

***Independent Assessment Committee  
Report***

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

**between**

**Sault Area Hospital**

**and**

**Ontario Nurses' Association**

**March 2011**



## ***Independent Assessment Committee***

### ***Sault Area Hospital and Ontario Nurses' Association***

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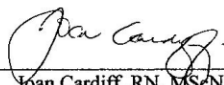
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The members of the Independent Assessment Committee respectfully submit the attached Report with findings and recommendations regarding the Professional Responsibility Complaint presented by Registered Nurses working in the Renal Unit of the Algoma Regional Renal Program at the Sault Area Hospital.

The Professional Responsibility Complaint was presented to the Independent Assessment Committee in accordance with Article 8.01 of the Collective Agreement between the Sault Area Hospital and the Ontario Nurses' Association.

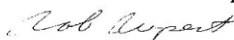
The members of the Independent Assessment Committee recognize and appreciate the efforts taken by representatives of the Hospital, the Association and Registered Nurses working in the Renal Unit to prepare and present information and respond to our questions. The attached Report contains a number of 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 hemodialysis patients within the Algoma Region Renal Program at the Sault Area Hospital.

Respectfully submitted on March 31, 2011.




Joan Cardiff, RN, MScN

Chairperson, Independent Assessment Committee



Rob Rupert, RN, BScN  
Ontario Nurses' Association Nominee



Lorraine Sunstrum-Mann, RN, BA, MBA  
Sault Area Hospital Nominee

*Sault Area Hospital / Ontario Nurses' Association  
Independent Assessment Committee Report  
March 2011*



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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 Sault Area Hospital ('the Hospital') and the Ontario Nurses' Association ('the Association'), outlines the referral of the Professional Responsibility Complaint to the IAC, and explains the Pre-Hearing, Hearing and Post-Hearing processes.
- Section II reviews the history leading to the referral of the Complaint to the IAC, and presents the IAC's understanding of the Association's and Hospital's perspective regarding the Complaint.
- Section III presents the IAC's findings, discussion and analysis of the issues relating to the Complaint.
- Section IV presents the IAC's conclusions and recommendations.
- Section V contains Appendices referenced in the 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 out the Professional Responsibility Complaint (PRC) process by which Registered Nurses (RNs) may raise their concerns regarding their perception 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 both the RNs and the Hospital. Article 8.01 (b) sets out the logistics associated with selection and remuneration of the IAC Chair and Hospital and Association Nominees (*Appendix 1*).

The IAC's jurisdiction thus relates to whether Registered Nurses are being requested and/or required to assume more work than is consistent with the provision of proper patient care. RN workload is influenced by the College of Nurses of Ontario (CNO) 'Three Factor Framework': client factors (complexity of care needs, predictability of outcomes, risk of negative outcomes), nurse factors (knowledge, skill and judgment 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)<sup>1</sup>. The IAC is responsible for

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<sup>1</sup> College of Nurses of Ontario: Practice Guideline: *Utilization of RNs and RPNs*, Publication # 41062, June 2009

examining all factors impacting workload, and for making recommendations to address workload issues. Concerns outside of workload are beyond the jurisdiction of the IAC.

The IAC's jurisdiction ceases with submission of its written Report. The IAC's findings and recommendations are intended to provide an independent, external perspective to assist the RNs, the Association and the Hospital to achieve mutually satisfactory resolution to the Professional Responsibility Complaint. The IAC is not an adjudicative panel, and its recommendations are non-binding.

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

Prior to April 2010, the RNs in the Algoma Regional Renal Program (ARRP) Renal Unit rarely submitted Professional Responsibility Workload Report Forms (PRWRFs): during the period January 1, 2009 to April 23, 2010, only 1 PRWRF was submitted. In April 2010, the skill mix in the Renal Unit changed from an all-RN staff to a RN-RPN staff mix. From the period April 24, 2010 to October 25, 2010, the RNs submitted 39 PRWRFs, the majority of which related to the RNs' concerns regarding perceived changes in their responsibilities and accountabilities following integration of the RPNs into the care delivery model.

The Hospital and the Association discussed the Renal Unit PRWRFs at regularly scheduled Hospital-Association Committee (HAC) meetings, and at two special HAC Renal Unit PRC meetings, held August 25<sup>th</sup> and October 22<sup>nd</sup> 2010. The Hospital and the Association were unable to resolve the issues, and agreed at the October 22<sup>nd</sup> meeting to move to an IAC. The Association formally indicated its intention to forward the Professional Responsibility Complaint to an IAC, as per Article 8 of the Collective Agreement, on October 25, 2010 (*Appendix 2*), and formally notified the IAC Chair on November 16, 2010 (*Appendix 3*).

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

#### **1.4.1 Pre-Hearing**

In accordance with Article 8.01 (a) (vii), the Hospital and the Association identified their Nominees to the IAC. The Chairperson received notification of the Association Nominee, Rob Rupert, and the Hospital Nominee, Lorraine Sunstrum-Mann, on November 16, 2010.

The IAC held an introductory teleconference on November 28, 2010. The IAC members reviewed the jurisdiction of the IAC within the context of the collective agreement, discussed the role of the Nominees and the Chairperson, reviewed the three phases of the IAC process, discussed logistics associated with the Hearing and the process for review of the Hearing Briefs, and planned the Pre-Hearing IAC Meeting. Following the teleconference, the Nominees discussed potential dates and location for the Hearing with their respective parties.

The IAC Chairperson wrote to the Hospital and the Association on December 6, 2010 to confirm the date and location of the Hearing and 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 their respective Hearing Briefs and associated Exhibits to the Chairperson by January 21, 2011 (*Appendix 4*).



The IAC Chairperson received and distributed the Hearing Briefs and supporting documents as per the following:

- ◆ The Association Brief and Exhibits were received on Friday January 21, 2011 and distributed to all parties by courier on Monday January 24, 2011;
- ◆ The Hospital Exhibits were received on Friday January 21, 2011 and distributed to all parties by courier on Monday January 24, 2011;
- ◆ The Hospital Brief was received on Wednesday January 26, 2011 and distributed to all parties by courier that day;
- ◆ The Association's additional information to supplement their Brief was received on Thursday January 27, 2011 and was distributed to the Hospital by courier on Friday January 28, 2011 and to the IAC Nominees in person on Monday January 31, 2011;
- ◆ The Hospital's additional information to supplement their Brief was received by all parties by email on Friday January 28<sup>th</sup>; additional Exhibit information was received by courier on Thursday February 3, 2011 and distributed to the Nominees on Monday February 7, 2011 and the Association on Tuesday February 8, 2011.

The IAC held a Pre-Hearing Meeting in Ottawa on January 31, 2011. The IAC reviewed the anticipated process of the Hearing, discussed the Hearing Briefs and Exhibits, determined the requirements for additional information and identified the key issues for exploration at the Hearing. Following this meeting, on February 2, 2011, the IAC Chairperson wrote to the Hospital to request the provision of specific additional information (*Appendix 5*) and wrote jointly to the Hospital and the Association to request clarification of the RN schedule and method of daily patient assignment (*Appendix 6*) and to clarify the scope of the IAC's jurisdiction (*Appendix 7*).

The IAC met early on the morning of February 8, 2011 to confirm the questions/issues for focus on the Site Tour.

The IAC conducted a Site Tour on the morning of Tuesday February 8, 2011. The Site Tour was jointly conducted by the following:

On behalf of the Association:

- Jewel Porter, RN, Renal Unit
- Jo Anne Shannon, Professional Practice Specialist
- Ruth Suraci, RN, Team Leader, Renal Unit

On behalf of the Hospital:

- Frank Angeletti, Counsel SAH
- Lise Corriveau, Former Nurse Manager, ARRP
- Brenda Lynn, Director, Oncology and Renal Programs
- Teighan Milne, Interim Nurse Manager, ARRP

The group toured the Plummer Site Renal Unit at the Plummer Site of the SAH from 0900 – 1045. The Tour included a walk-through of the

- ◆ core ('front') and alcove ('back') hemodialysis stations,
- ◆ multidisciplinary rounds/teaching room
- ◆ Dialysis Aides' work-room
- ◆ Bio-Med Technicians' work room
- ◆ staff lunchroom, and
- ◆ support staff and Nurse Manager offices

and included a short demonstration of the Patient Care System (PCS) electronic charting.

The group then drove to the new SAH site, located in the north end of the city on Great Northern Road, and toured the new ARRP area from 1115 - 1200. The group was joined by Vicky Whelan, an RN from the Renal Unit who was assisting with the transition to the new Renal Unit. The tour included a walk-through of the

- ◆ hemodialysis stations,
- ◆ Renal clinic waiting room and clinic rooms,
- ◆ multidisciplinary rounds/chart room,
- ◆ Dialysis Aides' work room,
- ◆ support staff, Nurse Manager and nephrologist offices, and
- ◆ staff lunchroom (located outside of the ARRP area).

#### 1.4.2 Hearing

The Hearing convened at 1330 hours in the Riverview Auditorium at the Plummer Site of the SAH. As indicated on the Hearing Agenda (*Appendix 8*), the Hearing was held over three days:

February 8, 2011: 1330 – 1700 hours

February 9, 2011: 0830 – 1130 hours  
1230 – 1600 hours

February 10, 2011: 0830 – 1300 hours

The participants and observers who attended the Hearing are listed in *Appendix 9*.

#### February 8, 2011

The IAC Chairperson opened the Hearing at 1330 hours. Following introduction of the IAC Committee members and round-table introductions of the Association and Hospital participants, the IAC Chairperson reviewed the following:

- ◆ the IAC Hearing process, including the anticipated organization and flow of each of the three days,
- ◆ 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 provide clarity of understanding of the issues from their perspective, and
- ◆ the 'ground rules' for the Hearing, to facilitate a respectful, constructive, non-adversarial environment.

The Association's Submission Presentation, presented by Jo Anne Shannon, Professional Practice Specialist, was based on the Association's written Brief and 69 Exhibits of supporting / explanatory information, as well as extensive documentation for each of the 58 PRWRFs submitted by the Renal Unit RNs between December 2009 and January 2011. Following the presentation, the Association responded to clarification questions posted by the IAC and the Hospital.

The Hospital's Submission Presentation, presented by Frank Angeletti, Counsel for the Hospital, and Brenda Lynn, Director of the Oncology and Renal Programs, was based on the Hospital's written Brief and 20 Exhibits of supporting / explanatory information, as well as extensive documentation for each of the 39 PRWRFs submitted by the Renal Unit RNs between April 2010 and October 25, 2010. Following the presentation, the Hospital responded to clarification questions posted by the IAC and the Association.

The IAC Chairperson adjourned the Hearing at 1700 hours.

The IAC met from 2030 – 2230 hours, to review, discuss and synthesize the information provided, and to begin to identify issues for which further and/or more detailed information was required.

February 9, 2011

The IAC Chairperson opened the Hearing at 0830 hours. Frank Angeletti, Counsel for the Hospital, Teighan Milne, Interim Nurse Manager of the ARRP, and David Berry, Medical Director of the ARRP, provided the Response on behalf of the Hospital. Following the presentation, members of both the Hospital and Association teams participated in active discussion.

After the lunch break, Jo Anne Shannon, Professional Practice Specialist, Ruth Suraci, Team Leader in the Renal Unit, and Catherine Maccarone, Kelly MacGregor and Jewel Porter, RNs in the Renal Unit, provided the Response on behalf of the Association. Members of both the Association and Hospital teams actively participated in the discussion that followed. The IAC Chairperson adjourned the Hearing at 1600 hours.

The IAC met from 1830 – 2100 hours to review and synthesize the information provided, and to finalize the questions to focus the Hearing discussions on February 10, 2011.

February 10, 2011

The IAC Chairperson opened the Hearing at 0830 hours. The Association completed their Response presentation, which opened with a short presentation by Karen Leclaire, RN in the Renal Unit, followed by presentations by Jo Anne Shannon, Ruth Suraci, Catherine Maccarone, Kelly MacGregor, and Jewel Porter.

Following a short break, the IAC explored issues for which the Committee wished a further understanding through an interactive Question and Answer session relating to the model of care, staff and patient scheduling, education (including orientation and ongoing professional development), quality assurance indicators and the SAH future Hospital Improvement Plan. All Hearing participants actively participated.

Following completion of the Question and Answer session, Jo Anne Shannon, on behalf of the Association, and Frank Angeletti and Teighan Milne, on behalf of the Hospital, provided closing comments.

At the close of the Hearing, the IAC Chairperson

- ◆ thanked the participants for their engagement in and commitment to the Hearing process, and for their active participation, recognizing the challenges and sensitivities of open and honest dialogue,
- ◆ expressed the IAC's hope that the opportunity for discussion during the Hearing will provide a sound basis for all parties to move forward constructively in the new Hospital,
- ◆ reconfirmed that the IAC's Report and Recommendations are intended to provide an independent external perspective to aid in the resolution of outstanding issues, and that although the recommendations are non-binding, it is hoped they will provide a solid foundation on which to build, and
- ◆ confirmed that the IAC Report will be forwarded to all parties by April 5, 2011.

The IAC Chairperson concluded the Hearing at 1300 hours.

#### 1.4.3 Post Hearing

Between closure of the Hearing and submission of the Report, the IAC held five teleconferences and two face-to-face meetings.

The IAC met immediately following the Hearing on February 10, 2011, to review the morning's discussion and key issues identified.

The IAC reviewed Draft I of the Report by teleconference on Monday February 28, 2011.

The IAC held a face-to-face meeting in Toronto on March 3 - 4, 2011 to review Draft II, and to discuss the IAC's analysis and proposed recommendations in depth. Following this meeting, on March 7, 2011, the IAC wrote to the Hospital to request additional clarifying information (*Appendix 10*).

The IAC met by teleconference on March 14, 2011 and March 16, 2011 to review Draft III, by teleconference on March 21, 2011 to review Draft IV, by teleconference on March 24, 2011 to review Draft V, and by teleconference on March 28, 2011 to review Draft VI. The IAC approved the Final Report by email on March 29, 2011.

The IAC Report was submitted to the Ontario Nurses' Association and the Sault Area Hospital in PDF format and hard-copy format by courier on March 30, 2011.

## **SECTION II**

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

#### **2.1 Development of the Professional Responsibility Complaint**

Since its inception, the Algoma Regional Renal Unit (ARRP) has operated with an all-RN nursing staff. In May 2009, the SAH submitted its Hospital Improvement Plan (HIP) to the North East LHIN. The HIP was to indicate how the Hospital intended to achieve a balanced operating budget by the fiscal year 2011/2012<sup>2</sup>. As part of the HIP, a comprehensive in-depth analysis (IDA) of operations was undertaken to identify initiatives to achieve the required balanced operating budget by 2011/2012. One of the 75 initiatives identified related to the ARRP, requiring the ARRP to operate within the direct funding received from the Ontario Renal Network (ORN) and the Ministry of Health and Long-Term care (MOHLTC) and no longer be supplemented by hospital global funding.

The Hospital notified the Association in July 2009 that, as a recommendation of the IDA, the RN-RPN skill mix on the Renal Unit would be changing effective January 1, 2010, resulting in two fewer full-time RNs. The former ARRP Manager made a presentation entitled *Introducing the RPN Role at Scope* to the Renal Unit RNs in September 2009, and to the Association in November 2009, which identified that one RN on each of the day and evening shifts would be replaced with a full-scope RPN. As indicated in the power-point presentation, the RPNs would be responsible for providing hemodialysis treatments for stable patients with predictable outcomes<sup>3</sup>, and would not care for unstable, off-unit or transient patients or those having a first dialysis treatment or post-line insertion, and would not remove a temporary central venous catheter or administer hypertonic saline<sup>4</sup>.

As part of the implementation plan, the RPN Scope of Practice Guideline was revised, and the RPN job description, the Clinical Policy: RPN Education Requirements for Hemodialysis, the RPN Hemodialysis Orientation Program, and the Hemodialysis Care Requirements Tool (HCRT) were developed.

There was extensive discussion regarding the planned skill mix change at ARRP Staff Meetings held in December 2009 and January and April 2010. The Hospital posted one full-time and three part-time RPN positions; one full-time and two part-time RPNs began an eight-week orientation on April 26, 2010, and began to practice with an independent patient assignment on June 21, 2010. The original plan had been for the RPNs to work days (0700 - 1500) and evenings (1500 - 2300); however, the RNs' recommendation that the RPNs work days (0700 – 1500) and the H shift (1100 – 1900) was implemented.

Over the same time period, a number of additional changes occurred that impacted day-to-day practice and workload in the Renal Unit. These included new dialysis machines, an electronic

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<sup>2</sup> This was a requirement for all hospitals in Ontario.

<sup>3</sup> *Introducing the RPN Role at Scope in Hemodialysis*: Lise Corriveau, November 20, 2009, slide 29

<sup>4</sup> *Ibid*, slide 30

(hospital-wide) documentation system (Patient Charting System (PCS)), new Crit-line monitors implemented with a train-the-trainer model, and revised medication protocols. A new position, Home Dialysis Transplant Nurse (0.5 FTE home dialysis and 0.5 FTE transplant), was initiated in May 2010.

The RNs began to document their workload and practice concerns on PRWRFs on April 23, 2010<sup>5</sup>. Documentation continued on a consistent basis throughout the summer and fall, as identified in Table 1.

**Table 1: Submission of Professional Responsibility Workload Report Forms**

	April 2010	May 2010	June 2010	July 2010	August 2010	Sept 2010	Oct 2010	Nov 2010	Dec 2010	Jan 2011*
# of PRWRFs	1	4	8	6	5	10	8	7	6	2

\* YTD: 01/01/11 to 17/01/11

In response to staff feedback regarding the draft HCRT tool and the need for a transfer of care, the former ARRP Manager requested the draft HCRT<sup>6</sup> be completed for all patients, and, on June 24, 2010 stated that “a total transfer of care will not be required in all situations – it may only be certain aspects of the care; for example cannulation, administering an IV medication”<sup>7</sup>. On June 28, 2010, the former ARRP Manager sent a memo to the Renal Unit staff entitled “Bullying in the Workplace / RPN Role” in which she stated

*There have been a number of workload grievances submitted, where there was proper notification or not, whether the issue was resolved or not, or whether there was a perceived or an actual issue. The root causes of these grievances raises a red flag.*

*It gives me reason to believe we are resisting the RPN role and reason to believe there are a few who have great difficulty in accepting this change and pressuring / influencing others to follow their lead. It concerns me that bullying may be taking place. I am more than willing and prepared to work with anyone who wants to work with me to improve, find solutions and further refine the collaborative model of care. However, I will not tolerate any bullying of the RPNs. Discipline will be issued if such behaviours are observed or reported.*<sup>8</sup>

In July 2010, the CNO provided two education sessions entitled *RNs and RPNs Working Together*. The presentation reviewed the legislated scope of practice of nursing, the similarities and differences between the two categories of nurses in Ontario, accountabilities of RNs and

<sup>5</sup> The SAH and the Association had agreed in principle, in February 2009, to an algorithm entitled “Process for the Submission and Review of Professional Responsibility Workload Report Form (PRWRF)” and accompanying process document entitled “Professional Responsibility Workload Process”. At this time, the Hospital also independently developed a “Manager Response Form for Professional Responsibility Workload Report Form”, for Managers to provide a written response as required in Article 8.01 (iii). Although these processes were in place, they had not been used in the Renal Unit, as only one PRWRF was submitted between January 2009 and April 2010.

<sup>6</sup> The HCRT was developed in November 2009, and revised in January, May, July, August and September 2010. The September 2010 version was in use at the time of the Hearing.

<sup>7</sup> June 24, 2010 Email: From Lise Corriveau; To: Renal Unit RNs. Re: Hemodialysis Care Requirements

<sup>8</sup> June 28, 2010 Memorandum: From: Lise Corriveau, Manager Renal Services; To: All Renal Program Staff; Re: Bullying in the Workplace / RPN Role

RPNs, the definition of and examples of collaboration and consultation, and the Three Factor Framework. It was not clear to the IAC how many of the Renal Unit nurses attended.

A regularly scheduled HAC meeting was held on August 17, 2010. The comprehensive agenda included discussion of unresolved PRCs in the Medical Units, ER and Renal Program. The Association stated that only 2 of the 24 submitted Renal Unit PRWRFs had been responded to by the former ARRP Manager, and expressed concern that the HCRT was not, in reality, being used and that RPNs were being assigned “the best patient on the shift with no regard to the three factor framework”.<sup>9</sup> In addition, there was extensive discussion regarding the accountabilities of both RNs and Managers within the PRC process (within SAH as a whole). It was agreed that a separate meeting would be held to focus on Renal Unit issues.

The Renal Unit PRWC Meeting was held on August 25, 2010. Discussion included

- concern that collaboration and/or transfer of care facilitates fragmentation of patient care, and is very difficult for the RN who already has the most complex patients;
- concern that the successive revisions to the HCRT have diluted its efficacy, and that it has been revised to fit the new staffing model, rather than ensuring assignment of the best care provider to the patient;
- concern that it is very difficult to select patients appropriate for care provision by the RPNs;
- need for more comprehensive information regarding the role of RPNs in Renal Units with an RN/RPN skill mix, to clarify whether the RPNs in other Renal Units carry an autonomous patient assignment or work in a team relationship with an RN;
- difference in understanding, from the July 2010 CNO presentation, regarding whether the assessment of patients (i.e. completion of the HCRT) being cared for by RPN needs to be completed by the RN.

It was agreed that the Hospital would develop and forward a ‘next steps’ action table to the Association in advance of the September HAC meeting, the former ARRP Manager would respond to the outstanding PRWRFs by September 15, 2010, and teleconference equipment would be available for the September HAC meeting in order to enable the Professional Practice Specialist to participate.

The former ARRP Manager sent an email to the Renal Unit staff on September 17, 2010, in which she proposed the creation of a Task Force, stating

*Despite considering and implementing many of the suggestions made about the RN/RPN skill mix, the Team Leaders spending much time to make it fair, safe and equitable for everyone, reviewing the care requirement tool several times to reduce the variability in interpretation, and the RPNs becoming more experienced and familiar with our patients each passing day, there continues to be issues with the staff assignment. We need a task force to help brainstorm about the staffing pattern, staff assignment, and the model of care so you can as a group come up with solutions. I would like to have you as members of this task force and encourage you to take part.”<sup>10</sup>*

The Association responded by email on September 22, 2010, stating

*“...the Union is not in agreement with formation of the proposed task force to deal with the staffing pattern, staff assignment and the model of care in the Renal Unit. These issues are now part of a formal HAC process that is dealing with the potential Professional Responsibility Complaint for the Renal Unit and the Union is the official bargaining agent for the resolution of*

<sup>9</sup> August 17, 2010 HAC Meeting Minutes, page 3.

<sup>10</sup> September 17, 2010 Email: From: Lise Corriveau; To: 14 named RNs; Subject: Task Force – Patient Assignment / RN/RPN Skill Mix

*such issues.....We trust that the Employer will immediately cease forming this task force and allow the appropriate process to take place”<sup>11</sup>*

The September HAC meeting was held on September 24, 2010. The comprehensive agenda included discussion of the Renal Unit PRWRFs. The Hospital stated that the ‘next steps action plan’ discussed at the August meeting would be provided by the end of the day<sup>12</sup>. The Association advised that they would be moving to an Independent Assessment Committee if no resolutions were achieved. A second Renal-specific meeting was planned.

The second Renal Unit PRWC Meeting held on October 22, 2010 included discussion of the PRC Action Table, the validity of the September 2010 version of the HCRT, and the use of the CNO Three Factor Framework in determining patient assignment to RPNs. Following extensive discussion and a caucus break, the Hospital and the Association agreed that they would move to an IAC process.

The Association formally indicated its intention to forward the Renal Unit PRC to an IAC, as per Article 8 of the Collective Agreement, and identified the Association’s Nominee to the IAC on October 25, 2010 (*Appendix 2*). The Hospital provided notification of its Nominee on November 15, 2010, and the Association referred the PRC to the IAC Chairperson on November 16, 2010 (*Appendix 3*). As discussed in Section 1.4, the IAC Hearing was held February 8 – 10, 2011.

## **2.2 Ontario Nurses’ Association and Sault Area Hospital Perspectives Regarding the Professional Responsibility Complaint**

The Hearing was structured such that:

- On February 8, 2011, the Association and the Hospital each made an oral Submission presentation highlighting the key elements of their previously submitted written Brief.
- On February 9, 2011, the Hospital and the Association each made an oral Response presentation, which concluded with an opportunity for the other party to clarify / discuss / challenge / question the information provided. The Association’s Response presentation and associated discussion continued on to, and concluded on, the morning of February 10, 2011.
- On February 10, 2011, the IAC posed a number of questions, to both parties, to obtain a more comprehensive understanding of the issues. The questions related to the model of care with respect to RN and RPN practice, development and use of medical directives, RN and RPN orientation and continuing education, staff scheduling, staff and patient assignment, clinical quality indicators and the SAH future HIP.

From the Hearing Briefs and supporting Exhibits submitted prior to the Hearing, and the presentations, discussion and response to questions at the Hearing, the IAC understands the Association’s and the Hospital’s respective perspectives regarding the PRC in the ARRP Renal Unit to be the following.

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<sup>11</sup> September 22, 2010 Email: From: David Cheslock; To: Lise Corriveau (and others); Subject: not identified

<sup>12</sup> The Renal Program PRC Action Table, distributed after the HAC meeting, contained three items:

1. Strike a Renal Unit Task Force to review the model of care;
2. Unit Task Force to review the process for patient assessments; and
3. All outstanding PRCs to be addressed.



### 2.2.1 Ontario Nurses' Association Perspective

#### Accountability of RNs:

The CNO *Professional Standards* state that RNs are accountable to provide, facilitate, advocate and promote the best possible care for their clients, and to take action in situations where client safety is compromised. The RNs in the ARRP Renal Unit believe that the current model of care and practice environment do not allow them to meet CNO Standards and Practice Guidelines, and that they are meeting their CNO accountabilities by documenting and reporting their nursing care and practice concerns to their Managers through completion of PRWRFs.

#### Professional Responsibility Workload Report Forms:

The RNs submitted two PRWRFs between December 21, 2009 and April 25, 2010. The 56 PRWRFs submitted between April 26, 2010 and January 17, 2011 identify the following issues:

- increase in patient complexity and acuity of RN assignment;
- inability to safely balance or manage the care of complex or highly acute patients;
- inability of RNs to safely assume transfer of care from the RPNs;
- increased RN workload requiring increased interventions and resulting in
  - incidences of delayed, improper and/or unsafe care, and
  - insufficient time and availability to consult and collaborate with the RPNs;
- RPNs assigned patients whose complexity and acuity are inconsistent with the CNO Practice Guideline *Utilization of RNs and RPNs* and the Three Factor Framework;
- fragmentation of patient care and negative patient outcomes;
- inability to replace RN vacant shifts resulting in 'working short';
- frequent re-assignment of the Team Leader, Home Dialysis and Transplant Nurse, Vascular Access Coordinator and Educator from their normal roles/responsibilities;
- inability to take or complete rest / meal breaks;
- new patient documentation system, PCS, with inadequate orientation;
- shortage of Dialysis Aide staffing; and
- multiple simultaneous changes in the Renal Unit.

The Hospital has responded to the PRWRFs submitted by the RNs by minimizing and belittling the value of the RNs' concerns. The test for filing PRWRFs, as defined in the Collective Agreement, is 'the nurse has cause to believe', so the nurses have been acting appropriately in documenting their concerns. In addition, the Hospital has accused the RNs of bullying behaviour (of the RPNs) and has 'targeted' specific RNs. The RNs are feeling non-supported with respect to their voiced concerns, and this has resulted in significantly reduced morale.

#### RN-RPN Skill Mix Staffing Models in Ontario Hemodialysis Units:

The Association is currently working with nine Renal Units across the province where RPNs are integrated into the care delivery model. In all but one of the nine, the RNs are reporting issues and experiences consistent with those of the ARRP Renal Unit RNs. In the one hospital where the RPN integration appears to be working well, one RN with no patient assignment or other responsibilities provides support to the 2 RNs and 1 RPN in each pod of 9 dialysis stations. The same level of consultation support in the new hospital ARRP Renal Unit would require the addition of one RN in each of the two 9-station pods.

#### Pending Arbitration re RPNs in the ARRP Renal Unit:

The Association has filed a grievance relating to the integration of RPNs into the Renal Unit, but this is not related to the PRC process. The IAC has been struck, not to protect bargaining unit work, but because RNs completed PRWRFs that were unable to be effectively resolved at HAC.

Summary:

RNs are the appropriate care provider for the hemodialysis patients in the ARRP, even in the presence of the identified practice supports. The Association is not saying there are no RPN patients, but there are an insufficient number of such patients to make this model of care effective and efficient in the ARRP Renal Unit. Too many factors are interfering, including lack of sufficient practice supports for RNs to collaborate and safely assume transfer of care, and there is a disturbing lack of flexibility to respond to the ebbs and flows of activity that is the norm in a Renal Unit. The Association's 25 proposed recommendations highlight required changes in the areas of skill mix, quality of patient care, staffing and relationship and partnership (*Appendix 11*).

## 2.2.2 Sault Area Hospital Perspective

Accountabilities of the Hospital:

In implementing the current RN/RPN model of care, the Hospital has

- put in place processes and resources necessary to provide workload consistent with proper patient care within current resources;
- properly utilized and applied the CNO Three Factor Framework and the CNO Practice Guideline *Utilization of RNs and RPNs*; and
- made significant efforts to educate and include the RNs in the process of introducing RPNs into the Renal Unit, and to work with the RNs to address concerns.

However, despite these efforts, there continues to be real or perceived concerns and issues associated with the integration of RPNs.

Decisions regarding the model of care, in the Renal Unit and elsewhere in the Hospital, are the responsibility of the Hospital, and must be made within the context of available resources. The issue is not whether RPNs should be removed from the Renal Unit, but rather, how RPNs can be effectively integrated into the Renal Unit.

Professional Responsibility Workload Report Forms:

39 PRWRFs were submitted between April 26, 2010 and October 25, 2010.

- Some of the PRWRFs deal with realities that exist on every unit in every hospital, such as when people are absent and are unable to be replaced.
- Others state 'RN not readily available to assist RPN' but there is no factual background that such assistance was in fact required.
- Others state that improper skill mix and patient assignment have resulted in delayed, improper and/or unsafe care. Review of the incidences where it was indicated that care was delayed shows that there is no factual basis for the statement. When discussing workload, there has to be a tangible 'cause and effect', not just a subjective statement.

In summary, while there may be feelings and/or perceptions of frustration, these are part and parcel of the workday in this type of clinical setting, are not necessarily directly correlated to integration of the RPNs, and do not demonstrate cause-and-effect of actual issues.

RN-RPN Skill Mix Staffing Models in Ontario Hemodialysis Units:

The Hospital is not breaking new ground with the RN-RPN skill mix, in light of the other hospitals within Ontario where a similar model has been implemented. The research referenced by the Association does not suggest that an all-RN staff is a requirement, but rather uses terms such as 'richer skill mix'. The current ratio of 80% RNs / 20% RPNs on the day shift is a 'rich skill mix' that is supported by research<sup>13</sup>.

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<sup>13</sup> Total nursing staff skill mix is 90% RN / 10% RPN.

Pending Arbitration re RPNs in the ARRP Renal Unit:

There are current grievances dealing with the integration of RPNs into the Renal Unit; the IAC Report should not be referred to in other (arbitration) proceedings regarding the Renal Unit.

Renal Unit Operations:

There is a need for more constructive communication between the Renal Unit RNs and RPNs. The RNs have demonstrated resistance to the introduction of RPNs, which, whether conscious, unconscious or inadvertent, has resulted in communication problems and lack of consultation between RNs and RPNs. The level of communication and collaboration that exists between and among RNs also needs to exist between RNs and RPNs. The June 28, 2010 memo from the former ARRP Manager was a request for the same level of collaboration and consultation between RNs and RPNs that has traditionally occurred between and among RNs.

The Interim ARRP Manager has identified three initiatives that he plans to discuss with the Renal Unit staff:

- a quick morning report to give the nurses a snapshot of today's anticipated patient-related events, and to give the ARRP Manager an opportunity to touch base with staff, and enable the nurses to "hit the floor running before you open a chart";
- additional Medical Directives relating to blood product administration, anaemia protocols and INR protocols which will streamline decision-making and provide a more structured approach to care; and
- revision of the staffing and patient assignment sheets, which are currently confusing and difficult to work with; revision will be especially beneficial with the move to the new Renal Unit in the new hospital, which has a different physical configuration of dialysis stations.

The new Renal Unit in the new hospital has two 9-station 'pods'. It is hoped that the imminent move to the new hospital will enable discussion of a collaborative pod model of care. In addition, the physical configuration of the Renal Unit includes space for the possible development of an in-centre self-care hemodialysis program.

Summary:

The 2008 – 2010 achievements of the ARRP (*Appendix 12*) and the five recommendations contained in the Submission Brief (*Appendix 13*) demonstrate the constructive progress made within the Renal Program over the past two years and the importance of looking forward, not back, when considering the role of RPNs in the ARRP Renal Unit. Many Renal Units in the province will review the IAC's Report, and recommendations focusing on integration of RPNs, rather than territorial protection of RNs, will be extremely important.

### 2.2.3 Ontario Nurses' Association and Sault Area Hospital Three Factor Framework Analysis

As indicated in Table 2, the Association believes that analysis of the CNO Three Factor Framework indicates that the client, nurse and environment factors in the ARRP Renal Unit do not support autonomous RPN practice. All three factors must be considered when determining the appropriate category of care provider; if even one of the factors changes, the category of nurse assigned to the patient should be reassessed.

As indicated in Table 2, the Hospital believes that the CNO Three Factor Framework has been appropriately considered; the client, nurse and environment factors support the RN-RPN skill mix currently implemented within the ARRP Renal Unit.

**Table 2: Ontario Nurses' Association and Sault Area Hospital Analysis of the  
CNO Three Factor Framework in the ARRP Renal Unit**

Three Factor Framework	Ontario Nurses' Association Perspective	Sault Area Hospital Perspective
Client Factor	<p><u>Complexity</u></p> <ul style="list-style-type: none"> <li>♦Multiple, overlapping co-morbid conditions, require frequent close assessment and monitoring. 97% of patients have at least two chronic illnesses in addition to ESRD, 89% have three to four and 55% have five or more.</li> <li>♦Increase in Level III treatments and decrease in Level II treatments over the past several years indicates overall increase in acuity.</li> </ul> <p><u>Predictability</u></p> <ul style="list-style-type: none"> <li>♦Patient care requirements are unpredictable, as changes in health condition are difficult to predict.</li> <li>♦the dialysis procedure itself creates unpredictability in patient condition.</li> </ul>	<p><u>Complexity</u></p> <ul style="list-style-type: none"> <li>♦50% of patients have diabetes, majority are hypertensive, and most have complications related to the development of ESRD. Patients on dialysis with minimal co-morbidities exist, but are the exception.</li> <li>♦Generally the same patients who received hemodialysis before RPNs introduced. Majority are outpatients. Number has decreased from 102 to 83.</li> <li>♦Of 83 current patients, HCRT indicates that:             <ul style="list-style-type: none"> <li>•19 patients (23%) are dialysed on evenings (not considered for RPN assignment, even though patients are stable and would be appropriate if received dialysis during the day);</li> <li>•5 patients (6%) 'questionable' for RPN assignment;</li> <li>•26 patients (29%) require RN care;</li> <li>•22 patients (28%) are appropriate for RPN care; of these, 11 consistently assigned to RPNs without a transfer of care being required, and 11 patients assigned to RPNs on occasion.</li> </ul> </li> <li>♦Of the 83 hemodialysis patients:             <ul style="list-style-type: none"> <li>•approx. 24 are stable patients: appropriate for independent home peritoneal dialysis (CAPD), and of these, 20 are appropriate for in-centre self-dialysis and 13 are appropriate for home hemodialysis.</li> <li>•the remaining 59 patients require professional nursing support for the provision of dialysis treatments in the Renal Unit.</li> </ul> </li> </ul> <p><u>Predictability</u></p> <ul style="list-style-type: none"> <li>♦Even with co-morbid conditions, patients can be concurrently complex and stable, with known and predictable needs and expected responses to dialysis.</li> <li>♦22% of the patients have been on hemodialysis for less than one year; 33% for one to three years and 45% for three or more years.</li> </ul>

Three Factor Framework	Ontario Nurses' Association Perspective	Sault Area Hospital Perspective
	<p><u>Risk of negative outcomes</u></p> <ul style="list-style-type: none"> <li>♦High risk; responses to treatment are unpredictable and may be systemic, signs and symptoms of change are subtle, may be difficult to detect, and may create an urgent situation.</li> </ul>	<p><u>Risk of Negative Outcomes</u></p> <ul style="list-style-type: none"> <li>♦Dialysis patients are at risk for complications, but such events rarely occur on dialysis: e.g. the patient will arrive at the Renal Unit with chest pain or will develop angina after the treatment, but it is rare that patients reach a level of 'extremis' (e.g. an MI) while receiving dialysis.</li> <li>♦Most common complications relate to hypotension but there is no factual basis / evidence suggesting incidence of complications has increased.</li> </ul>
Nurse Factor	<ul style="list-style-type: none"> <li>♦Foundational knowledge of RNs and RPNs differs in clinical practice, decision-making, critical thinking, leadership, research utilization and resource management. While continuing education and experience can enhance competence, RPNs will not acquire the same foundational competencies as RNs.</li> <li>♦Autonomous practice (ability to make decisions and independently carry out nursing responsibilities) is directly related to the nurse's foundational knowledge. This has been demonstrated by: <ul style="list-style-type: none"> <li>•instances where RPNs have not recognized need to obtain advice / guidance / support through collaboration, and/or have not taken initiative to implement a recognized nursing intervention, resulting in potential or actual negative clinical outcomes for patients, and</li> <li>•instances where RPNs have missed subtle (or not so subtle) signs and symptoms; because there is currently no system for RN assessment of patients being cared for by RPNs, these changes were not noticed within an appropriate time frame, and/or appropriate interventions were not implemented.</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>♦Renal Unit RNs have extensive renal experience: 24% have worked in the Unit for one to three years, 42% for four to nine years and 34% for ten years or more.</li> <li>♦97% of the RNs graduated from a diploma program.</li> <li>♦RPNs work a total of 3900 hours per year, equivalent to 2 full time RN positions.</li> </ul>
Environment Factor	<p><u>Practice Supports</u></p> <ul style="list-style-type: none"> <li>♦RPNs do not have authority to enact Medical Directives.</li> <li>♦September 2010 HCRT is not valid, helpful or meaningful and has resulted in inappropriate assignment of patients to RPNs.</li> <li>♦RN must be <u>immediately</u> available to consult or collaborate with an RPN, or to assume transfer of care. <ul style="list-style-type: none"> <li>•When RPN accesses advice / support / assistance, a transfer of care occurs between the</li> </ul> </li> </ul>	<p><u>Practice Supports</u></p> <ul style="list-style-type: none"> <li>♦Policies/procedures (Medical Directives to enhance practice consistency / highlight deficiencies, HCRT<sup>14</sup>) are available</li> <li>♦There has not been a transfer of care since the RN-RPN skill mix was introduced. There was one incident where there was a reassignment at the beginning of a shift from an RPN to an RN, but there has not been a transfer of care during a shift.</li> </ul>

<sup>14</sup> The Hospital is recommending that the HCRT be discontinued because it is not being properly utilized: rather than a checkmark indicating that a patient meets the identified criteria, a checkmark is placed only at the statement 'not care for by RPN'.

Three Factor Framework	Ontario Nurses' Association Perspective	Sault Area Hospital Perspective
	<p>RPN and the person providing support (RN, Team Leader, Educator, Vascular Access Nurse etc.) when the practice support person is actively involved in the patient's care for a period of time (e.g. 45 minutes) and the RPN is not autonomously directing the care. This differs from when an RN accesses advice / support / assistance, as the time requirement is much less.</p> <ul style="list-style-type: none"> <li>♦Educator has recently had a large number of out-of-unit meetings and has been unavailable for in-unit support. The Vascular Access Coordinator has extensive responsibilities in the Radiology Department, making her unavailable for RPN (and RN) support in the Unit. All of these individuals leave by 1600, leaving significantly less resources available to the RPNs between 1600 and 1900.</li> <li>♦Team Leader does not have an assignment, but provides clinical assistance 'as required' virtually every day; in addition, she is responsible to oversee and coordinate activity within the Unit and is not always easily available for consultation and support.</li> <li>♦Patient care requirements of the RNs' patients are more involved/more complex/more compromised/more time-consuming/have a higher risk for unexpected events, leaving them with minimal time to interact with and/or provide assistance as required to the RPN (or to the other RNs).</li> </ul> <p><u>Stability and predictability</u></p> <ul style="list-style-type: none"> <li>♦Patient population is fairly stable in terms of movement in and out of the hemodialysis program, but each 12-hour shift has three sets of patient turnovers. Patient assignments frequently 'juggled' during a shift, resulting in chaotic environment.</li> <li>♦0700-1900: each RN has five complex / compromised patients, while the 2 RPNs care for the six most predictable patients in the Unit that day. Scope of the RNs' assignment results in inability to flex assignments to reassign patients when an unexpected event occurs (e.g. Level 3 ICU treatment) as RPNs are unable to assume autonomous care of complex patients.</li> </ul>	<ul style="list-style-type: none"> <li>♦Former ARRP Manager provided leadership and direction to Renal Unit until Interim Manager started in January 2011. This was a difficult period but other supports (Team Leader without assignment, Vascular Access Coordinator, Home Dialysis Transplant Nurse, Educator etc) were available.</li> <li>♦Home Dialysis Transplant Nurse, hired in 2010, is responsible for preparing patients for transplant, previously the responsibility of the Team Leader.</li> <li>♦Logistical issues in terms of availability are a reality of the hospital environment.</li> <li>♦Nephrologist call schedule has been altered ( now on call for two weeks for both hemodialysis and inpatients, enabling improved coordination of care) to enhance consistency.</li> <li>♦Team Leader is without an assignment to allow better flow / overview of functioning of the Unit and available for consultation, collaboration and assistance from 0700-1500.</li> </ul> <p><u>Stability and Predictability</u></p> <ul style="list-style-type: none"> <li>♦Renal Unit can be chaotic, especially during noon and supper hour turnover; this is typical in all Renal Units, and has not changed with introduction of RPNs.</li> <li>♦No increase in nurse : patient ratio</li> </ul>

## **SECTION III**

### **FINDINGS, DISCUSSION AND ANALYSIS**

#### **3.1 Introduction**

The IAC believes that it has developed a comprehensive understanding of the professional responsibility concerns of the RNs working in the ARRP Renal Unit. This understanding was achieved through review and analysis of the written submissions, exhibits, oral presentations and discussion at the Hearing, review of information provided by the Hospital and Association, at the IAC's request, following the Hearing, and review of literature available in the public domain regarding hemodialysis practice.

Discussion of professional responsibility concerns within the ARRP Renal Unit must be considered within the context of the practice environment. The IAC has framed its analysis and recommendations on the basis of a contextual review of the following:

- scope of the ARRP in relation to other Renal Programs in Ontario;
- geographical configuration of the immediate practice environment within the Renal Unit;
- other actual/anticipated changes emanating from the Hospital's HIP which may impact the ARRP Renal Unit;
- prevalence of End Stage Renal Disease (ESRD) in Canada, and the consequent continued pressure for the provision of hemodialysis;
- standards of practice for nephrology nurses in Canada;
- potential complications of the hemodialysis treatment procedure; and
- CNO Guideline regarding utilization of RNs and RPNs in Ontario.

The IAC was requested to examine the impact of the introduction of autonomously practicing RPNs on the workload of the ARRP Renal Unit RNs. Article 8.01 of the Collective Agreement states 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. The IAC believes that these issues have impacted the workload of the ARRP Renal Unit RNs relating to the introduction of RPNs, and, based on the contextual review noted above, has focused its analysis and recommendations on the following within the ARRP Renal Unit: nursing leadership, role of the RN and RPN, practice supports and nursing staffing.

#### **3.2 Context of Practice**

##### **3.2.1 Algoma Regional Renal Program**

Hemodialysis services in Ontario are organized in a 'hub and spoke' model, comprised of 26 regional programs (hubs), and 65 satellites and 7 independent health facilities (spokes). The ARRP is one of four regional programs within the North East LHIN<sup>15</sup>, and one of the 26 regional programs in Ontario. While the ARRP is smaller in terms of patient numbers than many of the regional programs in the province, and does not offer services including satellites, home

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<sup>15</sup> The four regional renal programs within the North East LHIN are Sault Ste. Marie (Algoma Region), Timmins (Timiskaming Region), North Bay (Nipissing Region) and Sudbury (Manitoulin-Sudbury Region). Sudbury is the main dialysis referral center for North East Ontario and cares for 225 hemodialysis patients.

conventional dialysis program, nocturnal daily dialysis program and/or a self-care hemodialysis unit, the ARRP is recognized as a regional program as it provides the following.

Acute kidney injury program	•ICU services for previously healthy individuals who have abrupt sustained decrease in kidney function
Chronic kidney disease program	•Pre-dialysis and treatment option clinics •Nephrology clinics for chronic kidney disease management
In Centre Dialysis program	•Level II chronic and Level III acute hemodialysis •In-hospital peritoneal exchanges •Follow-up clinics
Home Dialysis program	•Training -Continuous ambulatory peritoneal dialysis (CAPD) -Continuous cycler peritoneal dialysis (CCPD) •Maintenance -CAPD -CCPD adult
Body Access Creation and Maintenance	•Central venous catheter insertions (permanent) •Central venous catheter insertions (temporary) •AV fistula /graft insertions •PD catheter insertions
Transplant Program <sup>16</sup>	•Pre-transplant work-up for cadaver and living donors •Post-transplant clinics

The ARRP provides Level II chronic dialysis in the Renal Unit, and Level III acute dialysis in the ICU. The MOHLTC Joint Policy and Planning Committee (JPPC) identified three levels of hemodialysis in the late 1990s<sup>17</sup> in order to provide a framework for costing and funding ERSD in Ontario. The definitions describe the staff : patient ratio, length of treatment, and interdisciplinary hours of care for each of the three levels as the following:

- Chronic Hemodialysis Care Level I: Hemodialysis treatment for stable chronic ESRD patients – self-care, assisted self-care or dependent full care. The interdisciplinary team hours may be variable, as they relate to patient acuity. The team hours per treatment will not exceed 2.25 hours. Staff : Patient Ratio is 1:4. Measured by number of treatments (e.g. patient dialyzes between 3-5 hours per treatment)
- Chronic Hemodialysis Care Level II: Hemodialysis treatment, performed in an acute care dialysis unit located in a hospital, for unstable, chronic and acute ESRD patients. The patients are of high acuity, may be unstable during the dialysis procedure and must be seen by a Nephrologist each visit. The interdisciplinary team hours may be variable, as they relate to patient acuity. The hours of care will be 2.26 to 3.25 hours. Staff : Patient Ratio 1:3. Measured by number of treatments (e.g., patient dialyzes between 3-5 hours per treatment)

<sup>16</sup> The ARRP transplant program is shared with the London Health Sciences Centre

<sup>17</sup> *An Approach to Funding End Stage Renal Disease*. Prepared by the End Stage Renal Disease Funding Working Group. Reference Doc RD5-3, April 1997. Retrieved from:  
<http://www.ontla.on.ca/library/repository/mon/7000/10317010.pdf>



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

The ARRP hemodialysis program opened in 1969 with one hemodialysis station at the Plummer Memorial Hospital. The service gradually expanded, and the Renal Wing, housing the hemodialysis unit, home dialysis program, Renal Clinic and support areas (offices, clean and soiled utility rooms, biomed room and staff lunch room) was built at the Plummer Memorial Hospital in 1994.

Hemodialysis numbers have continued to increase, reaching a high of 102 patients in 2008/2009. At the time of the IAC Hearing, there were 83-86<sup>18</sup> patients within the chronic hemodialysis program, of whom 22% have been on dialysis for one year or less, 33% for one to three years, and 45% for more than three years. Approximately 57% of the patients have a central venous catheter, 30% have an AV-fistula, and 13% have an AV graft. Patient ages range from 20 to 90, with 68% over age 60. 63% of the current hemodialysis patients are male.

The Sault Ste. Marie General Hospital and Plummer Memorial Hospitals amalgamated to form the Sault Area Hospital (SAH) in 2002, with 291 beds located over four sites<sup>19</sup>. The SAH moved to a new state-of-the-art facility on March 6, 2011.

### 3.2.2 Configuration of the Renal Unit

At the time of the Hearing in February 2011, the ARRP was located in the Plummer Site of the “old” SAH, and the RNs were practicing in this location when the PRWRFs referenced in Section 2.1 were completed. As noted above, the Hospital moved to the new SAH site on March 6, 2011. The IAC anticipates that the concerns relating to and/or resulting from the lack of visibility and sense of isolation between the ‘core’ and ‘alcove’ practice areas in the Plummer Site Renal Unit will be eliminated in the new Renal Unit.

#### 3.2.2.1 Plummer Site Renal Unit:

The Plummer site Renal Unit had 18 stations, with 12 stations located in the ‘core’ area and 6 stations located in the ‘expanded area’ or ‘alcove’. The Unit was equipped with two over-bed lifts and one mechanical lift, and had one isolation room for patients with MRSA, VRE, C-difficile etc. In addition to the patient bed and dialysis machine, each station had a TV/DVD system on a cart.

The 12 stations in the core area wrapped around the central desk in an L-shape, with eight stations on the long L-arm and four stations on the short-L arm. All eight of the long L-arm stations, and two of the short L-arm stations could be directed visualized from the desk. The core area stations all contained beds.

The alcove was located behind a wall behind the central desk. There was a door immediately beside the desk into the alcove behind. The alcove was truly an “alcove”, in that one of the four

<sup>18</sup> The Hearing Briefs, and discussion at the Hearing, identified the number of hemodialysis patients as 83 in some instances, and 86 in others; it was agreed that the maximum number of patients at the time of the Hearing was 86.

<sup>19</sup> The General and Plummer sites, and two satellite hospitals located in Mathews and Thessalon.

walls was completely open, enabling visualization between the alcove and the core area stations 1, 2 and 3. However, none of the alcove stations could be visualized from the central desk. Five of the alcove stations contained chairs; one station had a bed. The alcove contained two workstations for the nurses.

The small medication room was located in the core area adjacent to the central desk, and was accessible to the nurses in the alcove area through the door between the alcove and the desk area.

The Renal Clinic was located just outside the Unit and the waiting room was shared between patients awaiting clinic appointments and patients awaiting dialysis. The Home Dialysis Program, including offices for the Home Dialysis Nurse and Home Dialysis Transplant Nurse, was located down a short corridor. The Home Dialysis teaching room was also used for weekly multi-disciplinary rounds.

The Dialysis Aides' room, where the trays and carts were prepared in advance of dialysis treatments, was located along the Home Dialysis corridor, and the Biomed room, where the machines were maintained, was located at the end of the short L-arm of the core unit.

When the Renal Wing opened in 1994, the Unit included 10 hemodialysis stations. As the Unit grew to include 18 stations, supply storage became an increasing problem and supply carts and other equipment were stored in the hallways.

The staff break/lunch room was located immediately outside the door of the Renal Unit, opening onto the Renal Clinic/Renal Unit waiting room.

Level III acute dialysis treatments were provided in the ICU, which was located across the parking lot at the General Site of the SAH.

### 3.2.2.2 New Hospital Renal Unit

The ARRP is located in a much larger space on the third level of the new hospital. The new Renal Unit has 23 stations, 20 of which will be operational initially. The Unit is airy and bright, and has an open configuration with two 'pods', each with a large central desk. The first pod has nine stations, forming a semi-circle around the central desk, with two isolation rooms and a intervention/treatment room with a ceiling mounted light on the back wall behind the central desk. The second pod has 12 stations forming a semi-circle around the central desk. A half-height headwall separates the two pods, which are visually open to each other (unless station curtains are pulled for patient privacy). All of the stations in the pods are equipped with dialysis chairs; the two isolation rooms contain beds. Each of the dialysis stations contains a ceiling mounted TV.

The medication room is beside the first pod, requiring the nurses caring for patients in the second pod to walk past the first pod to reach it. There are two wheelchair weigh stations, an eyewash station and ample room for computer/tablet documentation.

There is ample space for supply storage, machine preparation and maintenance, as well as a large Renal Clinic with associated waiting room, a separate multi-disciplinary rounds room, and offices for the allied health (social worker, dietician, pharmacist) staff, the nephrologists, the ARRP Manager and Educator, and the Home Dialysis program.

The ICU, and the inpatient units (medical, surgical and surgical step-down) where most patients requiring dialysis will be admitted are on the same level as the Renal Unit. The ICU has been plumbed for dialysis. The Laboratory is directly beside the Renal Unit, also on the third level.

The break room for the Renal Unit staff is located outside of the ARRP area, approximately 50 feet down the hall towards the ICU. It is expected that the break room may be used less often than in the Plummer Site Renal Unit, as the new hospital contains a large cafeteria, which the Renal Unit staff expects to use.

The new ARRP area will provide an opportunity for the Program to expand its current range of services. Specifically, the Hospital plans to explore the possibility of seeking approval for a self-care in-centre hemodialysis program.

### 3.2.3 Hospital Improvement Plan

The SAH is in the process of implementing a multi-year HIP, as is every other hospital in the province. The IAC anticipates that two initiatives within the HIP will have a direct impact on the work environment of nurses.

The first relates to the discontinuation of the Staffing Office, which previously assumed responsibility for calling part-time and casual nurses for shift replacement. With the closure of the staffing office in January 2011, this responsibility has shifted to each Program. In the Renal Unit, the Ward Clerk makes the calls until she leaves at 1900, after which the Additional Responsibility (AR) Nurse is responsible. Depending on the number of sick calls received after 1900 for the next day shift, this may or may not be an onerous responsibility.

The second relates to the planned discontinuation of the in-hospital evening, night and weekend Supervisor role, which will occur in April 2011 as part of the 2011-2012 HIP. Clinical Managers will rotate taking call from home. The IAC understood that the current plan is that each Program will initially cover its respective area(s); once the on-call system is refined, the SAH will move to having one Clinical Manager on call for the entire hospital. The IAC anticipates that the impact on the ARRP will likely be less than elsewhere in the hospital, as the ARRP is not open at night, does not depend on the Supervisor for clinical direction, and is internally responsible for its own staffing.

### 3.2.4 Prevalence of End Stage Renal Disease

The incidence of kidney disease has tripled in Canada over the past 20 years. As of December 31, 2009, there were 37,744 people in Canada with end stage renal disease (ESRD), of whom 59% were being treated with dialysis. Since 1990, the rate for patients receiving dialysis has increased 212%, and the average age of new hemodialysis patients has increased from 55 in 1990 to 65 in 2009. Of the 15,347 ESRD patients being treated in Ontario in 2009, 7511 (48.9%) received hemodialysis in an institutional setting. Ontario has almost 43% of the in-centre hemodialysis patients in Canada and has the second highest patients per station ratio (4.9).<sup>20</sup> The experience of the ARRP mirrors this trend, as the number of hemodialysis patients increased 35% (from 57 to 86 patients) between 2002 and 2010, and is not expected to decrease. The ability to

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<sup>20</sup> Canadian Organ Replacement Registry Annual Report *Treatment of End-Stage Organ Failure in Canada 2000-2009*. Retrieved from [http://secure.cihi.ca/cihiweb/products/2011\\_CORR\\_Annual\\_Report\\_final\\_e.pdf](http://secure.cihi.ca/cihiweb/products/2011_CORR_Annual_Report_final_e.pdf)

continue to provide hemodialysis, both in terms of the approximately \$60,000 per patient annual cost<sup>21</sup> and decreasing numbers of RNs<sup>22</sup>, will be an increasing challenge in Canada (and elsewhere in the world) and will require continual exploration of alternate staffing modalities.

### 3.2.5 Standards of Practice for Nephrology Nurses

The Canadian Association of Nephrology Nurses and Technologists (CANNT) describe nephrology nursing as “a specialized area of nursing practice focusing on needs of patients with kidney disease and their families, across the lifespan and continuum of kidney disease care. This specialized care requires the nephrology nurse to promote competent, safe, ethical care, and demonstrate current specialty knowledge and practice”.<sup>23</sup> The CANNT *Nursing Standards and Practice Recommendations* identify detailed practice standards in five areas for the nephrology nurse providing hemodialysis (*Appendix 14*):

- hemodialysis vascular access,
- hemodialysis adequacy,
- hemodialysis treatment and complications,
- medication management, and
- infection control practices.

The IAC believes that all nurses providing hemodialysis must meet these standards in order to ensure safe and effective patient care to their assigned patients.

### 3.2.6 Potential Complications of the Hemodialysis Treatment Procedure

Although the first documented hemodialysis treatment occurred in Germany in 1924, and the first practical hemodialysis machine was developed in the Netherlands in 1943, the provision of chronic hemodialysis on a regular basis did not begin until the 1960s with the development of a vascular access called a Schribner shunt. Dialysis technology continued to improve through the 1970's and 1980's, with new machines, more efficient dialysers and the development of a synthetic form of erythropoietin (EPO) that eliminated the need for frequent and ongoing blood transfusions. Home hemodialysis programs began in the mid-1990's.<sup>24</sup>

Although the safety of the hemodialysis treatment procedure has improved greatly over the past 50 years, it is not without risk. The commonly experienced complications include the following<sup>25</sup>.

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<sup>21</sup> Ibid

<sup>22</sup> Retrieved from: [http://www.cna-aiic.ca/CNA/documents/pdf/publications/RN\\_Highlights\\_e.pdf](http://www.cna-aiic.ca/CNA/documents/pdf/publications/RN_Highlights_e.pdf)

<sup>23</sup> CANNT: *Nephrology Nursing Standards and Practice Recommendations*, August 2008. Retrieved from [http://www.cannt.ca/en/files/CANNT\\_Nursing\\_Standards\\_2008.pdf](http://www.cannt.ca/en/files/CANNT_Nursing_Standards_2008.pdf)

<sup>24</sup> *The History of Hemodialysis*: Independent Dialysis Treatment Workbook, BC Renal Agency. Retrieved from <http://www.bcrenalagency.ca/NR/rdonlyres/0CD1022B-7B23-41D7-9BD6-6EA897A07970/40541/2HistoryofHemodialysis.pdf>

<sup>25</sup> References retrieved from:

<http://www.renal.org/Clinical/GuidelinesSection/Hemodialysis.aspx#s8>

<http://classes.kumc.edu/cahe/respcared/cybercas/dialysis/francomp.html>

<http://www.uphs.upenn.edu/renal/renal%20curr%20pdfs/hemodialysis%20complications.pdf>

<http://www.advancedrenaleducation.com/Hemodialysis/DisequilibriumSyndrome/tabid/449/Default.aspx>

<http://www.advancedrenaleducation.com/Hemodialysis/DialyzerReactions/tabid/448/Default.aspx>

- Dialysis-related hypotension, an acute symptomatic fall in blood pressure during dialysis requiring immediate intervention to prevent syncope, is the most frequent symptomatic complication of hemodialysis, occurring in 15-30% of treatments. It is more common in older patients and in women. When fluid is removed during dialysis, the osmotic pressure is increased, prompting fluid moving from the interstitial space, which is in turn refilled by fluid from the intracellular space. Excessive ultrafiltration with inadequate vascular refilling leads to hypotension.
- Muscle cramps occur in up to 20% of dialysis treatments during the end of the dialysis procedure after a significant volume of fluid has been removed by ultrafiltration. The likelihood of muscle cramping can be lowered by decreasing the ultrafiltration rate, administering small boluses of isotonic saline, and increasing estimated dry weight.
- Arrhythmias and angina frequently occur in patients on chronic hemodialysis, both during treatment and between dialysis treatments. They can be precipitated by hypotension and coronary ischemia. Cardiac arrest is uncommon in outpatient dialysis.
- Dialysis Disequilibrium Syndrome (DDS) is characterized by nausea, vomiting, headaches and fatigue and can result in life-threatening seizures, coma and arrhythmias. Although DDS was a frequent complication in the early years of dialysis, the full-blown syndrome occurs less often now. It occurs most commonly during initial dialysis treatments and in patients with pre-existing CNS lesions (e.g. recent stroke), cerebral edema (e.g. malignant hypertension), high pre-dialysis BUN and severe metabolic acidosis. The likelihood of DDS can be decreased by identifying high-risk patients, using smaller surface area dialyzers, reducing rates of blood and dialysate flow and administering mannitol and diazepam intravenously.
- Hypoxemia, a drop in arterial PO<sub>2</sub> between 5 to 35 mm Hg, occurs between 30 – 60 minutes of beginning dialysis in up to 90% of patients.
- Hemolysis occurs as the half-life of red blood cells in patients with ESRD is one-half to one-third of normal and the cells are susceptible to membrane injury.
- Dialyser reactions are divided into two types: anaphylactoid reactions and mild reactions. Anaphylactoid reactions, while rare, are very severe, with an onset within 20 minutes of starting dialysis. Symptoms include dyspnea, a burning/heat sensation at the access site or throughout the body, and angioedema. Mild reactions occur 20 – 40 minutes into the dialysis treatment, and are characterized by chest and back pain that disappears or lessens over the dialysis treatment period.

The IAC believes that all effort must be taken to ensure that the nurse caring for a patient undergoing hemodialysis treatment has the requisite knowledge, skill and judgment and the appropriate practice supports to effectively manage the anticipated complications of the hemodialysis procedure, including taking actions to minimize complications before they occur, to maximize the adequacy of the dialysis treatment.

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

The CNO Practice Guideline *Utilization of RNs and RPNs*<sup>26</sup> was developed to support nurses, employers and others to make effective decisions regarding the utilization of nurses. The decision factors, relating to the client, nurse and environment and known as the “Three Factor Framework”, are based on a number of guiding principles:

- RNs and RPNs practice within the same legislated scope of practice;

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<sup>26</sup> CNO Practice Guideline *Utilization of RNs and RPNs*, Publication # 41062, June 2009

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

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

#### Client Factors:

- *Complexity* of care needs are determined by how well the care needs are defined, whether multiple issues exist, the extent of monitoring or reassessment required, the risk of negative outcomes and the level of support systems in place.
- *Level of predictability* of care needs relates to the possibility of change in the patient's condition, the timing of such change, and the possible outcomes.
- *Risk of negative outcomes* relates to the extent to which signs and symptoms are difficult to detect, whether possible negative outcomes will have a localized or systemic effect, and whether the outcomes result in an urgent or emergency situation.

#### Nurse Factors:

- Performance of client care intervention requires
  - knowledge, skill and judgment relating to the technical aspects of performing the care intervention, and
  - cognitive aspects relating to critical thinking and decision-making to manage the intra-intervention and post-intervention outcomes of the care intervention.
- The difference in foundational knowledge between RNs and RPNs results in a difference in their ability to practice autonomously / make decisions and independently carry out nursing responsibilities as client care needs increase.

#### Environment Factors:

- *Practice supports* relate to policies, procedures, guidelines, assessment tools, pre-developed care plans etc and the presence of expert nurses familiar with the practice environment.
- *Consultative resources* relate to the availability of information, advice or assistance from a more knowledgeable health care provider(s).
- *Stability and predictability* relate to the rate of client turnover and extent of unpredictable events.

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

### 3.3 Nursing Leadership

Effective nursing leadership is a key requirement for professional practice within a quality practice environment. Effective strategic, operational and clinical leadership requires both the correct number and nature of leadership positions and a participative approach on the part of the nursing leaders that supports and respects staff involvement in organizational and clinical decision-making. The RNAO Best Practice Guideline *Healthy Work Environments* identifies five transformational leadership practices that result in healthy outcomes for nurses, patients, organizations and systems<sup>27</sup>:

- building relationships and trust,
- creating an empowering work environment,
- creating an environment that supports knowledge development and integration,
- leading and sustaining change, and
- balancing competing values and priorities and demands.

Trust, along with fairness and respect, are key values that lead to healthy organizations. When nurses feel they are respected, the results are higher job satisfaction, trust in management, lower emotional exhaustion and higher nurse ratings of quality of care and staffing adequacy. An environment that supports a sense of empowerment on the part of the nursing staff is one that includes opportunities for dialogue, clear vision and direction, and shared governance structures and processes, such as nursing practice councils and unit-based councils, to govern nurses' scope of practice. Factors that assist nurses to adopt new knowledge into practice include participation in continuing education, access to information and literature, sanctioned time to participate in research and availability of colleagues with advanced education to facilitate knowledge transformation. Effective management of change is a key component of effective leadership. Successful change occurs when nurse leaders engage staff by providing structures and opportunities for involvement during all phases of the change process, and assist the team to build confidence in its ability to manage the change through training, communication and listening empathetically rather than judgmentally.

The IAC believes that these leadership practices were generally lacking within the ARRP during the planning and implementation of the RN/RPN skill mix.

#### 3.3.1 ARRP Manager

The ARRP Manager is responsible for ensuring the full range of services are provided to patients with chronic and acute kidney disease, and so is accountable for effective management of, and provision of leadership to, the six areas within the ARRP identified in Section 3.2.1. The SAH has a matrix reporting structure:

- for operational issues, the ARRP Manager reports to the Director of Oncology and Renal Programs, who in turn reports to the Vice President and Chief Operating Officer (COO), and
- for professional practice issues, the ARRP Manager reports to the Chief Nursing Officer (CNO), who also reports to the Vice President and COO.

The ARRP Manager has approximately 50 direct reports, including RNs, RPNs, Dialysis Aides and Ward Clerks in the Renal Unit, the Renal Clinic staff, the Vascular Access Coordinator, Home Dialysis Nurse, Home Dialysis Transplant Nurse and the Educator. The ARRP Allied

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<sup>27</sup> Registered Nurses Association of Ontario Best Practice Guideline: *Healthy Work Environments*, June 2006, pg 30

Health Professionals, including Dietitians, Social Worker and Pharmacist, have a matrix reporting relationship to the ARRP Manager for operational issues and to their respective Managers for professional practice issues. SAH has set the expectation that all Nurse Managers will be present in/on their Unit 70% of the time<sup>28</sup>, with a maximum of 30% directed to administrative (office) responsibilities and/or off-unit activities (e.g. meetings).

The former ARRP Manager moved to the position of Regional Director with the Ontario Renal Network (ORN) for the North East Region (LHIN) in August 2010. From August 2010 to March 31, 2011, her role includes three days per week with the ORN and two days per week as Project Manager with the ARRP. She will move to the Regional Director position full-time in April 2011. However, as the ARRP Manager position was not replaced until January 2011, the former ARRP Manager filled this role in addition to her new dual position for the period August through December 2010. The Interim ARRP Manager began the position on January 4, 2011. He brings extensive clinical experience in the specialty of nephrology nursing to his first management role.

The IAC recognizes the challenges experienced by the Renal Unit staff during the period between August 2010, when the former ARRP Manager assumed her new position with the ORN, and January 2011, when the Interim ARRP Manager<sup>29</sup> assumed his new role. The IAC believes that although the former ARRP Manager tried to provide support to the Renal Unit during this interim period, she was unable to provide the level of on-site leadership or focused attention and responsiveness to the RNs' concerns required during the initial months of implementation of the RN-RPN skill mix<sup>30</sup>. Considering the importance of leadership and support during a transition such as the skill mix change, the IAC was surprised that the SAH did not choose to appoint an Acting Manager to provide a greater degree of on-site support during this time, but assumes there were reasons for this decision that the IAC is not privy to. There is no question, however, that the RNs' sense of trust and sense of 'team' have been damaged, and will need to be rebuilt in order for the ARRP to move forward.

The IAC strongly supports the SAH expectation that the Manager be present on her/his Unit 70% of the time, and believes that adherence to this expectation will be extremely important for the Renal Unit over the next 6-12 months. The IAC believes that this will likely require the Interim ARRP Manager to be relieved of other expected (corporate or administrative) duties in order for him to be 'present' and to begin to repair the lost trust between management and staff and within the RN-RPN staff team.

In light of the current challenges within the ARRP, the IAC believes that leadership by an experienced manager would be ideal. Leadership of the ARRP is the Interim ARRP Manager's first management position. The IAC was impressed with his enthusiasm, evident desire to 'get things back on track', and open recognition of the challenges that exist. However, the IAC believes that successful healing within the ARRP will require expertise and skills that are beyond those of a novice leader, and that his success will be maximized if he receives coaching to transition to the leader role. Therefore, the IAC believes that the Interim ARRP Manager should

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<sup>28</sup> The Nurse Manager Job Description, provided by the Hospital, dated May 1997 and revised August 2006, states that "75% of time is spent visible on the unit. 25% is spent on administrative functions related to operation of the unit". The Hospital stated at the Hearing that this expectation has changed to 70%/30%.

<sup>29</sup> The IAC understands that the ARRP Manager position is 'Interim' until April 1, 2011, when the former ARRP Manager will transfer to the ORN full-time.

<sup>30</sup> The IAC is not intending to be critical of the former ARRP Manager with this statement; from August to December inclusive she held two full-time jobs, and did her best to be available through email and telephone when her competing role responsibilities required her absence from the Renal Unit.



be supported through focused mentoring from an expert leader outside of the organization, and participation in a leadership program such as the Dorothy Wylie Nursing Leadership Institute<sup>31</sup>.

*The IAC recommends:*

- 1. The SAH support the Interim ARRP Manager to attend the 2011 Dorothy Wylie Nursing Leadership Institute as an emerging leader with an established nursing leader from the SAH.**
- 2. The CNO and Program Director, Oncology and Renal organize and implement a formal mentorship relationship with an experienced first-line Nurse Manager or Director from an external organization to assist the Interim ARRP Manager to develop expertise in strategies to foster trust, effective working relationships among the ARRP staff and an empowering work environment.**

### 3.3.2 ARRP Team Leader

The former “Desk Nurse” position was converted to a Team Leader role in May 2009. Currently, two RNs job-share the Team Leader position, each working alternate weeks from 0700 – 1500 Monday through Friday. The Team Leader is responsible for the coordination and flow of patient and staff activity within the Renal Unit. She does not have a regularly scheduled patient assignment.

The IAC understood that prior to implementation of the RPN role in the Renal Unit, the Team Leader assumed a patient assignment if an RN called in sick or a Level III treatment in the ICU was required, and was responsible for coordinating the pre-transplant work-up and monitoring of patients awaiting transplant. The latter is now managed by the Home Dialysis Transplant Nurse, who also, with the Vascular Access Coordinator, provides last-minute and/or Level III treatment support when possible, in order to enable the Team Leader to be immediately available for a transfer of care from an RPN and/or support of, or consultation and collaboration with, RNs, RPNs and other members of the inter-professional team as required. The IAC believes that these altered role responsibilities indicate recognition on the part of the SAH leadership of the potential impact that the skill mix change on the smooth functioning of the Renal Unit, and applauds this decision.

Coordination of patient activity includes patient treatment scheduling for in-centre, off-unit and transient patients, as well as communication and collaboration with the medical staff, other hospital departments and other Renal Programs as required. The Team Leader monitors results of blood work, anaemia/iron protocols etc, transcribes the majority of physician orders received during the day, attends weekly Multidisciplinary Rounds and is the point of contact for the nephrologist-on-call. As noted in Section 3.6.1, the IAC believes that the Team Leader’s current responsibilities for monitoring patients’ bloodwork and other diagnostic tests, interacting with the nephrologist etc., are, within a Total Patient Care model, the responsibility of the nurse providing the patient care, and that this responsibility should transition from the Team Leader to the staff

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<sup>31</sup> The Dorothy Wylie Nursing Leadership Institute (DWNLI) is a 2-part, 7-day inter-professional residential leadership institute. The DWNLI brings together health care leaders from across Canada for a concentrated program of study of leadership principles, models, behaviours, skills, and tools. Two individuals, an established leader and an emergent leader, attend from (optimally) the same organization. During the first session, they identify a change project; at the second session, they report on the progress achieved. The 2011 dates for the two-part DWNLI program are May 24-27 and November 7-9, 2011.

nurses. The IAC believes that the Ward Clerks should assume responsibility for transcription of orders, with these being reviewed / 'checked' by the nurse providing patient care.

Coordination of staff activity currently includes preparing the daily staff assignment, and determining staffing needs in conjunction with the ARRP Manager. The IAC believes that staffing is a management responsibility, and that while the Team Leader may make day-to-day decisions, the Manager is responsible for providing oversight and for having daily discussions with the Team Leader to support, coach and debrief. Therefore, while the IAC agrees that the Team Leader's current responsibility to review the next day's scheduled patients and scheduled staff to determine what changes are required for the next day's staffing (i.e. whether an 8-hr versus 12-hr RN is required, whether a part-time RN or RPN can be cancelled) is appropriate, the IAC cautions that decisions regarding alteration in planned staffing are the overall responsibility of the ARRP Manager.

The IAC believes that the day-to-day role responsibilities of the Team Leader now need to be clarified, in light of the expectation for the ARRP Manager to be present in the Unit 70% of the time, and the fact that the Team Leader position is currently job-shared between two individuals. The IAC sensed that during the period August to December 2010, when the former ARRP Manager was not regularly present in the Renal Unit and was not regularly involved in at-the-time decision-making, the Team Leader assumed more extensive management responsibilities regarding staffing. While the IAC supports the continued job-sharing of the Team Leader role, the IAC sensed, from comments made at the Hearing and the written Briefs, that the two Team Leaders approach their responsibilities in a different manner, leading to potential confusion and/or frustration among the staff and ARRP Manager.

The IAC strongly believes that the continued presence of the Team Leader, without a patient assignment, is important and should be continued<sup>32</sup>. The two Team Leaders are experienced nephrology nurses, and their availability and expertise to assist/consult with/discuss patient care needs with both RNs and RPNs is a valuable support. In addition, as noted in Section 3.3.4, the IAC believes that strategies to support RN and RPN continued professional development are needed; this could be in the form of the Team Leader assuming responsibility for an RN's or RPN's morning assignment, providing the RN or RPN with an opportunity for professional development (internet, articles, library). The IAC believes that, for the next number of months until the ARRP transitions to a Primary Nursing (PN) Model (see Section 3.6.1), it will continue to be appropriate for the Team Leader to attend Multidisciplinary Rounds. However, as noted in Section 3.6.1, the IAC believes that this responsibility should eventually be transferred.

### ***The IAC recommends***

- 3. The ARRP Manager, Program Director and Team Leaders review and clarify the Team Leader's role and responsibilities to maximize consistency re how the role is enacted, to support a Total Patient Care delivery model in the Renal Unit, and to support ongoing professional development opportunities for the nursing staff.***

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<sup>32</sup> This does not mean that the Team Leader will never participate in patient care: she will continue to provide support and assistance to the nurses by covering for breaks and it may from time to time be necessary for her to put a patient on or take a patient off treatment. However, the IAC believes that the Team Leader should not have a regularly scheduled patient assignment during the development and implementation of Total Patient Care and Primary Nursing models of care (See Section 3.6.1)

- 4. *The Renal Unit Ward Clerks assume accountability for transcribing physicians' orders before 1900, with review of the orders completed by the RN or RPN providing the patient's care, rather than the Team Leader.***

### 3.3.3 Professional Practice Governance Structure

As noted in Section 3.3, the IAC believes that the use of different strategies to support future changes relating to professional nursing practice will facilitate a more positive outcome than that experienced with the staff mix change in the ARRP Renal Unit.

The nursing professional practice governance structure at the SAH is based on the Nursing Advisory Council (NAC), which develops and approves policies, procedures and practices relating to nursing professional practice at a corporate level. The NAC is composed of RNs and RPNs, as well as Educators and Managers, and is chaired by the CNO. The IAC understood that the ARRP Educator is a member of the NAC, but that as no ARRP RNs or RPNs volunteered to participate, there is no ARRP staff RN or RPN membership on the NAC.

The Hospital is planning to strike a Professional Practice Committee in April 2011, which will review practice issues and policies of the 'allied health' group from an inter-disciplinary perspective. The IAC understood that the NAC will continue (i.e., that the NAC and new Professional Practice Committee will not be integrated to form a health disciplines council).

The ARRP Program has a recently implemented a Program Governance Committee, comprised of the Program Director, the Medical Director, and representatives from the Program (Social Worker, Educator and Team Leader). An issue such as the altered skill mix in the Renal Unit would have been discussed at the Program Governance Committee had it been in place in 2009 when the initiative was proposed.

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

There is currently no vehicle, within the ARRP Renal Unit, that enables staff RNs and RPNs and the leadership team (ARRP Manager and Educator) to discuss challenges / opportunities / differences of opinion with respect to practice issues, and for the staff nurses to have a 'voice' in terms of operational or clinical decision-making. The staff meetings, which the former ARRP Manager held regularly, and the ARRP Newsletter, *The Chrysalis*, are excellent tools for disseminating information but they do not provide an opportunity for discussion / debate / development of consensus on issues such as the revision of the skill mix model in the Renal Unit. The newly structured Program Governance Committee provides an opportunity for discussion relating to policy development etc., but its current membership does not include staff RNs and RPNs.

There are times when change is the only option. The IAC understands that the Hospital approached the skill mix change in the Renal Unit from this perspective, in light of the fiscal and resource challenges facing the ARRP, but believes that the change would have had a greater

chance of successful implementation if it had been approached from a perspective that involved the RNs in the decision, helped them to understand that similar fiscal/resource challenges are being experienced in hemodialysis units across the country, and provided an opportunity for discussion of possible options. The initial presentation to the staff in September 2009 appeared to the IAC to be a leadership initiative, rather than an engagement of the individuals who were going to be most affected by implementation of the new staffing approach. The RNs were presented with correct and appropriate information re why the skill mix change was acceptable from a regulatory perspective, but there appeared to be little opportunity for the RNs, who it was evident to the IAC care strongly about patient care, to become active participants in, rather than recipients of, the outcomes.

The IAC believes that implementation of an ARRP Practice Council, co-chaired by the Team Leader and Educator, will provide the Program nurses with a venue to discuss issues impacting their practice, including ongoing revision to the care delivery model, development and revision of protocols and Medical Directives to enhance quality care outcomes, clear definition of patient assignment criteria etc. At the Hearing, the Interim ARRP Manager identified a number of changes he would like to propose to streamline the functioning of the unit, including implementation of a morning report, revision of the assignment sheets, development of protocols re anaemia etc. The new SAH opened on March 6, 2011, and the Renal Unit staff will need to re-evaluate how care can be best provided in their new geographical space. Discussion and decisions regarding these need to involve the staff RNs and RPNs, and cannot be made in isolation by the leadership team. The IAC believes that a Practice Council will provide an excellent venue for such discussion and decision.

***The IAC recommends that***

***5. The ARRP implement an inter-disciplinary Practice Council as a mechanism for discussion of and resolution of issues relating to operational functioning of the ARRP and clinical practice issues relating to the provision of patient care.***

***Terms of Reference to include:***

- i) ***Purpose: to work collaboratively on decision-making related to practice and procedures that enhance the quality of patient care, work environment and relationships among staff.***
- ii) ***Chair: Co-chaired by the Renal Unit Team Leader and the ARRP Educator.***
- iii) ***Membership: Defined membership, selected by nomination, including three RNs, one RPN, one allied health team member, the Team Leader, Educator and ARRP Manager, with a defined membership term of two years.***
- iv) ***Meetings: held bi-weekly initially, until practice/policy changes in the new unit are solidified, then monthly.***
- v) ***Agenda: developed jointly by the co-chairs and published in advance of the meeting.***
- vi) ***Minutes: adopt the format used for SAH HAC meetings.***
- vii) ***Distribution of minutes: reference highlights during morning and afternoon report (see Recommendations 20/21), include in communication book, develop Practice Council binder for review by all staff.***

### 3.3.4 Supporting Learning

The ARRP, and indeed the entire SAH, has a tremendous opportunity for a ‘fresh start’ as they move to their new (and lovely) hospital. While some of these opportunities will relate to development of new approaches to patient care delivery in a new ‘geography’, some will relate to the development of a new culture in the new environment.

The IAC believes that a move towards a ‘culture of learning’ will be a valuable approach for the ARRP. In a learning culture, people take responsibility and support one another. They share experience and learn from mistakes as well as successes. A learning culture will support the nurses to move forward in terms of professional nursing practice, at both a Program level, through practice changes identified by the Practice Council, and a personal level, through continued professional development.

The IAC was surprised to note that none of the RNs in the Renal Unit have completed their CNA Nephrology Nursing Certification<sup>33</sup>. While not all nurses working in the specialty of nephrology choose to achieve certification, it would be anticipated that within a hemodialysis unit with the number of experienced nurses such as the ARRP Renal Unit, at least some of the RNs would have formalized their expertise through certification. The IAC believes that this low level of engagement is not the norm across Renal Programs in Canada. Although expertise is definitely developed through years of clinical experience, actively reviewing the competencies required for certification helps to open one’s eyes to the ‘wider world’, particularly for RNs who have developed their specialty expertise working in only one hospital/program. The IAC believes that support for the nursing staff to develop/gain additional competencies, including active engagement of the RNs in the certification process, will be beneficial.

The IAC was concerned regarding the apparent blurring of the Educator’s role. The IAC understood that the Educator is responsible for nursing staff education, but also understood, during the Site Tour, that she provides patient education classes. As well, it appeared to the IAC that the Educator was a major resource to the former ARRP Manager in terms of decision-making regarding patient assignment. The IAC believes that the ARRP requires a dedicated staff Educator, and that the Educator’s role needs to focus on support and development of nursing staff, including assuming a greater role in facilitating practice change, with minimal formal and informal patient care responsibilities.

#### ***The IAC recommends***

- 6. The Educator implement a support group to assist RNs to explore preparation for Nephrology Certification.***
- 7. The ARRP continue to support a full-time staff Educator position within the ARRP.***
- 8. The ARRP clarify that the Educator’s role focuses on support and development of staff RNs and RPNs within the ARRP.***

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<sup>33</sup> The IAC understood that only one member of the ARRP (the Nurse Educator) has achieved a CNephC designation.

### 3.4 Role of RNs and RPNs in the ARRP Renal Unit

#### 3.4.1 Scope of Practice of RNs and RPNs

RPNs have been practicing at the SAH for a number of years. The “RPN Scope of Practice Guideline”<sup>34</sup> states “in accordance with the SAH Clinical Policy on Scope of Professional Practice, the SAH is committed to ensuring that all professional staff are working at scope”. The Guideline identifies that RPNs who graduated from a practical nurse program prior to 2003 did not complete the range of courses required to enable them to practice at a full scope, and so are required to complete the following courses from either Sault College (SC) or George Brown College (GBC):

- Pharmacology and Theory of Medication Administration (SC or GBC);
- Health Assessment (SC or GBC);
- Nursing Theory (SC) or Management of the Acute and Chronically Ill (GBC);
- Professional Growth (SC) or Leadership and Communication (GBC);
- RPN Skills Transition (SC) or Clinical Skill Assessment (GBC); and
- IV Therapy (SC)

The three RPNs hired into the Renal Unit met the above requirements to enact ‘full scope of practice’. The RPN who graduated prior to 2003 completed the five required courses at George Brown College and had acquired skills in IV therapy, and the two who graduated since 2003 completed the IV Therapy course<sup>35</sup>.

In the presentation entitled *Introducing the RPN Role at Scope* presented to the Renal Unit staff in September 2009 and to the Association in November 2009<sup>36</sup> the former ARRP Manager noted that the RN does not have a supervisory role over the RPN, and stated that

- nurses are accountable for their own actions;
- RNs are not accountable for the RPN actions; and
- all nurses are accountable for taking action to ensure client safety; this may include intervening with client care and/or informing the employer<sup>37</sup>

Although the Hospital stated that RPNs would practice at ‘full scope’ in the Renal Unit, the former ARRP Manager’s presentation indicated that restrictions would be placed on RPN practice<sup>38</sup>. In the presentation, she clarified that:

- The RPN in Renal will:
  - initiate, monitor and discontinue hemodialysis patients using a fistula, a graft or a central venous line;
  - work within her/his full scope of practice and practice the skills approved for Renal;
  - be fully responsible and accountable for the complex but stable hemodialysis patients with predictable outcomes.
- The RPN will not:
  - care for a patient having his/her first dialysis treatments;

<sup>34</sup> Developed August 2008, Revised January 2009, May 2009 and November 2009

<sup>35</sup> *The Chrysalis*, Newsletter of the Algoma Regional Renal Program, April 5, 2010

<sup>36</sup> *Introducing the RPN Role at Scope in Hemodialysis*: Lise Corriveau, November 20, 2009

<sup>37</sup> Ibid, slide 12

<sup>38</sup> The CNO expects that all RNs and RPNs will practice within the regulatory framework identified in the *Regulated Health Professions Act* and the *Nursing Act*, and within this, will base the parameters of their practice on personal competence and employer policy. Rather than indicating that RPNs in the Renal Unit would practice within their personal scope of competence and in accordance with the clinical policies of the ARRP, the Hospital identified specific restrictions.

- care for a patient post line insertion;
- remove a temporary central venous catheter;
- care for a complex off-unit hemodialysis patient;
- administer hypertonic saline; or
- care for a transient patient<sup>39</sup>

These restrictions regarding the RPN role in the Renal Unit were reflected in the Role Description for the RPN Renal Services, approved in November 2009. The Role Description identifies the RPNs' primary job functions as:

- participates and collaborates with the multidisciplinary team in the provision of care to the pre-dialysis, home dialysis and hemodialysis patients; and
  - provides, as a member of the multidisciplinary team, patient/family health teaching;
- and listed 24 major responsibilities.

The RN Renal Services Role Description<sup>40</sup> identifies the RNs' primary job functions as:

- participates and collaborates with the multidisciplinary team in the provision of care to the hemodialysis patients; and
- provides, as a member of the multidisciplinary team, patient/family education as it relates to the dialysis treatment, modality options, diet, fluid restrictions, and medication administration;

and lists 13 major responsibilities.

Of the major responsibilities identified for the RN and RPN (*Appendix 15*), six are identical, seven address common responsibilities but identify specific expectations for the RN and RPN<sup>41</sup> and eleven are unique to the RPN. Of the eleven unique statements, four describe CNO accountabilities that are consistent with those for RNs (e.g. "maintains competency of functions identified on the Unit Knowledge and Skills Checklist), and seven describe specific elements of the hemodialysis treatment that the RPN is responsible for (e.g. "regulates heparin dosage during the hemodialysis treatment").

The IAC believes that care needs to be taken when using the term 'scope of practice'. The CNO uses the term to refer to the scope of practice defined in the *Nursing Act*, which is the same for all nurses (RNs and RPNs) registered in Ontario; employers use the term to describe different roles and responsibilities between RNs and RPNs; and nurses use the term to describe their knowledge, skill and judgment within their category<sup>42</sup>. While the Hospital has indicated that RPNs are practicing at 'full scope', the IAC believes that the Hospital is actually defining restrictions on the practice of RPNs. The IAC believes that the wiser course is to identify the restrictions in an ARRP policy that defines the conditions/characteristics of the patients who may be assigned to RPNs (see Section 3.5.2). This supports the regulatory perspective that the RN and RPN scope of practice is identical, but the expectations for practice, for example in terms of the range of patients who may be cared for by RNs and RPNs, differ.

<sup>39</sup> *Introducing the RPN Role at Scope in Hemodialysis*: Lise Corriveau, November 20, 2009, slide 29-30

<sup>40</sup> Developed December 1997 and revised September 2001, January 2003, February 2004 and January 2008

<sup>41</sup> For example,

- The RN description states "Initiates, monitors and discontinues prescribed dialysis treatments in the Hemodialysis, Critical Care and Medical Units depending on patient's medical condition"
- The RPN description states "Initiates, monitors and discontinues prescribed dialysis treatments on stable patients with predictable outcomes in the Hemodialysis Unit using a central venous catheter, fistula or graft."

<sup>42</sup> CNO Learning Module re Utilization of RNs and RPNs, slide 4. Retrieved from <http://www.cno.org/en/learn-about-standards-guidelines/educational-tools/learning-modules/utilization-of-rns-and-rpns/overview/>

In addition, the IAC noted that the RN and RPN role descriptions appeared to be developed on the basis of differing frames of reference. The RN role description does not delineate basic CNO accountabilities for practice, such as “reflects on whether she or he has the knowledge, skills and judgment to manage the outcomes and the risk of implementing a skill”. Either both of the role descriptions should reference basic CNO accountabilities, or neither should.

*The IAC recommends that:*

**9. The SAH revise the Role Descriptions for the RN Renal Services and RPN Renal Services to ensure that both equally do or do not reflect basic CNO practice accountabilities.**

**10. The SAH revise the clinical policies for the ARRP to delineate specific practice expectations/restrictions for the RPN in the Renal Unit. For example, policies regarding practice expectations would include pre-printed orders and protocols (Section 3.5.1); policies regarding practice restrictions would include policies relating to patient assignment (Section 3.5.2).**

#### 3.4.2 RN and RPN Orientation

A new orientation program was designed for the three RPNs who joined the ARRP Renal Unit in April 2010. The original five-week orientation program, previously provided to new RNs, was expanded to six weeks to enable inclusion of additional theory<sup>43</sup> for specialty knowledge acquisition. The six-week program included a component of theoretical classroom learning as well as a preceptored patient care experience (*Appendix 16*). Although the Hospital stated that the new six-week program was developed for the RPN orientees, the policy provided to the IAC was dated February 2009. The Hospital stated during the Hearing that the six-week program will become the standard for all new nurses (RN and RPN) joining the Renal Unit in the future.

At the completion of the six-week program (April 10 – June 18, 2010), the RPNs completed a Nursing Skills Checklist (part of the previous five-week program), which included a self-evaluation of competence in relation to hemodialysis nursing practice. Competence was also evaluated through completion of three written exams, which were a new component of the orientation.

During the weeks of June 7 and June 14, 2010, the RPNs cared for patients in the Renal Unit, mentored and supported by RNs. They began to practice with an independent patient assignment on June 21, 2010.

The IAC believes that both RNs and RPNs need to develop a specialty knowledge base in order to practice safely and effectively in the hemodialysis unit. The orientation program content needs to be common for both RNs and RPNs, and needs to include all expectations identified in the *CANNT Nephrology Nursing Standards and Practice Recommendations*. As noted in Section 3.4.1, the range of patients cared for by the RPN will differ from the range of patients cared for by the RN, but the ‘entry to practice competencies’ within the Renal Unit need to be the same for both. In addition, the IAC believes that before beginning to practice autonomously, the practice of all nurses, RN and RPN, new to the Renal Unit needs to be evaluated.

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<sup>43</sup> The IAC did not receive information regarding the similarities and differences between the five and six week programs.



*The IAC recommends that:*

- 11. The six-week orientation program become the standard for all nurses entering the Renal Unit, and that it be revised as required to ensure that all practice standards identified by CANNT are included.*
- 12. The knowledge base and practice competencies of all RNs and RPNs new to the Renal Unit be evaluated using a range of mechanisms, including, for example, written exams, observation, mentored practice, and clinical simulations etc. prior to commencement of autonomous practice.*

### **3.5 Practice Supports**

As discussed in Section 3.2.7, “practice supports” relate to policies, procedures, guidelines, assessment tools, pre-developed care plans etc., and the presence of expert nurses familiar with the practice environment.

The IAC believes that the high proportion of experienced RNs is a strength of the ARRP Renal Unit. The IAC noted that the turnover of RNs within the Unit does not appear to be high, with 76% of the RN staff having worked in the Renal Unit for more than four years.

However, the IAC believes that attention is required to address deficits in the practice supports available to the RPNs and RNs in the Renal Unit.

The IAC noted that the SAH performance review tool is currently at a very high level, and does not easily enable an RN or RPN to assess her/his practice in relation to profession-specific expectations. The IAC understood that the corporate performance review system is currently under revision by the Human Resources Department, and that the revised process will include nurse self-assessment of clinical and technical competency and discussion with the Manager regarding opportunities for development. The IAC encourages this approach, and encourages consistent completion of performance reviews within the Renal Unit.

At a program level, the IAC believes that revision of the use of Medical Directives, revision of the HCRT, development of more formalized intra-Unit communication systems, and placing a temporary hold on the implementation of the PCS will enhance the practice supports available to RNs and RPNs.

#### **3.5.1 Medical Directives**

The IAC was very impressed with the Medical Directives policy in place at SAH<sup>44</sup>, with the depth of content of the information contained in the Directives and with the evident involvement of the physician staff in their development. Program-specific directives, such as those for the ARRP, are approved initially by the Program Governance Committee, then by the Pharmacy and Therapeutics Committee (P&T) if medications are involved, and finally by the Medical Advisory Committee (MAC). In the ARRP, the Educator develops the Medical Directives in conjunction

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<sup>44</sup> Medical Directive Policy, approved October 2008

with the Medical Director and/or the Quality Management Team (including the Dietician, Pharmacist, and Social Worker).

The ARRP currently has 19 Medical Directives. Of these, 12 relate specifically to care of patients during hemodialysis treatments, and seven relate to other areas within the ARRP. As indicated in Table 3, Medical Directives have been in place in the ARRP since June 2006 and specifically in the Hemodialysis Unit since March 2007. The Hospital indicated at the Hearing that it is currently revising the ARRP Medical Directives, to include the title ‘nurse’ rather than ‘RN’ and revise some specific content areas.

Table 3: ARRP Medical Directives

Medical Directive		MAC Approval Date
Hemodialysis Unit	<ul style="list-style-type: none"> <li>♦Bloodwork orders for new hemodialysis patients</li> <li>♦Bloodwork orders for ongoing assessment of hemodialysis pts</li> <li>♦PRN laboratory &amp; diagnostic imaging tests of the hemodialysis pt</li> <li>♦Chest pain and dyspnea medications</li> <li>♦Hypotension</li> <li>♦PRN analgesic medications</li> <li>♦Nausea/vomiting, dyspepsia</li> <li>♦Management of a non-functioning central venous catheter</li> <li>♦Local anaesthesia for vascular access cannulation</li> <li>♦Management of diarrhea</li> <li>♦Management of hypoglycemia in the hemodialysis unit</li> <li>♦Hemodialysis anticoagulation</li> </ul>	March 2007 March 2007 March 2007 October 2008 October 2008 October 2008 October 2008 October 2008 January 2009 January 2009 December 2009 November 2010
Non-hemodialysis specific	<ul style="list-style-type: none"> <li>♦Renal dose adjustment for selected antimicrobials</li> <li>♦Management of dialysate potassium</li> <li>♦Renal Health Clinic: ongoing laboratory assessment</li> <li>♦Erythropoietin (EPO) and iron protocols for non-hemodialysis dependent CKD patients</li> <li>♦Renal Health Clinic: initial assessment, laboratory, diagnostic imaging</li> <li>♦Renal dietitian orders</li> <li>♦Home Dialysis Program: laboratory, diagnostic imaging</li> </ul>	June 2006 January 2009 August 2009 December 2009 December 2009 December 2009 December 2009

The IAC identified a number of concerns regarding the implementation of the ARRP Medical Directives in the Renal Unit.

- The IAC understood that Medical Directives are discussed at the Program Governance Committee, but that there is currently no opportunity for RNs in the Renal Unit to review and discuss the Directives, in terms of their anticipated impact on nursing practice, before they are approved. The IAC understood that while program-specific Directives such as those implemented in the ARRP would not be discussed at the corporate-level NAC, hospital-wide

Medical Directives are also not discussed and endorsed at NAC before being approved at the MAC.

- There did not appear to be any formal mechanism for the evaluation of knowledge / competence of the nurses implementing the Medical Directives, or engagement of the nephrologists in this process. It was stated at the Hearing that the Educator gave the RNs the Medical Directives to review and sign off, after which the RNs were apparently free to implement them. In addition, it appeared that the approval of RNs to implement specific Medical Directives is a nursing monitored process, in that there did not appear to the IAC to be documented evidence that authority to assess the competence of the RNs has been delegated from the physician(s) to the Educator.
- Although implementation of Medical Directives appeared to be a key component of autonomous nursing practice in the Renal Unit, the RPNs have not yet been authorized to independently implement the Directives. Given that the current Medical Directives address dialysis treatment complications that frequently occur (e.g. hypotension, nausea) as well as routine treatment (e.g. bloodwork orders for ongoing assessment of hemodialysis patients), the need for the RPN to seek consultation each time such intervention was required gave the impression that the RPN was unable to make potentially routine client care decisions and was time-consuming for the RNs.
- In light of the fact that RPNs could not implement Medical Directives, the IAC understood that it was considered acceptable practice for the Team Leader to transcribe an order(s) from a Directive into the patient's health record, in order for the RPN to implement the care (such as administration of Gravol for nausea). The IAC understood that this practice was known by and supported by the former ARRP Manager, but was unclear if the Medical Director was aware of the practice. The IAC emphasizes that this is not acceptable practice.
- The large number (12) of Medical Directives specifically relating to hemodialysis treatment was concerning, as it suggested a possible lack of physician involvement in day-to-day decision-making regarding patient care. Medical Directives are not intended to be for convenience, and they are not intended to place an inappropriate level of accountability on the implementing RN. It did not appear to the IAC that there was a process of physician oversight regarding use of the Medical Directives on specific patients.
- The IAC understood that at times the RNs implemented treatment interventions outside of the parameters of the Medical Directives, for example, administered fluid or medications in advance of when the Directive indicated that they were to be administered. A Medical Directive is an order; administering medications or other treatment interventions without an order is not within the regulatory scope of practice of nursing.

The IAC believes that the ARRP would be wise to move to a combination of Medical Directives and pre-printed orders within the Renal Unit. Although Medical Directives and pre-printed orders have a similar purpose, in that they grant authority to nurses to implement particular interventions for a patient or group of patients with specific conditions or needs, they differ in implementation. Pre-printed orders are reviewed for the specific patient, modified as needed to meet the patient's care needs and signed by the physician, and they are implemented as written. Medical Directives do not routinely require patient-specific authorization by the physician, and are implemented at the discretion of the nurse.

Pre-printed orders are an essential component of clinical pathways and clinical protocols, and have been used effectively in hemodialysis units in Ontario<sup>45</sup>. The IAC believes that transferring a number of the current Medical Directives into pre-printed orders will facilitate best practice. A pre-printed order set for in-centre hemodialysis will enable the physician to indicate, on a patient-specific basis, which protocols (e.g. to address nausea, hypotension, pain) are to be implemented during the course of dialysis treatment. This approach enables the physician to be accountable for initially considering what the patient will/may require during the dialysis treatment, and allows for the nurse's autonomous practice and decision-making in terms of patient presentation during treatment. This approach will also enable both RNs and RPNs to practice autonomously, without requiring the RPNs to consult with an RN when a routine intra-treatment intervention is required. The IAC emphasizes that this approach is predicated on the assumption that RNs and RPNs have an appropriate patient assignment (see Section 3.5.2).

Medical Directives require the assessment and professional judgment of a nurse to determine when implementation is indicated and what follow-up is required. The IAC believes that Medical Directives should not be used as a means of ordering routine interventions for commonly anticipated complications, but rather should be reserved for interventions in crisis situations where care needs / complications have an unpredictable and/or systemic level outcome. The Federation of Health Regulatory Colleges of Ontario has an excellent toolkit to assist employers and practitioners in the development of pre-printed orders and Medical Directives.

*The IAC recommends that*

- 13. The ARRP develop a pre-printed “Physician’s Orders for Hemodialysis Patient”, using references from the Ontario Hospital Association <sup>46</sup> and other Ontario hospitals as a guide.**
- 14. The ARRP review the content of the current Medical Directives to determine**
  - i) the elements to be transferred into protocols addressing commonly anticipated complications (e.g. nausea, hypotension, pain) which will become part of the pre-printed order set and**
  - ii) the elements to remain as Medical Directives.**
- 15. The practice of RN transcription of orders for medications/treatment interventions contained within Medical Directives into a patient’s health record, in order to enable the RPN to administer the medication/treatment without contacting the physician, cease immediately.**
- 16. A defined process for**
  - a. evaluation of competence of all nurses to implement protocols within pre-printed orders and Medical Directives,**
  - b. evaluation of the content of pre-printed orders/protocols, and**
  - c. evaluation of the implementation of protocols and Medical Directives**

**be jointly developed by the Medical Director, ARRP Manager and Educator in accordance with the CNO and Federation of Health Regulatory College of Ontario guidelines<sup>47</sup>.**

<sup>45</sup> For example: Credit Valley Hospital: Physician’s Orders Hemodialysis Patient (Adult) Retrieved from:

<http://www.cvh.on.ca/pro/ppo/php>

<sup>46</sup> <http://www.oha.com/KnowledgeCentre/Library/Documents/Module4.pdf>

### 3.5.2 Hemodialysis Care Requirements Tool (HCRT)

Prior to integration of the RPNs into the Renal Unit, the Team Leader did not use any formal criteria or a consistent methodology to develop the nurse : patient assignment, and stated at the Hearing that any nurse could care for any patient.

The HCRT was developed in November 2009 to provide a consistent methodology for assignment of patients to the RPNs. The HCRT was based on a document obtained from the Kingston General Hospital and the November 2009 draft (*Appendix 17*) listed a number of criteria from which a patient was determined as being appropriate, or not appropriate, for RPN care in accordance with the CNO Practice Guideline *Utilization of RNs and RPNs*. The November 2009 HCRT draft considered the client factors within the CNO Three Factor Framework, but did not include elements associated with the nurse or environment/practice setting. The HCRT was revised six times between November 2009 and September 2010. The September 2010 (*Appendix 18*) version takes a different approach, in that it identifies the criteria (client factors), which if present, indicate that an RN is required to provide care. As with the original November 2009 draft, the September 2010 version does not consider the nurse or environmental factors that impact appropriate utilization of RNs and RPNs.

Beginning in June 2010, the HCRT was used as the basis for selecting the RPNs' patients. However, numerous challenges were experienced. The Team Leader stated at the Hearing that determining the RPN assignment, using the HCRT criteria as she understood them at the time, was taking up to four hours per day, and that there were a number of instances where the HCRT criteria indicated that there were no patients appropriate for RPN assignment. In several of these instances, the Educator selected the patients for assignment to the RPNs<sup>48</sup>.

The IAC believes that the HCRT needs to be crisp and simple, and, to function as an effective staffing decision-making tool, it should include only the criteria that must be present for an RPN to autonomously provide care. The presence of any condition/situation other than those identified in the HCRT means that an RN must care for the patient; this should be clearly articulated in an ARRP policy. The IAC also believes that the HCRT should focus only on the client factors within the Three Factor Framework.

As discussed in Section 3.2.6, virtually all patients undergoing hemodialysis have the potential to experience complications during the course of the treatment. The key is to differentiate the nature of those complications. The HCRT must, therefore, clearly differentiate those patients whose status prior to initiation of dialysis suggests that complications occurring during dialysis will be:

- localized, minor, transient, likely to respond quickly to defined interventions within protocols, unlikely to require disruption of the dialysis treatment, and unlikely to last beyond the dialysis treatment;
- versus
- systemic, significant, unlikely to respond quickly to defined interventions, have an unpredictable course/outcome that may last beyond the dialysis treatment and require in-depth and/or time-critical assessment and decision-making.

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<sup>47</sup> CNO Practice Guideline *Directives*. Pub # 41019, June 2009; Federation of Health Regulatory Colleges of Ontario: *An Interprofessional Guide on the Use of Orders, Directives and Delegation for Regulated Health Professionals in Ont*

<sup>48</sup> The IAC was unclear as to whether the Educator used the HCRT, which would suggest a lack of clarity of understanding / consistency of application of the HCRT criteria, or whether she selected the RPNs' patients independent of the HCRT.

The IAC believes that while the first group (patients with localized etc. complications) may be cared for by an RPN, the second group (patients with systemic etc. complications) must be cared for by an RN.

The IAC understood that, initially, the Team Leader completed the HCRT for all patients once per week. In August 2010, the former ARRP Manager requested that the nurse (RN or RPN) caring for the patient complete the HCRT each Monday /Tuesday (i.e. the patient's first run of the week). The IAC understood that at the time of the Hearing, this expectation was still in place, but was not being consistently met. The IAC further understood that with the expectation that each RN and RPN complete the HCRT for her/his patient assignment on Monday/Tuesday, there is no formal mechanism for the RPNs' HCRT patient assessments to be reviewed by an RN.

The IAC believes that, optimally, the HCRT needs to be completed prior to the initiation of each dialysis treatment, with a decision regarding appropriate care provider made at that time. However, the IAC recognizes that this would be extremely difficult to achieve operationally. Therefore, the IAC believes that the HCRT should be completed at the end of each dialysis treatment by the RN or RPN who provided the care, and reviewed/evaluated by the Team Leader on the off-dialysis day (i.e. Tuesday for patients who received dialysis on Monday and will have the next treatment on Wednesday)<sup>49</sup>. This approach will ensure that review of the patient's condition is current, and will ensure RN assessment of all patients on an ongoing basis.

The lack of consensus between the Hospital and the Association regarding the HCRT was evident to the IAC at the Hearing. The IAC understood that the Association was concerned that, over the course of the six drafts, the HCRT criteria have been 'watered down' in order to support a six-patient RPN assignment each day regardless of patient condition, while the Hospital was concerned that the value of the HCRT was being lost as it was being completed less and less frequently and with less detail. The IAC recognizes validity in both perspectives. In order to enable assignment of the appropriate category of nurse, the HCRT must be sufficiently stringent to differentiate the impact of potential intra-dialysis complications, and, in order to be an effective staffing tool, the HCRT must be consistently completed.

The IAC members do not have expertise in nephrology nursing, and are therefore cautious about recommending the specific content for inclusion in the HCRT and in an ARRP policy specifying patient situations/conditions where RPN care is appropriate. However, the IAC believes the following principles must be used:

- The philosophy for development of the HCRT and 'RPN appropriate' policy must differentiate care provider based on the anticipated intra-dialysis complications, not on the available/scheduled staffing resources.
- Development of the HCRT content and ARRP 'RPN appropriate' policy must involve staff RNs and RPNs, Team Leader, Educator, ARRP Manager and the Medical Director. Development in isolation of staff input and consideration is inappropriate and will not result in an effective outcome.
- The HCRT and 'RPN appropriate' policy must identify those patient situations/conditions where there is a likelihood that intra-dialysis complications will be localized, minor, transient, likely to respond quickly to defined interventions within protocols, unlikely to require

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<sup>49</sup> HCRTs completed Friday afternoon for patients receiving dialysis on Monday be reviewed by the charge nurse.

disruption of the dialysis treatment and unlikely to last beyond the dialysis treatment. For example,

- which patient conditions suggest less likelihood of intra-dialysis hypotension and muscle cramps?
  - e.g. ♦no evidence of intra-dialytic SBP > 60 mmHg from pre-dialysis assessment or SBP<90 mmHg with hypotensive symptoms during fluid removal during the past 4 weeks,
  - ♦has experienced no hypotensive/cramping episodes during past 4 weeks except during a post-weekend treatment
- ♦which patient conditions suggest less likelihood of arrhythmias?
  - e.g. ♦no evidence of intra-dialytic angina over the past 4 weeks

Patients who are likely to experience intra-dialysis complications that are systemic, significant, unlikely to respond quickly to defined interventions, have an unpredictable course/outcome that may last beyond the dialysis treatment and require in-depth and/or time critical assessment and decision-making will require the care of an RN and should not be included in the HCRT criteria. For example:

- which patient conditions predispose to the likelihood of DDS?
  - e.g. ♦new dialysis patient (less than 6 weeks), presence of recent CNS event such as stroke etc
- which patient conditions predispose to the likelihood of vascular access issues?
  - e.g. ♦access occurrence of arterial BP < 250 mmHg and/or venous pressure > 250 mmHg
- which patient conditions predispose to the likelihood of a major hypotensive episode?
  - e.g. ♦admitting BP is unstable

The IAC believes that the workload-intensive requirement for per-treatment completion of the HCRT can be balanced with patient care needs. The IAC anticipates that the need for a daily assessment of all patients will decrease over time as the HCRT is consistently used. The IAC anticipates that the HCRT will identify a core of patients whose condition remains consistently within the parameters identified for RPN assignment. Once this core patient group is identified, completion of the HCRT within this group can be completed less frequently, i.e. from per-treatment to weekly to (potentially) monthly unless a significant intra-dialysis complication occurs. The IAC believes that the less frequent assessment of RPN patients by means of the HCRT will be balanced by the ongoing assessment, monitoring and review of the patient by the (RN) Primary Nurse (see Section 3.6.1).

***The IAC recommends that:***

- 17. A Working Group of the Practice Council, comprised of 3-4 RNs, 1-2 RPNs, the Team Leader, Educator, ARRP Manager and Medical Director, develop***
  - i) a revised HCRT to identify the patients whose condition indicates an RPN can safely and effectively provide autonomous care during the dialysis procedure, and***
  - ii) a new ARRP policy identifying the patients whose situation/condition indicate an RPN is appropriate to provide safe and effective care during the dialysis procedure.***

***18. The criteria in the HCRT be based on the principle of identifying, to the greatest extent possible, the likelihood of occurrence of intra-dialysis complications which are localized, minor, likely to respond quickly to defined interventions within protocols, unlikely to require disruption of the dialysis treatment and unlikely to last beyond the dialysis treatment.***

***19. The Practice Council evaluate the effectiveness of the HCRT in terms of:***

- i) the extent to which a transfer of care was required for patients identified as 'RPN appropriate' by the HCRT; and***
- ii) the requirement for continued daily completion of the HCRT for all patients once a core of RPN-appropriate patients are identified.***

### 3.5.3 Intra-Unit Communication

The IAC was concerned that communication within the Renal Unit has broken down. The IAC was unsure how strong or effective the communications systems, between the RNs and the leadership team and among the RNs, were before integration of the RPNs, but there is no question that they provide ineffective support now.

Both the Association and the Hospital reflected, at the Hearing, on the denegation of team spirit within the Renal Unit. Both parties commented that the Renal Unit used to be seen within the Hospital as a 'great place to work', with 'great teamwork', and it was evident to the IAC that both parties are concerned that this is no longer the case.

It appeared to the IAC that the RNs are currently working in a 'cloak of isolation'. As an outcome of concern regarding the expectations for collaboration and consultation with RPNs, RNs appear to be 'hunkering down', with an almost blindered focus on their own three (or two in the afternoon) patient assignment, and minimal knowledge of potential or actual events occurring with the other patients. While there is no question that the RNs' (and RPNs') primary focus needs to be their personal patient assignment, and that the geographical configuration of the Plummer Site Renal Unit made awareness of events in another part of the Unit difficult, feeling that one is working in isolation, alone, does not engender a sense of team spirit, teamwork or a feeling of belonging. In addition, the lack of consistent leadership at the Manager level has contributed to a sense of dissonance between the staff and the leadership team.

The IAC believes that mechanisms to facilitate intra-unit communication are required. These need to include:

- the utilization of transformational leadership strategies on the part of the Interim ARRP Manager, as discussed in Section 3.3.1,
- the development of strategies to enable the nurses, at both staff and management levels, to discuss practice issues, concerns, new approaches etc, as discussed in Section 3.3.3 relating to a shared governance model and the implementation of a Program-based Practice Council,
- the development of a learning culture within the Renal Unit as discussed in Section 3.3.4, and
- the implementation of approaches that will support the staff RNs and RPNs to feel involved and connected during the course of each shift.

With respect to strategies to enable the RNs and RPNs to feel more involved and more of a team working together on a day-to-day basis, the IAC supports the Interim ARRP Manager's proposal for the implementation of a morning report. Recognizing the importance of getting treatments



started on time, the IAC believes that a focused report, in the morning after the 0830 treatments have started and before the staff begin to go for morning break and in the afternoon when the evening staff arrive at 1530, will foster a more collaborative approach among the staff, and enhance a sense of ‘team’ within the group. The IAC emphasizes the principle, within the CNO Guideline *Utilization of RNs and RPNs*, that consultation and collaboration are essential elements of nursing practice. A morning report, providing an overview of the ‘total patient picture’ and a quick management update, will enable both expert and novice practitioners to be aware of anticipated patient-related and staff-related events within the Unit, and to plan their practice over the course of the shift accordingly.

The IAC also supports the Interim ARRP Manager’s proposal to revise the staffing/assignment sheet.

***The IAC recommends that***

- 20. The ARRP Renal Unit implement a morning report format, maximum 15 minutes, beginning at 0845 after the 0830 treatments have started.***
  - i) for the period April to August, the morning report be a ‘joint pod report’ including patients and staff from both Pod A and Pod B***
  - ii) after September, the Practice Council determine whether the joint pod approach should continue, or whether an individual pod report will suffice.***
- 21. The ARRP Renal Unit implement a ‘joint pod’ afternoon report format, maximum 15 minutes, beginning at 1530.***
- 22. The Practice Council design, trial, implement and evaluate a revised staff assignment sheet.***

### 3.5.4 Patient Charting System

The SAH is in the process of implementing an electronic documentation system, known as the Patient Charting System or PCS. The IAC understood that as a dialysis module was unavailable, electronic documents were created from the paper documentation system, and that, at present, problems are existing with the interface between the dialysis machines and the PCS. Therefore, there is currently no transfer of clinical data from the dialysis machine to the PCS, requiring the nurses to manually enter the information. In addition, the IAC understood that only 40% of the hemodialysis patients are “on PCS”, and that clinical documentation for the remaining 60% is based on the original paper documentation tools. The IAC noted that the challenges associated with the lack of wireless connection in some areas of the Plummer Site Renal Unit will disappear in the new Unit. However, the IAC noted that while the configuration of the new Renal Unit includes substantial space for nurses to document on tablets at a counter facing the central station in each pod, when documenting the nurses will have their backs turned to the patients.

There is no question that a move towards electronic documentation is appropriate. From the perspective of staff RNs and RPNs, implementation of a new system such as the PCS involves both ‘additions to’ and ‘take aways from’ nursing practice. When the ‘additions to’ do not balance the ‘take aways from’, the result is an increased workload for the staff using the system. The IAC was concerned that the current status of the PCS in the Renal Unit, i.e. lack of an effective interface and inconsistent implementation within the patient population, has resulted in

an imbalance between the positives and negatives of the system, and has resulted in an increased workload for the nursing staff.

The IAC recognizes that the PCS is a hospital-wide system, and that changes in one clinical area may have an impact in other areas. However, given that the IAC understood that the hemodialysis module is a 'stand-alone' module, and given the challenges associated with implementation of the PCS in light of the other challenges currently facing the Renal Unit, the IAC suggests that the SAH consider placing PCS implementation on hold within the ARRP until the interface issues are resolved and PCS can be implemented with all hemodialysis patients.

*The IAC recommends that*

**23. The SAH and ARRP consider placing PCS implementation within the ARRP on hold until the interface issues are resolved and PCS can be implemented with all hemodialysis patients.**

### 3.6 Renal Unit Nursing Staffing

Nursing staffing in hemodialysis units is changing from the provision of care by only an all-RN staff.

A national survey completed by Providence Health Centre (British Columbia) in 2007<sup>50</sup> identified four national trends in the provision of hemodialysis treatments in Canada:

- RN-based care (1RN: 3 patients);
- variation in role of renal technician – renal tech, NRT, technical assistants, dialysis assistants, health care aide;
- continued/increasing use of LPNs and enhanced scope of practice; and
- increasing focus on community, nocturnal and home dialysis services

and identified increasing scope of practice of LPNs as one of seven Creative Staffing Solutions<sup>51</sup>.

In the United States, a comprehensive study published in the Clinical Journal of the American Society of Nephrology in 2008 noted that staffing of dialysis clinics has moved to a heavy reliance on technicians to provide care with a 1:3 or 1:4 ratio, and oversight by RNs with a 1:4 to 1:12 ratio, with no consensus regarding perceived best practice patient-to-nurse staffing ratios<sup>52</sup>.

An 2008 article published in the CANNT Journal identified that the growing numbers of hemodialysis patients and the declining numbers of registered nurses in Canada, referenced in Section 3.2.4, have provided some of the impetus for the introduction of registered practical nurses (RPNs) or licenced practical nurses (LPNs) into hemodialysis units<sup>53</sup>. In Ontario, the roles and responsibilities of RPNs working in hemodialysis units range from functioning as an assistant setting up machines, monitoring vital signs, assisting patients in and out of the Unit etc., to sharing a patient assignment in a team nursing model with an RN, to autonomous practice.

<sup>50</sup> Providence Health Centre. *Shifting our Models of Care Delivery*. October 18, 2007. Slide 12. Retrieved from: <http://www.bcrenalagency.ca/NR/rdonlyres/D33FEBBC5-5B2F-46EA-942A-18CF63C968A8/25601/ThursdayAMConcurrentLeeClark.pdf>

<sup>51</sup> Ibid, slide 13

<sup>52</sup> Desai, A., et al *Identifying Best Practices in Dialysis Care: Results of Cognitive Interviews and a National Survey of Dialysis Providers* Clinical Journal of the American Society of Nephrology, 2008, Vol 3, pg 1066-1076.

<sup>53</sup> Elyn, F., MacPhee, S., and Pritchard, L. *Introduction of Registered Practical (RPNs)/Licenced Practical Nurses (LPNs) into hemodialysis units: experiences in three units across Canada*. CANNT Journal, July 2007.

The entry to practice requirements for RPNs in Ontario changed in January 2005, when the basic educational requirement for new RPN registration became a two-year diploma program in Practical Nursing from a Community College of Applied Arts and Technology, with the expectation that RPNs be able to autonomously meet the predictable needs of stable clients from the first day of practice<sup>54</sup>. The IAC understands that the impact of this change on RPN practice in Ontario hemodialysis units has led to an increase in RPNs providing patient care and a decrease in RPNs acting in an assistant or technician role. The IAC supports autonomous RPN practice with an appropriate patient assignment.

### 3.6.1 Model of Care

The goal of selecting of a model of care within an in-centre hemodialysis unit is to achieve a balance of professional accountability and autonomy, patient centred care, and optimal patient outcomes.

- In a *team nursing* model, RNs and RPNs work together to provide comprehensive care to a defined group of patients. The role responsibilities of the RPN may vary, and may or may not include such responsibilities as cannulating fistulas or grafts or administering narcotics. The RN holds overall accountability for patient outcomes for the group of patients, and is accountable for her/his actions and decisions but not those of the RPN. A team model requires clear communication between the care providers.
- In a *Total Patient Care (TPC)* model, both RNs and RPNs provide autonomous care to specifically assigned patients, usually in a 1:3 ratio. Each RN / RPN is totally responsible for providing the care and managing the care outcomes during the shift (or in the case of hemodialysis, during the treatment), and for accessing external support/resources when required.
- In a *Primary Nursing (PN)* model, an RN has primary accountability for monitoring the care needs and outcomes for specific patients, within the hemodialysis context usually on a monthly basis. The patient may receive care/hemodialysis treatments from the primary nurse, or from associate nurses who may be RNs or RPNs, but the primary RN has overall accountability. Primary nursing is viewed as the preferred model of care in hemodialysis units; a 2008 literature review confirmed that primary nursing is the most suitable model for care in the hospital hemodialysis unit<sup>55</sup>.

The nurses in the Renal Unit provide care in what they defined at the Hearing as a TPC model. The IAC believes that the current model of care delivery is in fact a fragmented TPC model. The perception of fragmentation is based on two factors:

- The Team Leader monitors bloodwork, INR protocols and other diagnostic test outcomes and identifies required actions, and she transcribes physician orders: both of these are, in a true TPC model, the responsibilities of the nurse caring for the patient.
- TPC is based on the concept of autonomous practice. Although the patients cared for by the RN are different than those cared for by the RPN, all RNs and RPNs are accountable for autonomously meeting care needs of their patients and for seeking consultation/collaboration as required. The IAC does not believe that the RPN has been practicing autonomously, as the tools and resources available to the RN to practice autonomously (specifically Medical Directives) have not been available to the RPN.

<sup>54</sup> CNO Factsheet: *Education for Registered Practical Nurses in Ontario*, 2004

<sup>55</sup> Dobson, S., and Tranter, S. *Organizing the work; choosing the most effective way to deliver nursing care in a hospital hemodialysis setting*. Renal Society of Australia Journal, July 2008, Vol 4, No 2, pg 55-59

The IAC believes that the ARRP should move to practicing within a true TPC model of care. Specifically:

- RNs and RPNs receive an appropriate patient assignment based on the (revised) HCRT;
- RNs and RPNs be accountable for
  - administering the dialysis treatment as per the pre-printed order and implementing as appropriate the protocols for anticipated complications/events for their patients;
  - monitoring all bloodwork and other diagnostic information for their patients, reviewing orders transcribed by the Ward Clerk and/or directly transcribing orders received after 1900;
  - notifying the Team Leader when the RN or RPN wishes to speak with the nephrologist-on-call and discussing patient concerns directly with the MD; and
  - accessing consultative resources, including each other, the Team Leader, the Vascular Access Coordinator and the Educator, as appropriate when required.

The IAC recommends that once a true TPC model has been in place for at least six months, the ARRP Practice Council explore moving to a PN model, where each full-time RN would hold primary accountability for monitoring 5-6 hemodialysis patients. A Primary Nursing model is in place in a number of hemodialysis units in Ontario, and there are resources available for the Practice Council to review. The IAC understood that there was a form of PN in the ARRP Renal Unit a number of years ago, but that this was disbanded in favour of a TPC model as it was difficult to consistently assign the same patients to each RN in light of the complexity of patient care needs (some patients are very challenging and exhausting to care for on a continual basis) and/or the patient treatment schedule (especially difficult for those patients receiving evening treatments).

The IAC recognizes these challenges, but notes that a PN model is based on the concept of one primary nurse and several associate primary nurses for each patient. The goal is that the patient will receive care from one of these nurses, not from the primary nurse alone.

The IAC believes that there may have been, or may be, discussion within the ARRP regarding moving to a team nursing model in the new Unit, with 2 RNs and 1 RPN providing care to nine patients in each pod. The IAC encourages the ARRP to not move in this direction. On the one hand, it looks easier, and will on the surface, eliminate a number of the issues regarding the additional perceived responsibilities of RNs to support RPNs' care through consultation, collaboration and/or transfer of care. However, this approach diminishes the value of the individual nurse, relies on effective and timely communication (not an evident current strength within this Unit) and does not support continuity of patient care. In addition, the IAC is concerned that a team nursing approach may open the door to the US model of provision of direct patient care by a technician with oversight only provided by an RN.

The IAC is aware that these recommendations will, at least initially, create both perceived and actual additional workload for the RNs, and it will be important that supportive strategies be put in place to support the changes in the RNs' and RPNs' day-to-day responsibilities. The IAC suggests, for example, that the Team Leader, Educator and Medical Director develop an algorithm to guide the review of bloodwork to ensure key factors are identified. The IAC believes that the change, if implemented using effective change strategies, will result in a positive practice environment and a sense of accomplishment and of making a difference for patients, for both the RN and RPN staff.

*The IAC recommends*

**24. The ARRP Renal Unit transition to a true TPC model over a six month transition period (May to October 2011).**

**25. The Practice Council explore moving to a Primary Nursing Model in 2012, once the Renal Unit has used a true TPC model for at least six months.**

### 3.6.2 RN – RPN Patient Assignment

It was evident to the IAC that the ‘best laid plans’ to match the RPNs’ competence to provide patient care for the patients with the ‘most predictable outcomes’ has not worked. The IAC believes that this situation developed because of a differing interpretation of the CNO Three Factor Framework analysis.

The Hospital and the Association/Renal RNs approached the concept of ‘patient stability / predictable outcomes’ from two different paradigms:

- The Hospital considered the patients to be stable with predictable outcomes:
  - the chronic hemodialysis patients are all outpatients,
  - at least one third of the current patients would be able to dialyse through home self-care or in-centre self care dialysis if such programs were available in the ARRP,
  - intra-dialysis complications are generally anticipated, can be managed with known approaches, and are rarely ‘major’, and
  - no data exists to indicate that numbers, levels or extent of intra-dialysis complications have increased since RPNs began providing care.
- The Association/Renal RNs considered the patients to be complex with unpredictable outcomes:
  - patients have multiple co-morbid conditions,
  - even though a patient may have a history of minimal intra-dialysis complications, there is no guarantee that this will continue,
  - the dialysis procedure itself may result in unpredictable outcomes, such as a clogged access, even among patients who appear ‘stable’ at the beginning of treatment, and
  - signs and symptoms precursor to complications may be subtle, difficult to detect and result in an urgent situation.

The Hospital and the Association/Renal RNs used differing principles underlying decisions regarding determination of the appropriate category of nurse.

- The Hospital considered that staffing decisions should be based on the ‘actual’, that is, when there was factual basis indicating that the RPN assignment was inappropriate. The Hospital believed that the fact that a full transfer of care from an RPN to an RN has not occurred indicated that the staffing decisions regarding RPN assignment have been appropriate.
- The Association/Renal RNs considered that staffing decisions should be based on the ‘potential’, that is, the possibility of events occurring which would result in the RPN assignment to be inappropriate. The Association/Renal RNs believed that because RNs’ assignment responsibilities rendered them unable to be immediately available in the event that a transfer might be required indicated that at least some of the staffing decisions regarding RPN assignment have been inappropriate.

The Hospital and the Association/Renal RNs had differing perspectives regarding the practice supports and consultative resources within, and level of stability and predictability of, the ARRP Renal Unit.

- The Hospital believed that the existence of Medical Directives and the HCRT staffing decision tool and existence of consultative resources available to the RPN (Educator, Vascular Access

- Coordinator, Team Leader) provided a quality practice environment, and that the Unit activity during treatment turnovers was consistent with that in other Renal Units.
- The Association/Renal RNs felt that the practice supports were inadequate, as the Medical Directives were not available to the RPNs and the HCRT was not an effective staffing decision tool, that while the consultation resources existed in theory they were frequently unavailable in practice, and that the level of chaos in the Unit during treatment turnovers presented a high risk.

The IAC believes that decisions regarding RN or RPN assignment for patient care during hemodialysis treatments in the ARRP Renal Unit need to be based on the following:

- expectations for practice competence for provision of care to patients undergoing hemodialysis, as defined in the *CANNT Nursing Standards and Practice Recommendations*;
- the nature of anticipated intra-dialysis complications in light of the patient status at the initiation of the dialysis treatment; and
- the practice and consultative supports available to the RN or RPN at the time the dialysis treatment is provided.

In terms of practice competencies, the IAC assumes that the revised six-week orientation program, which the current RPNs completed and all future RNs and RPNs will complete, addresses the competencies identified in the *CANNT Nursing Standards and Practice Recommendations*. As noted in Section 3.4.2, the IAC believes that RNs and RPNs new to the specialty of hemodialysis can both develop the technical skills required to operate the dialysis machines, and can also develop an understanding of the theory related to patient care requirements. The difference between the RPN and the RN relates to the application of the technical skills and theoretical knowledge within the context of care requirements, that is, to the appropriateness of the patient assignment.

With respect to determination of anticipated intra-dialysis complications, the IAC believes that there is sufficient evidence in the literature and within the nephrology community to enable a clear delineation of the patient conditions with a high probability of resulting in intra-dialysis complications that are localized, minor, transient, likely to respond quickly to defined interventions, unlikely to require disruption of the dialysis treatment, and unlikely to last beyond the dialysis treatment. The IAC believes that these patients can be safely and appropriately assigned to an RPN to provide autonomous care but emphasizes that appropriate assignment is key to patient safety, and that Recommendations 17 to 19 must be implemented.

With respect to practice and consultative supports, the IAC believes that the practice supports are currently inadequate, and that Recommendations 13 to 16 must be implemented as soon as possible. The IAC believes that the ARRP Renal Unit is a stable and predictable practice environment, in terms the consistency of the patient population, geographical layout of the new unit providing easy visualization of and access to all other nurses and patients, and availability of consultative resources.

In addition, the IAC believes that the following must become standard practice within the ARRP Renal Unit. Once the HCRT tool has identified the patients who can be appropriately cared for by an autonomously practising RPN for this dialysis treatment, this patient assignment must be adhered to. RPNs must not be assigned to patients whom the HCRT has identified as being inappropriate for autonomous RPN care, even if this means calling in an additional RN and assigning the RPN, for that treatment, to provide general assistance in the Unit. The decision regarding appropriate category of care provider must be made on the basis of patient care needs and optimal patient care outcomes, not on availability of staffing resources.

*The IAC recommends that:*

**26. The ARRP implement a policy specifying that:**

- i) only those patients who are identified by the HCRT as being RPN-appropriate are assigned to RPNs,**
- ii) when there are no patients appropriate for RPN care, an RN(s) is called in to provide care so that an appropriate patient assignment is ensured, and**
- iii) when an insufficient number of RPN-appropriate patients exist, the RPN provides general assistance in the unit and does not carry an inappropriate patient assignment.**

### 3.6.3 RN – RPN Staffing

The Renal Unit is open 0700 – 2300 Monday to Friday, and 0700 – 1900 Saturday and Sunday. Chronic hemodialysis patients receive treatments three times per week. At the time of the Hearing, approximately 48 patients were on a Monday/Wednesday/Friday rotation, and 45 patients on a Tuesday/Thursday/Saturday or Sunday rotation. The hemodialysis patients remain fairly consistently on their Monday/Wednesday/Friday or Tuesday/Thursday/weekend schedule, but within this, may vary the time of their dialysis treatment between the morning and afternoon, due to personal preference, transportation logistics, other health care appointments etc. The evening patients generally remain on their evening treatment schedule.

In order to accommodate the treatment schedule, the RNs work a hybrid schedule of 12-hr shifts and 8-hr shifts<sup>56</sup> based on a rotating 18-week master rotation. At the time of the move to an RN-RPN skill mix in June 2010, two of the 18 lines were filled by RNs on long-term disability (LTD). One RN moved to the newly created Home Dialysis Transplant Nurse position in May 2010. As of June 2010, the 18-line master is being filled as 16 lines, with 15 lines filled by full-time RNs, and one RN on LTD<sup>57</sup>. The RNs will be moving to a 16-week schedule in June 2011<sup>58</sup>. The Team Leader and two RNs who job-share an 8-hr position are not included in the master rotation schedule. The RN staffing schedule, as it existed prior to the RPN integration, is listed in *Appendix 19*.

After June 21, 2010, when the RPNs assumed an independent patient assignment, the RN and RPN staffing schedule changed to include one RPN on (D) 0700-1500 and one RPN on (I) 1100 – 1900 (Table 4).

At the time of the Hearing<sup>59</sup>, each RN and RPN had a 1:3 ratio for the morning treatments. The RNs had a 1:2 ratio for the afternoon treatments, while the RPN had a 1:3 ratio. The evening 1:3 ratio remained consistent for the RNs<sup>60</sup>. The weekend staffing remained status quo, that is, RN only with a nurse : patient ratio of 1:3 for the morning treatments and 1:2 for the afternoon

<sup>56</sup> The 12-hr shifts are: (A) 0700 – 1900 and (I) 1100 – 2300; the 8-hr shifts are (H) 1100 – 1900 and (E) 1500 – 2300.

<sup>57</sup> The IAC understood that no nurses were deployed, due to the LTD positions and the move of an RN to the new position. However, the master rotation decreased by two full-time lines.

<sup>58</sup> Within the 18-week master rotation, the RNs rotate through each line in the schedule to work a total of 1950 hours per year. The SAH is moving to a new scheduling system in June 2011, and within the new 16-week master rotation, each RN will have her/his own “line”, which will total 1950 hours per year.

<sup>59</sup> The Renal Unit was located in the Plummer Site of the ‘old’ SAH.

<sup>60</sup> The nurse : patient ratio considers direct care providers only.

treatments. On the weekend, the RNs are each responsible for tearing down and disinfecting two machines at the end of the afternoon treatments<sup>61</sup>

Table 4: Renal Unit Nursing Schedule June 21, 2010 to March 5, 2011

Time	Nursing Staff M/W/F	# of Patients	Nursing Staff T/Th	# of Patients	Nursing Staff Sat/Sun	# of Patients
0700 – 1100	1 Team Leader 5 RNs 1 RPN	18 pts 1:3 ratio	1 Team Leader 5 RNs 1 RPN	18 pts 1:3 ratio	5 RNs	22-23 pts per day 1:3 ratio
1100 –1500	1 Team Leader 7 RNs 2 RPNs	18 pts 1:2 ratio	1 Team Leader 7 RNs 2 RPNs	18 pts 1:2 ratio		
1500 – 1900	7 RNs 1 RPN	12 pts 1:3 ratio*	6 RNs 1 RPN	9 pts 1:3 ratio*		
1900 – 2300	4 RNs		3 RNs			
Total Patients		48		45		45 split over 2 days

\* The nurse:patient ratio has remained 1:2 until completion of the afternoon treatments, and 1:3 for the evening treatments beginning at 1730.

Original # RNs with an all-RN staff

New # RNs with RN-RPN skill mix

New # RPNs with RN-RPN skill mix

There are currently 8 part-time RNs and 1 casual RN. Due to the specialty nature of nephrology / hemodialysis practice, the SAH casual pool nurses do not work in the Renal Unit, requiring all expected (e.g. vacation, approved leave, long term disability (LTD)) and unexpected (e.g. sick, bereavement leave) vacancies to be covered internally by the part-time/casual RNs. When an expected or unexpected vacant shift is scheduled and/or a Level III treatment<sup>62</sup> is required, the Team Leader reviews the patient treatment schedule / anticipated patient care needs to determine if the shift requires replacement and if so, whether an 8-hr or 12-hr RN or an 8-hr RPN is required. When necessary (when a replacement is required and there are no staff available), the Vascular Access Coordinator and Home Dialysis Transplant Nurse are requested to take a hemodialysis patient assignment.

Although the original plan was to hire 3 part-time RPNs, this has not occurred, so the RPN staffing coverage of 2 shifts per day Monday through Friday are covered by the one full-time and

<sup>61</sup> Two Dialysis Aides work 0600-1400 on the weekend. During the week, two Dialysis Aides work 0600-1400, one works 1100-1900 and one 1500-2300. Although there were a number of instances when the 1100-1900 shift was not covered during the summer and fall, the Hospital has recently hired an additional casual Dialysis Aide and anticipates that the number of uncovered shifts will decrease.

<sup>62</sup> The IAC understood that the RNs provide Level III treatments on a rotational basis, and that the frequency of call in an additional RN to cover the Level III treatments has increased since the integration of RPNs, due to the decreased flexibility of juggling patient assignments (as the RPNs are unable to assume care of the RN's complex patients).



two part-time RPNs. It was originally intended that the RPNs would work days (D): 0700-1500 hours and evenings (E): 1500 – 2300 hours, but the evening shift was replaced with a mid-day shift of (H): 1100 – 1900 hours, in order for the RPNs to maximally benefit from the presence of the Team Leader, Educator, Vascular Access Coordinator etc. With this revision to the RPN schedule, there is now a 4-hour overlap between 1100 and 1500. The (D) 0700-1500 RPN provides assistance as required to the other nurses once her three morning patient treatments are complete. The 1100 – 1900 RPN has a three-patient assignment within the afternoon treatment group of patients, and provides assistance to the evening RNs once her afternoon patient treatments are complete. The two RPNs therefore care for 6 of the 45 – 48 patients per day. The remaining 39 – 42 patients are cared for by the RNs<sup>63</sup>.

As noted in Section 3.2.2.2, the Renal Unit in the new hospital site is structured in two 9-station pods. The IAC understands that the RN and RPN scheduling has remained consistent, and that the master scheduling is as follows.

5 RN (A): 0700 – 1900	1 RPN (D) 0700 – 1500
2 RN (I): 1100 – 2300	
1 RN (H): 1100 – 1900	1 RPN (H): 1100 – 1900
2 RN (E): 1500 – 2300	

Therefore:

- ♦for the hours 0700 – 1100: 5 RNs and 1 RPN are scheduled: total 6 nurses
- ♦for the hours 1100 – 1500: 8 RNs and 2 RPNs are scheduled: total 10 nurses
- ♦for the hours 1500 – 1900: 8 RNs and 1 RPN are scheduled: total 9 nurses
- ♦for the hours 1900 – 2300: 4 RNs are scheduled: total 4 nurses

However, the IAC understands that the 2 RN (I) shifts and the RN (H) shift are not consistently filled.

The IAC understands that with the move to the new unit on March 6, 2011 the following is in place:

- Pod 1 is being maintained as an ‘all-RN pod’.
  - The 3 (A) RNs have a 1:2 (or occasionally 1:3) ratio for the morning and afternoon treatments, (total 4 to 5 patients over the 12-hr shift).
  - The (I) RN has a 1:1 or 1:2 ratio for the afternoon treatments, and a 1:3 ratio for the evening treatments, (total 4 to 5 patients over the 12-hr shift).
  - The 2 (E) RNs have a 1:3 ratio, (total 3 patients over the 8hr-shift). One of the three RNs (one (I) and 2 (E)) is also the Additional Responsibility Nurse (AR)<sup>64</sup>.
- Pod 2 is being maintained as a ‘RN-RPN skill mix pod’.
  - The Team Leader is located in Pod 2 from 0700-1500, without a defined patient assignment.
  - The 2 (A) RNs have a 1:2 (or occasionally 1:3) ratio for the morning and afternoon treatments, (total 4 to 5 patients over the 12-hr shift).
  - The (H) RN has a 1:2 ratio for the afternoon treatments (total 2 patients over the 8-hr shift).
  - The (D) RPN has a 1:3 ratio for the morning treatments.
  - The (H) RPN has a 1:3 (occasionally 1:2) ratio for the afternoon treatments.
  - Pod 2 closes at 1900

<sup>63</sup> The IAC understands that as of March 11, 2011, the number of hemodialysis patients has dropped to 80.

<sup>64</sup> The Additional Responsibility Nurse (AR) was introduced throughout SAH in March 2010; it is consistent with the Group, Unit or Team Leader described in Article 19.04 of the Collective Agreement. It is implemented in the Renal Unit on the evening shift Monday-Friday and on the 12-hr day shift on the weekend.

- The weekend scheduling has remained constant, with 4 RNs between the two pods for the hours 0700 – 1900, carrying a 1:2 to 1:3 ratio (i.e. each RN caring for 4 to 5 patients per day). One RN fulfills the AR role.

The current RN and RPN schedule, as the IAC understands it, is presented in Table 5

Table 5: Renal Unit Nursing Schedule March 6, 2011 to Present

Time	Treatments	Nursing Staff Mon - Fri	# Patients Nurse:Pt Ratio	Nursing Staff Sat-Sun	# Patients Nurse:Pt Ratio
0700 - 1100	Start morning treatments:  0730 – 1130 0800 – 1200 0830 – 1230	Pod 1 •3 RNs  Pod 2 •2 RNs •1 RPN •Team Leader	6-7 patients •1:2 or 1:3 ratio  6-7- patients •1:2 or 1:3 ratio •1:3 ratio •no assignment	Pod 1 •2 RNs  Pod 2 •2 RNs	16-20 pts per day  1:2 to 1:3 ratio  1:2 to 1:3 ratio
1100 - 1500	Complete morning treatments; additional 3 RNs* and 1 RPN who come on at 1100 cover lunch break and assist with taking morning patients off treatment				
	Start afternoon treatments:  1230 – 1630 1300 – 1700 1330 – 1730	Pod 1 •3 RNs •1 RN  Pod 2 •3 RNs •1 RPN •1 RPN  •Team Leader	9 patients •1:2 or 1:3 ratio •1:3 ratio  9 patients •1:2 ratio •1:3 ratio •no assignment after AM treatments completed •no assignment		
1500 - 1900	Complete afternoon treatments; once afternoon treatments are complete, the 5 RNs and 1 RPN leaving at 1900 assist with supper break coverage				
	Start evening treatments:  1730 – 2130 1800 – 2200 1830 – 2230	Pod 1 •2 RNs •1 AR	9 patients •1:3 ratio •1:3 ratio		
1900 - 2300	Complete evening treatments in Pod 1. Pod 2 closed at 1900.			Unit Closed	
Total Pts			42 patients		32-40 pts split over 2 days

\*May be only 2 RNs: (one (I) 1100-2300 and one (H) 1100-1900)

The IAC supports the decision to locate the Team Leader in the pod where the RPNs are working. As indicated in Section 3.5.2, the patients assigned to the RPNs in Pod 2 must meet the criteria identified in the HCRT. The IAC believes that if the patient assignment is appropriate and the RPNs have the required practice supports (e.g. authority to implement protocols within the pre-printed orders – see Section 3.5.1), the need for consultation, collaboration or a transfer of care to an RN will be decreased and will be within the scope of the Team Leader to provide.

The break coverage in the Renal Unit is very complex, due to the number of nurses who must be present for the morning treatment starts and the morning/afternoon and afternoon/evening treatment turnovers. As noted in Table 5, the RNs and RPN who come on at 1100 provide break coverage and/or take the morning patients off treatment before assuming responsibility for their afternoon treatment patients. They also provide coverage for the supper break of the evening shift nurses. The IAC considers the treatment turnover period to be a critical time, and believes that consideration to ensure maintenance of patient safety standards is required. The IAC understands that the ARRP is considering these issues with the break coverage schedule for the new unit.

In comparison to the majority of Renal Programs within the province, the ARRP is small, and its small critical mass results in a low economy of scale. Within a population of Level II patients, there will likely be some who meet the criteria for appropriate assignment to RPNs; those programs with a hemodialysis patient population above 200 or 300 have flexibility in their RN - RPN scheduling. However, as the total number of patients decreases, the number who are appropriate for RPN autonomous care decreases as well. With a patient population in the low 80's, the IAC believes that the ARRP is at the very lower limit of being able to support an RN-RPN skill mix, and that the ratio of RNs to RPNs should not increase beyond the current 90% RN – 10% RPN total nursing skill mix unless the hemodialysis patient population increases significantly.

In addition, while the RPN nurse : patient ratio has remained at 1:3 for both the morning and afternoon treatment cycles, the IAC is concerned with the balance of patients, as the number of evening patients, who from discussion at the Hearing appear to meet the criteria of intra-dialysis complications that are localized, minor, transient, likely to respond quickly to defined interventions within protocols, unlikely to require disruption of the dialysis treatment, and unlikely to last beyond the dialysis treatment, appears to have remained constant. Unless care is taken to ensure that RPNs and patients who can appropriately be cared for by RPNs are in the Unit at the same time, and unless Recommendation 26 is strictly adhered to, the likelihood of inappropriate patient assignment increases.

The IAC understands that the decision to move the RPNs from an (E) 1500 – 2300 shift to an (I) 1100 – 1900 shift was based on the desire to maximize the benefits from the consultative resources (Team Leader, Educator, Vascular Access Coordinator). However, the IAC believes that this will become less relevant when patients are appropriately assigned and the required practice supports are in place. In light of the decreasing patient numbers, the IAC is concerned with maintaining the 80% RN - 20% RPN ratio during the morning and afternoon, and recommends consideration of either

- moving patients who are identified by the HCRT as being appropriate to be cared for by RPNs to a morning or afternoon dialysis treatment schedule, or
- scheduling RPNs to work on the day (D) 0700 – 1500 and evening (E) 1500 – 2300 shifts,

to maximize the contact between the RPNs and the 'RPN appropriate' patients. The IAC appreciates the comments made at the Hearing regarding the importance of patient outcomes/quality of life, and the desire to enable the evening patients to remain on this schedule. The IAC believes that if the decision is made for the current evening patients to remain on evening dialysis, the RPN schedule needs to change<sup>65</sup>.

Finally, the IAC understands that the SAH/ARRP hopes to explore the possibility of developing a self-care in-centre hemodialysis program. If this occurs, and a number of the patients being cared for by the RPNs move to this program, the mix of patients remaining in the Renal Unit may change. The IAC believes that the ARRP will need to ensure an ongoing balance/match between the RPNs and the patients identified by the HCRT as being appropriate for autonomous RPN care. This may require transferring one or both of the RPN shifts to the self-care program and/or revising the RN/RPN skill mix within the Renal Unit to ensure that it continues to be appropriate to meet the patients' care needs.

***The IAC recommends that:***

- 27. The ARRP ensure that there is a balance/match between the RPNs' schedule and the treatment schedule of the patients identified by the HCRT as being appropriate for RPN autonomous care. The ARRP therefore either alter the RPN schedule to (D) 0700-1500 and (E) 1500 – 2300, or reschedule the (current evening) patients who are appropriate for RPN care to a day/afternoon treatment schedule.***
- 28. The ARRP maintain the current 90% RN – 10% RPN skill mix as the maximum unless the hemodialysis patient population increases significantly.***
- 29. If a self-care hemodialysis program is implemented, and the patients who are identified by the HCRT as being appropriate for RPN autonomous care move to this program, the ARRP assign the RPNs to the self care program, and move to a skill mix model within the in-centre program that is most appropriate to meet the remaining patients' care needs.***
- 30. The ARRP assess the possibility of assigning one RPN to the Pre-dialysis Clinic.***

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<sup>65</sup> The IAC noted that the RPNs were originally hired on the expectation that they would work (D) 0700-1500 and (E) 1500 – 2300 shifts.

## SECTION IV

### CONCLUSION AND RECOMMENDATIONS

#### 4.1 Conclusion

Article 8.01 of the Collective Agreement between the Ontario Nurses' Association and Sault Area hospital requests the IAC to specifically address the issue of whether or not the RNs in the ARRP Renal Unit are being requested to perform more work than is consistent with proper patient care.

Following a thorough analysis, including review of written and oral submissions, focused discussion at a 2-1/2 day Hearing, extensive Committee deliberation and discussion prior to and following the Hearing, and a literature review regarding hemodialysis practice, the IAC concluded that the integration of RPNs into the ARRP Renal Unit was appropriate in light of the CNO Three Factor Framework, but that the professional practice supports and decision-making tools provided by the Hospital were insufficient to support the integration.

The IAC believes that the regulatory scope of practice for RNs and RPNs is identical, but the expectations for practice, based on foundational knowledge and specialty expertise, differ between RNs and RPNs. RPNs care for a narrower range of patients than RNs. While the Hospital indicated that RPNs were practicing at 'full scope', the IAC found that the Hospital had in fact defined restrictions on the practice of RPNs. The IAC believes that the wiser course is to identify restrictions in an ARRP policy that defines the conditions/characteristics of the patients who may be assigned to autonomously practicing RPNs. This supports the regulatory perspective that the RN and RPN scope of practice is identical, but the expectations for practice, in terms of the range of patients who may be cared for by RPNs, differ.

The IAC believes that there is an appropriate role for autonomous RPN practice within the ARRP chronic Level II hemodialysis unit ***if decisions regarding assignment of patients to the RPNs are appropriate and if necessary practice supports are in place***. Autonomous RPN practice in the absence of these two requirements is inappropriate and does not support proper patient care.

The IAC believes the following principles must be adhered to within the ARRP:

- Patient assignment must be made on the basis of anticipated patient care needs and optimal patient care outcomes, not on the availability of scheduled care providers.
- Patient assignment criteria must be specifically identified through the HCRT and consistently applied.
- Analysis of anticipated patient care needs must consider the likelihood of intra-dialysis complications. RPNs can autonomously care for patients whose status prior to dialysis indicates that complications occurring during dialysis will be localized, minor, transient, likely to respond quickly to defined interventions within protocols, unlikely to require disruption of the dialysis treatment and unlikely to last beyond the dialysis treatment. All other patients must be cared for by RNs.
- Authority to enact treatment protocols and Medical Directives must be consistent for RNs and RPNs.

The IAC believes that effective integration of autonomously practicing RPNs into a chronic hemodialysis unit is influenced by the size and characteristics of the patient population. The IAC

believes that the ARRP is currently at the very lower limit of having a sufficient critical mass of in-centre hemodialysis patients to support an RN-RPN skill mix model. If the size or characteristics of the current in-centre hemodialysis patient population changes, the ARRP will need to re-evaluate the percentage mix of RNs and RPNs providing direct patient care in the Renal Unit. In addition, the IAC believes that the RPNs' schedule must balance/match the treatment schedule of patients identified as being appropriate for RPN autonomous care. In order to ensure a balance/match within the current patient population, the IAC believes the ARRP will need to alter either the treatment schedule of the evening patients identified by the HCRT as being appropriate for RPN autonomous practice, or the work schedule of the RPNs from 1100 – 1900 to 1500 - 2300.

The IAC believes that while there is an appropriate role for autonomous RPN practice within the ARRP Renal Unit, in order to ensure that the RNs' workload enables provision of proper patient care, specific strategies to support RPN practice are required in the areas of:

- supportive leadership with a shared governance approach to decision-making,
- articulation of RN and RPN roles and responsibilities on the basis of the regulatory scope of RNs and RPNs,
- practice supports that enable effective and consistent decision-making regarding patient assignment,
- a model of care that supports hemodialysis practice, and
- RN and RPN work schedules that balance/match the identified care needs of patients.

The IAC identified 30 recommendations to address these issues.

The IAC emphasizes that the issue referred to the IAC, and therefore its jurisdiction for this review, related to the impact of the introduction of autonomously practicing RPNs on the workload of the ARRP Renal Unit RNs. The IAC recognizes that other issues, outside of this jurisdiction, also have a direct impact on RN workload. While the IAC has not commented on issues such as, for example, the availability of portering services, availability of relief staffing, strategies to address the 'glitches' associated with the move to a new department/hospital etc., the IAC encourages the Association and the Hospital to identify and address these issues as required.

## 4.2 Recommendations

The IAC identified 30 recommendations, in the areas of nursing leadership, RN and RPN roles within the ARRP, practice supports and staffing and scheduling, to address identified issues related to the introduction of autonomously practicing RPNs in the ARRP Renal Unit.

### Nursing Leadership:

Successful implementation of a skill mix change within a specialty program such as the ARRP requires effective leadership from an experienced Manager. The Interim ARRP Manager is in his first management position, and will benefit from support and mentoring.

1. *The SAH support the Interim ARRP Manager to attend the 2011 Dorothy Wylie Nursing Leadership Institute as an emerging leader with an established nursing leader from the SAH.*
2. *The CNO and Program Director, Oncology and Renal organize and implement a formal mentorship relationship with an experienced first-line Nurse Manager or Director from*

*an external organization to assist the Interim ARRP Manager to develop expertise in strategies to foster trust, effective working relationships among the ARRP staff and an empowering work environment.*

The Team Leader position is integral to the smooth operation of the ARRP Renal Unit, but the specific day-to-day responsibilities of the position will benefit from review.

3. *The ARRP Manager, Program Director and Team Leaders review and clarify the Team Leader's role and responsibilities to maximize consistency re how the role is enacted, to support a Total Patient Care delivery model in the Renal Unit, and to support ongoing professional development opportunities for the nursing staff.*
4. *The Renal Unit Ward Clerks assume accountability for transcribing physicians' orders before 1900, with review of the orders completed by the RN or RPN providing the patient's care, rather than the Team Leader.*

There is currently no vehicle within the ARRP Renal Unit that enables staff RNs and RPNs and the ARRP leadership team to discuss practice issues and that provides RNs and RPNs with a 'voice' in terms of operational and clinical decision-making. Implementation of a Practice Council will provide nurses with a venue to discuss issues impacting practice.

5. *The ARRP implement an inter-disciplinary Practice Council as a mechanism for discussion of and resolution of issues relating to operational functioning of the ARRP and clinical practice issues relating to the provision of patient care.*  
*Terms of Reference to include:*
  - i) *Purpose: to work collaboratively on decision-making related to practice and procedures that enhance the quality of patient care, work environment and relationships among staff.*
  - ii) *Chair: Co-chaired by the Renal Unit Team Leader and the ARRP Educator.*
  - iii) *Membership: Defined membership, selected by nomination, including three RNs, one RPN, one allied health team member, the Team Leader, Educator and ARRP Manager, with a defined membership term of two years.*
  - iv) *Meetings: held bi-weekly initially, until practice/policy changes in the new unit are solidified, then monthly.*
  - v) *Agenda: developed jointly by the co-chairs and published in advance of the meeting.*
  - vi) *Minutes: adopt the format used for SAH HAC meetings.*
  - vii) *Distribution of minutes: reference highlights during morning and afternoon report (see Recommendations 20/21), include in communication book, develop Practice Council binder for review by all staff.*

Strategies to support learning, including exploration of CNA Nephrology certification and clarification of the staff Educator's role will enhance development of a 'culture of learning' within the ARRP.

6. *The Educator implement a support group to assist RNs to explore preparation for Nephrology Certification.*
7. *The ARRP continue to support a full-time staff Educator position within the ARRP.*

8. *The ARRP clarify that the Educator's role focuses on support and development of staff RNs and RPNs within the ARRP.*

#### Role of RNs and RPNs in the ARRP Renal Unit

Identification of practice restrictions for RPNs through an ARRP policy that defines the conditions/characteristics of patients who may be assigned to RPNs is more appropriate than attempting to delineate practice restrictions through the role description.

9. *The SAH revise the Role Descriptions for the RN Renal Services and RPN Renal Services to ensure that both equally do or do not reflect basic CNO practice accountabilities.*
10. *The SAH revise the clinical policies for the ARRP to delineate specific practice expectations/restrictions for the RPN in the Renal Unit. For example, policies regarding practice expectations would include pre-printed orders and protocols (Section 3.5.1); policies regarding practice restrictions would include policies relating to patient assignment (Section 3.5.2).*

An orientation program that is consistent for both RNs and RPNs, and which includes evaluation of knowledge and practice competencies prior to autonomous practice, is required.

11. *The six-week orientation program become the standard for all nurses entering the Renal Unit, and that it be revised as required to ensure that all practice standards identified by CANNT are included.*
12. *The knowledge base and practice competencies of all RNs and RPNs new to the Renal Unit be evaluated using a range of mechanisms, including, for example, written exams, observation, mentored practice, and clinical simulations etc. prior to commencement of autonomous practice.*

#### Practice Supports

The ARRP has 12 Medical Directives relating to hemodialysis that currently only RNs may implement. Development of pre-printed orders with associated protocols, to be implemented by RNs and RPNs, will assist with safe, effective and consistent care provision. A defined process for evaluation of the competence of nurses implementing the protocols and Medical Directives, and of the content and implementation of the protocols and Medical Directives is required.

13. *The ARRP develop a pre-printed "Physician's Orders for Hemodialysis Patient", using references from the Ontario Hospital Association<sup>66</sup> and other Ontario hospitals as a guide.*
14. *The ARRP review the content of the current Medical Directives to determine*
  - i) *the elements to be transferred into protocols addressing commonly anticipated complications (e.g. nausea, hypotension, pain) which will become part of the pre-printed order set and*

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<sup>66</sup> <http://www.oha.com/KnowledgeCentre/Library/Documents/Module4.pdf>



ii) *the elements to remain as Medical Directives.*

15. *The practice of RN transcription of orders for medications/treatment interventions contained within Medical Directives into a patient's health record, in order to enable the RPN to administer the medication/treatment without contacting the physician, cease immediately.*

16. *A defined process for*

- a. *evaluation of competence of all nurses to implement protocols within pre-printed orders and Medical Directives,*
  - b. *evaluation of the content of pre-printed orders/protocols, and*
  - c. *evaluation of the implementation of protocols and Medical Directives*
- be jointly developed by the Medical Director, ARRP Manager and Educator in accordance with the CNO and Federation of Health Regulatory College of Ontario guidelines<sup>67</sup>.*

The Hemodialysis Care Requirements Tool (HCRT) must clearly identify the patients who can be safely cared for by autonomously practicing RPNs, and develop a policy which identifies the patient conditions/situations where RPN is appropriate to provide safe and effective care. The current HCRT needs to be jointly revised by the staff RNs and RPNs and the ARRP leadership team.

17. *A Working Group of the Practice Council, comprised of 3-4 RNs, 1-2 RPNs, the Team Leader, Educator, ARRP Manager and Medical Director, develop*

- i) *a revised HCRT to identify the patients whose condition indicates an RPN can safely and effectively provide autonomous care during the dialysis procedure, and*
- ii) *a new ARRP policy identifying the patients whose situation/condition indicates an RN is appropriate to provide safe and effective care during the dialysis procedure.*

18. *The criteria in the HCRT be based on the principle of identifying, to the greatest extent possible, the likelihood of occurrence of intra-dialysis complications which require are localized, minor, likely to respond quickly to defined interventions within protocols, unlikely to require disruption of the dialysis treatment and unlikely to last beyond the dialysis treatment.*

19. *The Practice Council evaluate the effectiveness of the HCRT in terms of:*

- i) *the extent to which a transfer of care was required for patients identified as 'RPN appropriate by the HCRT; and*
- ii) *the requirement for continued daily completion of the HCRT for all patients once a core of RPN-appropriate patients are identified.*

Intra-unit communication strategies will assist both the RNs and the RPNs to develop a greater sense of 'team' and decrease the current 'cloak of isolation' that both are working within. Specifically, implementation of strategies that will support nurses to feel involved and connected over the course of a shift will be beneficial.

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<sup>67</sup> CNO Practice Guideline Directives. Pub # 41019, June 2009; Federation of Health Regulatory Colleges of Ontario: *An Interprofessional Guide on the Use of Orders, Directives and Delegation for Regulated Health Professionals in Ontario*. Sault Area Hospital / Ontario Nurses' Association Independent Assessment Committee Report March 2011

20. *The ARRP Renal Unit implement a morning report format, maximum 15 minutes, beginning at 0845 after the 0830 treatments have started.*
  - i) *for the period April to August, the morning report be a 'joint pod report' including patients and staff from both Pod A and Pod B*
  - ii) *after September, the Practice Council determine whether the joint pod approach should continue, or whether an individual pod report will suffice.*
21. *The ARRP Renal Unit implement a 'joint pod' afternoon report format, maximum 15 minutes, beginning at 1530.*
22. *The Practice Council design, trial, implement and evaluate a revised staff assignment sheet.*

The Patient Charting System (PCS) is currently not interfaced with the dialysis machines and is implemented with only 40% of the hemodialysis patients, leading to fragmented documentation. Until the interface issue is rectified and PCS can be implemented with all patients, placing further implementation of the PCS within the ARRP may be wise.

23. *The SAH and ARRP consider placing PCS implementation within the ARRP on hold until the interface issues are resolved and PCS can be implemented with all hemodialysis patients.*

#### Renal Unit Nursing Staffing

The current model of care within the ARRP Renal Unit is 'fragmented' Total Patient Care (TPC). Implementation of a true TPC model over a transition period of six months, and eventual implementation of a Primary Nursing model will result in a positive practice environment and will provide the RNs and RPNs with a sense of accomplishment and of making a difference for patients.

24. *The ARRP Renal Unit transition to a true TPC model over a six month transition period (May to October 2011).*
25. *The Practice Council explore moving to a Primary Nursing Model in 2012, once the Renal Unit has used a true TPC model for at least six months.*

Assignment of patients to RNs and RPNs must be based on a tool which is consistently implemented. The decision regarding the appropriate category of care provider must be made on the basis of patient care needs and optimal patient care outcomes, not on availability of scheduled care providers.

26. *The ARRP implement a policy specifying that:*
  - i) *only those patients who are identified by the HCRT as being RPN-appropriate are assigned to RPNs,*
  - ii) *when there are no patients appropriate for RPN care, an RN(s) is called in to provide care so that an appropriate patient assignment is ensured, and*
  - iii) *when an insufficient number of RPN-appropriate patients exist, the RPN provides general assistance in the unit and does not carry an inappropriate patient assignment.*

RN and RPN scheduling needs to be balanced with the anticipated care needs of the patients. This may require revision of the treatment schedule of patients whose care needs can be met by autonomously practicing RPNs, or revising the work schedule of RPNs, to ensure that both are in the Renal Unit at the same time. The current skill mix ratio of 90% RN / 10% RPN is the maximum that the current ARRP can support, will require revision if the patient population within the Renal Unit changes.

- 27. The ARRP ensure that there is a balance/match between the RPNs' schedule and the treatment schedule of the patients identified by the HCRT as being appropriate for RPN autonomous care. The ARRP therefore either alter the RPN schedule to (D) 0700-1500 and (E) 1500 – 2300, or reschedule the (current evening) patients who are appropriate for RPN care to a day/afternoon treatment schedule.*
- 28. The ARRP maintain the current 90% RN – 10% RPN skill mix as the maximum unless the hemodialysis patient population increases significantly.*
- 29. If a self-care hemodialysis program is implemented, and the patients who are identified by the HCRT as being appropriate for RPN autonomous care move to this program, the ARRP assign the RPNs to the self care program, and move to a skill mix model within the in-centre program that is most appropriate to meet the remaining patients' care needs.*
- 30. The ARRP assess the possibility of assigning one RPN to the Pre-dialysis Clinic.*

The IAC encourages the Hospital and the Association to work together to achieve these 30 recommendations within the ARRP Renal Unit. The IAC believes that implementation will result in a positive impact on the quality of patient care, nursing workload and nursing staff satisfaction, and that, if the recommendations regarding Practice Supports and Nursing Staffing are implemented as a 'package', the RNs in the ARRP Renal Unit will have a workload that will enable them to provide proper patient care.



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

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

*(Article 8.01 Ia) (vii), (viii) (ix) and (x) and 8.01 (b) applies to nurses only)*

- vii) *Failing resolution of the complaint within fifteen (15) calendar days of the meeting of the Hospital-Association Committee the complaint shall be forwarded to an Independent Assessment Committee composed of three (3) registered nurses; one chosen by the Ontario Nurses' Association, one chosen by the Hospital and one chosen from a panel of independent registered nurses*

*who are well respected within the profession. The member of the Committee chosen from the panel of independent registered nurses shall act as Chair.*

- viii) *The Assessment Committee shall set a date to conduct a Hearing into the complaint within fourteen (14) calendar days of its appointment and shall be empowered to investigate as necessary and make what findings are appropriate in the circumstances. The Assessment Committee shall report its findings, in writing, to the parties within thirty (30) calendar days following completion of its Hearing.*
- ix) *It is understood and agreed that representatives of the Ontario Nurses' Association, including the Labour Relations Officer(s), may attend meetings held between the Hospital and the Union under this provision.*
- x) *Any complaint lodged under this provision shall be on the form set out in Appendix 6. Alternately the local parties may agree to an electronic version of the form and a process for signing.*
- (b) i) *The list of Assessment Committee Chairs is attached as Appendix 2. During the term of this Agreement, the central parties shall meet as necessary to review and amend by agreement the list of chairs of Professional Responsibility Assessment Committees.*

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

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

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



## Ontario Nurses' Association

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

October 25, 2010

**VIA FAX AND EMAIL**

Johanne Messier-Mann  
Chief Nursing Officer  
Sault Area Hospitals  
969 Queen Street East  
Sault Ste. Marie, ON P6A 2C4

Dear Ms. Messier-Mann,

**RE: Professional Responsibility Complaint Renal Unit**

The Registered Nurses of the Renal Unit, Sault Area Hospital (SAH) have identified ongoing practice and workload concerns as evidenced by the data consistently submitted on numerous Professional Responsibility Workload Report Forms.

The Union is seeking resolution of the concerns on behalf of our members and the patients that they care for. To date the employer has been unable to propose or agree to sufficient measures to resolve the concerns. Timely resolution of the Professional Responsibility Complaint is vital to enable the RNs to deliver safe, competent and ethical patient care. Accordingly, the Union is forwarding the complaint to an Independent Assessment Committee as per Article 8 of the collective agreement.

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

Rob Rupert  
919 Goreval Road  
Thunder Bay, ON P7G 2H1  
Home phone 807-767-7806  
Blackberry 807-621-1745  
e-mail rob.rupert@ontario.ca

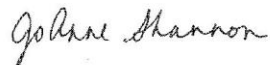
Please provide written confirmation concerning the name, mailing address, home or cell and office phone numbers, fax number and e-mail address of your nominee. A Chairperson will be been invited from the list in Appendix 2, pending confirmation from the Ontario Hospital Association.

Yours truly,

**ONTARIO NURSES' ASSOCIATION**

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





Jo Anne Shannon, RN  
 Professional Practice Specialist

js/kb/

- C:
- Rob Rupert, ONA Nominee
  - Ron Gagnon, SAH Chief Executive Officer
  - Marie Paluzzi, SAH Interim Chief Operating Officer
  - Elaine Pitcher, SAH Chair
  - Jamie Melville, SAH 1<sup>st</sup> Vice Chair
  - Lorne Carter, SAH Treasurer
  - Dr. Alan McLean, SAH Chief of Staff
  - Dr. Heather O'Brien, SAH President of Medical Staff Association
  - Dr. Malcolm Brigden, SAH Vice President of Medical Staff Association
  - David Bockman, SAH Board of Directors
  - Joanne Dumanski, SAH Board of Directors
  - Joy Haley, SAH Board of Directors
  - Anthony P. Marrato, SAH Board of Directors
  - Luisa Martone, SAH Board of Directors
  - Susan Myers, SAH Board of Directors
  - Dr. Michael Nanne, SAH Board of Directors
  - Philip Virene, SAH Board of Directors
  - Connie Witty, SAH Board of Directors
  - Laurel Young, Volunteer Association Representative, SAH Board of Directors
  - Dr. David Berry, Clinical Director of the Algoma Regional Renal Program
  - Sam Mandelbaum, Ontario Hospital Association
  - Linda Haslam-Stroud, ONA President
  - Glenda Hubley, ONA Local Coordinator
  - David Cheslock, ONA LRO





## Ontario Nurses' Association

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

November 16, 2010

Joan Cardiff  
306 Freedom Private  
Ottawa, ON, K1G 6W4

Dear Joan Cardiff,

**RE: Employer and Ontario Nurses' Association: Professional Responsibility  
Complaint – Program (s): – Independent Assessment Committee – ONA  
File (s)**

Thank you for accepting the nomination to chair an Independent Assessment Committee (IAC) investigating a Professional Responsibility Complaint in the Renal Unit at Sault Area Hospital. I have confirmed with Mr. Sam Mandelbaum at Ontario Hospital Association that both parties have agreed to you chairing this IAC.

The attached letters provide the Association's and employer's nominee names and contact information. Please set up dates with the nominees, who will confirm with their respective parties.

Yours truly,

**ONTARIO NURSES' ASSOCIATION**

Jo Anne Shannon  
Professional Practice Specialist

Encl.

C: Glenda Hubley, ONA Local Coordinator  
Craig Watson, Bargaining Unit Professional Responsibility and Workload Rep  
David Cheslock, ONA LRO  
Rob Rupert, ONA Nominee  
Lorraine Sundstrom Mann, Hospitals Nominee  
Johanne Messier-Mann, Chief Nursing Officer SAH  
Sam Mandelbaum, Director, Ontario Hospital Association

Provincial Office: **Toronto**

Regional Offices: **Ottawa • Hamilton • Kingston • London**

**Orillia • Sudbury • Thunder Bay • Timmins • Windsor**





December 6, 2010

*Appendix 4*

416 Lakeshore Road  
R.R. #2  
White Lake, Ontario  
K0A 3L0

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

Dear Ms. Shannon:

Re: Sault Area Hospital and Ontario Nurses' Association: Professional Responsibility  
Complaint – Independent Assessment Committee Hearing

I am writing to confirm the plans for the Independent Assessment Committee Hearing regarding the Professional Responsibility Complaint between the Sault Area Hospital Renal Unit and the Ontario Nurses' Association.

The Independent Assessment Committee (IAC) Hearing will be held at the Plummer Site of the Sault Area Hospital on Tuesday February 8<sup>th</sup>, Wednesday February 9<sup>th</sup> and Thursday February 10<sup>th</sup>, 2011, as per the attached draft Hearing Agenda.

The IAC would like to tour the Renal Unit on the morning of Tuesday February 8<sup>th</sup>, prior to the Hearing, beginning at 1000 hours. I am requesting that the Ontario Nurses' Association and Sault Area Hospital coordinate the arrangements for the tour. Please jointly decide:

- ◆ how many ONA and Sault Area Hospital representatives will accompany the three IAC members on the tour, and who these representatives will be,
- ◆ if areas in addition to the Renal Unit need to be included, and if so, which these will be, and
- ◆ who will lead the tour.

Please provide this information by Friday January 28<sup>th</sup>, 2011.

The Hearing will begin at 1300 hours on Tuesday February 8<sup>th</sup>, 2011. As indicated on the draft Hearing Agenda, each of the Ontario Nurses' Association and Sault Area Hospital 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 recommence at 0900 on Wednesday February 9<sup>th</sup>, with the Response from the Sault Area Hospital, followed by the Response from the Ontario Nurses' Association. 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 Hearing adjournment to determine areas/issues requiring further clarification.

The Hearing will recommence at 0830 on Thursday February 10<sup>th</sup>, with Questions to both the Ontario Nurses' Association and Sault Area Hospital 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.

The Hearing will be held in the St Mary's Room, which is close to the Renal Unit at the Plummer Site. The Ontario Nurses' Association caucus room will be the Riverview Room (Tuesday February 8<sup>th</sup> and Thursday February 10<sup>th</sup>) and Room C114 (Wednesday February 9<sup>th</sup>). Refreshments will be available in the St Mary's Room, but lunch will not be provided.

In order to support the principles of full disclosure, and to enable the IAC to effectively prepare for the Hearing, the IAC requests individual, independent written submissions be provided by Friday January 21st, 2011. Please submit five copies of your submission and attachments 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 by courier on Monday January 24<sup>th</sup>, 2011 as follows:

- ◆ One (1) copy of the Sault Area Hospital submission and one (1) copy of the ONA submission to Lorraine Sunstrum-Mann (Hospital Nominee);
- ◆ one (1) copy of the Sault Area Hospital submission and one (1) copy of the ONA submission to Rob Rupert (ONA Nominee);
- ◆ two copies (2) of the Sault Area Hospital submission to the Association (attention Jo-Anne Shannon);
- ◆ two copies (2) of the ONA submission to the Sault Area Hospital (attention Johanne Messier-Mann).

In the event that the Ontario Nurses' Association wishes to provide supplemental information after January 21<sup>st</sup>, 2011, supplemental information will be accepted until Friday January 28<sup>th</sup>, 2011, and will be distributed as above. Supplemental information may be sent via email, with hard copy to follow. Please note that supplemental information is information to support/clarify the Ontario Nurses' Association presentation; it is not information to respond to the Sault Area Hospital submission.

The IAC will hold a Pre-Hearing Meeting the week of January 31<sup>st</sup>, 2011, to review the submissions in detail in advance of the Hearing. If the IAC requires additional information in order to comprehensively understand the issues, this will be requested prior to the Hearing.

The IAC looks forward to working with you to address the professional responsibility issues of concern. If you have any questions, please contact me by phone at 13-622-7743 or by email at [jcardiff@cheo.on.ca](mailto:jcardiff@cheo.on.ca).

Sincerely

Joan Cardiff

cc. Lorraine Sunstrum-Mann, Hospital Nominee  
 Rob Rupert, ONA Nominee  
 Johanne Messier-Mann, Chief Nursing Officer, Sault Area Hospital

*Appendix 4*

December 6, 2010

416 Lakeshore Road  
R.R. #2  
White Lake, Ontario  
K0A 3L0

Ms. Johanne Messier-Mann  
Chief Nursing Officer  
Director, Maternal Child & Medical Programs  
Sault Area Hospital  
Sault Ste. Marie, Ontario  
P6A 2C4

Dear Ms. Messier-Mann

Re: Sault Area Hospital and Ontario Nurses' Association: Professional Responsibility  
Complaint – Independent Assessment Committee Hearing

I am writing to confirm the plans for the Independent Assessment Committee Hearing regarding the Professional Responsibility Complaint between the Sault Area Hospital Renal Unit and the Ontario Nurses' Association.

The Independent Assessment Committee (IAC) Hearing will be held at the Plummer Site of the Sault Area Hospital on Tuesday February 8<sup>th</sup>, Wednesday February 9<sup>th</sup> and Thursday February 10<sup>th</sup>, 2011, as per the attached draft Hearing Agenda.

The IAC would like to tour the Renal Unit on the morning of Tuesday February 8<sup>th</sup>, prior to the Hearing, beginning at 1000 hours. I am requesting that the Sault Area Hospital and the Ontario Nurses' Association coordinate the arrangements for the tour. Please jointly decide:

- ◆ how many ONA and Sault Area Hospital representatives will accompany the three IAC members on the tour, and who these representatives will be,
- ◆ if areas in addition to the Renal Unit need to be included, and if so, which these will be, and
- ◆ who will lead the tour.

Please provide this information by Friday January 28<sup>th</sup>, 2011.

The Hearing will begin at 1300 hours on Tuesday February 8<sup>th</sup>, 2011. As indicated on the draft Hearing Agenda, each of the Sault Area Hospital and the Ontario Nurses' Association 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 recommence at 0900 on Wednesday February 9<sup>th</sup>, with the Response from the Sault Area Hospital, followed by the Response from the Ontario Nurses' Association. 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 Hearing adjournment to determine areas/issues requiring further clarification.

The Hearing will recommence at 0830 on Thursday February 10<sup>th</sup>, with Questions to both the Ontario Nurses' Association and Sault Area Hospital 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 principles of full disclosure, and to enable the IAC to effectively prepare for the Hearing, the IAC requests individual, independent written submissions be provided by Friday January 21<sup>st</sup>, 2011. Please submit five copies of your submission and attachments 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 by courier on Monday January 24<sup>th</sup>, 2011 as follows:

- ◆ one (1) copy of the Sault Area Hospital submission and one (1) copy of the ONA submission to Lorraine Sunstrum-Mann (Hospital Nominee);
- ◆ one (1) copy of the Sault Area Hospital submission and one (1) copy of the ONA submission to Rob Rupert (ONA Nominee);
- ◆ two copies (2) of the Sault Area Hospital submission to the Association (attention Jo-Anne Shannon);
- ◆ two copies (2) of the ONA submission to the Sault Area Hospital (attention Johanne Messier-Mann). (Note: if you would like one copy submitted directly to your legal counsel, please let me know).

In the event that the Sault Area Hospital wishes to provide supplemental information after January 21<sup>st</sup>, 2011, supplemental information will be accepted until Friday January 28<sup>th</sup>, 2011, and will be distributed as above. Supplemental information may be sent via email, with hard copy to follow. Please note that supplemental information is information to support/clarify the Sault Area Hospital's presentation; it is not information to respond to the Ontario Nurses' Association submission.

The IAC will hold a Pre-Hearing Meeting the week of January 31<sup>st</sup>, 2011, to review the submissions in detail in advance of the Hearing. If the IAC requires additional information in order to comprehensively understand the issues, this will be requested prior to the Hearing.

Thank you for making the arrangements for the Hearing to be held at the Plummer Site. The following 'logistical support' will assist the Hearing to run smoothly:

#### Hearing and IAC:

- ◆ Please configure the table in the St Mary's Room into a U-shape, with 3 seats (for the IAC) at the head of the table, and approximately 10 seats on either side.
- ◆ Please provide
  - an extension cord if an electrical plug is not close to the IAC,
  - an LCD projector (Tuesday and Wednesday only), and
  - a flip-chart with markers.
- ◆ Please ensure that the IAC will have access to the St Mary's Room into the evening (beyond 1800 hours) on Wednesday February 9<sup>th</sup>.

#### Catering:

- ◆ Please arrange for tea, coffee, juices and water to be available in the St Mary's Room for all times that the Hearing is in session. Please provide muffins for the morning break on

- Wednesday and Thursday, and cookies/fruit for the afternoon break on Tuesday and Wednesday.
- ◆ Please arrange for tea, coffee and water to be available in the ONA caucus room over the full three days.
  - ◆ Please provide a working lunch for the three IAC members on Tuesday, Wednesday and Thursday in the St Mary's Room.

The IAC looks forward to working with you to address the professional responsibility issues of concern. In the meantime, if you have any questions or would like to discuss any of the 'logistical support' requests, please contact me by phone at 613-622-7743 or by email at [jcardiff@cheo.on.ca](mailto:jcardiff@cheo.on.ca).

Sincerely

Joan Cardiff

cc. Lorraine Sunstrum-Mann, Hospital Nominee  
Rob Rupert, ONA Nominee  
Jo Anne Shannon, Professional Practice Specialist, ONA





February 2, 2011

VIA EMAIL

416 Lakeshore Road  
R.R. #2  
White Lake, Ontario  
K0A 3L0

Ms. Johanne Messier-Mann  
Chief Nursing Officer  
Director, Maternal Child & Medical Programs  
Sault Area Hospital  
969 Queen Street St East  
Sault Ste. Marie, Ontario  
P6A 2C4

Dear Ms. Messier-Mann:

Re: Sault Area Hospital and Ontario Nurses' Association: Professional Responsibility Complaint – Independent Assessment Committee (IAC)

The Independent Assessment Committee (IAC) met on January 31, 2011 to prepare for the IAC Hearing scheduled for February 8 – 10, 2011.

We reviewed the Briefs submitted by the Sault Area Hospital and the Ontario Nurses' Association in detail. Our review identified a number of areas for which we require additional information.

#### Renal Unit Tour

- ◆ With respect to the physical environment of the Renal Unit, the IAC is looking forward to the tour of the current Renal Unit on the morning of February 8<sup>th</sup>.
- ◆ However, given that the Renal Unit in the new hospital will be functioning by the time the IAC submits its Report, we believe it will be important to gain a perspective of the physical configuration of the new Unit as well.
- ◆ We would like to tour the Plummer Site Renal Unit Tour from 0900 – 1100 (rather than 1000 – 1200) on the morning of February 8<sup>th</sup>. We would then drive to the new site (approx 20 minutes), and tour the Renal Unit in the new facility from 1130 – 1200.
- ◆ For this second tour, we would be happy to be accompanied by one person only from each of SAH and ONA (i.e. all three do not need to come if this poses transportation difficulties, but are of course most welcome to do so).

With respect to information provided, we would like to request that the following additional information be provided.

### Organizational Chart and Function

- ◆ We would like to see an organizational chart for the SAH as a whole, and for the Oncology and Renal Program.
- ◆ We are interested in the scope/span of control of the Renal Unit Manager's role, and would appreciate a more detailed explanation of this, particularly in relation to expectations of the Manager being/not being present in the care experience.
- ◆ We would like to better understand the role of the Desk Nurse / Team Leader / AR Nurse.

### Hemodialysis Care Requirements Tool

- ◆ We understand that the September 8, 2010 revision of the tool is currently in use.
- ◆ We would like to gain an understanding of the 'trending' of patients over the past months, in order to understand what proportion (if any) of patients have been consistently appropriate for RPN care according to the Tool, what proportion (if any) have never been appropriate, and what proportion (if any) have varied.
- ◆ We understand that the 'outcome' of the Tool evaluation is noted on the Team Leader's patient assignment list (following which the Tools themselves are destroyed).
- ◆ Please provide the patient assignment list, by patient number (i.e. patient #1, patient #2), for the first week of each of the past six months.

### Quality Assurance

- ◆ We would like to receive information regarding the Renal Program's QA Program, specifically,
  - the indicators that the Program tracks, and
  - outcomes related to these indicators (e.g., if hypertensive episodes on treatment is an indicator, what have been the tracked outcomes)
- ◆ Please provide this information for the 2009-2010 fiscal year, and the 2010-2011 YTD fiscal year.

### Medical Directives

- ◆ Both the SAH and ONA Briefs referred to the existence of medical directives within the Renal Program.
- ◆ Please provide a copy of those relating to hemodialysis.
- ◆ Please provide information regarding
  - the process for approval of the directive(s), and
  - the process for initial and ongoing assessment of the RN's/RPN/s knowledge, skill and judgement to enact the directive(s).

### Attendance

With respect to sick time, please provide:

- ◆ Total number of sick time hours for
  - RNs for the 2009-2010 and 2010-2011 YTD fiscal years
  - RPNs for the 2010-2011 YTD fiscal year
  - DAs for the 2009-2010 and 2010-2011 YTD fiscal years

With respect to overtime, please provide:

- ◆ Total number of overtime hours (i.e. premium time) for
  - RNs for the 2009-2010 and 2010-2011 YTD fiscal years
  - RPNs for the 2010-2011 YTD fiscal year
  - We recognize that this will also include 'incremental' overtime (missed breaks, additional time at the end of a shift etc; it is not necessary to break this out).

- ◆ Total number of paid hours for RNs and RPNs for the 2009-2010 and 2010-2011 YTD fiscal years.

We recognize that some of this information will be readily available, and some will require time to prepare. Please provide as much information as possible at the start of the Hearing (1300 Tuesday February 8<sup>th</sup>) and the remainder by 1600 on Wednesday February 9<sup>th</sup>. Please provide copies for both the IAC members and ONA.

We are looking forward to meeting with you and the SAH team on Tuesday. If you have any questions in the meantime, please contact me by phone at 613-622-7743 or by email at [jcardiff@cheo.on.ca](mailto:jcardiff@cheo.on.ca).

Sincerely

Joan Cardiff  
Chair, IAC

cc. Rob Rupert, ONA Nominee  
Lorraine Sunstrum-Mann, Hospital Nominee  
Frank Angeletti, Hospital Counsel  
Jo Anne Shannon, Professional Practice Specialist, ONA



February 2, 2011

VIA EMAIL

416 Lakeshore Road  
R.R. #2  
White Lake, Ontario  
K0A 3L0

Ms. Johanne Messier-Mann  
Chief Nursing Officer  
Director, Maternal Child & Medical Programs  
Sault Area Hospital  
969 Queen Street St East  
Sault Ste. Marie, Ontario  
P6A 2C4

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

Dear Ms. Messier-Mann and Ms. Shannon

Re: Sault Area Hospital and Ontario Nurses' Association: Professional Responsibility Complaint – Independent Assessment Committee (IAC)

The Independent Assessment Committee (IAC) met on January 31, 2011 to prepare for the IAC Hearing scheduled for February 8 – 10, 2011. We appreciate the detailed information provided by both parties.

Both the SAH and ONA Briefs and supporting documents included information regarding the previous all-RN and current RN/RPN schedules. These were presented in differing formats, and from our review, appear to include inconsistencies.

The IAC requests that SAH and ONA work together to provide, for the morning of Wednesday February 9<sup>th</sup>, the following:

The Schedule:

- ◆ The previous schedule (18 line RN master), including the scheduling of both the FT and PT RNs. Please include information regarding which of the lines were vacant due to LTD, which were job-shared, and which were filled by various PT RNs.
- ◆ Please provide the actual schedule, so we can see how the 11.25 hr and 7.5 hr shifts are assigned across the FT and PT RNs.
- ◆ The current schedule (16 line RN master) that began in June 2010. (The SAH Brief indicated that this schedule is to begin in June 2011, but we understand this to be a typo – please confirm). Please include the scheduling of both the FT and PT RNs as above.
- ◆ Please provide the actual schedule, as above.

- ◆ The current schedule for the Dialysis Assistants.

#### Daily Assignment

- ◆ We understand that there are three 'groups' of patients per day during the week -- morning (0730/0800/0830 start), afternoon (1230/1300/1330 start) and evening (1730/1800/1830 start) and two groups on the weekend – morning and afternoon.
- ◆ Please indicate how the RN and RPN staff are assigned across the three patient 'groups' during the week and on the weekend (RN only).
- ◆ Please include specific information re break coverage over the lunch and dinner hours.
- ◆ Please indicate how staff members are assigned within the 'core unit' and within the 'expanded alcove'.

The IAC will review the above information at the beginning of the Hearing on February 9<sup>th</sup>, before hearing the Response Submissions. The above information can be provided as an information package, or information package with short (10 min) presentation. However, the content must be jointly agreed between SAH and ONA.

If you have any questions in relation to this request, please contact me by phone at 613-622-7743 or by email at [jcardiff@cheo.on.ca](mailto:jcardiff@cheo.on.ca).

Thank you.

Sincerely

Joan Cardiff  
Chair, IAC

cc. Rob Rupert, ONA Nominee  
Lorraine Sunstrum-Mann, Hospital Nominee  
Frank Angeletti, Hospital Counsel

February 2, 2011

*Appendix 7*  
VIA EMAIL

416 Lakeshore Road  
R.R. #2  
White Lake, Ontario  
K0A 3L0

Ms. Johanne Messier-Mann  
Chief Nursing Officer  
Director, Maternal Child & Medical Programs  
Sault Area Hospital  
969 Queen Street St East  
Sault Ste. Marie, Ontario  
P6A 2C4

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

Dear Ms. Messier-Mann and Ms. Shannon

Re: Sault Area Hospital and Ontario Nurses' Association: Professional Responsibility Complaint  
– Independent Assessment Committee (IAC)

The IAC held a Pre-Hearing Meeting on January 31, 2011, to prepare for the IAC Hearing scheduled for February 8<sup>th</sup>-10<sup>th</sup>, 2011.

The IAC reviewed the letters received from the Sault Area Hospital (January 18, 2011 and January 28, 2011) and the Ontario Nurses' Association (January 31, 2011) regarding the Professional Responsibility Complaints within the IAC's jurisdiction.

The IAC is not in a position to comment, and will not be commenting, on any individual Professional Responsibility Workload Complaint Form. The IAC's role is to review the issues emanating from the Forms, in order to make recommendations for future action. The specific issue upon which the IAC has been asked to provide recommendations relates to the integration of RPNs into the SAH Renal Unit. All PRWCFs that relate to this issue will be considered by the IAC, including those submitted after the referral to the IAC on October 25, 2010. PRWCFs that relate to other issues, such as implementation of the PRC documentation system, will not be considered, regardless of the date on which they were submitted.

If you have any questions regarding the above, please contact me by email at [jcardiff@cheo.on.ca](mailto:jcardiff@cheo.on.ca).

Sincerely

Joan Cardiff  
Chair, IAC

cc. Rob Rupert, ONA Nominee  
Lorraine Sunstrum-Mann, Hospital Nominee  
Frank Angeletti, Hospital Counsel

*Sault Area Hospital / Ontario Nurses' Association  
Independent Assessment Committee Report  
March 2011*





# Independent Assessment Committee Hearing

**Ontario Nurses' Association / Sault Area Hospital**

## Agenda

**Tuesday February 8, 2011  
Riverview Auditorium**

08:00 – 09:00	<i>Independent Assessment Committee Meeting (Committee members only)</i>
09:00 – 11:00	Tour of Renal Unit: SAH Plummer Site ♦Attending: •Independent Assessment Committee •For the Hospital: Lise Corriveau, Teigan Milne, Brenda Lynn •For the Association: Jo Anne Shannon, Ruth Saraci, Jewel Porter
11:00 – 11:30	Travel to new SAH site
11:30 – 12:00	Tour of Renal Unit: SAH new hospital
12:00 – 12:30	Travel to SAH Plummer Site
<b>13:30</b>	<b>Commencement of Hearing</b>
13:30 – 13:45	♦Introduction and Review of Proceedings by Chairperson
13:45 – 15:15	♦Ontario Nurses' Association Submission Presentation ♦Response to questions of clarification from •Independent Assessment Committee •Sault Area Hospital
15:15 – 15:30	Break
15:30 – 17:00	♦Sault Area Hospital Submission Presentation ♦Response to questions of clarification from •Independent Assessment Committee •Ontario Nurses' Association
17:00 – 17:15	♦Review of Process for February 9, 2011 by Chairperson
17:15	Adjournment of Hearing

# Independent Assessment Committee Hearing

**Ontario Nurses' Association / Sault Area Hospital**

## Agenda

**Wednesday February 9, 2011  
Riverview Auditorium**

07:30 – 08:30	<i>Independent Assessment Committee Meeting (Committee members only)</i>
08:30	Continuation of Hearing
08:30 – 11:30	<ul style="list-style-type: none"> <li>♦Sault Area Hospital Response to Ontario Nurses' Association Submission               <ul style="list-style-type: none"> <li>•Response to questions from                   <ul style="list-style-type: none"> <li>•Independent Assessment Committee</li> <li>•Ontario Nurses' Association</li> </ul> </li> <li>♦Discussion</li> </ul> </li> </ul>
11:30 – 12:30	Lunch Break
12:30 – 15:30	<ul style="list-style-type: none"> <li>♦Ontario Nurses' Association Response to Sault Area Hospital Submission               <ul style="list-style-type: none"> <li>•Response to questions from                   <ul style="list-style-type: none"> <li>•Independent Assessment Committee</li> <li>•Sault Area Hospital</li> </ul> </li> <li>♦Discussion</li> </ul> </li> </ul>
15:30 – 15:45	♦Review of Process for February 10, 2011 by Chairperson
15:45	Adjournment of Hearing
16:00 – 20:30	<i>Independent Assessment Committee Meeting (Committee members only)</i>

*Note: The timing of the agenda is 'fluid'. If the Sault Area Hospital Response discussion is concluded before lunch, we will proceed with the ONA Response submission/discussion before the lunch break. If the ONA Response 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 / Sault Area Hospital**

## Agenda

**Thursday February 10, 2011**  
*Riverview Auditorium*

08:30	Continuation of Hearing
08:30 – 12:30	♦Questions to both Parties by Independent Assessment Committee
12:30 – 13:00	♦Closing Remarks and Identification of Next Steps by Chairperson
<b>13:00</b>	<b>Closure of Hearing</b>
13:00 – 15:00	<i>Independent Assessment Committee Meeting (Committee members only)</i>



## Hearing Participants and Observers

Tuesday February 8, 2011

Hearing Participants:

For the Association:	Colin Johnston Glenda Hubley Catherine Maccarone Kelly MacGregor Jewel Porter Ruth Suraci Jo Anne Shannon	ONA Litigation Team Leader Bargaining Unit President Local 46 RN, Renal Unit RN, Renal Unit RN, Renal Unit RN, Team Leader, Renal Unit Professional Practice Specialist
For the Hospital:	Frank Angeletti Lise Corriveau Kim Lemay Brenda Lynn Johanne Messier-Mann Teighan Milne	Hospital Counsel Former Nurse Manager, Renal Unit Director, Human Resources Director, Oncology/Renal Program Chief Nursing Officer Interim Nurse Manager, Renal Unit

Hearing Observers:

For the Association:	David Cheslock Karen Leclair Craig Watson	Labour Relations Officer RN, Renal Unit Chair, Prof. Practice, Local 46
For the Hospital:	Lori Bertrand Marie Paluzzi Ila Watson	Director, Surgical Program Vice President & COO Vice President, Human Resources

Wednesday February 9, 2011

Hearing Participants:

For the Association:	Colin Johnston Glenda Hubley Catherine Maccarone Kelly MacGregor Jewel Porter Ruth Suraci Jo Anne Shannon	ONA Litigation Team Leader Bargaining Unit President Local 46 RN, Renal Unit RN, Renal Unit RN, Renal Unit RN, Team Leader, Renal Unit Professional Practice Specialist
For the Hospital:	Frank Angeletti Dr David Berry  Lise Corriveau Kim Lemay Brenda Lynn Johanne Messier-Mann Teighan Milne	Hospital Counsel Medical Director, Algoma Regional Renal Program Former Nurse Manager, Renal Unit Director, Human Resources Director, Oncology/Renal Program Chief Nursing Officer Interim Nurse Manager, Renal Unit

## Hearing Observers:

For the Association:	David Cheslock Kierston Miron Colin Watson	Labour Relations Officer Treasurer, Local 46 Chair Prof Practice, Local 46
For the Hospital:	Lori Bertrand Katherine Gosselin  Anita Steiert Ila Watson	Director, Surgical Program Manager, HR Client & Corporate Services Human Resources Consultant Vice President, Human Resources

Thursday February 10, 2011

## Hearing Participants:

For the Association:	Colin Johnston Glenda Hubley Catherine Maccarone Kelly MacGregor Jewel Porter Ruth Suraci Jo Anne Shannon	ONA Litigation Team Leader Bargaining Unit President Local 46 RN, Renal Unit RN, Renal Unit RN, Renal Unit RN, Team Leader, Renal Unit Professional Practice Specialist
For the Hospital:	Frank Angeletti Lise Corriveau Kim Lemay Brenda Lynn Johanne Messier-Mann Teighan Milne	Hospital Counsel Former Nurse Manager, Renal Unit Director, Human Resources Director, Oncology/Renal Program Chief Nursing Officer Interim Nurse Manager, Renal Unit

## Hearing Observers:

For the Association:	David Cheslock Karen Leclair Craig Watson	Labour Relations Officer RN, Renal Unit Chair Prof. Practice, Local 46
For the Hospital:	Lori Bertrand Katherine Gosselin  Anita Steiert Ila Watson	Director, Surgical Program Manager, HR Client & Corporate Services Human Resources Consultant Vice President, Human Resources

**Cardiff, Joan**

**From:** Cardiff, Joan **Sent:** Mon 3/7/2011 11:03 AM  
**To:** messierj@sah.on.ca  
**Cc:** franka@fillion.on.ca; joannes@ona.org; themanns@rogers.com; rob.rupert@ontario.ca  
**Subject:** IAC: Further Questions  
**Attachments:**

Good morning Johanne

I hope the move to the new hospital is going well.

The IAC held its post-Hearing meeting on March 3rd - 4th, and identified a number of areas on which we would like further clarification.

1. We understand that the ARRP is a Regional Program. What is the difference between 'Regional Program' and 'Regional Centre'? With the move to the new structure with the Ontario Regional Network, is the term 'centre' no longer in use? Would the ARRP also be considered a 'regional centre'?

2. In June 2010, when the RPNs began to assume an independent patient assignment, we understand that the 18-line master rotation continued to be used, but that only 16 of the 18 lines were used. Is this correct? We understood that the 18 lines were: 2 RNs on LTD, 1 line filled by 2 RNs job-sharing and 15 lines filled by full-time RNs. We understand that the 16 lines are: 1 RN on LTD, 1 line filled by 2 RNs job-sharing and 14 lines filled by full-time RNs. What happened to one of the RNs on LTD and to one of the full-time RNs? Were there any layoffs or deployments at this time? (We noted the documented possibility of layoff of two positions, but we are unclear as to whether this actually happened). Was the Home Dialysis Transplant Nurse 1.0 FTE implemented in April 2010, and did the RN who assumed this position come from within the Renal Unit? How was/is this position funded?

3. SAH provided us with information regarding sick time:

2009 Fiscal Year: RN sick time 4503 hours RN overtime 2024.14 hours total paid hours (excluding unpaid sick) 63,938.7 hours

RPN sick time 604.5 hours RPN overtime 461.5 hours total paid hours (excluding unpaid sick) 13275.25 hours

2010 Fiscal YTD January 30/11: RN sick time 3397.75 hours RN overtime 2253.57 hours total paid (excluding unpaid sick) 56,671.4 hours

RPN sick time 408.75 hours RPN overtime 344.95 hours total paid (excluding unpaid sick) 11,852.45 hours

Please break out the long-term illness from short term illness for RNs and RPNs (we understand that there is at least one RN on LTD, and would like to understand the extent of sick time outside of this)

4. We would like information re costs per weighted unit. Please provide the number of visits (hemo treatments), weighted unit and cost per weighted unit for 2008/09, 2009/10 and 2010/11 TYD. Are you anticipating a change in the new Renal Unit?

5. Re the Hospital Improvement Plan, we understand that the elimination of the Staffing Office occurred in January 2011 – is this correct? If not, please confirm the correct date. We understand that the Supervisor role will be discontinued as of April 2011, as part of the 2011/2012 HIP – is this correct? Will this involve elimination of the Supervisor role 7 days per week on all shifts?

6. We understand the reporting structure to be a matrix model: that is, the ARRP Manager reports to the Director Oncology/Renal for operational issues, and to the CNO for professional practice issues. Is this correct? We understand that the allied health professionals in the ARRP (dietician, social worker, pharmacist) report to the ARRP Manager for operations and to their professional practice leader for professional practice issues – is this correct, and if so, who is the professional practice leader(s) for the allied health group? We understand that the Vascular Access Coordinator, Educator and the Home Dialysis and Home Dialysis Transplant Nurses all report to the ARRP Manager – is this correct?

7. After June 21, 2010, was there a change in total paid hours in the Renal Unit? What was the difference in

<https://www3.cheo.on.ca/exchange/jcardiff/Sent%20Items/IAC:%20%20Further%20Questi...> 3/7/2011

RN paid hours? We understand that the goal had been to decrease by 2.2 FTE RN positions while increasing by 2.0 FTE RPN positions -- is this correct, and if so, what were the anticipated decrease/savings in paid and total hours?

8. We understand that the going-forward requirement is that the ARRP operate within the renal envelope, and that 'subsidies' from the hospital global funding will no longer be provided. What is the difference (in round numbers) between the renal envelope funding and the ARRP annual operating costs? -- ie what is the difference that the ARRP will need to absorb/make up?

We understand that these are exceedingly busy and exciting days for the Hospital, and that you will have many competing priorities as you settle into the new hospital this week. However, if you could arrange for provision of the above information by Friday March 11th, we would be very appreciative, as our next teleconference is scheduled for Monday March 14th.

Thanks very much. Please call if you have any questions, and best wishes with the move.

Joan Cardiff

<https://www3.cheo.on.ca/exchange/jcardiff/Sent%20Items/IAC:%20%20Further%20Questi...> 3/7/2011



## **Ontario Nurses' Association Recommendations**

### **Skill Mix**

Improper skill mix and patient assignment inconsistent with the CNO Practice Guideline Utilization of RNs and RPNs (2009) and the Three Factor Framework resulting in incidences of delayed, improper and/or unsafe care.

1. Increase the number of RN staff in accordance with client acuity and complexity, predictability and risk of negative outcomes.
2. Return to an all RN model of care in the Renal Unit.
3. An RN will assess every patient as they arrive for their treatment.
4. The Hospital and the Union, including consultation with the Renal RNs, will develop an appropriate, valid, safe and meaningful Hemodialysis Care Requirement Tool.
5. Staffing decisions will be evidence-based and in the best interests of clients and professional practice.

### **Quality of Patient Care**

Increased RN workload, quality of care and care delivery process issues resulting in incidences of delayed, improper and/or unsafe patient care; and increased RN staff frustration and stress.

6. RN staffing levels shall ensure that the time and resources required are available to allow the provision of safe, ethical and competent patient care.
7. RN staffing levels shall ensure that there are sufficient resources to allow all nurses to take their scheduled rest and meal breaks on a consistent basis.
8. RN staffing levels shall ensure that there is sufficient time for computerized charting (PCS).
9. Provide adequate notification, training/education prior to implementing new processes, procedures, tools and equipment on the unit.
10. All new processes, procedures and tools will be properly evaluated with front-line input within 3-6 months of implementation.
11. A Nursing Unit Council will be implemented within 3 months and shall include Union representation and involvement.
12. Revise policies, procedures and practices to be inline with CNO Standards and RNAO Best Practice Guidelines, and that front-line RN staff be consulted and provided an opportunity for input and participation.
13. A quality practice setting will be created and sustained that supports nurses ability to deliver safe, ethical and competent care.

### **Staffing**

Inadequate part-time relief staffing to replace sick calls and other absences of both professional and support staff resulting in incidences of delayed, improper and/or unsafe patient care.

14. Staffing quotas and patient assignments shall ensure that enough time is available for patient care.
15. Staffing quotas shall ensure that enough time is available for RNs to properly coach, collaborate, consult with and provide direction to other regulated and unregulated nursing staff.
16. Ensure that relief staff are consistently available such that the baseline nursing staff complement shall be maintained.
17. Develop an improved staffing/contingency plan to be put in place when the activity and/or acuity exceeds the numbers of RNs available to provide care.
18. An adequate number of trained support staff will be hired and trained to eliminate or greatly reduce time spent on non-nursing activities.

### Relationship and Partnership

Relationship and partnership issues between management and RNs that have resulted in communication problems and a perceived lack of professional support and respect for the Registered Nurses, culminating in a toxic and unhealthy work environment.

19. Effective, consistent and comprehensive mechanisms for on-going communication shall be established that promote dignity and respect.
20. The contributions that Hemodialysis nurses make to the health and well-being of their clients shall be valued and acknowledged.
21. Staff meetings will be held at least every two months, with adequate notice and agendas; and the minutes shall be posted within 1 week of such meetings.
22. The Professional Responsibility Workload Report Form process will be jointly revised and adhered to by May 1, 2011. This process will ensure that professional respect is maintained through all steps of the process.
23. An evidence-based decision making process will be implemented, and all decisions shall be evaluated for the impact on nursing practice and patient outcome.
24. That management, with the involvement of front-line RNs, will develop a plan to implement the following RNAO Healthy Work Environment Best Practice Guidelines:
  - Preventing and Managing Violence in the Workplace
  - Embracing Cultural Diversity in Health Care
  - Workplace Health, Safety and Well-being of the Nurse
  - Developing and Sustaining Effective Staffing and Workload Practices
  - Collaborative Practice Among Nursing Teams
  - Professionalism in Nursing
  - Developing and Sustaining Nursing Leadership
25. That management, with the involvement of front-line RNs, will develop a plan to implement the following RNAO Best Practice Guidelines:
  - Adult Asthma Care Guidelines
  - Assessment and Care of Adults at Risk for Suicidal Ideation and Behaviour
  - Assessment and Management of Foot Ulcers for People with Diabetes
  - Assessment and Management of Pain
  - Assessment and Management of Venous Leg Ulcers
  - Best Practice Guidelines for the Subcutaneous Administration of Insulin in Adults with Type 2 Diabetes
  - Care and Maintenance to Reduce Vascular Access Complications
  - Client Centred Care
  - Crisis Intervention
  - Decision Support for Adults Living with Chronic Kidney Disease
  - Establishing Therapeutic Relationships
  - Nursing Care of Dyspnea: the 6<sup>th</sup> Vital Sign in Individuals with Chronic Obstructive Pulmonary Disease
  - Nursing Management of Hypertension
  - Oral Care: Nursing Assessment and Interventions
  - Prevention of Constipation in the Older Adult Population
  - Prevention of Falls and Fall Injuries in the Older Adult
  - Reducing Foot Complications in People with Diabetes
  - Risk Assessment and Prevention of Pressure Ulcers
  - Screening for Delirium, Dementia and Depression in Older Adults
  - Strategies to Support Self-Management in Chronic Conditions: Collaboration with Clients
  - Stroke Assessment Across the Continuum of Care
  - Supporting and Strengthening Families through Expected and Unexpected Life Events

**Sault Area Hospital: Algoma Regional Renal Program**  
**Achievements: 2008 – 2010**

- Established infrastructure for Home Dialysis Program with dedicated Home Dialysis Nurse and space.
- Implemented role of the Dialysis Access Coordinator
- Implemented new dialysis machines (30)
- Discontinued Bicart reprocessing for single use cartridges
- Dialysis measurement analysis reporting (DMAR) – approved as one of seven sites for a research project; four RNs participated
- Implemented the role of the Home Dialysis Transplant RN
- Increased resources for Allied Health – 0.4 FTE Dietician and 0.4 FTE Social Worker
- Implemented a Volunteer Program
- Core group of nurses trained to Crit Line monitoring to assess HCT, oxygen saturation, changes in blood volume, re-circulation, blood flow to prevent morbid symptoms
- Implemented Community Wide Scheduling
- Implemented Patient Care System (PCS) and use of Tablets for Clinical Documentation
- Implemented Unplanned Start Program
- Participate in Ontario Renal Reporting System (ORRS)
- Social Worker representative on the Regional Steering Committee of the Kidney Foundation
- Medical Director member of the Provincial ORN Clinical Advisory Committee
- Former Manager, selected Regional ORN Director North East Region

## **Sault Area Hospital Recommendations**

### Recommendation 1:

All ARRP Registered Nurses maintain practice standards according to CNO three factor framework.

### Recommendation 2:

Discontinue the use of the Hemodialysis Care Requirement Tool.

### Recommendation 3:

ONA to educate its members on the proper utilization of professional responsibility workload report forms and the need for ongoing discussion of workload issues with Hospital management as an essential component of this process.

### Recommendation 4:

The Renal Unit Task Force be established including Management and with an equal membership by RNs and RPNs to discuss workload concerns.

### Recommendation 5:

The Team Leader should remain without an assignment on days.

## **Canadian Association of Nephrology Nurses and Technologists Nephrology Nursing Standards and Practice Recommendations**

### **Hemodialysis**

Hemodialysis is a common renal replacement therapy offered in hospital based units, freestanding units not in hospitals, or as a self care home modality. Prescriptions and methods for hemodialysis vary depending on the individual. Despite the technological advances and strengths in dialysis programs, the key to successful dialysis remains the ability to establish a good vascular access. The arteriovenous fistula is the gold standard for access related to its decreased complication rate (Thomas, 2005). Only when an arteriovenous fistula is not able to be created, should a synthetic graft, central venous catheter or other vascular access be considered as there is no benefit associated with other forms of vascular access. Access is closely linked to adequacy of the treatment (Thomas, 2005). Adequate dialysis decreases morbidity and mortality.

*Using the best available evidence and incorporating appropriate clinical practice guidelines, the nephrology nurse:*

### **Hemodialysis Vascular Access**

**Assesses patients for, and promotes arteriovenous fistula as first line long-term hemodialysis access including, but not limited to:**

- providing education about the benefits of arteriovenous fistulas over other forms of vascular access;
- identifying patients for referral for arteriovenous fistulas;
- exploring concerns around arteriovenous fistula creation, clarifying misconceptions and developing a plan with the patient to address concerns;
- providing arteriovenous fistula candidates with instructions regarding protecting the chosen arteriovenous fistula limb and blood vessels from injury that may compromise creation and development of an arteriovenous fistula; and
- providing information about arteriovenous grafts and central venous catheters if an arteriovenous fistula is not an option.

**Assesses the arteriovenous fistula/graft and limb after creation and prior to each dialysis to determine physical and functional readiness for use including, but not limited to:**

- impaired healing of the incision site over the new arteriovenous fistula/graft;
- swelling;
- redness;
- bleeding/bruising;
- drainage;
- tenderness;
- aneurysm formation;
- skin irritation;
- maturation of arteriovenous fistula;
- vessel size;
- cyanosis of the finger tips and delayed capillary refill of the nail beds;
- numbness, tingling, pain in extremity;
- presence and quality of bruit and thrill temperature of the skin around the arteriovenous anastomosis for abnormal warmth; and
- comparative temperature of digits in both access and non-access limbs.

**Monitors, records, and reports the access flow of the arteriovenous fistula/graft as per unit guidelines.**

**Addresses any concerns from the patient regarding arteriovenous fistula/graft access.  
Develops and documents an access care and cannulation plan.**

**Assesses the patient for complications post insertion of a central venous catheter including, but not limited to:**

- airway management and/or respiratory arrest;
- respiratory distress;
- cyanosis;
- bleeding, bruising, or swelling;
- hypotension with tachycardia;
- cardiac arrhythmia;
- catheter and dressing integrity; and
- pain.

**Ensures that central venous catheter tip placement is verified after new catheter insertion, before proceeding with dialysis treatment.**

**Assesses the patient and central venous catheter access and exit site prior to each treatment including, but not limited to:**

- patency;
- redness;
- discharge;
- swelling;
- bruising;
- bleeding;
- tenderness;
- line integrity;
- neck and facial swelling; and
- any concerns from the patient regarding central venous catheter access.

**Assesses the patients' access for complications during hemodialysis treatment including, but not limited to:**

Arteriovenous fistula/graft

- cannulation difficulties;
- pain;
- bleeding;
- infiltration;
- hematoma;
- blood flow rates; and
- arterial/venous pressures outside established parameters.

Central venous catheter

- pain;
- bleeding;
- blood flow rates;
- arterial/venous pressures outside established parameters;
- respiratory distress; and
- catheter integrity.

**Notifies physician or appropriate health care provider regarding assessment findings that preclude or alter use of access and hemodialysis treatment plan.**

**Administers a thrombolytic agent ie. tissue plasminogen activator (tPA) as per unit protocol or physician/appropriate health care provider orders for treatment of central venous catheter thrombotic catheter dysfunction.**

**Cannulates arteriovenous fistula/graft in accordance with established unit protocol and using CANNT endorsed clinical educators network nursing recommendations for management of vascular access in hemodialysis patients (2006) Appendix A as a guideline.**

**Educates the patient about possible complications associated with hemodialysis vascular access including, but not limited to:**

Arteriovenous fistula/graft

- infection;
- thrombosis;
- stenosis;
- bleeding;
- steal syndrome;
- failure of fistula maturation; and
- access infiltration.

Central venous catheter

- infection;
- central vein stenosis/thrombosis;
- catheter occlusion/fibrin sheath formation;
- catheter malfunction;
- bleeding;
- air or thrombo embolism;
- hemothorax/pneumothorax/cardiac tamponade; and
- vascular erosion, laceration, perforation.

**The nephrology nurse provides instruction for the appropriate cleaning of the arteriovenous fistula/graft.**

**The nephrology nurse provides education and instruction about the care and protection of the access and access limb including, but not limited to:**

- checking the thrill/pulse in access daily;
- using the access site only for dialysis;
- protecting from injury such as bumps and cuts;
- avoiding blood pressure checks, injections, and blood drawing;
- avoiding sleeping on access limb;
- avoiding tight jewelry or tight clothing is worn over access site; and
- avoiding heavy lifting.

**Instructs the patient to report signs and symptoms suggestive of complications, and seek medical attention for, but not limited to:**

- fever;
- chills;
- bleeding;
- drainage;
- absence of /or diminished thrill;
- swelling of access limb; and
- numbness, tingling, and or decreased motor function of the access limb.

**Uses appropriate cleaning and infection control techniques when accessing any type of hemodialysis access.**

**Hemodialysis Adequacy**

**Assesses the patient on an ongoing basis for signs and symptoms of inadequate dialysis including, but not limited to:**

- fatigue;
- loss of appetite;
- nausea;
- vomiting;
- pruritis;
- difficulty concentrating;
- weight loss;
- anemia;
- secondary hyperparathyroidism;
- neuropathy;
- restless legs;
- abnormal electrolytes;
- pericarditis; and
- changes in cognitive function;

**Assesses possible causes for hemodialysis delivered dose parameters that are below the minimum acceptable level (i.e. urea clearance < 65% or Kt/V < 1.2) including, but not limited to:**

- low pump speeds;
- inadequate dialysate flow for dialyser size;
- recirculation;
- lost dialysis time;
- arteriovenous fistula/graft stenosis;
- error in sampling procedure;
- inappropriate dialyzer size or clearance;
- inadequate dialyzer priming;
- excessive dialyzer clotting; and
- incorrect needle placement.

**Develops a plan in collaboration with the patient to achieve adequate dialysis treatments including, but not limited to:**

- adhering to prescribed dialysis treatment time;
- maximizing pump speeds;
- minimizing complications such as hypotension and cramps that potentially reduce dialysis time;
- appropriate needle size and placement; and
- adherence to dietary and fluid restriction.

**Collects data and participates in quality assurance activities to improve hemodialysis adequacy outcomes.**

**Educates the patient about dialysis adequacy, the importance of receiving full dialysis treatments, possible consequences and complications related to inadequate dialysis.**

### **Hemodialysis Treatment and Complications**

**Assesses the patient's health status/health concerns between hemodialysis treatments for intercurrent illness and complications that might affect current hemodialysis treatment including, but not limited to:**

- dizziness;
- weakness;
- hypotension;
- feeling unwell;
- fever;
- nausea;



- vomiting;
- diarrhea;
- chest pain;
- shortness of breath;
- new medications, changes in medication dosing, or discontinued medications;
- bleeding;
- bruising;
- falls; and
- medical/surgical treatments or procedures.

Assessment includes:

- symptom onset;
- location/radiation;
- duration;
- intensity/character; and
- aggravating and relieving factors.

**Collaborates with physician or appropriate health care provider and the patient to develop and implement a plan of care to improve dialysis adequacy.**

**Completes a focused physical assessment of the patient before, during, and after dialysis including, but not limited to:**

weight (pre and post dialysis);  
blood pressure;  
heart rate;  
respiratory rate and quality;  
edema (peripheral, facial, sacral, periorbital);  
jugular venous distention;  
level of consciousness and orientation; and  
heart and lung sounds.

**Confirms dialysis prescription and orders prior to initiating hemodialysis treatment including, but not limited to:**

- dialyzer;
- electrolyte/molecular composition of dialysate;
- frequency and length of treatment;
- blood flow and dialysate flow rate;
- anticoagulation;
- dialysate temperature;
- ultrafiltration profiling;
- sodium profiling; and
- target weight.

**Reviews and assesses the most recent laboratory tests prior to dialysis treatment and assesses for conflict with dialysis prescription.**

**Assesses hemodialysis equipment prior to dialysis initiation for:**

- disinfection;
- blood pump occlusion;
- functioning alarms;
- integrity of extracorporeal circuit;
- dialysate conductivity; and
- water treatment congruent with unit policy.

**Assesses the patient during the dialysis treatment to ensure that access is secure (i.e. needles and lines securely taped, access is visible).**

**Assess the patient during the hemodialysis treatment for complications and responds to unexpected outcomes including, but not limited to:**

- hypotension;
- cramping;
- disequilibrium syndrome;
- air embolism;
- hemolysis;
- bleeding/hemorrhage /exsanguination;
- blood leak;
- clotting of circuit;
- cardiac events (e.g., dysrhythmias, angina, uremic pericarditis, cardiac arrest);
- dialyzer reaction;
- pyrogenic reaction;
- infection; and
- monitoring the hemodialysis machine and extracorporeal circuit.

**Engages the patient in the hemodialysis treatment and encourage participation and self management where possible.**

**Collaborates with the patient to evaluate the hemodialysis treatment, set between treatment goals, and revises the plan of care as necessary for next treatment.**

**Assesses knowledge needs and develops and implements a plan in collaboration with the patient regarding hemodialysis therapy and associated treatments including, but not limited to:**

- diet/fluid;
- anemia;
- bone and mineral metabolism;
- medications; and
- care of access.

### **Medication Management**

**Assesses medication regimen and develops a plan with the patient that includes, but is not limited to:**

- current medication regimens, successes, and challenges;
- assists the patient to simplify medication regimens;
- administers prescribed medications during the hemodialysis treatment;
- identifies indications and interactions for commonly administered hemodialysis medications (e.g., erythropoiesis stimulating agents, iron preparations, vitamin D sterols, antibiotics, thrombolytic agents);
- completes and documents a medication history as per unit policy and assesses for any dosing changes, new or discontinued medications with each treatment; and
- educates the patient about medications, including timing in relation to hemodialysis schedule and assists patient to simplify medication regimen where possible.

### **Infection Control Practices**

**Follows unit-based infection control procedures for:**

- cleaning and disinfection of equipment and work area between patient appointments;
- handling medications;
- handling and disposal of contaminated supplies;
- adherence to infection and prevention and control measures;

- ensures appropriate isolation techniques;
- vaccinations for influenza and pneumonia as per unit policy;
- screening patients for antibiotic resistant organisms (e.g., Methicillin Resistant Staphylococcus Aureus, Vancomycin Resistant Enterococcus) as per unit policy.

Viral Infections (CDC, 2001)

- assesses patients Hep B, C and HIV status prior to initial dialysis, and longitudinally, as per unit protocols;
- vaccinates all susceptible patients against hepatitis B;
- follows unit policy for initial testing, vaccination and follow up of hepatitis B and C.

**Adheres to unit policies related to prevention and transmission of blood-borne pathogens:**

- ensures inspection of the internal pressure tubing set and pressure sensing port for possible blood contamination -- if contaminated, the machine is disinfected before it is used again;
- uses an external transducer protector and alarm capabilities as indicated in the manufacturer's instructions;
- assesses the external transducer protector for wetness. If this becomes wetted, it is replaced immediately and inspected. If fluid is visible on the side of the transducer protector that faces the machine, ensures qualified personnel should open the machine and check for contamination after the treatment is completed;
- ensures that if contamination has occurred, the machine is taken out of service and disinfected before further use; and
- monitors for frequent venous and arterial pressure alarms or frequent adjustment of blood drip chamber levels which may indicate that this problem is occurring.



## Sault Area Hospital

### ARRP Renal Unit RN and RPN Major Responsibilities

RN Major Responsibilities / Duties	RPN Major Responsibilities
1. Initiates, monitors and discontinues prescribed dialysis treatments in the Hemodialysis, <b>Critical Care and Medical Units depending on patient's medical condition.</b>	1. Initiates, monitors and discontinues prescribed dialysis treatments <b>on stable patients with predictable outcomes</b> in the Hemodialysis Unit using a central venous catheter, fistula or graft.
	2. <b>Provides all nursing functions defined within the RPN scope of practice and clinical policies of the Renal Program.</b>
	3. <b>Reflects on whether she or he has the knowledge, skills and judgment to manage the outcomes and the risk of implementing a skill. If not, this must be verbalized so that appropriate resources may be found to manage the patient's care including re-assignment.</b>
2. Checks availability and function of emergency equipment (wall suction, emergency cart, AED, dialysis stations) prior to initiation of dialysis.	4. Checks availability and function of emergency equipment (wall suction, emergency cart, AED, dialysis machines) prior to the initiation of dialysis.
3. Understands and applies all infection control practices and precautions related to hemodialysis. Uses appropriate personal protective equipment (gloves, hand washing, gown, sharps containers, goggles etc.)	5. Understands and applies all infection control practices and precautions related to hemodialysis. Uses appropriate personal protective equipment (gloves, hand washing, gown, sharps containers, goggles etc.)
4. Reviews each patient's orders / treatment protocol prior to initiating treatment. Checks blood work parameters, and double checks treatment parameters within 30 minutes of commencement of dialysis.	6. Reviews each patient's orders / treatment protocol / <b>plan of care</b> prior to initiating treatment. Checks blood work parameters, and double checks treatment parameters within 30 minutes of commencement of dialysis.
5. Reports and/or discusses patient issues with the <b>desk nurse</b> or allied health member.	7. Reports and/or discusses patient issues with the <b>Team Leader, Registered Nurse and</b> or allied health member.
	8. <b>Takes blood samples from vascular accesses of hemodialysis blood tubing pre and post dialysis.</b>
6. Participates in patient care rounds as a member of the multidisciplinary team to discuss patient care issues and initiate timely intervention and/or changes to the prescribed dialysis treatment.	9. Participates in patient care rounds as a member of the multidisciplinary team to discuss patient care issues and initiate timely intervention and/or changes to the prescribed dialysis treatment.

RN Major Responsibilities / Duties	RPN Major Responsibilities
7. Evaluates each patient's condition prior to and during treatment. Reports significant findings to the nephrologist and carries out any order changes.	10. Evaluates each patient's condition prior to and during treatment. Recognizes ethical situations, problems and concerns and consults with the Registered Nurses / Team Leader. Aspects of care may be transferred or a reassignment of patient(s) may be required depending on the predictability and complexity of care.
	11. Monitors patients and equipment during the hemodialysis treatments.
	12. Provides interventions as necessary in collaboration with the RN and/or Team Leader.
	13. Regulates heparin dosage during the hemodialysis treatment.
	14. Administers intravenous medications into the hemodialysis blood tubing including eruthropoietin products, IV Vitamin D, dimenhydrate, Venofer and antibiotics.
8. Provides ongoing emotional support and alerts dietician, pharmacist and social worker of patient care needs.	15. Provides ongoing emotional support and alerts dietician, pharmacist and social worker of patient care needs.
	16. Anticoagulate the central venous catheters post dialysis.
	17. Dismantles, cleans and disinfects the dialysis equipment as required post treatment.
9. Documents care and monitoring provided.	18. Documents care and monitoring provided using the Data Intervention Outcome (DIO) documentation methodology.
10. Relieves coworkers for scheduled breaks.	19. Relieves coworkers for scheduled breaks.
11. Tidies and restocks dialysis stations, workstations and L-carts as required.	20. Tidies and restocks dialysis stations, workstations and L-carts as required

RN Major Responsibilities / Duties	RPN Major Responsibilities
12. Accepts an assignment in the Renal Clinic or Home Dialysis depending on staffing requirements and staffing issues in the Renal Program.	21. Provides assistance in the Renal Health Clinic or Home Dialysis as required.
	22. Maintains competency of functions identified on the Unit Knowledge and Skills Checklist
	23. Maintains own continuing education to enhance professional knowledge and growth by preparing an annual learning plan based on a self-assessment of needs and input from the manager.
13. Identifies, assesses and communicates safety concerns to the manager. Provides assistance in planning corrective actions to ensure safety for patients and staff.	24. Identifies, assesses and communicates safety concerns to the team leader and/or manager. She/he provide assistance in the planning and implementation of corrective actions to ensure safety of patients and staff.





## **SAH Clinical Policy: Hemodialysis Nursing Orientation Program**

Issued by: Manager Renal Services  
 Authorized by: Manager Renal Services

Issue date: February 2009  
 Revision date: February 2011

### Purpose

To outline the nursing orientation program for newly-hired nursing staff who have no previous dialysis experience.

### Supportive Data

Newly hired nursing staff with previous dialysis experience will successfully complete a written test prior to starting to work in the unit.

A learning plan will be developed with the Nurse Educator to address unit specific differences in nursing practice with all new experienced hemodialysis nurses.

This is a plan for a 6 week orientation program.

The nurse will be expected to purchase the recommended test (*sic*) prior to the beginning of the orientation period. Other materials will be provided by the Nurse Educator as appropriate.

### Orientation Plan

#### Week 1

- Unit orientation to staff, including scheduling of the work day and physical space.
- Outline of the parts and functions of the parts of the Renal Program, CKD, Home Dialysis, Transplantation, Hemodialysis.
- Role and responsibilities of the team members – Dialysis Access, Hemodialysis Team Leader, Nurse Educator, Manager, Dietician, Social Worker, Pharmacist
- Hemodialysis machine set-up including: procedure for application of disposables, completing all required safety checks predialysis, priming of the extracorporeal circuit and dialysate circuit, programming of a therapy
- Theory of the principles of dialysis, function and assessment of an artificial kidneys, dialysate function and preparation.
- Medical Directives, including bloodwork
- Pre-printed orders
- Will examine the hemodialysis kardex as it pertains to the preparation for treatment
- Review of aseptic technique
- Discussion regarding water treatment
- Infection Control issues as they relate to the hemodialysis machine and the treatment station include PPE
- Emergency equipment in the unit
- Preparation of the station prior to each treatment
- Learn the procedure to tear down a machine following treatment, and the requirements in cleaning the station between patients
- Learn the required documentation during the preparation for the treatment

#### Week 2

Topics will include

- Renal anatomy and physiology
- Anatomy and physiology related to AVF, AVG and dialysis catheters
- Renal failure
- Uremic syndrome
- General treatments

## UF calculations

- Pre-intra and post dialysis assessment
- FRI screening tool
- Central line use and care
- Initiations of dialysis – procedure and trouble-shooting
- Arterial and venous alarms
- TMP
- Blood pump speed
- Flushing of extracorporeal circuit
- Use of saline during the treatment: use of hypertonic saline
- Medications
  - Heparin
  - Alteplase
  - Na Citrate
  - Expre / Aranesp
  - Xylocaine/Emla
- Documentation of care

Will have initial patients with the Nurse Educator and then be assigned with the preceptor as appropriate

Will continue to practice machine set-up, programming

Will and/or assist with initiation / discontinuation of dialysis treatment

### Week 3

Topics will include

- AV Fistual
- AF Graft
- Completion of an on-line education module about hemodialysis access
- Patient and staff safety
- Complications of ERSD
  - Renal bone disease (phosphate binders, Calcitriol, Sensipar)
    - Monitoring
  - Renal anemia (Exprex, Aranesp, Venofer)
    - Monitoring
  - Blood pressure control (antihypertensives)
- Medications and monitoring
  - NSIAD
  - Coumadin
  - Chemo agents
  - Narcotics
- Target weight and fluid management

### Week 4

Topics will include

- Complications during hemodialysis treatment
  - Hypotension
  - Blood leak
  - Air and form
  - Air embolism
  - Disequilibrium
  - Accidental disconnection of blood lines
  - Cardiac arrest
  - Dialyzer reaction

Practice with patients who have an AVF / AVG

Week 5

Topics will include

- Medication reconciliation
- Blood and blood products
- Biofiltration
- Malnutrition – IDPN
- Infection control topics
  - Hepatitis B
  - Hepatitis C
  - HIV
  - VRS and MRSA
  - C-diff
  - Shingles
  - Influenza-like illness
- Isolation in hemodialysis
- Foot surveillance
- Transient patients – both coming and going
- Transplantation
  - Preparation required
  - Our responsibilities
  - Patient responsibilities
  - LHSC role

Week 6

Topics will include

- Quality tools
  - Hemoscan
  - Diascan
  - O2 sats
- K/DOQI guidelines
- CSN guidelines
- Missed dialysis treatments
- Welcome to Hemodialysis Booklet

RELATED POLICIES AND PROCEDURES

REFERENCES

APPENDICES



## Sault Area Hospital Hemodialysis Care Requirements (November 2009 Draft)

**SHIFT TIME:** Circle appropriate time    **AM**    **PM**    **EVENINGS**

Please complete this assessment using documented information.

		YES	NO
1	The patient is stable with needs that are readily definable (based on the individual patient) <ul style="list-style-type: none"> <li>• UF goal manageable</li> <li>• BP stable (for the particular patient and consistent with other treatments)</li> <li>• No severe shortness of breath (documented)</li> </ul>		
2	The patient has been on hemodialysis at least 4 to 6 weeks		
3	The patient has dialysis access problems / new access / intervention in past 48 hours		
4	The patient is a transient		
5	The patient has a history of or signs, symptoms or responses in relation to a condition / treatment intervention that requires heightened vigilance and possible intervention Examples include: - Introdialytic weight gain resulting in symptoms during fluid removal during previous month -symptomatic drop in systolic BP > 60 mmHg or not below 90 mmHG -intradialytic angina -recent fall or surgery -transfer from ER (if reason for ER visit – hemodynamic instability) -increasing BP during therapy requiring intervention -acute episode in co-morbid cardiovascular or respiratory conditions in previous 6 weeks		
6	The patient has an unexpected event or crisis that <u>happens during</u> this treatment Examples include: -seizure -severe hypotension -chest pain that requires Nitro, O2 therapy -cardiac arrest -history includes suspected reason for increased risk of bleeding		
7	The patient requires complex meds / therapy during their treatment		
	- EPO agents		
	- tPA (Cathflo) Depends on situation		
	- Chemo (requires Cytotoxic precautions)		
	- Blood transfusion unstable, for example, history of allergic reactions, actively bleeding		
	- Blood transfusion stable, for example, low hemoglobin		
	- Hypertonic solutions (50% dextrose, 23.4% NaCl)		
	- Venofer (First dose per RN)		
	- Antibiotics (First dose per RN)		
	- Narcotics		
	- Lipids and Travasol		
8	The patient requires interventions / treatments that may have an immediate systemic effect creating an urgent or emergent situation Examples include: -GI bleed -Access Needle / Line falls out -Requires TPA -Electrolyte imbalance (elevated K+, Ca levels)		
9	The patient has complex social / psychological health issues		
	<b>Total answers in open sections</b>		
	<b>Patients needs can be met by an RPN</b> (stable, less complex with predictable outcomes)		

Revised November 2009Appendix

**Sault Area Hospital**  
**Hemodialysis Care Requirements Tool (September 2010 Draft)**

\*Please complete this assessment using documented information

**PLACE A CHECK MARK (✓) IN THE COLUMN IF THE PATIENT MEETS ANY OF THE FOLLOWING CRITERIA**

<p><b>The patients may NOT be cared for by the RPN when:</b></p> <ul style="list-style-type: none"> <li>♦ Patient has been on hemodialysis less than 4 to 6 weeks</li> <li>♦ Patient is a transient</li> <li>♦ Patient is a transfer from the ER</li> <li>♦ UF goal not manageable and greater than 1.5 kg/hr</li> <li>♦ Admitting BP is not stable (for the particular patient and consistent with other treatments)</li> <li>♦ A new AVF/AVG has not been used successfully for greater than 6 weeks</li> <li>♦ Renal catheter does not support flows greater than 200 mL/min</li> <li>♦ A Catheter insertion / Angioplasty / cryoplasty has occurred in past 48 hours</li> <li>♦ A Surgical intervention (creation / revision / thrombectomy) has occurred in past 6 runs</li> <li>♦ A drop in SPB &gt; 60 mmHg and /or SBP less than 90 during fluid removal has occurred in previous 2 weeks</li> <li>♦ Severe shortness of breath is present</li> <li>♦ Cardiac concerns (angina, pulse above 120) are present</li> <li>♦ An acute cardiovascular or respiratory event has occurred in previous 3 weeks</li> <li>♦ A history of allergic reactions to blood products and blood products are ordered for this treatment</li> <li>♦ Active bleeding is present</li> <li>♦ Administration of Hypertonic solutions (50% Dextrose, 23.4% NaCl) has occurred on more than 1 run in last 3 runs</li> <li>♦ IDPN therapy of less than 2 weeks duration</li> </ul>	
<p><b>Patient meeting above criteria may not be cared for by a RPN</b></p>	

Revised September 8, 2010

DATE \_\_\_\_\_ SIGNATURE: \_\_\_\_\_

### ARRP Renal Unit Nursing Schedule to June 20, 2010

Time	Nursing Staff M/W/F	# of Patients	Nursing Staff T/Th	# of Patients	Nursing Staff Sat/Sun	# of Patients
0700 - 1100	1 Team Leader 6 RNs	18 pts 1:3 ratio	1 Team Leader 6 RNs	18 pts 1:3 ratio	5 RNs	22-23 pts per day 1:3 ratio
1100 - 1500	1 Team Leader 8 RNs	18 pts 1:2 ratio	1 Team Leader 8 RNs	18 pts 1:2 ratio		
1500 - 1900	8 RNs	12pts 1:3 ratio*	7 RNs	9 pts 1:3 ratio*		
1900 - 2300	4 RNs		3 RNs			
Total Patients		48		45		45 over two days

\*The nurse:patient ratio was 1:2 from 1500 to completion of the afternoon treatments, and 1:3 for the evening treatments beginning at 1730.

Original # RNs

