meet following the day's adjournment to determine areas/issues requiring further clarification.

The Hearing will recommence at 0830 hours on Thursday January 9th, with Questions to both ONA and RVHS by the IAC. The Hearing will close at 1300 hours; if additional time is required, arrangements will be made at that time for continuation of the Hearing at a mutually convenient date.

Please make the following arrangements to hold the Hearing at the Centenary Site of the RVHS.

Hearing and IAC:
- A Board Room / Conference Room capable of seating 23 people, booked from 0830 – 1900 hours on Tuesday January 7th, from 0700 – 2100 hours on Wednesday January 8th and from 0700 – 1500 hours Thursday January 9th, 2014.
- Configuration of the room:
  - Table configured in a U-shape, with
    - 3 seats at the top of the "U" for the IAC members, and
    - 10 seats on either side of the "U" for the RVHS and ONA Hearing participants.
- Provision of
  - An extension cord if an electrical plug is not close to the IAC seats,
  - An LCD projector (Tuesday and Wednesday only), and
  - A flip chart with markers.

Caucus ONA:
- A Conference Room capable of seating 10 people, booked from 0700 – 1900 hours on Tuesday January 7th, Wednesday January 8th and Thursday January 9th, 2014.
- Telephone and internet access

Caucus RVHS:
- A Conference Room capable of seating 10 people, booked as for the ONA Caucus Room above.

Catering: Hearing Room:
- Provision of
  - tea, coffee, juice and water for all times the Hearing is in session.
  - muffins for the morning breaks on Wednesday January 8th and Thursday January 9th
  - cookies and fruit for the afternoon breaks on Tuesday January 7th and Wednesday January 8th
- Provision of a working lunch for the three IAC members on Tuesday January 7th, Wednesday January 8th, and Thursday January 9th.

Catering: ONA Caucus Room and RVHS Caucus Room:
- Provision of tea, coffee and water from 0800 Tuesday January 7th – Thursday January 9th, 2014.

In order to support the principle of full disclosure, and to enable the IAC to effectively prepare for the Hearing, the IAC requests that individual, independent written submissions be provided by *Friday December 13th, 2013*. Please submit five copies of your submission and attachments/supporting documents in hard copy to my address. Please note that this is a rural address, with courier service only once daily. As Chair of the IAC, I will retain one (1) copy of each submission, and will distribute the

remaining four (4) submissions with attachments/supporting documents by courier on Monday December 16th, 2013 as follows:

- One (1) copy of the RVHS submission and one (1) copy of the ONA submission to each of Carol Anderson (RVHS Nominee) and Glenda Hubley (ONA Nominee);
- Two (2) copies of the RVHS submission to the ONA (attention Jo Anne Shannon);
- Two (2) copies of the ONA submission to the RVHS (attention Amelia McCutcheon).

In the event that RVHS wishes to provide supplemental information after December 16th, 2013, this will be accepted until Monday December 30th, 2013and will be distributed as above. Supplemental information may be sent by email, with hard copy to follow. Please note that supplemental information is information to support/clarify RVHS's submission; it is not information to respond to the ONA submission.

The IAC will hold a Pre-Hearing Meeting on Monday January 6th, 2014, to review the submissions in detail. If the IAC requires additional information in order to understand the key issues prior to the Hearing, this will be requested immediately following the Pre-Hearing Meeting.

It is understood that RVHS will be in contact with the Nominee, Carol Anderson, prior to the Hearing. In order to ensure integrity of the IAC process, following completion of the Hearing the Nominee will not discuss development of the draft IAC Report with, or seek feedback, comments or input from RVHS while the Report is being developed, and will not share draft copies of the Report.

The IAC looks forward to working with RVHS to address professional responsibility issues of concern on the 3 Margaret Birch Wing. If you have any questions, please contact me by phone at 613-622-7743 or by email at jcardiff@cheo.on.ca.

Sincerely

Joan Cardiff
Chair, IAC

cc.   Carol Anderson, RVHS Nominee
        Glenda Hubley, ONA Nominee
        Jo Anne Shannon, Professional Practice Specialist, ONA

Independent Assessment Committee Hearing

Ontario Nurses' Association / Rouge Valley Health System
3 Margaret Birch Wing
Dr. Bruce Johnston Conference Room

Agenda

Tuesday January 7th, 2014

08:30 – 09:00	Discussion re Signing of RVHS Confidentiality Agreement
	◆Attending: IAC Panel
	ONA: Marcia Barry, Jo Anne Shannon,
	RVHS: Kathy Gooding, Shane Smith
09:00 – 10:00	*Independent Assessment Committee Meeting (Committee Members only)*
10:00 – 11:30	Tour of 3 Margaret Birch Wing
1300	**Commencement of Hearing: Dr. Bruce Johnston Conference Room**
13:00 – 13:30	●Introduction and Review of Proceedings by Chairperson
13:30 – 15:00	●Ontario Nurses' Association Submission Presentation
	◆Response to questions of clarification by
	·Independent Assessment Committee
	·Rouge Valley Health System
15:00 – 15:15	Break
15:15 – 16:45	●Rouge Valley Health System Submission Presentation
	◆Response to questions of clarification by
	·Independent Assessment Committee
	·Ontario Nurses' Association
16:45 – 17:00	●Review of Process for January 8th, by Chairperson
17:00	Adjournment of Hearing

Independent Assessment Committee Hearing

Ontario Nurses' Association / Rouge Valley Health System
3 Margaret Birch Wing
Dr. Bruce Johnston Conference Room

Agenda

Wednesday January 8th, 2014

07:30 – 08:30   Observation of Shift Change: 3 Margaret Birch Wing

08:30   Continuation of Hearing

08:30 – 11:30   ●Rouge Valley Health System Response to Ontario Nurses' Association Submission
- ◆Response to questions from
  - ·Independent Assessment Committee
  - ·Ontario Nurses' Association
- ◆Discussion

11:30 – 12:30   Lunch Break

12:30 – 15:30   ●Ontario Nurses' Association Response to Rouge Valley Health System Submission
- ◆Response to questions from
  - ·Independent Assessment Committee
  - ·Rouge Valley Health System
- ◆Discussion

15:30 – 15:45   ●Review of Process for January 9th, by Chairperson

15:45   Adjournment of Hearing

16:00 – 20:00   *Independent Assessment Committee Meeting (Committee members only)*

Note: The timing of the agenda is 'fluid'. If the Rouge Valley Health System Response submission/discussion is concluded before lunch, we will proceed with the ONA Response submission/discussion before the lunch break. If the ONA Response submission/discussion concludes before 15:30, the Hearing will adjourn. The Hearing will adjourn at 16:00 at the latest.

Independent Assessment Committee Hearing

Ontario Nurses' Association / Rouge Valley Health System
3 Margaret Birch Wing
Dr. Bruce Johnston Conference Room

Agenda

Thursday January 9th, 2014

08:30   Continuation of Hearing

08:30 – 12:30   ●Questions to both ONA and RVHS by IAC

12:30 – 13:00   ●Closing Remarks and Discussion of Next Steps by Chairperson

13:00   **Closure of Hearing**

13:00 – 14:30   *Independent Assessment Committee Meeting (Committee members only)*

Hearing Participants and Observers

Hearing Participants: January 7 – 9, 2014

For the Association: Brenda Barnes   Unit Coordinator, 3MBW
                        Mary Deli   ONA RVHS Professional Responsibility Representative
                        Meni Didimos-Bryant   Professional Practice Specialist, ONA
                        Carol Oates   Local 24 Bargaining Unit President
                        Connie Ortiz   RN, 3MBW
                        Sue Peschke   RN, 3MBW
                        Ann Richardson   RN, 3MBW
                        Jo Anne Shannon   Professional Practice Specialist, ONA

For the Hospital: Kathy Gooding   VP, Human Resources
                        Justine Lee   Clinical Practice Leader, Post-Acute Services
                        Amelia McCutcheon   VP, Cardiac, Critical Care, Surgery and Chief Nurse
                                                   Executive
                        Aaisha Savvas   Manager, 3MBW
                        Shane Smith   External Counsel
                        Cheryl Williams   VP, Acute and Post-Acute Services
                        Karl Wong   Director, Post-Acute Services & Allied Health

Hearing Observers:

January 7, 2014:

For the Association: Chris Axtell   PRC Advisor, United Nurses of Alberta
                        Marlene Badgley   RN, 2 North, Post-Acute Service, Ajax Site
                        Marcia Barry   Internal Counsel, ONA
                        Diane Brunton   Local 24, Local Coordinator
                        Andrea Kay   Labour Relations Officer, ONA
                        Vicky McKenna   1st Vice President, ONA
                        Stacey Papernick   Labour Relations Officer, ONA
                        Andy Summers   Board of Directors, ONA

For the Hospital: Dawn Chin   Manager, Post-Acute Services, Ajax Site
                        Lisa Coppins   HR Consultant
                        Susan Fyfe   Director, Maternal & Child
                        Erin Miller   Internal Counsel, RVHS
                        David Nissan   Administrative Assistant, Chief Nurse Executive

January 8, 2014:

<u>For the Association</u>: Chris Axtell   PRC Advisor, United Nurses of Alberta
Marcia Barry   Internal Counsel, ONA
Marlene Badgley RN, 2 North, Post-Acute Services, Ajax Site
Diane Brunton   Local 24, Local Coordinator
Andrea Kay   Labour Relations Officer, ONA
Sherry Percell   RN, 2 North, Post-Acute Services, Ajax Site
Andy Summers   Board of Directors, ONA

<u>For the Hospital</u>: Dawn Chin   Manager, Post-Acute Services, Ajax Site
Lisa Coppins   HR Consultant
Erin Miller   Internal Counsel, RVHS

January 9, 2014:

<u>For the Association</u>: Chris Axtell   PRC Advisor, United Nurses of Alberta
Marlene Badgley RN, 2 North, Post-Acute Services, Ajax Site
Diane Brunton   Local 24, Local Coordinator
Stacey Papernick Labour Relations Officer, ONA
Andy Summers   Board of Directors, ONA

<u>For the Hospital</u>: Dawn Chin   Manager, Post-Acute Services, Ajax Site
Lisa Coppins   HR Consultant
Erin Miller   Internal Counsel, RVHS

Ontario Nurses' Association Recommendations

RN and RPN Practice

1. The Chief Nurse Executive will work with the management team to ensure that utilization decisions for staffing on 3MBW take into account client, nurse and environment factors, and are evidenced-based.
2. The employer will ensure adequate RN staffing levels that provide the time and resources needed to allow RNs and RPNs to consult as often as if necessary to meet client needs.

Unregulated Care Providers

3. That the employer clarify and communicate the role of unregulated care providers on the unit and the role of RNs and RPNs when working with UCPs and vice versa.
4. That education be provided to all RN and RPN staff regarding their role and accountabilities when assigning and supervising UCPs.
5. That education be provided to UCPs related to the professional and leadership role of the RN and RPN and the employment accountabilities of UCPs when working as a member of the health care team.
6. Ensure replacement of nurses with the same category of nurse and eliminate substitution models where unsafe, fragmented care results.
7. That there be adequate base RN and RPN staffing levels to allow ongoing assessment of each client's situation, condition and care needs; the activity to be assigned and it associated risks; and the ability to ensure that the UCP knows when and whom to ask for assistance; and when and how to report and/or document the outcomes of the procedure(s) to the nurse.

Model of Care

8. Commit to an action plan to achieve a safe staffing model on the unit. Such action should include safe staffing ratios that replace like with like and ensure that the right nurse with the right skills is matched with the patient.
9. Specifically increase the number of RNs on days and evenings by one (1) on each side (East and West) to achieve a nurse:patient ratio of 1:6.6

Proposed Staffing Levels for Each Side (East and West)

	Days	Evenings	Nights
RN	2	2	1
RPN	1	1	1
UCP	2	2	0

10. Ensure that staffing models and practices are based on evidence available in national and international research and that they follow evidence-based guidelines such as the RNAO Best Practice Guidelines.

11. In order to ensure that proper patient care is being provided, the four "P" rounding model should be removed from the practice environment of 3MBW or, at the very least, significantly remodeled. Nurses should be trusted to use their professional judgement when caring for patients on the unit, and should have appropriate staffing resources in place. These patients have complex needs and require full ongoing assessment and care, not just limited, scripted rounding every hour.
12. The model of care be resdesigned to eliminate or minimize as much as possible interruptions and fragmentation of care.

Staff Nurse Leadership

13. Ensure adequate RN staffing levels to support the accountability of the RN to provide leadership and expertise to the professional team.
14. That the Complex Continuing Care Unit Based Council be co-chaired by 2 Registered Nurses.
15. That all RNs be supported to attend leadership development and training including managing conflict and conflict resolution.

Designated Nursing Authority

16. Implement a meaningful nursing governance reporting structure so that there is accountability to address all nursing practice issues and support nurses on the front-line on a day to day basis.
17. More transparency and accountability of management.
18. Education to be provided to the non-nurse members of the RVHS management team related to CNO Standards of Practice Guidelines.

Excellent Care for All Act

19. Rouge Valley needs mechanisms to ensure that management is being held accountable for staffing/skill mix/workload decisions and their impact on patients and staff.
20. Include nurses at all levels when making staffing and patient care decisions.
21. Greater transparency in decision-making affecting nursing practice.

Canadian Gerontological Nurses Association Standards of Practice

Standard I: Physiological Health
- Gerontological nurses assist clients to maintain homeostatic regulation through assessment and management of physiological care to minimize adverse events associated with medications, diagnostic or therapeutic procedures, nosocomial infections or environmental stressors.

Standard II: Optimizing Functional Health
- Gerontological nurses promote older adults to optimize functional health that includes an integration of abilities that involve physical, cognitive, psychological, social, and spiritual status.

Standard III: Responsive Care
- Gerontological nurses provide responsive care that facilitates and empowers client independence through life course changes. A responsive care approach recognizes that certain behaviors are not necessarily related solely to pathology, but instead may be related to circumstances within the physical or social environment surrounding well older persons and those with dementia, and maybe an expression of unmet need.

Standard IV: Relationship Care
- Gerontological nurses develop and preserve therapeutic relationship care. Relationship-centered care is an approach that recognizes the importance and uniqueness of each health care participant's relationship with every other, and considers these relationships to be central in supporting high quality care, a high-quality work environment, and superior organizational performance.

Standard V: Health System
- Gerontological nurses are aware of economic and political influences by providing or facilitating care that supports access to and benefit from the health care delivery system. Systems to support and sustain practice changes should be in place, including ongoing education, policies and procedures and job descriptions.

Standard VI: Safety and Security
- Gerontological nurses are responsible for assessing the client and the environment for hazards that threaten safety, as well as planning and intervening appropriately to maintain a safe environment.

Appendix 10

	Week 1							Week 2							Week 3							Week 4							D	E	N	A	P	Annual Hours
	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S						
1	D	D	D	N	N	N	N		E	E	E	E			D	D	E	D	D	D			E	D	D	D	D	D	10	3	7	0	0	1950
2	E	E	E	E	N	N	N		E	N	E	E	N	N	E	E	E	E			N		E	E	E	E	D	D	0	14	6	0	0	1950
3	D	D	D	D	D	D	D		N	E	D	D	D	D	D	E	D	D			D		E	E	E	D	D	N	13	3	4	0	0	1950
4	E	E	E	E				E	E	E	E	D			E	E	D	E	N	N				E	E		D	E	5	12	3	0	0	1950
5	N	N	N	N	D	D	D	E	D	N	Z	N	D	D	E	N	N	N	N		N	D	N	N	N	N	N	N	9	0	11	0	0	1950
6	N	N	N	N				D	D	D	D	D	D	D	N	N	N	N				N	N	N	N	N	N	N	5	6	9	0	0	1950

Part Time Shifts

Scheduled

	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S
D	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2
E	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2
N	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2
A	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
P	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Appendix 12

Hybrid Mix (7.5 & 11.25 hour) Master

Week	1							2							3							4							D	E	N	A	P	Annual Hours
	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S						
1	D	A		P	A	A	P	D	A		P	A	A	P	N		P	A	A	A	P	D	A		P	P	P	P	1	0	1	6	6	1950
2			P	P	P	P	P	D		P	P	P	P	P	N		P	P	P	P	P	D		P	P	P	P	P	1	0	1	6	6	1950
3	N	P	A	A	A	A	A	N	D	A	A	A	A	A	D	A	A		A	A	A	D	A	A	A	A	A	A	1	0	1	6	6	1950
4		A	A	A	A				A	A	A					P		P					A	A	P				1	0	1	6	6	1950
5	D	P	P	P	P	P	P	D	P	P	P	P	P	P	D	P	P	P	P	P	P	D	P	P	P	P	P	P	1	0	1	6	6	1950
6		A	A	A	A	A	A		A	A	A	A	A	A		A	A	A	A	A	A		A	A	A	A	A	A	1	0	1	6	6	1950
7	N	P	P	P	P	P	P	N	P	P	P	P	P	P	N	P	P	P	P	P	P	N	P	P	P	P	P	P	1	0	1	6	6	1950
Part	A	A						N	E	E					D	E	E					D	E	E										
Time	E							E	E						E	E						E	E											
Shifts	E							E							E							E												

Legend

D 7.5 hour day
E 7.5 hour evening
N 7.5 hour night
P 11.25 hour night
A 11.25 hour day

Appendix 13 (6 reg lines + 1 Weekend Worker Line (line 7))

Legend:
D 7.5 hour day
E 7.5 hour evening
N 7.5 hour nights

Part Time Shifts:
A 11.25 hour day
P 11.25 hour night

D 7.5 hour day
E 7.5 hour evening
N 7.5 hour night