Independent Assessment Committee

Report

Constituted Under Article 8.01 of the
Collective Agreement
between

Sault Area Hospital
and
Ontario Nurses’ Association

June 2012
The members of the Independent Assessment Committee respectfully submit the attached Report with findings and recommendations regarding the Professional Responsibility Complaint presented by the Registered Nurses working in the Emergency Department of 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 Independent Assessment Committee recognizes and appreciates the efforts taken by representatives of the Sault Area Hospital, the Ontario Nurses’ Association and the Registered Nurses working in the Emergency Department to prepare and present information and respond to our questions. The attached Report contains unanimously supported recommendations which we hope will assist all parties to continue to work together, within the context of a quality practice environment that supports professional practice, to provide proper patient care to the patients accessing the Emergency Department at the Sault Area Hospital.

Respectfully submitted on June 14, 2012

Joan Cardiff, RN, MScN
Chairperson, Independent Assessment Committee

Diane Baigrie, RN
Sault Area Hospital Nominee

Cindy Gabrielli, RN(EC)
Ontario Nurses’ Association Nominee
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SECTION 1

INTRODUCTION

1.1 Organization of the Independent Assessment Committee Report

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

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

Section II reviews the background leading to the referral of the PRC to the IAC, and presents the IAC’s understanding of the Association’s and Hospital’s perspectives regarding the PRC.

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

Section IV presents the IAC’s conclusions and recommendations.

Section V contains Appendices referenced in the IAC Report.

1.2 Jurisdiction of the Independent Assessment Committee

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

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

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

- 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

\(^1\) College of Nurses of Ontario: Practice Guideline: *RN and RPN Practice: The Client, the Nurse and the Environment*, Publication # 41062, December 2011

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The IAC is responsible for examining the client, nurse and environmental factors impacting workload, and for making recommendations to address workload issues. Concerns outside of workload are beyond the jurisdiction of the IAC.

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

1.3 Referral to the Independent Assessment Committee

The RNs in the Emergency Department (ED) at the Hospital began to consistently document workload and practice concerns in 2009. A total of 289 Professional Responsibility Workload Report Forms (PRWRFs) were submitted between January 1, 2010 and April 12, 2012. Of these, 140 were submitted following the Hospital’s move to a new site on March 6, 2011.

Beginning in March 2010, ED PRWRFs were discussed at regularly scheduled Hospital-Association Committee (HAC) meetings. In addition, HAC meetings specifically focused on ED workload issues were held in 2010 and 2011 in an attempt to address identified issues. In July 2010, the Hospital and the Association reached agreement on a Letter of Understanding, which included an action plan with an evaluation review in December 2010. Although there was disagreement on the status of resolution of the issues at that time, the Association agreed to monitor the situation until after the move to the new Hospital site in March 2011. An ED Task Force was convened in April 2011 and met several times through 2011, but was unable to achieve consensus on resolution of the identified workload issues. The Association formally indicated its intention to forward the Complaint to an IAC as per Article 8 of the Collective Agreement on December 5, 2011 (Appendix 2) and formally notified the IAC Chairperson on December 7, 2011 (Appendix 3).

1.4 Proceedings of the Independent Assessment Committee

1.4.1 Pre-Hearing

In accordance with Article 8.01 (a) (viii), the Hospital and the Association identified their Nominees to the IAC. The IAC Chairperson received notification of the Association Nominee, Cindy Gabrielli, on December 5, 2011, and the Hospital Nominee, Diane Baigrie, on December 13, 2011.

The IAC held an introductory teleconference on December 18, 2011. The Chairperson reviewed the jurisdiction of the IAC within the context of the Collective Agreement, and the IAC discussed the role of the Nominees and the Chairperson, reviewed the three phases of the IAC process, and discussed logistics associated with the Hearing and the process for review of the Hearing Briefs. Following the teleconference, the Nominees discussed potential dates for the Hearing with their respective parties.

The IAC Chairperson wrote to the Hospital and the Association on December 29, 2011 to confirm the date and location of the Hearing and to provide the draft Hearing Agenda. Respecting the principle of full
disclosure and to streamline the process of the Hearing by enabling the IAC to become familiar with the issues in advance, the IAC requested the Hospital and the Association to submit their Hearing Briefs and associated Exhibits to the Chairperson by April 13, 2012 (Appendix 4).

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

- The Association and Hospital Briefs were received on Friday April 13, 2012 and were distributed to all parties by courier on Monday April 16, 2012.
- The Hospital Brief and supporting Exhibits were resent to the Association on Thursday April 19, 2012.
- The Association’s additional information to supplement their Brief was received on Friday April 20, 2012 and was distributed to all parties on Wednesday April 25, 2012.

The IAC held a Pre-Hearing meeting in Sault Ste. Marie on April 30, 2012. The IAC reviewed the anticipated process of the Hearing, discussed the Hearing Briefs and Exhibits, and identified key issues for exploration at the Hearing. The IAC held a further brief meeting on the morning of May 1, 2012, to confirm the questions/issues for focus on the Site Tour.

1.4.1.1 Site Tour

The IAC conducted a Site Tour of the Emergency Department on the morning of May 1, 2012. The Site Tour was jointly conducted by the following:

On behalf of the Association:
- Tammy Marsh, RN, Emergency Department
- Jo Anne Shannon, Professional Practice Specialist, ONA
- Carol Thorold, RN, Emergency Department

On behalf of the Hospital:
- Vance Boyer, HR Consultant, SAH
- Vanda Cooper, Director, Emergency Department, Critical Care and Access, SAH
- Robin Joanisse, Manager, Emergency Department, SAH

The Site Tour began at the Emergency Department entrance to view the Triage and Reception Registration areas, and included a walk-through of the following:
- Fast Track Zone, including
  - Waiting Room, Communication Workstation, Medication Room and Exam Rooms;
- Sub-Acute Zone, including
  - See and Treat Waiting Room and Treatment Rooms
  - Communication Workstation,
  - Treatment Rooms, including Exam Rooms, Minor Procedure Rooms and Fracture, Eye/Dental and Gynecology Rooms
  - Medication, Supply and Utility Rooms
- Clinical Decision Unit Zone, including
  - Communication Station
  - Holding Bays
- Acute Zone, including
  - Communication Workstation,
  - Treatment Rooms,
At the completion of the Tour, the group reviewed the Emergency Department Information Tracker system, to gain an understanding of the intra-Department communication regarding patient status.

**1.4.2 Hearing**

The Hearing convened at 1300 hours in the Batchewana/Goulais Room at the Hospital. As indicated on the Hearing Agenda (*Appendix 5*), the Hearing was held over three days:

- **May 1, 2012**: 1300 – 1700 hours
- **May 2, 2012**: 0830 – 1200 hours
  1300 – 1630 hours
- **May 3, 2012**: 0830 – 1230 hours

The participants and observers who attended the Hearing are listed in *Appendix 6*.

**1.4.2.1 May 1, 2012**

The IAC Chairperson opened the Hearing at 1300 hours. Following introduction of the three IAC members and round-table introductions of the Association and Hospital participants, the IAC Chairperson reviewed the following:

- the IAC Hearing process, including the anticipated flow and organization of each day,
- the jurisdictional scope of the IAC, including the purpose of the IAC and the nature of its non-binding recommendations,
- the role of Hearing participants to 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 Hearing Submission, presented by Jo Anne Shannon, was based on the Association’s written Brief and 56 Exhibits of supporting/explanatory information, as well as copies of the PRWRFs submitted by the Emergency Department RNs between January 1, 2010 and April 12, 2012. Following the presentation, the Association responded to questions of clarification from the Hospital and the IAC.

The Hospital’s Hearing Submission, presented by Vanda Cooper, was based on the Hospital’s written Brief and 21 Exhibits of supporting/explanatory information. Following the presentation, the Hospital responded to questions of clarification from the Association and the Hospital.

The IAC Chairperson adjourned the Hearing at 1700 hours.
1.4.2.2   May 2, 2012

The IAC Chairperson opened the Hearing at 0830 hours. Vanda Cooper, supported by Robin Joanisse and Johanne Messier-Mann, provided the Response on behalf of the Hospital. Throughout and following the presentation, members of both the Hospital and Association teams participated in active discussion.

Following the lunch break, Jo Anne Shannon, supported by Tammy Marsh, Carol Thorold, Linda Walsh, and Glenda Hubley provided the Response on behalf of the Association. Throughout and following the presentation, members of both the Association and Hospital teams participated in active discussion.

The IAC Chairperson adjourned the Hearing at 1615 hours. The IAC met from 1630 – 2030 hours to review and synthesize the information provided, and to identify questions to focus the Hearing discussions on May 3, 2012. When leaving the Hospital at 2030, the IAC walked through the Emergency Department to gain an enhanced understanding of the practice environment during the evening hours.

1.4.2.3   May 3, 2012

The IAC met from 0730 – 0830 to finalize their Questions. The IAC Chairperson opened the Hearing at 0830 hours. The IAC explored issues for which the Committee wished a further understanding through an interactive Question and Answer session relating to staffing, practice issues, quality assurance monitoring and indicators, and policy issues. All Hearing participants actively participated.

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

At the close of the Hearing, the IAC Chairperson
- thanked the participants for their engagement in and commitment to the Hearing process, noting that the large number of observers at each of the three Hearing days was a clear indication of both the importance the ED RNs were placing on the IAC process, and their support for their colleagues who participated at the Hearing;
- expressed the IAC’s hope that the opportunity for open and honest dialogue during the Hearing would provide a sound basis for all parties to move forward constructively,
- 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 would be submitted within the 45 calendar day timeframe stipulated in the Collective Agreement.

The IAC Chairperson closed the Hearing at 1230 hours.
1.4.3 Post-Hearing

Between the closure of the Hearing and submission of the Report, the IAC held one face-to-face meeting and four teleconferences.

The IAC held a Post-Hearing meeting in Toronto on May 18, 2012. The IAC reviewed Draft 1 of the Report, and discussed the IAC’s analysis and proposed recommendations in depth. The IAC met by teleconference on May 29, 2012 to review Draft II, by teleconference on June 5 to review Draft III, and by teleconference on June 12 to review Draft IV. The IAC approved the Final Report by email on June 13, 2012.

The IAC Report was submitted to the Ontario Nurses’ Association and the Sault Area Hospital in PDF and hard-copy format by courier on June 14, 2012.
SECTION II

PRESENTATION OF THE PROFESSIONAL RESPONSIBILITY COMPLAINT

2.1 Development of the Professional Responsibility Complaint

RNs in the Emergency Department (ED) began submitting PRWRFs on a consistent basis in 2009, and expressions of concern regarding workload have continued since. As indicated in Table 1, RNs submitted 289 PRWRFs between January 1, 2010 and April 12, 2012, with the average number of PRWRFs submitted per month consistently increasing.

Table 1: Submission of PRWRFs by ED RNs

<table>
<thead>
<tr>
<th></th>
<th>2010 (Jan 1 – Dec 31)</th>
<th>2011 (Jan 1 – Dec 31)</th>
<th>2012 (Jan 1 – Apr 12)</th>
</tr>
</thead>
<tbody>
<tr>
<td># PRWRFs</td>
<td>113</td>
<td>127</td>
<td>49</td>
</tr>
<tr>
<td>Average # PRWRFs/month</td>
<td>9.4</td>
<td>10.6</td>
<td>14.4</td>
</tr>
</tbody>
</table>

Outstanding PRWRFs were discussed for the first time at HAC on March 26, 2010, in relation to 30 forms that had been submitted during February and March. In addition to the specific issues of concern identified in the PRWRFs, extensive discussion occurred at the April 22, 2010 HAC meeting regarding the manner in which the PRC process was implemented at SAH. The SAH Manager response included the terms ‘acknowledged’ if the Manager agreed with the workload and the process had been followed, and ‘filed’ “if either the process for putting in the PRC has not been followed, or if the matter is not agreed to and discussions regarding the issues have been referred to HAC”

2 Email from Johanne Messier-Mann to Jo Anne Shannon, January 11, 2011
3 Hospital-Association Committee Meeting Minutes, April 22, 2010, pg 4.

A subcommittee of HAC met with the ED RNs on May 4, 2010, and a Special ED HAC Meeting was held on May 26, 2010, resulting in a Letter of Understanding (LOU) signed July 5, 2010 which identified 10 agreed resolutions:

- strike a Task Force to optimize patient flow,
- review overcapacity policy with respect to ED and inpatient unit room turn-around time,
- provide updates re Post Construction Operating Plan (PCOP) funding at HAC meetings,
- conduct Value Stream mapping with staff of Emergency and support departments,
- review ED medical directives to facilitate more timely physician reassessment,
- ensure availability of adequate Psychiatric Attendant resources,
- provide training for staff caring for inpatients in the ED, including admission process, creating MARs etc.,
- review need for equipment, and establish a system to identify equipment belonging to the Emergency Department,
- review stock supplies to identify required inventory and type, and
- obtain a medication cart (or similar solution) to store inpatient medications.

The Association and the Hospital agreed to evaluate implementation and effectiveness of these resolutions in December 2010, and that if the evaluation was positive, the PRWRFs submitted up to May 26, 2010 would be considered resolved.

The Patient Flow Task Force identified in the LOU met on July 22, 2010 to “work together on optimizing patient flow and ensure quality patient care and ensure that nurses are able to meet their professional standards of practice”. Membership included 15 RNs/RPNs, the four Program Directors, a Case Manager, 10 Nurse Managers including the Manager of Emergency and Satellites, and a representative from ONA and CAW. Following small group brainstorming, three key issues/barriers were identified:

- communication, including nurse-to-nurse report, ED to floor communication, patient/community expectations, use of proper channels and appropriate inclusion of patient/family/health care team to discuss issues and use of constructive tone in message delivery;
- staffing, including availability of part-time and float nurses and consistency of assignment to Emergency, and flexibility of patient assignment; and
- physician issues, including proactive planning for discharge, engagement with the health care team, and delays in accessing consultants.

It was intended that an action table would be created from the above for review and discussion at HAC. This occurred at the August 17, 2010 HAC meeting. The IAC understands that a planned follow-up Patient Flow Task Force meeting was not held.

In September 2010, the Hospital indicated its intention to eliminate the Generic and Program Specific (including Critical Care) Float Pools through attrition. Concern regarding the impact of this on the ED was expressed at the December 14, 2010 meeting held to discuss the status of resolutions/action plan of the July 2010 LOU. Although it was evident that efforts had been made to address issues, the Association indicated that it was “looking for a concrete significant plan to take back to the Nurses for input”. It was agreed that additional updates would be provided electronically in preparation for further discussion at the January 28, 2011 HAC meeting, and that if resolution was not achieved, the issues would be referred to an IAC.

The Hospital presented an updated ED PRC Action Plan at the January 28, 2011 HAC meeting. Although the Association continued to express concern that workload issues relating to overcapacity, high acuity, lack of appropriate staff to manage ED patients, inpatients awaiting bed placement and ambulance off-load patients, insufficient availability of constant care attendants, lack of required capital and operating equipment etc. were still outstanding, it was agreed that decision regarding referral to an IAC would be deferred until after the move to the new hospital site in March 2011.

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4 Patient Flow Task Force Summary, July 22, 2010, page 1
5 Care units 1RN/1RPN; Critical Care 1RN; Emergency Department 3RNs; Maternal Child Program 1RN/1RPN; Medicine 1RN/2RPNs; Mental Health 1RN/1RPN; Oncology & Palliative Care 1RN; Surgery 1RN
6 The Emergency Department Manager did not attend the July 22, 2010 meeting.
7 ED PRC Follow-up Meeting Minutes, December 14, 2010, pg 6

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The Hospital moved to its new site on Great Northern Road on March 6, 2011. The new ED encompassed five distinct care ‘zones’ within a 19,000 sq. ft. footprint. The new Hospital configuration included three 30-bed medical units, one of which had facilities for telemetry monitoring, and a ‘closed’ ICU, with admission decisions made by intensivists only. In addition, a number of corporate changes occurred within the first several months, including elimination of the central staffing office, and allocation of the (formerly Emergency Department specific) Nurse Educator to Emergency and Critical Care.

The Hospital announced its participation in the ED Process Improvement Program (PIP), being launched by the Ministry of Health and Long-Term Care (MoHLTC), at the April 29, 2011 HAC meeting, and confirmed that the ED Manager would be seconded for this initiative. The ED PRC Action Table was again discussed, and the Association proposed creation of a task force outlining ‘cause/effect/resolution’ of the identified issues. The Association forwarded an ‘Emergency Department Cause and Effect Plan for PRC Task Force’ to the ED Nurse Manager on May 3, 2011, and stated “as agreed, the Task Force will report back to the Hospital-Association Committee at a meeting scheduled on June 20, 2011 from 1500-1700. Following this meeting, should the issues/complaint remain unresolved, ONA will forward the complaint to an IAC”.

The ‘Cause and Effect Task Force’ met on May 13, 2011 and June 2, 2011. Discussion focused on four key areas:

- **overcapacity** – more than five admitted patients in the CDU, inadequate number of telemetry packs, patients too sick for the medical unit but not meeting the ICU admission criteria remaining in the ED for long periods, impact of reduction in Medical Day Care hours, direct admission of oncology patients through the ED;
- **patient acuity** – inappropriate patient assignment with nurse:patient ratios higher than 1:3 in Acute, and 1:4 in Subacute;
- **working short** – RNs calling in staff for incidental vacancy replacement, inadequate break coverage; and
- **lack of supplies** – linen, pillows and blankets.

At the June 2, 2011 meeting, the Hospital indicated an increase in RN staffing to 12 RNs on days and 11 RNs on nights. Extensive discussion (but no decision) ensued at the June 20, 2011 ED Follow-up HAC Meeting regarding the Association’s suggestion to reallocate the 1000 – 2200 shift to 1900 – 0700 to provide consistent 24/7 coverage, as the Hospital was concerned that there would be less nursing resources during the busy mid-shift period. Based on the Hospital’s commitment to maintain the increased staffing levels and positive feedback from the RNs regarding the impact of this on the practice environment, and the anticipated outcomes of the ED-PIP initiative, the Association agreed to postpone a decision regarding referral to an IAC until after the September 8, 2011 HAC meeting.

The Cause and Effect Task Force held a third meeting on August 5, 2011. The RNs expressed concern that the ‘upstaffing’ to 12 RNs on days and 11 RNs on nights ceased in mid-July. In order to maintain the nurse:patient ratios of 1:3 in acute and 1:4 in subacute, four treatment stretchers in the Acute Zone were specified for admitted patients, and two stretchers in the Subacute Zone and two hallway stretchers were closed, resulting in a decrease of eight stretchers for ER assessment and treatment. In addition, the Clinical Decision Unit (CDU), which had previously housed up to five admitted patients, opened in early August for patients with a high likelihood for discharge following no more than 24 hours of evaluation or

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8 Acute zone, Subacute Zone, Fast Track Zone, Clinical Decision Unit Zone and Triage Zone
9 Email from Glenda Hubley to Robin Joanisse, May 3, 2011. This statement was confirmed in a letter from Jo Anne Shannon to Johanne Messier-Mann, dated May 4, 2011.
treatment. This resulted in admitted patients awaiting bed placement to be located in the Acute and Subacute Zones.

ED PRC Follow-up HAC Meetings were held on September 8, 2011 and October 20, 2011. During this period, a ‘See and Treat’ program was implemented within the Subacute Zone for stable and ambulatory Canadian Triage Acuity Scale (CTAS) 2 and 3 patients. One of the initiatives of the ED-PIP program, the goal of ‘See and Treat’ was to reduce Physician Initial Assessment time from 3.2 hours to 1.0 hour, thereby decreasing both patient length of stay within the ED and the number of triage reassessments required. Discussion at both the September and October ED PRC Follow-up HAC Meetings indicated that while progress was made on a number of issues relating to equipment, non-nursing duties, implementation of the CDU, and that the ‘See and Treat’ initiative worked well when staffed with a dedicated physician, base staffing remained an outstanding issue with the Association requesting a base staffing level of 12 RNs on days and 12 RNs on nights. The Association requested a “yes or no” response regarding staffing by November 21, 2011.

The Hospital responded on November 18, 2011, stating that “the Hospital is not in a position to make the requested changes to the RN staffing in the ED or on 3C at this time and looks forward to further discussing in our meeting scheduled on December 16th”. The Association responded on November 21, 2011, indicating that it would continue to closely monitor the workload issues as documented on PRWRFs, and that the Association “believe(s) that the significant financial, public and human cost to the parties of referring these files to the Independent Assessment Committee can be much better applied to improving the working and practice environment for our members and the patients that they care for”.

The final ED PRC Follow-up HAC Meeting was held on December 2, 2011. The Association stated while the RNs understood plans were being made to improve, they could no longer cope, and if a commitment was not made to staff the ED with 12 RNs 24/7, the Association would move to an IAC process.

The Association formally indicated its intention to forward the ED PRC to an IAC, as per Article 8 of the Collective Agreement, and identified the Association’s Nominee to the IAC on December 5, 2011 (Appendix 2). The Association referred the PRC to the IAC Chairperson on December 7, 2011 (Appendix 3), and the Hospital provided notification of its Nominee on December 13, 2011. As discussed in Section 1.4, the IAC Hearing was held May 1 – 3, 2012.

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10 Email from Kim Lemay, Director Human Resources to David Cheslock, Glenda Hubley and Jo Anne Shannon, November 18, 2011.
11 Letter from Jo Anne Shannon to Kim Lemay, November 21, 2011

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

The Hearing was structured such that:
- On May 1, 2012, the Association and the Hospital each made an oral Submission presentation highlighting the key elements of their previously submitted written Brief.
- On May 2, 2012, the Hospital and the Association each made an oral Response presentation, which included an opportunity for the other party to clarify / discuss / challenge / question the information provided.
- On May 3, 2012, the IAC posed a number of questions, to both parties, to obtain a more comprehensive understanding of the issues. The questions related to the current and proposed staffing pattern including the integration of part-time staff in the baseline schedule, patient assignment within the four Zones, downloading of patient care responsibilities from other Departments, non-nursing responsibilities and availability of support services, operation of the Fast Track zone, medical directives, use of telemetry within the ED and within the Hospital, quality assurance indicators, overcapacity and surge policies, placement of acute medical patients within the Hospital, the PRC process within the Collective Agreement as practiced at SAH, capital equipment, and support for mental health patients in the ED.

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

2.2.1 Ontario Nurses’ Association Perspective

Accountability of RNs
The CNO Professional Standards state that RNs are accountable to advocate on behalf of their clients, to provide, facilitate, advocate for and promote the best possible outcomes for clients, to seek assistance in a timely manner, and to take action in situations where client safety has been compromised. The RNs in the ED are meeting their CNO accountabilities by documenting and reporting their nursing care and practice concerns to their nursing leaders through documenting PRWRFs.

The CNO Professional Standards state that administrative nurses are accountable to ensure mechanisms allow for staffing decisions that are in the best interest of clients and patients and support the appropriate use, education and supervision of staff, to create a practice environment that supports quality nursing practice, to utilize leadership and management principles, and to involve nursing staff in decisions that affect their practice. The Association believes that, in relation to the ED, administrative nurses have acknowledged RNs’ workload concerns but have made staffing decisions based on budgetary issues that are not in the best interests of clients and patients.

Professional Responsibility Workload Report Forms
A total of 289 PRWRFs were submitted by the ED RNs between January 1, 2010 and April 12, 2012. This is an unprecedented number for a single unit. 149 of these were submitted in the “old” ED located at the Plummer Site; 140 have been submitted since the move to the new hospital in March 2011. The key issues identified since March 2011 relate to the following:
- high volume and acuity of patients presenting to the ED resulting in overwork, frustration and stress, frequent feelings of being overwhelmed;
- overcapacity and hallway nursing, lack of sufficient number of stretchers to assess and treat ED patients, ambulance off-load delays;
- insufficient cardiac telemetry capability in ED with respect to ‘closed ICU’ and elimination of the medical step-down unit;
- insufficient RN staffing levels, inability to staff for admitted and hallway patients or respond to changes in acuity/activity, resulting in delayed, improper and/or unsafe patient care and negative patient outcomes;
- inability to conduct CTAS assessments and reassessments;
- vacant shifts on the posted schedule, inability to augment staff when needed for acuity, activity and sick calls, increased overtime and denial of requests for stat holidays;
- lack of privacy and confidentiality for ED patients;
- inability to take or complete rest and meal breaks;
- non-nursing duties, such as calling in staff, unit aide duties, stocking, cleaning and patient portering;
- lack of constant care attendants for Form 1 patients; and
- lack of equipment and supplies including special order items and IV pumps.

The RNs feel that their concerns have not been adequately recognized or addressed by the nursing leadership team, especially with respect to “ongoing issues” for which there is no easy fix. The RNs have felt the only way to express their frustration and advocate for change has been to complete PRWRFs, both in specific instances where collaborative efforts to address workload issues have been made with the Manager at the time, and in relation to ongoing issues where, as per the Collective Agreement, at-the-time discussion with the Manager is not required.

SAH Emergency Patient Profile
With 55,000 annual visits and an average of 150 patients per day, the SAH ED is busy in terms of volume of patients, and is being accessed at a 90% greater rate on a per capita basis than the average hospital in the province. This high activity is compounded by high patient acuity, as evidenced by the higher percentage of CTAS 1 / 2 patients (33.4%) in comparison to the comparable cohort group hospitals (17.9% - 18.4%).

The high acuity levels relate to the demographics of the local population. Sault Ste. Marie has a higher percentage of the population over age 65 than elsewhere in the province (18.0% vs 13.6%), and has a higher Aboriginal population with higher disease rates such as diabetes and heart disease (9.8% vs 2.0%). A higher percentage of residents of the Algoma district are overweight/obese (56% vs 48% elsewhere in the province) and there is a higher prevalence of smoking and heavy drinking. The rate of chronic illness in Algoma, including hypertension, diabetes and heart disease, is higher, as is the Age-Standardized Mortality Rates (ASMR) for circulatory system and heart diseases.

Hospital Decisions Impacting Nursing Workload in the Emergency Department
The Hospital has made a number of decisions since the March 2011 move which have directly impacted (negatively) the workload of the RNs in the ED. These include
- closure of the Central Staffing Office in February 2011, requiring RNs to call in part-time staff to cover incidental vacancies such as sick calls and high volume/acuity;
- decision in September 2010 (reversed in October 2011) to discontinue the Critical Care Float Pool, resulting in difficulty replacing short-term vacancies;
- reduced staffing in the Laboratory, resulting in RNs being responsible for phlebotomy for all Emergency patients;
move from an “open” ICU, to which a range of physicians including internists and GPs could admit patients, to a “closed” ICU with admission criteria controlled by ICU Intensivists, and closure of beds outside the ICU designated as ‘medical step-down’; this has resulted in a group of “orphan patients” whose care needs are too acute to be admitted to the high acute medical floor (3C) but whose condition is not sufficiently unstable to be admitted to Level 2 beds in the ICU ….. leaving them in the ED;

- insufficient number of telemetry beds/telemetry channels available on 3C Medicine, resulting in admitted patients remaining in the ED for long periods;
- implementation of a ‘See and Treat’ model of care for stable ambulatory CTAS 2 and 3 patients with insufficient physician and nursing resources; the Association believes that ‘See and Treat’ should be staffed with a dedicated physician and two RNs -- there is currently one RN and one physician 8 hours per day two days per week with coverage by the Acute / Subacute MD(s) at all other times;
- re-assignment of an RN from Fast Track (now staffed with 2 RPNs), resulting in frequent requests for assistance from RPNs for IV access, complex dressing care etc.;
- lack of timely response to safety concerns regarding the layout of the Triage Assessment area which were identified by the Occupational Health and Safety Committee; an RN was assaulted by a patient in Triage in January 2012;
- insufficient base nurse staffing resources to meet patient care needs; patient capacity has increased by 33% (in terms of additional number of treatment stretchers within the new ED) but RN staffing has increased by only 11%. This has resulted in inability to conduct CTAS assessments and reassessments in accordance with practice standards, extensive reliance on overtime (15 RNs on the “sunshine list” earning over $100,000 per year in 2011), high statutory holiday banks, inability to provide effective patient health teaching and counselling etc.

Summary
Patient care is enhanced if concerns related to professional practice, patient acuity, fluctuating workloads and fluctuating staffing are addressed. The Association has proposed 18 recommendations, in the areas of professional practice, fluctuating workload and patient acuity/fluctuating staffing (Appendix 7). The Association recognizes the Hospital’s initiatives to facilitate patient flow through the ED and from the ED into the hospital inpatient beds, but believes that the key to improving RN workload is an increase in base staffing levels to 12RNs on days and 12 RNs on nights. This will ensure two RNs in ‘See and Treat’ between 0700 and 2200, two RNs at Triage between 1000 and 0200, will enable safe break coverage, and will provide time on nights to complete educational requirements (such as Medical Directives review).

2.2.2 Sault Area Hospital Perspective

Emergency Department Volume and Acuity
- The ED has seen 53,000 – 55,000 patients per year consistently over the past three years. This trend is expected to continue.
- The ED has a high acuity, with approximately 80% of the volume relating to CTAS 1 /2/ 3 patients, and 20% relating to low acuity CTAS 4 /5 patients. This places the Hospital above many hospitals of comparable size in terms of ED volumes by acuity.
- In the current fiscal year to date, 45% of patients have been treated in the Fast Track zone, 37% in the Subacute zone and 18% in the Acute zone. The majority of admitted patients awaiting beds are cared for in the Acute zone.
- The Hospital has set a target for a maximum of five admitted patients in the ED, and for 90% of admitted patients to wait in ED no more than 20 hours for an inpatient bed. The current average
number of admitted patients ranges from 5 to 12, with a high of 18-29 (highest was 29) and the 90% percentile Length of Stay (LOS) is currently 35 hours.

- The ED experiences a surge in patient volume between 0900 – 2200 and an additional Triage RN was scheduled for 1000 – 2200 hours to address this.
- The Clinical Decision Unit (CDU) opened in September 2011 for care of longer stay (up to 24 hours) of ED patients awaiting definitive diagnosis. The CDU averages 1.3 – 2.3 patients per hour.
- The ‘See and Treat’ initiative was implemented in August 2011 to optimize utilization of exam stretchers in the Acute and Subacute Zones to get more patients to see the physician earlier.
- ED LOS decreased from 28-35 hours during April – September 2011 to 90% percentile less than 24 hours during December 2011 – March 2012. As 90% of patients move out of the ED within 24 hours, the circulating volume of patients within the ED is increasing; 90% of CTAS 1 / 2 / 3 patients are discharged in less than seven hours, and 90% of the CTAS 4 / 5 patients are discharged within four hours.

Emergency Department Staffing

- The Program Director has been with the SAH for six months, and is responsible for the ED, Critical Care, Cath Lab, Access and Flow and Bed Allotment. The position is a good fit as the Hospital makes future improvements for flow of inpatients from the ED.
- The Nurse Manager is moving to another position on May 7, 2012. Recruitment is currently ongoing, and an interim manager will be in place until a new permanent Manager is hired.
- RNs:
  - The full-time RNs work 12 hour shifts on a master 1950 hours schedule.
  - There are currently 37 full-time lines with no vacancies. As of January 2012, 27 of the full-time RNs work an innovative schedule of 4-on / 5-off, four RNs work a day/evening (0700-1900 and 1000-2200) rotation and four are weekend workers. Two RNs (Patient Care Coordinators) work a traditional 12-hour rotation schedule on days. The innovative schedule has been the first introduction for the Hospital, and was introduced in response to RNs’ concerns regarding quality of work-life issues.
  - The Hospital has recently posted four additional full-time positions, to provide effective coverage in the CDU without drawing extensively on the part-time RNs.
  - There are currently 22 part-time RN positions, with seven vacancies.
- RPNs:
  - The RPNs also work on a master cyclic 1950 hour schedule. There are 3 full-time RPN lines with no vacancies, and three part-time RPN positions with one vacancy.
- Unit assistants (“ward clerks”) work 12-hour shifts, and provide 24/7 coverage within the ED. There are four full-time and five part-time positions with no current vacancies.
- A Nurse Practitioner works 0930 – 1730 Monday to Friday in the Fast Track Zone.
- The nursing staff is assigned as follows:
  - Triage: 1 RN 24/7 with second RN 1000-2200
  - Acute Zone: 5 RNs 24/7 plus PCC (who has responsibility for flow and coordination throughout the ED) 0700 – 1900, and 1 UA 24/7
  - Subacute Zone: 2 RNs 24/7 and 1 UA 24/7
  - CDU: 1 RN 24/7
  - Fast Track Zone: 2 RPNs (0900 – 2100 and 1000-2200)
- The clinical assignment includes only the based budgeted hours, and does not capture the additional RNs called in as required to manage surges issues. The clinical assignment is not static, and it is expected that the PCC (AR on nights) will reassign nursing resources to meet fluctuating patient care demands. In addition, the base RN staffing is augmented with additional RNs as required to meet surge issues.
**Professional Responsibility Workload Report Forms**

- The main concerns listed on the PRWRFs have related to large volumes of admitted patients awaiting transfer/bed on the inpatient units and the impact this has had on departmental flow and workload.
- The Hospital is concerned that in some instances, RNs have filed PRWRFs at the beginning of the shift, and/or without discussing the workload concerns with the Nurse Manager (or Administrator-on-Call), and/or when alternate plans of care and staffing have been implemented and the issue resolved. The Hospital recognizes that in some instances, a timely response was not provided by the Manager.
- The ED Task Force struck to focus specifically on issues in the ED identified the key workload concerns to be overcapacity, staffing, transfer of critically ill patients out of the ED to the ICU, access to telemetry beds, lack of supplies, constant care resources, non-nursing duties such as staffing, lack of beds for patients to be seen and Triage nurses not maintaining standards of reassessment.

**Process Improvement Initiatives**

The Hospital has implemented a number of initiatives since the move to the new Hospital site in March 2011 to address patient flow, and resulting workload, issues. These have included:

- Optimization of patient flow within the ED with the implementation of the ‘See and Treat’ model and Clinical Decision Unit, use of a daily performance huddle to discuss bed placement, implementation of a faxed rather than nurse-to-nurse report when patients are transferred to inpatient units, enhancement of the ED Tracker and Medi-Tech Bed Board, integration of new hand-held portable phones with the nurse-call system, and purchase of additional monitors and computers.
- Addressing equipment issues, including the 5S of equipment and trauma rooms to ensure quick access to equipment and supplies, purchase of additional equipment (thermometers, commode chairs, IV pumps), and standardizing Automated Medication Dispensing Units (AMDUs) between the Acute and Subacute zones.
- Enhancement of staffing resources, including four new full-time RN positions for the CDU, expanding the Critical Care Float Pool from 4 to 10 RNs, and allocating funds for a physician coverage of the ‘See and Treat’ area two days per week.
- Re-evaluation of admission criteria to medical units and ICU to clarify expectations for admission of Level 2 patients to the ICU.
- Initiatives with community partners (Group Health Centre, CCAC, LTC homes, North Shore Tribal Council) to improve coordination of patient care, reduce hospital length of stay and enhance referral to Chronic Disease Management Clinics.

**Summary**

The Hospital recognizes the significant challenges associated with the move to the new ED, in terms of altered work flow patterns within the designated zones, but believes that additional efficiencies, obtained through more effective allocation of nursing and physician resources within the Department on a shift-by-shift basis, can be obtained, as identified by the Hospital’s five recommendations (*Appendix 8*). The Hospital does not believe that additional RN staffing is required at this time.
SECTION III

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 Emergency Department at the Sault Area Hospital. 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, at the IAC’s request following the Hearing, and review of literature available in the public domain regarding the practice of emergency nursing.

3.2 External Factors Impacting the Practice Environment

Discussion of professional responsibility concerns within the ED must be considered within the context of the practice environment. In addition to the information provided by the Hospital and the Association prior to, during and following the Hearing, the IAC reviewed the following four areas to provide additional context to the expressed workload concerns:

- triage assessment and documentation;
- ED Program standards and activity;
- Ministry of Health and Long-Term Care funding; and
- standards of practice for emergency nurses.

The IAC also reviewed the geographical configuration of the ED in relation to workload requirements.

3.2.1 Triage Assessment and Documentation

3.2.1.1 Canadian Triage Acuity Scale (CTAS)

Triage is the process of prioritizing patients according to the urgency of their presenting illness or injury, and is critical to effective management of EDs as it enables immediate allocation of resources to patients with urgent life-threatening conditions.12

Since 1998, Canadian hospitals have utilized the CTAS scale to more accurately define patients’ needs for timely care and to allow EDs to evaluate their acuity level, resource needs and performance. The CTAS scale is based on establishing a relationship between a group of sentinel events which are defined by the ICD9CM diagnosis at discharge from the ER (or from an inpatient database) and the ‘usual’ way patients with these conditions present at the ED.13 The CTAS scale was developed and endorsed by the Canadian Association of Emergency Physicians (CAEP), the National Emergency Nurses Affiliation of Canada (NENA) and l’Association des médecins d’urgence du Québec in 1998, and was revised in 2004 and

13 http://www.calgaryhealthregion.ca/policy/docs/1451/Admission_over-capacity_AppendixA.pdf (accessed May 21, 2012)

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2008. CTAS levels are designed such that Level 1 represents the sickest patients and Level 5 represents the least ill group.

As indicated in Table 2, categorization of the CTAS level by presenting symptom(s) provides a time guideline for required RN and MD assessment. It is expected that the initial triage assessment will be completed by an RN within 10 minutes of the patient’s presentation to the ED.

Table 2: CTAS Scale

<table>
<thead>
<tr>
<th>CTAS Level</th>
<th>Acuity</th>
<th>Time to RN/MD Assessment</th>
<th>Examples of Usual Presentation¹⁴</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Resuscitation</td>
<td>Immediate</td>
<td>*cardiac and/or pulmonary arrest</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>*major trauma (severe injury and burns)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>*near death asthma</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>*altered mental state (unconscious, delirious)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>*seizures</td>
</tr>
<tr>
<td>2</td>
<td>Emergent</td>
<td>15 min</td>
<td>*chest pain with cardiac features</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>*CVA with major deficit</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>*altered mental status (lethargic, drowsy, agitated)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>*GI bleed (abnormal vital signs)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>*serious infection (purpuric rash, toxic)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>*vaginal bleeding (acute, pain &gt; 5, abnormal vital signs)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>*sexual assault</td>
</tr>
<tr>
<td>3</td>
<td>Urgent</td>
<td>30 min</td>
<td>*moderate abdominal pain</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>*head injury (alert with vomiting)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>*moderate trauma (fracture, dislocation)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>*dialysis problems</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>*mild/moderate asthma, dyspnea</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>*GI bleed with normal vital signs</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>*vaginal bleeding (acute, normal vital signs)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>*acute psychosis +/- suicidal ideation</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>*pain scale 8 – 10 with minor injuries</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>*pain scale 4-7/10 (headache, CVA, back)</td>
</tr>
<tr>
<td>4</td>
<td>Less urgent</td>
<td>60 min</td>
<td>*head injury, alert, no vomiting</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>*minor trauma</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>*abdominal pain (acute)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>*earache</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>*suicidal ideation / depression</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>*allergic reaction (minor)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>*chronic back pain</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>*pain scale 4 – 7</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>*headache (non-migraine, not sudden)</td>
</tr>
<tr>
<td>5</td>
<td>Non urgent</td>
<td>120 min</td>
<td>*sore throat, no respiratory symptoms</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>*diarrhea alone (no dehydration)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>*vomiting alone (normal mental status, no dehydration)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>*mild abdominal pain (chronic or recurring)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>*minor trauma (sprains, minor lacerations)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>*psychiatric complaints</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>*pain scale &lt; 4</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>*medication request or dressing change</td>
</tr>
</tbody>
</table>

¹⁴ Improving Access to Emergency Care: Addressing System Issues

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3.2.1.2 Electronic Print on Demand (ePOD) Documentation

In September 2006, the SAH ED, together with four other EDs in the province, began using an Electronic Print on Demand (ePOD) program developed by an emergency physician at Sudbury Regional Hospital. The goal of the ePOD implementation was to improve accuracy and wait times and to provide decision support to less experienced triage nurses.

The ePOD program contains over 250 age and gender-specific presenting complaints. The Triage RN enters the patient’s symptoms and the ePOD program automatically determines the triage level. The ePOD program then generates a Nursing Record and Physician Chart for each patient.

- The Triage RN’s documentation at the time of triage is included on both the Nursing Record and Physician Chart.
- The Nursing Record provides cues for a nursing history and nursing exam tailored to the presenting complaint, identifies orders (time ordered, ordered by, time done), provides for documentation of vital signs, interventions and nursing progress notes, and identifies final disposition from the ED, in terms of both condition (improved, worse) and location (to home, admitted) and provision of discharge instructions.
- The Physician Chart provides cues for a history and physical tailored to the presenting complaint, and identifies medical decision-making, impression/diagnosis, and final disposition from the ED.

The IAC understood that there is a general sense (not, as far as the IAC could determine, substantiated by data) that ePOD “over-classifies” triage levels, resulting in a possible skewing of CTAS level 4 to CTAS level 3, and CTAS level 3 to CTAS level 2\(^{15}\). This concern regarding possible over-classification will soon be addressed, as ePOD does not interface with the Meditech informatics system used by the Hospital, and use of ePOD will be discontinued in the near future. The IAC understood that the Hospital was part of a pilot initiative in 2009 to develop a Meditech-generated CTAS scoring system, and that the Hospital is planning to work with Meditech to reopen the pilot initiative, with the eventual goal of implementing a Meditech-generated CTAS score that will interface with the Meditech nursing and physician documentation system.

3.2.2 ED Program Activity

ED activity is impacted by both volume and acuity of patients attending the ED.

3.2.2.1 ED Volume

In terms of volume, Sault Ste. Marie is located within the Algoma District of the Northeast Local Integration Health Network (LHIN). The SAH, the referral hospital for the Algoma District, is supported by five rural hospitals\(^{16}\) and provides care to a population of approximately 155,000 across the Algoma District. The SAH ED is identified by the Ministry of Health and Long-term Care (MOH-LTC) as a

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\(^{15}\) The IAC noted that even with possible upward skewing of the CTAS levels, the SAH ED has a very high acuity for a community hospital.

\(^{16}\) Hearnepayne Community Hospital, Lady Dunn Health Centre in Wawa, Blind River District Health Centre, Matthews Memorial Hospital in St Joseph Island and Thessalon Hospital in Thessalon. The latter two are part of the SAH; Matthews Memorial Hospital, located 30 minutes from SAH, provides emergency and outpatients services, and Thessalon Hospital, located 60 minutes from SAH, is a four-bed hospital with no emergency services.
“very high volume community hospital”\textsuperscript{17}, with consistently 53,000 to 55,000 visits per year, or 145-150 visits per day. As indicated in Table 3, in the 12-month period between March 1, 2011 and February 29, 2012, the SAH ED provided care to 53,382 patients in the Acute, Subacute\textsuperscript{18} and Fast Track Zones.

Table 3 indicates that 19.2\% of patients received care in the Acute Zone, 37.5\% in the Subacute Zone, and 43.3\% in the Fast Track Zone, and that distribution of patients within the Zones was as follows:

- Virtually all (95\%) CTAS 1 patients received care in the Acute Zone;
- Most (83\%) CTAS 4 and most (85\%) CTAS 5 patients received care in the Fast Track Zone;
- CTAS 2 patients were distributed evenly between the Acute (48\%) and Subacute (46\%) Zones; and
- CTAS 3 patients were distributed evenly between the Subacute (43\%) and Fast Track (50\%) Zones.

### Table 3: SAH ED Volume by CTAS Level and Zone Location

<table>
<thead>
<tr>
<th>CTAS Level</th>
<th>Acute Zone</th>
<th></th>
<th>Subacute Zone</th>
<th></th>
<th>Fast Track Zone</th>
<th></th>
<th>Total</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of Patients in Zone</td>
<td>% of Patients in Zone</td>
<td>Number of Patients in Zone</td>
<td>% of Patients in Zone</td>
<td>Number of Patients in Zone</td>
<td>% of Patients in Zone</td>
<td>Number of Patients in CTAS Level</td>
<td>Total % of Patients in CTAS Level</td>
</tr>
<tr>
<td>CTAS 1</td>
<td>936</td>
<td>95.1%</td>
<td>47</td>
<td>4.8%</td>
<td>1</td>
<td>.1%</td>
<td>984</td>
<td>100%</td>
</tr>
<tr>
<td>CTAS 2</td>
<td>7,661</td>
<td>48.0%</td>
<td>7,308</td>
<td>45.8%</td>
<td>981</td>
<td>6.2%</td>
<td>15,950</td>
<td>100%</td>
</tr>
<tr>
<td>CTAS 3</td>
<td>1,559</td>
<td>6.3%</td>
<td>10,810</td>
<td>43.4%</td>
<td>12,545</td>
<td>50.4%</td>
<td>24,914</td>
<td>100%</td>
</tr>
<tr>
<td>CTAS 4</td>
<td>84</td>
<td>.75%</td>
<td>1,836</td>
<td>16.3%</td>
<td>9,326</td>
<td>82.9%</td>
<td>11,246</td>
<td>100%</td>
</tr>
<tr>
<td>CTAS 5</td>
<td>8</td>
<td>3.3%</td>
<td>36</td>
<td>14.8%</td>
<td>244</td>
<td>84.7%</td>
<td>288</td>
<td>100%</td>
</tr>
<tr>
<td>Total</td>
<td>10,248</td>
<td>19.2%</td>
<td>20,037</td>
<td>37.5%</td>
<td>23,097</td>
<td>43.3%</td>
<td>53,382</td>
<td>100%</td>
</tr>
</tbody>
</table>

The IAC identified two issues from the data noted in Table 3, relating to CTAS 1 and CTAS 2 patients. Specifically, the IAC was unsure why 48 CTAS patients (almost 5\%) received care in the Subacute and Fast Track Zones, and questions whether in fact these were true CTAS 1 patients. Similarly, the IAC was unclear how 981 CTAS 2 patients could have been sent to the Fast Track Zone for care. CTAS 2 patients should not be in the Fast Track Zone, in light of the location of and nursing staff mix within the Zone.


\textsuperscript{18} Includes patients in the subacute ‘See and Treat’ patients and CDU areas.

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The IAC believes that this data flags a concern with the possible over-classification issue noted in Section 3.2.1.2 (ePOD Documentation), whereby stable patients with a localized minor acute pain issue are classified as CTAS 2.

3.2.2.2 ED Acuity

In terms of acuity, the SAH ED has a high acuity ratio, as determined by CTAS level, in comparison to hospitals across Ontario, including those within a comparable cohort group. As indicated in Table 4, 78% of patients presenting with high acuity (CTAS levels 1 to 3) compared to 53% of ED patients across the province as a whole, and 66% of the comparable cohort hospitals. As noted in Section 3.2.1.2 ePOD Documentation), a portion of the high acuity levels may be attributed to ePOD triage assessment ‘creep’.

Table 4: SAH ED Acuity in Comparison to Provincial/Cohort Hospitals

<table>
<thead>
<tr>
<th>CTAS Level</th>
<th>% of ED Visits Across Ontario hospitals 19</th>
<th>% of ED Visits Across Cohort Hospitals 20</th>
<th>% of SAH ED Visits 21</th>
</tr>
</thead>
<tbody>
<tr>
<td>CTAS 1</td>
<td>0.6%</td>
<td>.7%</td>
<td>1.8%</td>
</tr>
<tr>
<td>CTAS 2</td>
<td>12.9%</td>
<td>52.5%</td>
<td>29.9% 78.4%</td>
</tr>
<tr>
<td>CTAS 3</td>
<td>39.0%</td>
<td>47.6%</td>
<td>46.7%</td>
</tr>
<tr>
<td>CTAS 4</td>
<td>39.0%</td>
<td>31.5%</td>
<td>21.1% 21.6%</td>
</tr>
<tr>
<td>CTAS 5</td>
<td>8.5%</td>
<td>2.5%</td>
<td>.5%</td>
</tr>
</tbody>
</table>

As noted in Section 3.2.1.2 (ePOD Documentation) and 3.2.2.1 (ED Volume), the IAC believes that the SAH ED acuity is high, but questions whether it is in fact as high as the data in Table 4 indicates.

3.2.3 Ministry of Health and Long-Term Care Funding

Two MoHLTC funding initiatives are relevant for Ontario hospital EDs: Pay-for-Results and Health System Funding Reform.

20 ONA Hearing Brief, pg 44. Comparable cohort group hospitals include: Guelph General Hospital, Cambridge Memorial Hospital, Niagara Health System – Greater Niagara, Niagara Health System – St Catherines General, Brant Community Healthcare System – Brantford, Kingston General Hospital and Hotel Dieu Hospital Kingston.
21 SAH Hearing Brief Appendix B (Revised): Volume by CTAS Level, Month and Registration March 2011 – February 2012
3.2.3.1 Pay-for-Results

Pay-for-Results (P4R) Program is an incentive program that provides funding to selected hospitals with high ED volumes and significant ED wait-time pressures. Initially implemented in the 2008/09 fiscal year, P4R provided a total of $85,902,400 to 74 hospitals across the province in 2011/12\textsuperscript{22}. SAH received $1,050,400\textsuperscript{23} in 2011/12, of which $465,000 was allocated to staff the Clinical Decision Unit, $176,000 to support MD coverage in the ‘See and Treat’ area two days per week, and the remainder to initiatives such as a psychogeriatric program to provide better care to repeat elderly patients.

The MOH-LTC has set specific targets for performance indicators relating to LOS in the ED for admitted and non-admitted patients. As indicated in Table 5, the SAH is currently in line with hospitals within both the Northeast LHIN and the province in terms of percent of non-admitted patients whose LOS within the ED is within the identified target of 8 hours for CTAS 1 and 2 patients, 6 hours for CTAS 3 patients and 4 hours for CTAS 4 and 5 patients. However, across all hospitals, significant efforts are required to improve the percentage of patients admitted within the target. SAH has set a target of 20 hours for ED LOS for admitted patients for 2012/13.

Table 5: Time Spent in ED by CTAS Level and Patient Type\textsuperscript{24}

<table>
<thead>
<tr>
<th>CTAS Level</th>
<th>Target</th>
<th>Provincial</th>
<th></th>
<th></th>
<th></th>
<th>Northeast LHIN</th>
<th></th>
<th></th>
<th></th>
<th>SAH</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Admitted Patients</td>
<td>Non-admitted Patients</td>
<td>Admitted Patients</td>
<td>Non-admitted Patients</td>
<td>Admitted Patients</td>
<td>Non-admitted Patients</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>% within target</td>
<td>% within target</td>
<td>% within target</td>
<td>% within target</td>
<td>% within target</td>
<td>% within target</td>
<td>% within target</td>
<td>% within target</td>
<td>% within target</td>
<td>% within target</td>
<td>% within target</td>
</tr>
<tr>
<td>1</td>
<td>8 hrs</td>
<td>29.4</td>
<td>58</td>
<td>8.6</td>
<td>88</td>
<td>27.5</td>
<td>60</td>
<td>7.8</td>
<td>91</td>
<td>22.2</td>
<td>62</td>
<td>8.4</td>
</tr>
<tr>
<td>2</td>
<td>8 hrs</td>
<td>35.0</td>
<td>38</td>
<td>8.5</td>
<td>88</td>
<td>32.5</td>
<td>42</td>
<td>8.6</td>
<td>87</td>
<td>24.4</td>
<td>42</td>
<td>7.6</td>
</tr>
<tr>
<td>3</td>
<td>6 hrs</td>
<td>32.4</td>
<td>24</td>
<td>7.1</td>
<td>84</td>
<td>25.9</td>
<td>43</td>
<td>6.7</td>
<td>87</td>
<td>23.0</td>
<td>26</td>
<td>5.8</td>
</tr>
<tr>
<td>4</td>
<td>4 hrs</td>
<td>28.5</td>
<td>21</td>
<td>4.5</td>
<td>86</td>
<td>21.2</td>
<td>32</td>
<td>4.6</td>
<td>86</td>
<td>24.1</td>
<td>11</td>
<td>3.5</td>
</tr>
<tr>
<td>5</td>
<td>4 hrs</td>
<td>24.8</td>
<td>32</td>
<td>3.8</td>
<td>91</td>
<td>21.5</td>
<td>30</td>
<td>3.5</td>
<td>93</td>
<td>NV</td>
<td>NV</td>
<td>4.1</td>
</tr>
</tbody>
</table>

The SAH is hoping to receive P4R funding for 2012/13 at a level similar to 2011/12\textsuperscript{25}, but will have to at least continue, if not improve, the current ED LOS times in order for P4R funding to be maintained.

\textsuperscript{22} MOH-LTC Backgrounder: Pay-for-Results Program, May 6, 2011
\textsuperscript{23} Northeast LHIN – SAH 2008-12 H-SAA Amending Agreement #2, pg 20
\textsuperscript{24} Data drawn from Wait Times listed on SAH website www.sah.on.ca (accessed May 22, 2012)
\textsuperscript{25} At the time of the Hearing, the SAH had not yet received confirmation from the Northeast LHIN regarding 2012/13 P4R funding.
3.2.3.2 Health System Funding Reform

In January 2012, the MoHLTC announced Ontario’s Health System Funding Reform, which will move health care organization funding away from the current global budget funding system towards Patient-Based Funding (PBF). To be phased in over the next three years, PBF will compensate health care organizations on the basis of the number of patients cared for, the services delivered, the evidence-based quality of those services and the specific needs of the population served. While the specific implications for SAH were not known at the time of the Hearing, it is clear that ongoing funding increases will no longer be a ‘given’, and that continual improvements in system efficiencies will be required.

The IAC believes that these fundamental changes to the manner in which hospitals are being and will be funded will have implications for nursing practice. Nurses will no longer be able to consider that the hospital budget is a ‘given’ and distinct from nursing practice expectations and outcomes. Specifically in the ED, RNs will need to actively integrate best practices to support patient flow in order to maintain funding resources.

3.2.4 Standards of Practice for Emergency Nurses

The Standards of Emergency Nursing Practice, developed by NENA, are specialty standards intended for Emergency Nurses working in a variety of settings; emergency departments, pre-hospital and military settings, ambulatory care centers and clinics/other health environments providing emergency care. Standards are written values defining the performance of Emergency Nurses that is predetermined and acceptable to authority, have contributed to the development of the Emergency Nursing Certification Exam, ENC(C), and reflect what is the minimally accepted competence level of the RN practicing in the Emergency Care setting.

NENA Standards of Emergency Nursing Practice (Appendix 9) are categorized in four areas:

- professionalism, including qualifications and professional status;
- practice, including triage, assessment, analysis/planning, intervention, evaluation, ethics and communication;
- education, including provision of information and education of self and peers; and
- research

The IAC believes that all RNs practising in the ED must meet these standards in order to ensure safe and effective care for their patients.

3.2.5 Geographical Configuration of the SAH ED

The ‘new’ 19,000 sq. ft. ED is configured in five separate zones.

The Triage Zone is located immediately inside the main Emergency Entrance doors. It includes two Triage RN assessment stations, separated by and surrounded by glass, and a Triage Workstation room located behind the assessment stations. The Triage Zone is physically separated from the other areas of the ED.

• The assessment stations enable two RNs to triage patients concurrently. The assessment stations are configured such that when interacting with a patient, the Triage RN has her/his back to the waiting room, and is ‘trapped’ between the patient and the desk.

• The Workstation room provides a private location for ECGs and phlebotomy.

• The Triage Waiting Room is located across the hall from the assessment stations, enabling close monitoring of triaged patients.

• The Reception Registration is located a short distance down the corridor, and includes three registration stations.

The **Fast Track Zone** is located immediately behind the Triage and Reception Registration areas. It includes a waiting room, a communication station (“nursing station”), medication and supply rooms, and six exam rooms (four equipped with chairs and two with stretchers).

• Patients in Fast Track access the specialty Minor Procedure Rooms (Fracture Room, Eye/Dental Room, Minor Procedure Room, Gynecological Room), which are shared with the Subacute Zone, as required.

The **Clinical Decision Unit** is located behind the Subacute Zone, and includes a communication workstation and five holding bays.

The **Subacute Zone** includes two areas: ‘subacute’ and ‘See and Treat’. The Zone is located behind and to the left of the Fast Track Zone, and is accessed from the Triage Waiting Room through the main ED door.

• The ‘See and Treat’ portion includes a waiting room, and three exam/treatment rooms (two equipped with stretchers and one with two chairs).

• The ‘subacute’ portion includes six exam/treatment rooms all equipped with stretchers, and one Mental Health Room, as well as two ‘virtual’ (hallway) stretchers.

• The two areas share a communication workstation, medication and supply rooms and soiled utility room.

• The two areas also utilize the specialty Minor Procedure Rooms (shared with Fast Track) as required.

The **Acute Zone** is located to the left of the Subacute Zone, and is accessed through the Subacute Zone. It includes four enclosed (trauma/resuscitation) treatment rooms one of which has an isolation anteroom, 10 exam/treatment rooms equipped with stretchers, and one Mental Health Room, as well as a large communication station, small medication and supply rooms, and a soiled utility room.

• The four-bay ambulance entrance is located at the back of the Acute Zone, enabling entry directly into the isolation treatment room if required.

• The majority of patients requiring admission are treated in the Acute Zone, and remain in the area until an inpatient bed is available.

• Four ‘virtual’ (hallway) beds are used to accommodate overflow situations.

The Medical Director and Nurse Manager offices are located at the back of the ED, beside the Clinical Decision Unit. Although technically within the ED, the location of the offices does not enable quick and easy interaction with any of the Acute, Subacute or Fast Track Zones.

The Hospital has a pneumatic tube system for transport to/from the Laboratory, Pharmacy etc. The one ED tube station is located in the Acute Zone, necessitating nurses working in the Subacute and Fast Track Zones to walk to the Acute Zone to access it.
The Diagnostic Imaging Department is located immediately behind the ED, and is accessed by the service corridor to the right of the Subacute Zone. As the service corridor door between the departments requires an access pass (staff ID card) to open, staff must accompany Subacute Zone patients to the DI in order to open the door. (Fast Track Zone patients access DI independently by means of the exterior public corridor). Imaging procedures are performed in the DI Department (not the ED).
3.3 Analysis and Discussion

The IAC was requested to examine whether the current RN staffing pattern supports proper patient care within the SAH ED. The IAC carefully reviewed the information provided by the Association and the Hospital prior to, during and following the Hearing, as well as the contextual information referenced in Section 3.2, to determine the ‘root cause’ for the professional workload concerns.

It appeared to the IAC that there is a disconnect between the level of discontent and distress that the RNs are experiencing, and expressed at the Hearing, and the data regarding volume, acuity, and nature of patients within the ED. The SAH ED is clearly a busy department, with additional challenges relating to a community with higher-than-average incidence of chronic disease and social issues, but the data regarding numbers of patients in relation to numbers of staff within the Acute and Subacute Zones did not suggest the level of discontent that the RNs are experiencing. While staffing resources are a factor, the IAC believes that other factors, relating to a sense of trust, empowerment and control, are also impacting the RNs’ ability to find an appropriate balance between patient care needs and workload requirements.

The IAC has focused its analysis and recommendations in four areas: leadership and empowerment, practice, staffing and workload, and corporate responsibilities.

The IAC is hopeful that the opportunity to openly express concerns and perspectives at the Hearing, together with the external objective analysis and associated recommendations provided by the IAC, will assist both the RNs and the leadership team to find common ground on which to move forward to address the identified workload concerns.

3.3.1 Leadership and Empowerment

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: Developing and Sustaining Nursing Leadership identifies five transformational leadership practices that result in healthy outcomes for nurses, patients, organizations and systems:

- Building relationships and trust is a critical leadership practice that provides the foundation upon which the remaining practices rest.
- Creating an empowering work environment depends on respectful trusting relationships among members of the work setting. An empowered work environment entails having access to information, support, resources and opportunities to learn and grow within a setting that supports professional autonomy and strong networks of collegial support.
- Creating an environment that supports knowledge development and integration involves fostering both the development and dissemination of new knowledge and the instillation of a continuous inquiry approach to practice within the work setting. This knowledge is used to inform efforts to continuously improve both clinical and organizational processes and outcomes.

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Leading and sustaining change involves taking a proactive and participative approach to implementing change that results in improved clinical and organizational processes and outcomes.

Balancing competing values and priorities and demands entails advocating for necessary nursing resources to ensure high quality patient care while recognizing the multiple demands that must be addressed in organizational decision-making.

The IAC believes that strategies to support transformational leadership within the SAH ED relate to the ED Nurse Manager and Nurse Educator roles, intra-Department communication/shared governance structure, the Charge Nurse (PCC – AR) role, the ED mentorship program, and the PRC process as it is implemented at SAH, and the role of the clinical Administrator-on-Call.

3.3.1.1  ED Nurse Manager Role and Nurse Educator Roles

The SAH ED Nurse Manager is accountable for the effective management of the ED at the SAH site. The SAH has a matrix reporting structure:

- for operational issues, the ED Nurse Manager reports to the Director of Emergency, Critical Care and Access, who in turn reports to the Vice President and Chief Operating Officer (COO), and
- for professional practice issues, the ED Nurse Manager reports to the Chief Nursing Officer (CNO), who also reports to the Vice President and COO.

The ED Nurse Manager has approximately 75 staff directly reporting to her, including full-time and part-time RNs, RPNs and Unit Assistants. The SAH expects that Nurse Managers will be present in/on their unit 70% of the time, with a maximum of 30% directly administrative (office) responsibilities and/or off-unit activities (e.g. meetings).

The first-line manager role is sentinel to the health and functioning of a nursing unit, especially in times of change, such as the move to the new hospital site in March 2011. In an example of ‘competing priorities’, the ED Nurse Manager was seconded from her position within the ED to lead the Hospital’s participation in the ED-PIP28. While her expertise was a definite benefit to moving the ED-PIP initiatives forward at a corporate level, the lack of her in-department leadership was detrimental to the internal functioning of the ED, as the staff worked to find new ways of practising in a very differently configured department. The staff RN appointed as Interim Manager did an admirable job, but she was, by definition, interim, and as such did not assume a defined leadership or decision-making role. Frustrations, especially with respect to staffing within the newly configured Zones and communication regarding corporate priorities and initiatives, festered.

These challenges continued into the winter of 2012, as the ED Nurse Manager made the decision, in March 2012, to move to another position within the Hospital immediately following the IAC Hearing. In preparation for leaving her role, she focused on completion of outstanding projects such as medical directive development, and so was, again, less than usually present within the ED, and thus less able to promote communication, strategize regarding staffing and practice issues etc.

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28 Emergency Department Process Improvement Program, sponsored by the MOH-LTC. Goals of the program: decrease ED LOS for all CTAS levels, improve patient satisfaction with the ED experience, provide a better working environment for ED staff, and build provincial capacity for quality improvement.

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It was evident to the IAC that the ED Nurse Manager was held in high regard by both the RNs and the leadership team, and that the RNs were very concerned regarding the impending lack of leadership within the ED. The Hospital indicated at the Hearing that an interim leader would be appointed; following the Hearing, the Director confirmed that she would be fulfilling this role until a permanent ED Nurse Manager is hired.

The IAC recognizes the challenge the Director faced in making this decision. On the one hand, she holds an aggressive corporate portfolio, and it will be difficult for her to provide the level of support, direction, coaching, intervention etc. required for effective front-line leadership. On the other hand, the ED has suffered from the lack of information sharing and communication from senior and middle management regarding corporate initiatives and decisions and ED funding parameters, and her direct involvement in day-to-day discussion will provide the RNs with a broader understanding of the issues.

The IAC strongly believes that the ED requires the support of a full-time Educator. The IAC understands that the decision to eliminate the full-time ED Nurse Educator in April 2011 was part of a corporate restructuring initiative which was not specifically focused on the ED. However, in light of the leadership gap resulting from the ED Manager’s resignation, the high number of new graduates entering the ED in both part-time and full-time positions, the scope of the new medical directives, and the challenges associated with moving to a more data-driven approach to care, the IAC believes that the support provided by a full-time Educator would be invaluable to the ED. At a minimum, the IAC believes seconding the Educator to the ED on a full-time basis is required until the new ED Manager is in place.

The IAC also believes that the Educator needs to be actively involved in clinical practice, focused on direct patient care teaching opportunities with the ED RNs and RPNs. The Educator role is not, and should not be seen as, an ‘office’ position.

**Recommendation:**

1. **Appoint the Educator to the ED on a full-time basis.** If this is not corporately possible, appoint the Educator to the ED on a full-time basis until the permanent ED Nurse Manager has been recruited and in place for six months, and thereafter ensure the Educator is available to the ED on a clearly defined basis (minimum 2.5 days per week).

2. **Focus the Educator’s role on practice and education issues, including implementation of medical directives, and integration of newly hired RNs into the ED, with active involvement in clinical practice issues within the ED.**

3.3.1.2 **Intra-Department Communication / Shared Governance Structure**

There is no question that the philosophical approach to the provision of emergency care is changing within Ontario. The province’s move towards a ‘pay for performance’ / ‘fee for service’ funding model has a direct impact on the structure and functioning of, and priorities within, EDs: if performance (e.g. improvement in wait times and ED LOS) is not evident, ongoing funding is not guaranteed and may not be provided. This will, in turn, impact the roles and responsibilities of care providers. The days of global funding, where individual health care providers could feel that the hospital budget ‘is not my problem’ are fast disappearing. The competing priorities of patient care and funding restrictions now belong to everyone.
The SAH ED RNs are currently feeling a ‘hurry up and go’ pressure to move patients through the department, resulting in anxiety about their ability to provide proper patient care, especially with respect to the ‘softer’ elements of patient counselling, teaching and support. It appeared to the IAC that there is currently no venue for nurses, in either leadership or direct care positions, to together discuss the impact of this dissonance, and to discuss/develop strategies to effectively address it. Without such opportunities, the RNs are feeling disempowered, with little ability to influence or control their Department.

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. Nurses who have a ‘voice’ in decisions impacting their practice and balancing competing values are more likely to support changes in practice and approach, and to have a higher sense of job satisfaction. As well, the IAC believes that shared governance models provides RNs with the opportunity to bring forth thoughts / suggestions / recommendations / ideas regarding unit/department practice, while at the same time communicates the expectation that RNs take an active and accountable role in constructive decision-making regarding unit/department function.

The IAC believes that the ED Nursing Unit Council, which began in early 2011 but was not sustained, needs to be resurrected. While the IAC was not clear as to why the initial implementation was not successful, the IAC is clear that while an effective Unit Council requires initial support and direction from the leadership team, the staff RNs, as well as the leadership team, need to be accountable for its success.

The IAC believes that the Unit Council will provide RNs with a venue to discuss issues impacting their practice, including, as an example, changes in patient assignments and implementation of medical directives to facilitate patient flow through the ED, revision of triage documentation (discontinuation of ePOD), etc. The Unit Council will also provide an opportunity for RNs to ‘take a step back’, and explore/discuss issues that contribute to a challenging shift from the perspective of ‘what can we do’ to both improve patient care and support the RNs in the provision of it. The IAC also believes that an effective Unit Council will enable the RNs to assume leadership and accountability for practice issues and decisions.

The IAC believes that both the Hospital leadership team and the ED RNs need to demonstrate recognition of and support for the Unit Council, the Hospital by ensuring that staffing resources are sufficient to enable the RNs on the Unit Council to be released from their patient assignments, and RNs by actively supporting the outcomes of the Unit Council decisions. The IAC encourages discussion of remuneration of Unit Council participants at HAC, to ensure consistency with other Unit Councils within the Hospital.

The IAC also believes that formal communication mechanisms, through which information regarding corporate and Program initiatives and issues are communicated, are required. For example, outcomes of discussions at the Emergency Governance Committee, information regarding ED quality indicators, information regarding corporate strategies regarding patient LOS, etc. need to be communicated to and understood by the ED RNs (in fact all hospital RNs). Due to the rotating nature of nurses’ work schedules, and the number of nurses within the Department, it is unrealistic to expect that all nurses will attend Staff Meetings (which the IAC believes must be regularly scheduled with minutes provided and

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posted), or that all nurses will be able to access their hospital email while on duty. Therefore, the IAC believes that the traditional form of intra-unit communication, the Communication Book, would be beneficial.

**Recommendation:**

3. **Resurrect the ED Nursing Unit Council,** to provide a venue for discussion of and resolution of issues relating to operational functioning of the ED and clinical practice issues relating to the provision of patient care.

   **Terms of Reference to include:**
   a. **Purpose:** to make collaborative decisions regarding practices and procedures that enhance the quality of patient care and practice environment
   b. **Chair:** co-chaired by ED Educator and an ED RN selected by nomination
   c. **Membership:** defined membership, including 4 RNs and 1 RPN selected by nomination, one allied health team member, ED PCC, ED Educator and ED Nurse Manager, with a defined membership term of two years
   d. **Meetings:** held biweekly until firmly established, then monthly
   e. **Agenda:** developed jointly by the co-chairs and published in advance of the meeting
   f. **Minutes:** adopt the format used by SAH HAC
   g. **Distribution of Minutes:** by email and in Communication Book

   Facilitate RN involvement by ensuring that RNs are relieved from patient care assignment during Unit Council meetings, and are remunerated as per discussion at HAC.

4. **Implement a Communication Book which is**
   a. located in a central location within the ED that enables easy access by all working RNs and RPNs,
   b. maintained by the ED Nurse Manager, and
   c. the responsibility of the RNs and RPNs to read.

5. **Maintain regular Staff Meetings,** held monthly and chaired by ED Nurse Manager.
   a. **Purpose:** ensure communication of corporate and program issues, initiatives and outcomes, including quality assurance indicator outcomes.
   b. **Minutes:** posted online and in Communication Book

3.3.1.3 **Charge Nurse and Triage Nurse Roles**

The IAC recognizes the value of consistency in the Charge Nurse role in a department as large and fast-paced as the SAH ED. However, the IAC believes that there is a significant benefit, in terms of creating an empowering work environment, when charge roles rotate among nurses. Having the opportunity to participate in a charge role provides RNs with both a sense of ownership of the Department and a more comprehensive understanding of the complex inter-relations required for smooth and effective Departmental functioning.

The IAC recognizes that the Patient Care Coordinator roles are currently permanent positions, held by two RNs, and is not suggesting that these RNs be displaced. However, the IAC strongly encourages the
ED Nurse Manager to rotate the Additional Responsibility (AR)\(^\text{30}\) role responsibilities among RNs with two to three years of ED experience and/or who demonstrate leadership qualities.

The IAC understands that the Hospital is planning to revise the Charge Nurse (PCC and AR) role to clarify the Charge Nurse’s responsibility to revise patient assignments to facilitate flow of patients through the ED in conjunction with a Charge Physician’s decision regarding physician assignments\(^\text{31}\), to ensure that nurses and physicians are located in the areas of greatest patient volumes. The IAC supports revision of the patient assignment within the Acute and Subacute Zones, believing that movement of staff through the various areas within the Acute and Subacute Zones provides RNs with an enhanced sense of ownership of the Department, and a more in-depth understanding of what is required for the Department as a whole, rather than just the RN’s specific assignment, to function on a given shift. This approach has been used successfully in high-volume community hospitals\(^\text{32}\).

The IAC believes that the Fast Track Zone, currently staffed by RPNs, should remain distinct, and that, specifically, revision of the patient assignment not include RPNs being independently responsible for patient care in either the subacute or ‘See and Treat’ areas within the Subacute Zone. The IAC believes that, in accordance with CNO Guidelines\(^\text{33}\), there are no circumstances in which RPNs should hold an independent patient assignment within the Acute Zone.

The IAC understands that the Triage role currently rotates among RNs, and that the daily assignment includes a ‘shadow triage RN’ who can relieve the Triage RN if the latter requires a break from Triage responsibilities. The Triage role can be both challenging and tiring, depending on the nature and number of patients presenting to the ED, and there are shifts when an 11.25-hour stretch is too long. The IAC is very supportive of the current approach of rotating the Triage role among experienced RNs, and of providing the Triage RN with an opportunity to ‘spell off’, as this provides the Triage RN with control over her/his work environment (an empowering concept).

**Recommendation:**

6. Implement revised role responsibilities for the Charge Nurse, specifying the expectation that the Charge Nurse will have authority to revise the patient assignment to ensure nurses are located in the areas within the Department with the greatest patient volumes/care needs.

7. Confirm in policy that RPN independent patient assignments will remain within the Fast Track Zone. RPNs may assist with the care provision in the Subacute and Acute Zones in collaboration with RNs, but should not assume an independent patient assignment.

8. Continue the practice of rotating the AR and Triage RN roles among ED RNs who have 2-3 years ED experience and/or demonstrate leadership qualities.

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\(^{30}\) The IAC understood that the AR role, introduced through SAH in March 2010, is consistent with the Group, Unit or Team Leader described in Article 19.04 (d) of the Collective Agreement. It is implemented in the ED on the night shift (1900 – 0700) seven days per week.

\(^{31}\) The IAC understands that Hospital plans to implement a formal Charge Physician role, to facilitate a similar realignment of assignment to facilitate patient flow. While physician assignment is outside of the IAC’s jurisdiction, the IAC believes this approach will be an effective support to the proposed changes to the Charge Nurse role and to the decrease of ED LOS.

\(^{32}\) For example: Credit Valley Hospital in Mississauga: [http://www.chqi.ca/pdfs/success_study_1_en.pdf](http://www.chqi.ca/pdfs/success_study_1_en.pdf) (accessed May 22, 2012)

\(^{33}\) College of Nurses of Ontario: Practice Guideline: *RN and RPN Practice: The Client, the Nurse and the Environment*, Publication # 41062, December 2011
9. *Continue the practice of ‘shadow assigning’ the Triage RN role.*

3.3.1.4 **Mentorship Program**

The IAC was confused regarding the current status of the Mentorship Program at SAH. At the Hearing, it appeared to the IAC that while a Mentorship Program formally exists at SAH, the formal Program did not appear to be in active use in the ED. The IAC understood that in addition to the corporate and nursing orientation, new recruits to the ED receive eight (8) weeks of ‘mentorship/orientation’, but that pairing the new RN with a consistent mentor was very challenging in light of the innovative (4-on / 5-off) schedule.

Subsequent to the Hearing, the IAC received copies of the very comprehensive Mentor and Mentee Workbooks, which were jointly developed by the SAH and Sault College in 2003. The seven modules\(^{34}\) include well-developed guidelines, such as a Unit Orientation Guide, as well as worksheets for both the mentor and mentee, and a ‘contract’ clarifying the relationship between and responsibilities of each of the mentor and mentee. In addition, the IAC noted that the #46 Local Agreement contains a Letter of Understanding Re: Mentorship Programs, and received confirmation from the Hospital that mentorship arrangements for both new staff and other staff currently exist and that a review of the Mentorship Program has been initiated as part of the corporate clinical education plan.

The IAC believes that the Mentorship Program needs to be revitalized across the Hospital in accordance with the Letter of Understanding, using the previously developed Workbooks as a base. The IAC fears that the Workbooks, while extremely comprehensive, will appear overwhelming to mentors and mentees. The IAC encourages the Hospital to synthesize the key elements of the Program Workbooks into a more streamlined format that will support ease of use by RNs.

The IAC believes that if the mentee is well prepared, in terms of understanding her/his learning needs, several RNs can function in the mentor role (a long-term 1:1 relationship is not required). The IAC strongly believes that a formal mentorship relationship is of tremendous benefit and support, especially for newly graduated RNs, in an active acute department such as the SAH ED.

**Recommendation:**

10. *Revise the existing Mentorship Program Workbooks to synthesize the key elements for mentors and mentees, and formally re-implement the Program in the ED (and elsewhere).*

3.3.1.5 **Professional Responsibility Complaint Process**

Article 8 of the Collective Agreement provides direction of the process to follow in the instance of a workload issue. Specifically, Article 8 specifies that:

- At time the workload issue occurs, the RN(s) is to discuss the issue within the unit/program, and if necessary, seek assistance from an individual who has responsibility for timely resolution of

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\(^{34}\) Mentoring Basics; Transitions in Professional Practice; Legalities Concerning Mentorship; Learning Styles; Quality Assurance and Learning Plans; Challenges for Novice Practitioners (time management/giving and receiving feedback/conflict resolution); and References.

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workload issues. At SAH this individual is the Nurse Manager during the day Monday through Friday, and is the Administrator-on-Call on evening, night and weekend shifts.

- If the workload issue is not resolved by the above at the time of occurrence, or if the issue is ongoing, the RN(s) is to discuss the issue with his/her Manager (or designate) on the next day that the Manager and nurse are both working, or within five calendar days, whichever is sooner.

The IAC understands that the differentiation in the Collective Agreement between a “one of” situation, and a workload situation which is part of an ongoing workload issue. In the former instance, the RN is expected to call the Nurse Manager / Administrator-on-Call to provide the management team with an opportunity to address/resolve the issue. In the latter instance, when the RN believes the workload situation is related to an ongoing workload issue, there is no requirement for the RN to call at the time the workload situation occurs.

The IAC clearly understands, and is in no way questioning, that it is within the RN’s right to complete a PRWRF whenever he/she believes that a workload situation has occurred.

The IAC further understands the RNs’ perspective that continuing to document workload concerns related to an ongoing issue provides evidence that the RN has made effort to communicate the issue to her/his Manager. The IAC recognizes that RNs have felt that the previous process of documenting ‘filed’ in the Management Response section of the PRWRF has led to the sense that the workload concern was perceived to be not valid and/or would not be addressed.

However, the IAC believes that the process which has evolved at the SAH over the past year, in which RNs do not always call at the time a workload situation occurs if it is deemed to be part of an ongoing issue, has contributed to the frustration and communication breakdown felt by both parties with respect to workload concerns.

The IAC encourages the Local Association and nursing leadership team to discuss the PRC process to ensure that the outcome both supports the RN’s concerns and supports a quality outcome for the patient. The IAC is concerned that failing to bring a workload situation to the attention of the Manager responsible for addressing/resolving it at the time it occurs, even when the situation is part of an ongoing issue, may result in less optimal patient care. The IAC believes that RNs will best advocate for quality patient care by documenting their workload concern in conjunction with notifying the responsible Manager at the time the issue occurs.

3.3.1.6 Administrator-on-Call

The IAC understands that the Administrator-on-Call rotation has recently changed, and that Nurse Managers are now on-call for the entire Hospital, not just within their own Program. This may result in an Administrator-on-Call not being familiar with the issues within another Program when called during off-hours. The IAC encourages the Hospital to ensure that the Administrator-on-Call policy binder is comprehensive and that supports are available for secondary calling as required.

The IAC noted that at the Hearing, the ED RNs appeared unsure as to how to escalate a call to the Senior Administrator-on-Call, if they believed that the issues of concern were not being effectively addressed. The IAC recommends that the notification policy, which is clear, be more comprehensively communicated.
Recommendation:

11. Develop a comprehensive education/guideline binder, to facilitate consistent decision-making among all Administrators-on-Call.

12. Re-communicate the process for notification of the Clinical Administrator-on-Call, the Service Administrator-on-Call, and the Senior Administrator-on-Call to all SAH nursing staff.

3.3.2 Practice

Nurses are responsible to practice in accordance with CNO practice standards and guidelines\(^{35}\), as well as clinical standards specific to the specialty. The NENA Standards of Practice for Emergency Nurses (Appendix 9) provide clear expectations for practice of RNs in a hospital ED. The scope of practice of emergency nursing, in a comprehensive department such as at SAH which provides the sole emergency resource for the city, is both vast and diverse. Emergency nursing practice encompasses all specialties of nursing, includes provision of care that ranges from birth to death, and requires a comprehensive knowledge base and high level of expertise.

The scope of the IAC’s jurisdiction relates to an evaluation of whether RNs are being requested to perform more work than is consistent with proper patient care, but does not include evaluation of the manner in which specific NENA standards are implemented within the ED. However, in the course of the Hearing, the IAC identified a number of practice-related issues, relating to CTAS documentation, fax transfer reports, medical directives, use of constant care attendants, patient education / discharge teaching, and Fast Track overflow, which it believes are impacting the RNs’ workload.

3.3.2.1 CTAS Documentation

From discussion at the Hearing, the IAC understood that there are instances where the Triage RN revises the CTAS level following the initial triage assessment. The IAC was not clear whether this related to changing the CTAS level generated by ePOD because the RN believed that the patient’s presentation did not fit with the ePOD-generated CTAS level, or whether it related to the RN revising the CTAS level based on subsequent changes in patient condition.

In any case, the IAC believes that this process must cease. CAEP guidelines clearly stipulate that priority placement within the ‘waiting queue’ may be revised following reassessment of the patient (e.g. the patient was initially assessed as a CTAS 3, but his condition is deteriorating and so he is placed with CTAS 2 patients to be seen more quickly by the MD), but that documentation of the initial triage categorization remain unchanged. The IAC also cautions against over-riding the ePOD triage categorization, as this will negate the validity of the ePOD system.

Recommendation

13. Cease the practice of altering the initial documented CTAS category, as determined at the time of initial patient presentation to the ED, during the patient’s visit in the ED.

3.3.2.2 Fax Transfer Reports: ED to Inpatient Unit

One of the projects implemented through the ED-PIP initiative was the implementation of a transfer of accountability form to communicate clinical information of patients being admitted to inpatient units from the ED. The goal of the project was to decrease the time required for the ED RN to locate and speak to the inpatient unit RN receiving the patient to provide a verbal report, which was requiring, on average, 73 minutes. This was resulting in delay in transferring the patient and contributing to a backlog of patients in the ED. The change to a faxed transfer report was made in conjunction with a revision to the ED Tracker system, which flags the availability of the inpatient bed when the discharge order is entered in Meditech. The intent is that when the ED RN notes that the bed is ready on the ED Tracker, she/he will ‘fax and go’, that is, fax the Patient Report Form and send the patient with the porter.

The IAC recognizes that there are likely a number of reasons why the ‘fax and go’ policy is not being consistently implemented, ranging from a difficulty in changing personal practice (‘I’ve always given a nurse-to-nurse verbal report’), to a concern about quality of care (‘some patients are complicated and you can’t get all the information on the form’). The IAC also recognizes that the ‘fax and go’ policy requires a change in practice on the inpatient units, who are now expected to receive the patient even if the room and bed have not yet been fully cleaned. Regardless, the IAC supports the consistent implementation of the ‘fax and go’ initiative, believes it is the responsibility of the receiving nurse to call the ED RN if she/he has any questions or concerns regarding the patient, and of the receiving unit to make short-term arrangements for patient placement as required.

The IAC believes that this, and other policies relating to the quicker movement of patients through the ED, would benefit from discussion at a Unit Council meeting, to enable the competing priorities of comprehensive patient care and management of ED wait times to be addressed.

Recommendation:

14. Communicate expectation that patient transfer from the ED to inpatient units uses the ‘fax and go’ policy, and take appropriate action to address issues as required.

3.3.2.3 Medical Directives

The SAH has a comprehensive process for the development of Medical Directives. Program-specific Directives, such as those within the ED, are approved initially by the Program Governance Committee, then by the Pharmacy & Therapeutics (P&T) Committee if medications are involved, and finally by the Medical Advisory Committee (MAC).

The ED has four Medical Directives currently in use, with an additional 13 in the approval process, as indicated in Table 6.

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36 The 13 were approved at P&T on April 19, 2012, and at the time of the Hearing, were yet to be approved by MAC.
### Table 6: ED Medical Directives

<table>
<thead>
<tr>
<th>Medical Directive</th>
<th>MAC Approval/Revision Date</th>
</tr>
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<tbody>
<tr>
<td>• Lidocaine for the insertion of a nasogastric tube</td>
<td>March 2006</td>
</tr>
<tr>
<td>• Administration of Acetaminophen to a child with fever or discomfort</td>
<td>October 2008</td>
</tr>
<tr>
<td>• Ordering / Initiating Diagnostics in the Emergency Department</td>
<td>May 2009</td>
</tr>
<tr>
<td>• Naloxone Administration</td>
<td>March 2010</td>
</tr>
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<td>Issue Date</td>
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</table>

<table>
<thead>
<tr>
<th>Issue Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>February 2012</td>
</tr>
<tr>
<td>March 2012</td>
</tr>
<tr>
<td>March 2012</td>
</tr>
<tr>
<td>April 2012</td>
</tr>
<tr>
<td>March 2012</td>
</tr>
<tr>
<td>April 2012</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Medical Directive</th>
<th>Issue Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Initiating treatment of the patient presenting to the ED with</td>
<td>February 2012</td>
</tr>
<tr>
<td>- chest pain</td>
<td></td>
</tr>
<tr>
<td>- suspicion of an overdose</td>
<td></td>
</tr>
<tr>
<td>- altered mental status</td>
<td></td>
</tr>
<tr>
<td>- SOB of unknown cause, syncope and/or palpitations</td>
<td></td>
</tr>
<tr>
<td>- seizures</td>
<td></td>
</tr>
<tr>
<td>- symptomatic hypoglycemia</td>
<td></td>
</tr>
<tr>
<td>• Initiating treatment and diagnostic testing of the patient presenting to the ED with</td>
<td></td>
</tr>
<tr>
<td>- abdominal pain/flank pain and/or vomiting with suspected dehydration</td>
<td></td>
</tr>
<tr>
<td>- a suspected GI bleed</td>
<td></td>
</tr>
<tr>
<td>- head injury or sudden onset of severe head pain and on anticoagulants</td>
<td></td>
</tr>
<tr>
<td>- a suspected cerebral vascular accident (CVA)</td>
<td></td>
</tr>
<tr>
<td>• Administration of Ondansetron to</td>
<td>April 2012</td>
</tr>
<tr>
<td>- a child with nausea and/or vomiting</td>
<td></td>
</tr>
<tr>
<td>• Administration of Acetaminophen or Ibuprophen to</td>
<td>April 2012</td>
</tr>
<tr>
<td>- a child for fever or discomfort</td>
<td></td>
</tr>
<tr>
<td>- an adult for fever or discomfort</td>
<td></td>
</tr>
</tbody>
</table>

The IAC identified two issues with respect to medical directives: time and location of implementation of medical directives, and the proposed roll-out plan for the medical directives in process.

With respect to time and location of implementation of the medical directives, the IAC understood that the SAH ED policy is that CTAS reassessments are the priority for the Triage RN, and that medical directives are to be implemented while the patient is in the Triage Zone only when time is available. The exception to this direction is the administration of acetaminophen to a child with fever, which is routinely implemented by the Triage RNs, and initiation of bloodwork and ECG for patients presenting with chest pain. Implementation of other medical directives is to occur once the patient has moved into the Acute or Subacute Zones.
This policy was successful when the ED had only four medical directives. However, with the move to an expanded range of directives, the IAC is concerned that continuation of this policy may negatively impact patient flow within the ED. Properly used, medical directives can improve patient flow and ensure early institution of diagnostic testing and treatment\(^{37}\). The IAC believes that medical directives should be implemented, as appropriate, during the Triage period. NENA Standard 1.4 states the following:

- Collaborative intervention: the Triage Nurse shall function collaboratively to facilitate timely care of the patients.
  - Ensures prompt initiation of resuscitative measures, if indicated
  - Initiates diagnostic testing if indicated
  - Initiates treatment, if indicated, in accordance with hospital policy and procedure.

The IAC believes that a policy which optimizes patient flow and empowers the RN to determine what will be in the patient’s best interest in light of the patient’s condition and the current activity within the ED, will be beneficial. Such a policy would indicate that medical directives are to be implemented:

- in the Triage Zone if the patient’s condition warrants immediate diagnosis/intervention and space is unavailable in the Acute or Subacute Zones;
- in the Triage Zone if the patient cannot be moved into the Acute or Subacute Zone prior to reassessment;
- in the Acute or Subacute Zone if the patient can be moved to the Acute or Subacute Zone within a time frame prior to reassessment being required.

This will enable the Triage RN to determine in which instances she/he should implement the diagnostic or treatment directive, and in which instances the directive should be implemented in the core zones of the ED.

The IAC believes that when two RNs are assigned to the Triage Zone, care will be most effectively provided if one RN conducts the CTAS assessments of patients presenting to the ED, and the second RN implements the required medical directives and conducts the CTAS reassessments. Assignment of the second RN to the Triage Zone is discussed in Section 3.3.3.1.2 (RN Staffing in the Acute, Subacute and Triage Zones)

With respect to the planned roll-out of the new medical directives, the IAC understood that the plan is to develop a self-directed learning package, which the RNs will review and sign off. The IAC is concerned that this approach will not provide for any form of evaluation of the knowledge/competence of the RNs implementing the medical directives, which is especially concerning in light of the large number of new graduates who are joining the RN full-time and part-time staff. In addition, the IAC is concerned that the approval of RNs to implement specific medical directives appears to be a nursing monitored process, in that the IAC was not provided with any evidence that authority to assess the competence of the RN(s) has been delegated from the physician(s) to the Nurse Educator.

In light of the above, the IAC believes that a more in-depth process for evaluation of knowledge and competence is required. As noted in Section 3.3.1.1 (ED Nurse Manager and Educator Roles), the IAC believes that the ED would benefit from a full-time Nurse Educator. Successful roll-out of the new medical directives will be a key focus for the Educator. The IAC also believes that authority for evaluation of competence of nurses to implement the medical directives needs to be formally delegated.

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from the Medical Director to the Nurse Educator. Both the Ontario Hospital Association\textsuperscript{38} and the Federation of Health Regulatory Colleges\textsuperscript{39} have excellent resources regarding the development, implementation and evaluation of medical directives, use of which the IAC encourages.

Finally, in light of the large number of new directives being implemented simultaneously, the IAC believes that a practice audit, completed by the Educator or one or more ‘SuperUser’ RNs, be completed in six months, and that the medical directive evaluation include feedback from the RNs regarding the resulting changes in practice.

**Recommendation:**

15. **Develop a policy regarding implementation of medical directives which will optimize patient flow within the ED and will enable implementation of the directives at a time and location that is in the best interest of the patient.**

16. **Nurse Educator, Nurse Manager and Medical Director jointly develop a defined process for evaluation of competence of all RNs to implement medical directives, which includes a formal delegation of authority for competence evaluation from the Medical Director to the Nurse Educator.**

17. **Evaluate the implementation of the new medical directives, following six months of use, by means of:**
   
   a. a random audit of 500 ED patients who did / did not have medical directives, and
   b. RN staff survey
to determine appropriateness of implementation and requirements for revisions of content, and addition/discontinuation of specific directives.

3.3.2.4 **Constant Care Attendants**

The lack of Constant Care Attendants to monitor the status of Form 1 patients and/or patients with dementia within the ED was frequently identified in the PRWRFs submitted by the ED RNs. The IAC understood that in theory, Form 1 patients are not ‘automatically’ considered to require constant care and it is the RN’s judgement as to whether the patient will be safe. In practice however, the RNs’ general expectation is that each Form 1 patient will have a separate Constant Care Attendant assigned, and that it is considered a ‘workload situation’ when this does not occur. The IAC also understood that there was a policy in the previous ED, which included criteria, such as pharmacological and non-pharmacological support, calling the family etc. to be considered before determining the requirement for constant care, but was not clear whether this policy had transferred to the new hospital site. Constant Care Attendants are Psychiatric Attendants within the Mental Health Program, and are not part of the ED staff.

The IAC does not believe that every Form 1 patient or dementia patient requires 1:1 supervision and monitoring, but rather that the need for Attendant Care is patient dependent and requires clinical judgement. However, the IAC clearly recognizes the challenges for the ED RNs when mental health

\textsuperscript{38} http://www.oha.com/KnowledgeCentre/Library/Toolkits/Pages/EmergencyDepartment(ED)MedicalDirectivesImplementationKit.aspx

\textsuperscript{39} http://ndguide.regulatedhealthprofessions.on.ca/templates/default.asp
patients remain in the ED without psychiatric support, and understands the anxiety and frustration which is engendered for the RNs when a patient remains isolated in a locked windowless room for long periods. The IAC does not support pre-scheduling of Constant Care Attendants within the ED, but does encourage the Hospital to ensure availability of Psychiatric Attendants when it is determined that safety of the patient(s) necessitates constant care.

The IAC believes that re-evaluation of the Constant Care Attendant policy is required, and suggests that this begin with discussion at a Unit Council meeting regarding, for example, instances when Form 1 / dementia patients can be cohorned, differing support required for patients who are a flight risk vs. suicide risk, approaches to support patient safety etc.

**Recommendation:**

18. **Re-evaluate the constant care policy to identify guidelines for determination of when constant care is and is not required on a 1:1 basis for patients for whom safety of self or others is a concern.**

### 3.3.2.5 Patient Education and Discharge Teaching

One of the issues which received considerable discussion at the Hearing related to the ability of the RNs to provide comprehensive patient education and discharge teaching. The IAC understood that it is the RNs’ sense that these elements of patient care are suffering within the ED, where the focus is increasingly on effective management of patient LOS. Numerous examples were provided, such as discharge teaching for a newly diagnosed diabetic, assisting a mother to learn how to administer a rectal suppository so her febrile child will not convulse, and showing a cardiac patient how to correctly administer nitroglycerine spray or an asthmatic patient how to effectively use an aerochamber. The RNs were concerned that patients are returning to the ED who might not have done so, had more effective education and discharge instructions been provided. It was clear to the IAC at the Hearing that the Hospital shares the RNs’ concerns regarding the provision of and efficacy of discharge teaching, and the appropriate referral of patients to community programs.

The IAC identified two issues with respect to patient education in the SAH ED: scope of the education that is required, and consistency of provision of education/discharge instructions across all nurses within all Zones.

The scope of patient education in the ED needs to specifically focus on enabling the patient/family to gain the knowledge/skill to manage the acute episode that caused the ED visit until either the (minor) episode is resolved or the (major) episode is followed up elsewhere. ED patient education is, by definition, not comprehensive. The IAC understood that an automatic referral to appropriate community resources is being developed within the Meditech system, and that the current Meditech system includes discharge information forms which will assist with focusing discharge teaching. The IAC strongly encourages implementation of both resources.

The use of structured tools and resources, together with the nurse’s personal knowledge base, enable consistent provision of appropriate patient education by all nurses. The IAC believes that one of the key roles of the Educator is to support nurses to gain the knowledge and expertise required – a young newly

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40 The Group Health Centre Chronic Disease Management Program has programs in diabetes, congestive heart failure, COPD and asthma.
graduated RN, with minimal obstetrical/pediatric experience and no personal experience, may not know what to teach a new mother with a dehydrated infant to assist her to successfully breastfeed - and that this is a further example of the benefits that will accrue from a full-time Educator within the ED. The IAC believes that ED policy needs to clearly identify the expectation that patient education, including discharge teaching, is a requirement for all patients, and that strategies need to be in place to support the provision of education within a department focused on efficient patient through-put. While there will always be time pressures in a busy ED, the IAC believes that selection and implementation of appropriate education/discharge teaching tools will assist RNs to focus their education/discharge teaching priorities to maximize patient learning.

**Recommendation:**

19. The ED Educator, ED Nurse Manager and Unit Council research standardized teaching tools, including those available through the Meditech system, from other EDs within the Northeast LHIN, from the Provincial Clinical Educators Group, and on the public domain on the internet, and select those with specific relevance for implementation in the SAH ED.

20. Continue to work with Meditech to implement an automatic referral to community agencies.

21. Survey the ED nursing staff regarding their perception of the scope, adequacy and content of patient education in 12 months.

### 3.2.2.6 Fast Track Patient Overflow

The Fast Track Zone operates relatively autonomously with the ED (see Section 3.2.5 Geographical Configuration of the SAH ED), with one exception: overflow patients in the evening. The goal is that, other than accessing the Minor Treatment Rooms as required, and (sometimes) walking through the internal service corridor to reach Diagnostic Imaging, patients within the Fast Track Zone should not need to enter or receive care in either the Subacute or Acute Zones. The reality is that, depending on patient volume and physician practice patterns, there are some evenings when Fast Track patients have not yet been seen by 2200 when Fast Track closes. In these instances, the patients are transferred back to the Triage Waiting Room, and integrated with the CTAS 1-3 patients receiving treatment in the Acute and Subacute Zones. This creates unanticipated workload for the Triage and the Acute/Subacute RNs. In addition, as they are of lower acuity, the Fast Track patients, who may have already waited up to 2 hours in the Fast Track waiting room, face a potentially long wait in the Triage waiting room -- not popularly received.

The IAC believes that the Charge Nurse (AR) and Charge Physician need to evaluate the status of the Fast Track Zone by 1800 each evening, to determine whether the pace of care and flow of patients will meld sufficiently to enable closure of Fast Track by 2200.

**Recommendation:**

22. SAH implement a formal policy whereby the Charge RN/Charge MD implement a resource allocation plan each evening by 1800, including the reassignment of nursing and/or physician resources to Fast Track from the Acute or Subacute Zones, and/or the integration of CTAS 4 and 5 patients into the Subacute Zone as required to ensure closure of the Fast Track Zone by 2200.
3.3.3 Staffing and Workload

Appropriate staffing is essential to the delivery of safe and effective patient care, and it helps to ensure efficient throughput processes in the ED. To help determine nurse staffing and improve patient safety, workforce measures such as hours-per-patient-visit and nurse-patient ratios have been considered. Specific nurse-to-patient ratios were mandated in California EDs in 2004. However, numerous studies have indicated that patient care outcomes have not been improved with a defined nurse-to-patient ratio model, especially since all nurses are not equally skilled and all ED patients do not have the same level of care needs. Staffing based solely on nurse-to-patient ratios or nursing hours per patient visit are limited in scope and do not consider the variables that affect the consumption of nursing resources in an ED.

To identify safe, effective, realistic best practice staffing in EDs, the Emergency Nurses Association has identified six key factors that are critical to project staffing requirements, develop staffing models and accurately predict budget requirements:

- **Patient census**, including annual volumes with seasonal fluctuations, and day of the week and hour of the day volumes;
- **Patient acuity**, based on triage assessment scores;
- **Patient length of stay in the ED**, including LOS of admitted patients awaiting inpatient bed placement;
- **Nursing time for nursing interventions and activities by patient acuity**;
- **Skill mix for providing patient care** based on nursing interventions that can be delegated to a non-registered nurse; and
- **An adjustment factor** for the non-patient care time (vacation, education time etc.) included in each FTE.

As part of this process, the ENA developed the *ENA Guidelines for Emergency Department Nurse Staffing* in 2003, which has remained a key resource.

Based on the above, the IAC believes that consideration of staffing patterns and resources in the ED is required in two areas: nursing staffing and support-staff staffing.

3.3.3.1 ED Nursing Staffing

The current nursing staffing within the ED is indicated in Table 7.

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44 Ibid

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Table 7: Current ED Nursing Staffing

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<thead>
<tr>
<th>Nurse</th>
<th>Day Shift</th>
<th>Mid Shift</th>
<th>Night Shift</th>
<th>Total</th>
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<tr>
<td></td>
<td>RN: 0700 – 1900</td>
<td>RN: 1000 – 2200</td>
<td>RN: 1900 – 0700</td>
<td>#   Hours</td>
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</tbody>
</table>

As noted in Section 3.2.5 (*Geographical Configuration of the SAH ED*), the SAH ED is geographically configured into five separate Zones: the Triage Zone located outside of the core ED, and the Acute, Subacute, CDU and Fast Track Zones. The IAC believes that staffing of the ED needs to reflect the Zone configuration, the volume and acuity of patients presenting to and remaining within each Zone, and the nursing skill mix providing patient care.
3.3.3.1.1 Fast Track Zone Staffing

The Fast Track Zone, which is staffed with 2 RPNs, one RN(EC) and two MDs (who work six-hour rotations from 1000 – 1600 and 1600 – 2200) is open from approximately 0930 to 2200. As noted in Table 3, 43% of the ED patients, including half of the CTAS 3 and the majority of CTAS 4 and CTAS 5 patients, are treated in the Fast Track Zone.

At the Hearing, the Association indicated that RNs assigned to Subacute are occasionally called to Fast Track to assist the RPNs with interventions such as IV starts, phlebotomy, flushing PICC lines, complicated dressing changes etc. The IAC understands that RPNs at SAH who graduated from a practical nurse program prior to 2003 have been required to complete six specific courses to enable them to meet the revised CNO RPN Entry to Practice Competencies. The IAC anticipates that in these instances, the RPNs possess the required competencies to provide care, and are appropriately accessing collegial support in specific situations.

The IAC believes that the RPN role within the Fast Track Zone is appropriate, in terms of the balance of client factors, nurse factors and environmental supports identified in the CNO Three Factor Framework. The IAC understood that the Hospital is exploring the possibility of integrating the ‘See and Treat’ area and Fast Track Zone from a physician coverage perspective. As noted in Section 3.3.1.3 (ED Nurse Manager and ED Educator Roles), the IAC does not support integration of the RPNs into the Subacute Zone, in light of the altered practice environment in that area. The IAC believes that the Fast Track Zone should continue to function ‘autonomously’ with no changes to the nursing skill mix or staffing pattern.

Recommendation:

23. Maintain the current nursing staff mix and nursing staffing pattern in the Fast Track Zone.

3.3.3.1.2 Acute, Subacute and Triage Zones Staffing

As indicated in Table 3, 57% of the ED patients receive care in the Acute and Subacute Zones, with 19% in Acute and 38% in the three areas of subacute, CDU and ‘See and Treat’ within the Subacute Zone. With an average of 150 patient visits per 24 hour period, this equates to approximately 85 patient visits per day, with an average of 28 patient visits per day in the Acute Zone and 57 visits per day in the Subacute Zone.

As indicated in Table 8, patient volume ebbs and flows over the course of the day, with the greatest number of total patients in the ED between 1000 and 2200 hours. Although 43% of patients receive care in the Fast Track Zone, their shorter LOS means that there are relatively few patients in the Zone at any given time. The longer LOS for non-admitted CTAS 1-3 patients in the Acute and Subacute Zones means that although fewer total patients are seen, the workload associated with their care is much greater. The Acute Zone is also impacted by the LOS of admitted patients waiting for inpatient bed placement.

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45 Pharmacology and Theory of Medication Administration; Health Assessment, Nursing theory or Management of the Acute and Chronically Ill; Professional Growth or Leadership and Communication; RPN Skills Transition or Clinical Skill Assessment; and IV Therapy.

46 College of Nurses of Ontario: Practice Guideline: RN and RPN Practice: The Client, the Nurse and the Environment, Publication # 41062, December 2011

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Table 8: Average ED Census by Hour of Day 2011-12

<table>
<thead>
<tr>
<th>Hour of Day</th>
<th>Average # of ED Outpatients in Acute/Subacute</th>
<th>Average # of ED Inpatients in Acute/Subacute</th>
<th>Total # ED Patients in Acute/Subacute</th>
<th>Average # ED Outpatients in Fast Track</th>
<th>Average Total Census</th>
</tr>
</thead>
<tbody>
<tr>
<td>0700</td>
<td>8.1</td>
<td>9.0</td>
<td>17.1</td>
<td>0.2</td>
<td>17.3</td>
</tr>
<tr>
<td>0800</td>
<td>9.1</td>
<td>9.2</td>
<td>18.3</td>
<td>0.7</td>
<td>19.0</td>
</tr>
<tr>
<td>0900</td>
<td>10.6</td>
<td>9.1</td>
<td>19.8</td>
<td>2.5</td>
<td>22.3</td>
</tr>
<tr>
<td>1000</td>
<td>11.9</td>
<td>8.9</td>
<td>20.8</td>
<td>6.3</td>
<td>27.1</td>
</tr>
<tr>
<td>1100</td>
<td>14.6</td>
<td>8.7</td>
<td>23.3</td>
<td>8.4</td>
<td>31.7</td>
</tr>
<tr>
<td>1200</td>
<td>16.7</td>
<td>8.3</td>
<td>25</td>
<td>8.6</td>
<td>33.6</td>
</tr>
<tr>
<td>1300</td>
<td>18.5</td>
<td>8.0</td>
<td>26.5</td>
<td>9.4</td>
<td>35.9</td>
</tr>
<tr>
<td>1400</td>
<td>19.8</td>
<td>7.7</td>
<td>27.5</td>
<td>10.5</td>
<td>38.0</td>
</tr>
<tr>
<td>1500</td>
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<td>7.4</td>
<td>27.6</td>
<td>11.0</td>
<td>38.6</td>
</tr>
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<td>27.0</td>
<td>9.7</td>
<td>36.7</td>
</tr>
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<td>26.8</td>
<td>9.8</td>
<td>36.6</td>
</tr>
<tr>
<td>1900</td>
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<td>7.3</td>
<td>26.4</td>
<td>9.9</td>
<td>36.3</td>
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<td>8.0</td>
<td>27.1</td>
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<td>26.8</td>
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<td>33.7</td>
</tr>
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</tr>
<tr>
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<td>7.9</td>
<td>27.6</td>
<td>0.8</td>
<td>28.4</td>
</tr>
<tr>
<td>2400</td>
<td>17.8</td>
<td>8.4</td>
<td>26.2</td>
<td>0.4</td>
<td>26.6</td>
</tr>
<tr>
<td>0100</td>
<td>16.1</td>
<td>8.4</td>
<td>24.5</td>
<td>0.2</td>
<td>24.7</td>
</tr>
<tr>
<td>0200</td>
<td>13.6</td>
<td>8.4</td>
<td>22.0</td>
<td>0.1</td>
<td>22.1</td>
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<td>0300</td>
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<td>8.3</td>
<td>19.8</td>
<td>0.1</td>
<td>19.9</td>
</tr>
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<td>8.4</td>
<td>18.7</td>
<td>0.1</td>
<td>18.8</td>
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<td>18.0</td>
<td>0.1</td>
<td>18.1</td>
</tr>
<tr>
<td>0600</td>
<td>8.6</td>
<td>8.6</td>
<td>17.6</td>
<td>0.1</td>
<td>17.4</td>
</tr>
</tbody>
</table>

90th percentile data drawn from SAH Exhibits Appendix I, J, and M

The IAC recognizes that the figures in Table 8 are the “average” census numbers: an “average” of 19 patients means that the actual number of patients will be either higher or lower. However, the IAC believes that the data in Table 8 indicates a clear trend of an increase (‘surge’) beginning around 1100 and declining around 2400. In light of this variation in patient census in the Acute and Subacute Zones over the 24-hour period, and in particular the lower number of patients during the night and early morning (approximately 2400 – 1100), the IAC does not support a consistent RN staffing level throughout the 24-hour period as recommended by the Association. In order to address patient volumes, the IAC believes that RN staffing resources need to be higher between 1200 – 2400 than between 2400 – 1200.

The IAC heard considerable discussion at the Hearing regarding the nurse:patient ratios currently in place in the Acute and Subacute Zones. The ratios were defined as 1:3 in Acute, 1:4 in Subacute and 1:5 in CDU. The IAC understood that the concept for the ratios came from discussions at ED PRC Meetings.

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97 Data drawn from SAH Exhibit “Average ED Census by Hour of Day FY 2011-12
98 90th percentile data drawn from SAH Exhibits Appendix I, J, and M
and ED Follow-up HAC meetings held during 2011, and that they ‘fell out’ of various discussions. However, on review of the meeting notes provided as part of the Hearing Exhibits, some of which were hand-written, the IAC could not find evidence of actual discussion between the SAH and the Association on this issue, but rather statements such as “Unit policy is that CDU ratio is 1:5”, or an understanding that two of the six stretchers in the subacute area are ‘closed’ because the ratio in that area is 1:4. The IAC does not believe that assignment based on a fixed nurse:patient ratio is appropriate within an ED, for the reasons identified in the evaluation of the California experience, and considers that the use of absolute patient ratios is counter-productive to patient flow within the ED.

The IAC believes that the baseline staffing for the Zones needs to support a combination of the volume (number) of patients entering the Zone, care requirements of patients (acuity – CTAS level) and length of stay of patients (turnover). The IAC believes that determination of staffing requirements needs to be based on evaluation of patient care needs, not solely on patient volume: a patient with new onset cardiogenic shock has significantly greater care needs, and therefore greater nursing resources, than a patient with chronic atrial fibrillation. The IAC believes that the ED needs to move away from the concept that additional staff are required when, for example, the 15 stretchers in the Acute Zone are full and there are several patients in the hallway resulting in an assignment of 1:4 or 1:5, if the patients in all 15 stretchers are stable and awaiting bed placement. Similarly, if only 10 stretchers are full, but 80% of the patients are of a CTAS 1 level requiring intense nursing care, additional resources would be required, even though each RN’s assignment would be 1:2. The 1:3 ratio as a “given” is not relevant in either case.

Similarly, in the Subacute Zone, the IAC understood that the 1:4 ratio developed when the ‘upstaffing’ of an additional RN 24/7 was removed in July 2011, which also resulted in the understanding that two of the six stretchers in the subacute area would be ‘closed’ (i.e. not staffed). Again, the IAC does not believe that a fixed ratio is appropriate: the subacute area includes CTAS 2 to CTAS 4 patients, who have a wide variation in acuity and consequent care needs. The RN’s ability to provide care for patients will depend on her experience/competence, the acuity/care needs of the patient and family, and the speed with which the MD is working.

The current staffing model places one RN in the CDU. However, the average census in the CDU is low, with an average census of 1.3 to 2.3 patients per hour\(^9\). The IAC questions the validity of assigning one RN to this area exclusively, and believes that the CDU can provide assistance in the Subacute Zone on a regular basis.

The IAC noted that a clear outcome of the ED’s focus on patient flow is a movement of patients out of the Triage waiting room into the core of the Department (Acute, Subacute or Fast Track Zones) as quickly as possible. This results in a lesser requirement for triage reassessment, which in turn decreases the workload in the Triage Zone, leading the IAC to question the need to assign a second Triage RN on a regular basis.

In summary, the IAC believes that allocation of RN staffing resources across the Acute, Subacute and Triage Zones needs to be rebalanced over the 24 hour period, to ensure that the nursing resources relate to the volume and care needs of patients located in the area. Specifically, the IAC recommends the following revisions to the current staffing plan, as indicated in Table 10:

- reassign one RN from the Acute Zone to the ‘See and Treat’ area of the Subacute Zone 24/7, to provide 2 RNs in the See-and-Treat area at all times;

\(^9\) SAH Exhibits: Appendix E: Hourly CDU Census by Day, March 2012

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- refine the midshift RN from 1000 – 2200 to 1100 – 2300, and assign this RN to the Acute Zone; and
- add one RN shift from 1200 – 2400, and assign this RN to ‘See and Treat’ with no defined patient assignment, to enable her/him to move between the Subacute and Triage Zones to provide additional assistance/coverage as required.

<table>
<thead>
<tr>
<th>Nurse</th>
<th>Day Shift</th>
<th>Midshift</th>
<th>Night Shift</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>RN: 0700 – 1900</td>
<td>RN: 1100 – 2300*</td>
<td>RN: 1900 – 0700</td>
<td></td>
</tr>
<tr>
<td>Charge Nurse:</td>
<td></td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>*PCC (days)</td>
<td></td>
<td></td>
<td></td>
<td>22.50</td>
</tr>
<tr>
<td>*AR (nights)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RN: Triage Zone</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>22.50</td>
</tr>
<tr>
<td>RN: Acute Zone</td>
<td>4</td>
<td>1*</td>
<td>4</td>
<td>9</td>
</tr>
<tr>
<td>RN: Subacute Zone</td>
<td>1-Subacute</td>
<td>1** See-and-Treat/Triage/Subacute</td>
<td>1-Subacute 2-See and Treat</td>
<td>7</td>
</tr>
<tr>
<td>RN: CDU</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>22.50</td>
</tr>
<tr>
<td>(provide support to Subacute as able)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RPN: Fast Track Zone</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>22.50</td>
</tr>
<tr>
<td>RN(EC) Fast Track Zone</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>7.5</td>
</tr>
<tr>
<td>Total</td>
<td>RN: 10</td>
<td>RN: 2</td>
<td>RN: 10</td>
<td>247.50</td>
</tr>
<tr>
<td>RN: 1</td>
<td>RPN: 1</td>
<td>RPN: 2</td>
<td>22.50</td>
<td></td>
</tr>
<tr>
<td>RN(EC): 1</td>
<td></td>
<td>RN(EC): 1</td>
<td>7.50</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>277.50</td>
<td></td>
</tr>
</tbody>
</table>

The baseline RN staffing is therefore increased by 11.25 hours per day, from 236.25 to 247.5 hours per day, providing between eight (8) and ten (10) RNs in the Acute and Subacute Zones as indicated in Table 11.
Table 11: Acute and Subacute Zones: Average Patient Census and Proposed Baseline RN Staffing

<table>
<thead>
<tr>
<th>Hour of Day</th>
<th>Average # of Outpatients</th>
<th>Average # of Inpatients</th>
<th>Average Total # of Patients</th>
<th>RN Staffing</th>
</tr>
</thead>
<tbody>
<tr>
<td>0700</td>
<td>8.1</td>
<td>9.0</td>
<td>17.1</td>
<td>8</td>
</tr>
<tr>
<td>0800</td>
<td>9.1</td>
<td>9.2</td>
<td>18.3</td>
<td>(4 Acute)</td>
</tr>
<tr>
<td>0900</td>
<td>10.6</td>
<td>9.1</td>
<td>19.8</td>
<td>(1 Subacute)</td>
</tr>
<tr>
<td>1000</td>
<td>11.9</td>
<td>8.9</td>
<td>20.8</td>
<td>(2 S and T)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(1 CDU)</td>
</tr>
<tr>
<td>1100</td>
<td>14.6</td>
<td>8.7</td>
<td>23.3</td>
<td></td>
</tr>
<tr>
<td>1200</td>
<td>16.7</td>
<td>8.3</td>
<td>25</td>
<td></td>
</tr>
<tr>
<td>1300</td>
<td>18.5</td>
<td>8.0</td>
<td>26.5</td>
<td></td>
</tr>
<tr>
<td>1400</td>
<td>19.8</td>
<td>7.7</td>
<td>27.5</td>
<td></td>
</tr>
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<td>1500</td>
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</tr>
<tr>
<td>1600</td>
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<td>7.1</td>
<td>27.6</td>
<td></td>
</tr>
<tr>
<td>1700</td>
<td>20.1</td>
<td>6.9</td>
<td>27.0</td>
<td>(5 Acute)</td>
</tr>
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</tr>
<tr>
<td>2000</td>
<td>19.1</td>
<td>8.0</td>
<td>27.1</td>
<td>(1 CDU)</td>
</tr>
<tr>
<td>2100</td>
<td>19.0</td>
<td>7.9</td>
<td>26.8</td>
<td>(1 float/Triage)</td>
</tr>
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<td>2200</td>
<td>19.6</td>
<td>7.7</td>
<td>27.3</td>
<td></td>
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<td>0200</td>
<td>13.6</td>
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<td>22.0</td>
<td>(1 Subacute)</td>
</tr>
<tr>
<td>0300</td>
<td>11.6</td>
<td>8.3</td>
<td>19.8</td>
<td>(2 S and T)</td>
</tr>
<tr>
<td>0400</td>
<td>10.4</td>
<td>8.4</td>
<td>18.7</td>
<td>(1 CDU)</td>
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<td>0600</td>
<td>8.6</td>
<td>8.6</td>
<td>17.6</td>
<td></td>
</tr>
</tbody>
</table>

The IAC’s rationale for the proposed baseline staffing is the following:

Triage:

- With the goal of moving patients out of the Triage waiting area into the core of the ED as soon as possible, and in light of the average number of patients who present at Triage per hour, the IAC believes that one (1) RN can effectively manage the Triage Zone between 0700 – 1200 and between 2400 – 0700.

- The IAC does not support assignment of two (2) RNs to Triage consistently, but believes that clearly defined ‘back-up’ should be available. The IAC recommends that the assignment sheet identify one (1) RN in the ‘See and Treat’ area who will move to Triage to provide support, on the direction of the Charge Nurse. This RN will also function as the ‘shadow Triage assignment’ identified in Recommendation 9.

- During the busier period between 1200 – 2400, a second RN, assigned to ‘See and Treat’ as a float will move to Triage whenever more than two (2) patients are waiting to be assessed and/or if the first Triage RN is unable to complete CTAS reassessments within the time frames identified by CTAS.
standards, and to provide lunch and supper break coverage for the Triage RN. This RN will also function in the ‘shadow assignment’ role.

Acute:
- The majority of patients in the Acute Zone between 0700 – 1100 are those who have been admitted and are awaiting bed placement. Relatively few patients are admitted to the Acute Zone during this period.
- The IAC believes that four (4) RNs can effectively manage the Acute Zone between 0700 – 1200 and 2400 – 0700, on the understanding that one or more RNs will be reassigned from the Subacute to Acute Zone as required (such as if a trauma patient is admitted) as per Section 3.3.1.3 (Charge Nurse/Triage Nurse Role).
- The goal is to move at least the majority of admitted patients out of the ED by 1100. The Acute Zone is busiest with new ED patients between 1100 and 2300, when an fifth RN is assigned to Acute for the midshift period.

Subacute:
- Effective functioning of both the subacute and ‘See and Treat” areas of the Subacute Zone depends on moving patients efficiently through the assessment, diagnosis, treatment and discharge process. The IAC believes that the ‘See and Treat’ area will function most effectively if two (2) RNs are consistently assigned, as, with the implementation of the broader range of medical directives, diagnosis and initial treatment decision will not depend exclusively on the MD.
- The subacute area, with six stretchers, can be managed by the RN in subacute, with assistance from the RN in CDU.

CDU:
- The current number of patients in the CDU does not warrant a dedicated RN 24/7. The IAC believes that the Hospital may wish to review the patient population in this area to expand its use (see Section 3.3.4.5 – Clinical Decision Unit), but in the meantime, the IAC believes that the RN assigned to CDU, who is caring for an average of 1.3-2.3 patients, can provide assistance in the subacute area, and that the Charge Nurse should note when an expansion of her/his assignment into the subacute area is appropriate.

Medical Coverage
- Physician coverage in the Acute and Subacute Zones provides for one (1) MD between 0200 – 1100, and two (2) MDs between 1100 – 0200. In addition, one (1) MD is dedicated to the ‘See and Treat’ area from 1000 – 1800 on Monday and Tuesday.
- Despite the enhanced implementation of medical directives, patient care decision-making, and therefore patient flow, is very dependent on the physician in the ED. The IAC believes that the proposed RN staffing levels in the Acute, Subacute and CDU Zones supports the pace of work with one (1) to two (2) MDs, but that RN staffing levels may need to be revised if the MD coverage changes.

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50 The physicians work the following 8-hour shifts to cover the Acute and Subacute Zones: 0630 – 1430, 1100 – 1900, 1500 – 2300, 1800 – 0200 and 2300 – 0700. Fast Track Zone is covered by two 6-hour shifts (1000 – 1600 and 1600 – 2200), and the ‘See and Treat’ area has additional designated MD coverage from 1000 – 1800 Mondays and Tuesdays.
Recommendation:

24. Alter the baseline RN staffing complement within the ED as follows:

   i. Reassign one (1) RN from the Acute Zone to the “See and Treat” area of the Subacute Zone on
the day (0700 – 1900) and night (1900 – 0700) shifts to provide two (2) RNs in ‘See and Treat’
on a 24/7 basis.

   ii. Revise the current 1000 – 2200 shift to 1100 – 2300, and assign this RN to the Acute Zone, to
provide five (5) RNs in the Acute Zone during the ‘surge’ period.

   iii. Assign one (1) RN in the ‘See and Treat’ area as a ‘shadow assignment’ for the Triage RN
between 2400 – 1200.

   iv. Add one (1) RN midshift. 1200 – 2400, and assign this RN as a float to “See and Treat”, with
the following as criteria for reassignment to the Triage Zone:
   a. more than two (2) patients awaiting initial CTAS assessment, and/or
   b. Triage RN unable to complete CTAS reassessments of patients in the Triage Waiting Room
within the time frames specified by the CTAS Standards, and
   c. lunch and supper break coverage for the Triage RN.

The key element impacting EDs, which tips the balance of patient census, patient flow and nursing
staffing, relates to the number of admitted patients waiting in the ED for inpatient bed placement. While
the Hospital is making significant and commendable effort to decrease the ED LOS of admitted patients
to a maximum of 5 patients with no more than a 20 hour LOS, admitted patients are still placing (and will
continue to place) a very significant pressure on ED resources. The IAC noted that the Hospital has
appeared consistently supportive of providing additional nursing staff when warranted for this issue, but
that there did not appear to be a clearly defined approach, or consistently applied criteria and decision-
making authority, regarding the decision to call in additional staff over the RN baseline numbers. The
PCC/AR has required approval of the Administrator-on-Call, which has at times been problematic.

The IAC strongly recommends that a core group of nursing leaders within the ED, including the ED
Nurse Manager, PCCs, and three RNs who regularly function in the AR role, develop a decision-tree to
determine when additional staff will be called in, above the RN/RPN baseline numbers, to manage
unanticipated workload associated with admitted patients. The IAC believes that an assessment regarding
staffing requirements should be made in the late morning, after bed rounds, for the night shift, and in the
late evening for the next morning shift. Once approved, the decision-tree should provide the PCC/AR (in
the absence of the ED Nurse Manager) with authority to make the decision. Optimally, the additional
staffing requirement will be filled by the Critical Care Float Pool, and will not necessitate calling in a
part-time RN.

Recommendation:

25. Develop and implement a decision-tree which determines when additional staff, above the RN
baseline, is required to effectively care for patients presenting to the ED and admitted patients
waiting in the ED for an inpatient bed, and clarifies decision-making authority.
3.3.3.2 Support Staffing

3.3.3.2.1 Unit Aide

The IAC strongly supports the Hospital’s recommendation to implement a Unit Aide position on 24/7 basis.

The IAC recommends that the Unit Aid be responsible for a range of patient-support activities, including but not limited to:

- 5-S (sort, straighten, sanitize, standardize and sustain) the Minor Treatment Rooms and Fracture Room, stocking the Acute, Subacute, CDU and Fast Track examination/treatment rooms and exterior room carts,
- intra-department portering, and helping to porter critically ill patients to Diagnostic Imaging,
- monitoring special supplies and re-ordering as required, and
- accessing urgently required supplies and equipment from other Departments as required.

The IAC believes that provision of the above support to the RNs and RPNs working in the Acute, Subacute, CDU and Fast Track Zones will enable the nurses to focus on patient care needs rather than patient care supplies, in turn enabling focus on counselling, education, support and discharge teaching as well as active treatment interventions.

Recommmendation:

26. Implement a Unit Aide position within the ED on a 24/7 basis.

3.3.3.2.2 Laboratory Technician

The IAC understood that phlebotomy is the responsibility of the RN and RPN staff, and that bloodwork is usually drawn within the core Department (i.e. usually not at Triage unless the Acute and Subacute Zones are very busy and the Triage RN anticipates that the patient will be waiting for a longer period in the Triage Zone). The IAC believes that phlebotomy can be quite time-consuming, and that the use of nurses to perform lab work is not an effective use of nursing or fiscal resources which may significantly slow patient flow within the ED, especially within the Triage and Subacute Zones.

The IAC understood that 12-lead ECGs are performed by the ECG Technician who is available from 0700 – 2300 to perform 12-lead ECGs, and by the X-Ray Technician from 2300 – 0700 but that there is sometimes a waiting period if the Technicians are tied up in the OR. Given that best practice is completion of a 12-lead ECG within 10 minutes of arrival of a patient with chest pain, the Hospital is considering moving to obtaining 12-lead ECGs through the hardwired Phillips monitors, which would then become an RN responsibility.

The IAC noted that a number of hospitals within the province have implemented an “emergency department technician” who initiates laboratory tests, ECGs and in some cases intravenous lines under the direction of an RN. In consideration of the SAH’s continued focus on wait times and LOS within the ED, and in light of the high volume of patients presenting to the SAH ED, the IAC believes that this approach may be worthy of consideration.
Recommendation:

27. Conduct a cost-benefit analysis to determine the most efficient and effective way to provide phlebotomy and ECGs within the ED.

3.3.3.2.3 Unit Assistant

The ED has a Unit Assistant (who performs a “ward clerk” role) in each of the Acute and Subacute Zones on a 24/7 basis. The IAC understood that the Unit Assistants may or may not call staff to replace short-term vacancies (e.g. sick call), but that they do not interpret the Collective Agreement in order to prepare the Call Sheet\(^51\). On the day shift, Monday to Friday, the Call Sheet is prepared by the Nurse Manager; on evening and weekend shifts, it is prepared by the Charge RN. As the ED is the only area with an ‘innovative schedule’ (4-on / 5-off and weekend worker), determination of the call order is more complicated.

The IAC understood that the hospital-wide Staffing Office was closed in February 2011, and that since then, each Unit has been responsible for filling vacant shifts independently. The IAC further understood that while the Critical Care Float Pool is managed effectively by a Unit Assistant in the ICU, Unit Assistants in the Hospital are generally not involved with staffing.

The IAC recognizes the challenges associated with correctly interpreting the Collective Agreement to ensure that nurses have the option of accepting additional shifts in the order of seniority at the same time as ensuring that short-notice replacement is as cost-effective as possible (i.e. that premium payment shifts are avoided if possible) while at the same time ensuring an appropriate balance between more-experienced and less-experienced ED RNs. The IAC was unsure why preparation of the Call Sheet would require 1-1/2 hours, as noted on a number of PRWRFs, but regardless of the time required, believes that this could and should be a clerical, rather than nursing, responsibility.

The IAC understood that the ED Nurse Manager has explored the possibility of supporting a Unit Assistant in the ICU to assume responsibility for staff replacement in both the ICU and ER. The IAC supports this approach, and, if this is not feasible, supports assumption of responsibility of determining the Call Sheet by an ED Unit Assistant, under the direction of the Charge Nurse. The IAC believes that the actual calling should be the responsibility of the Unit Assistant.

Recommendation:

28. Educate the ED Unit Assistants to develop the shift-by-shift Call Sheet, seeking clarification as required from the Charge Nurse.

29. Assign responsibility for calling in additional RN staff, in the order identified on the Call Sheet, to the Unit Assistants.

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\(^{51}\) A Call Sheet is prepared for each shift for which additional nurses are required. The ONA Call Sheet lists the full-time RNs in order of seniority on one side, and the part-time RNs in order of seniority and call preference on the other. Part-time RNs who have not yet completed their committed hours are to be called first.

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3.3.3.4 RN Scheduling

The IAC commends the Hospital, the Local Association and the ED RNs for implementing an ‘innovative schedule’ in January 2012 for a one-year pilot period. Of the 37 full-time RNs, 27 are working a 4-on / 5-off schedule, and four are ‘weekend workers’ as defined in the Collective Agreement. The IAC believes that this flexible approach, especially in the ED practice environment where day-to-day continuity of patient care is not an issue, is very appropriate.

The IAC therefore encourages the Hospital, Local Association and ED RNs to continue to explore innovative scheduling practices which will continue to support quality of work/life balance. For example, the IAC understood that granting of lieu days for statutory holidays is a challenge, and encourages consideration of an 1860 master schedule in the next Local Agreement negotiations. An 1860 hour rotation, which is supported within the Central Collective Agreement and has been successfully implemented within ONA hospitals, is the same as the 1950 hour rotation with one difference: the 12 statutory holidays (90 hours) are paid in cash, and thus do not require lieu days to be inserted into the master schedule. This allows for regularly scheduled stretches (up to 12 days) off, and provides nurses more control over their quality of work/life balance and the hospital with less scheduling challenges.

The IAC also encourages the Hospital to consider providing the four newly hired full-time RNs with the option to work a ‘traditional’ or ‘innovative’ schedule. The IAC recognizes that the current Letter of Understanding states that 27 RNs will work the ‘innovative schedule’, but encourages discussion with the Local Association to explore the possibility of expanding this number.

The IAC understood that the ‘innovative schedule’ will be evaluated following six (6) and nine (9) months of implementation (i.e. in June and September 2012) and that the Hospital will make a decision regarding ongoing implementation of the ‘innovative schedule’ between September and December 2012. The IAC encourages the Hospital to include qualitative (anonymous RN survey) as well as quantitative (sick time and overtime) data in this evaluation.

The IAC noted that the current master schedule is imbalanced, in that the scheduled shifts do not cover the required baseline staffing either consistently or evenly: on some shifts, only three (3) of the required eleven (11) shifts are filled by full-time staff. This places a heavy reliance on the part-time staff, whose flexibility for short-term relief coverage is impacted by being pre-scheduled up to or close to their committed hours. The IAC strongly encourages the new ED Nurse Manager to work with the ED RNs to review the master schedule, within the requirements of the Letter of Understanding, to rework the master rotation to provide a more even balance of baseline shift coverage among the full-time staff.

Recommendation:

30. Include both qualitative (anonymous RN survey) and quantitative (sick time and overtime) analysis when evaluating the current ‘4-on / 5-off innovative schedule’.

31. Revise the current master rotation, within the requirements of the Letter of Understanding, to ensure more consistent coverage of the baseline staffing requirements by the full-time staff.

32. Explore flexible/innovative approaches to RN scheduling, including but not limited to exploration of an 1860 hour rotation, inclusion of more than 27 RNs in the ‘innovative schedule’ currently being piloted, to support RN work/life balance.
3.3.4 Corporate Initiatives

The IAC noted several issues, outside of the ED but impacting on the functioning of the ED, which it believes are affecting RNs’ workload. These include placement of ‘orphan’ patients, management of IV pumps, telemetry resources, capital improvements (relating to the Triage Zone reconfiguration) and patient placement in the CDU.

3.3.4.1 ‘Orphan’ Patients

One of the key issues of concern identified in the PRWRFs, and in discussion at the Hearing, related to placement of patients who, in the old Hospital site, were admitted to the Medical Step-down Unit. In the new Hospital, both Level 2 (“stepdown”) and Level 3 patients receive care in the ICU. The IAC understood that there were some challenges with transition to the closed ICU model, (largely physician related … patient is inappropriate for admission to the acute medical unit, but ED MRP reluctant to refer to the intensivist or the intensivist wants to trial the patient in the ED rather than transferring to the ICU…) but that these have largely been addressed, and that the number of patients who are “not sick enough” for ICU but “too sick” for the acute medical unit have substantially decreased.

However, there are still a number of patients who do not appear to have a home on an inpatient unit, and so are remaining in the ED. These include patients requiring q1H vital sign monitoring (e.g. diabetic ketoacidosis rapid atrial fibrillation on cardizem drip), patients requiring intraosseous transfusions and patients weaning from BPAP.

The IAC understands the Hospital’s reluctance to place these patients on an inpatient unit, in light of their care needs in relation to available staffing resources, but believes that continuing to place these patients within the ED is inappropriate. The IAC believes that admission criteria need to be clarified, that use of the terms “Level 2” and “Level 3”, rather than “step-down” and “ICU” need to be consistently used. The IAC also encourages discussion among the ED physician group regarding current medical practice.

Recommendation

33. The Hospital determine the most appropriate location of ‘orphan’ patients, and provide appropriate staffing resources to support the required care needs in the unit/department selected.

3.3.4.2 IV Pumps

The lack of availability of IV pumps was frequently identified as an issue in the PRWRFs submitted both before and after the move to the new Hospital. The IAC recognizes that the Hospital has placed a significant priority on this issue, and that the ER has been allocated 4 triple pumps and 14 single pumps from the total of 180 pumps within the Hospital. This provides for a triple pump in each of the four resuscitation room in the Acute Zone, and 14 pumps across the remainder of the Acute and Subacute Zones, which is sufficient if the pumps are kept within the ED. The challenge ensues when a patient on a

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52 The “old” 5th floor included three distinct areas: an ICU, a medical step-down unit, and a medical telemetry unit. In the new Hospital, the ICU and medical step-down areas have been combined into one (within the ICU).
53 The IAC understood that additional IV pumps, ordered through the capital equipment budget, will arrive within the next three months, and that some of these will be allocated to the ED. There appears to the IAC to be ample capital capacity.
pump is transferred to an inpatient unit and the inpatient unit does not have an available pump, the ED pump remains with the patient and does not return to the ED.

The IAC believes that the Hospital needs to develop, implement and monitor a corporate policy regarding IV pump usage within the Hospital as a whole. While the Institute of Safe Medical Practice (ISMP) recommends that all patients receive IV medication by means of a pump, safe nursing practice does not require that all patients receiving straight intravenous therapy be on a pump. Each hospital unit/department, including the ED needs to prioritize IV pump allocation among the patients from within the unit/department’s allocation.

Further, the IAC believes that a culture change is required among the nursing and porter staff within the Hospital as a whole, and that “buy-in” from all nurses and porters is required. The clear expectation needs to be that IV pumps belong to the unit/department, not the patient, and that when a patient with a pump is transferred between units/departments, the pump returns to the transferring department.

**Recommendation:**

34. **Manage the IV Pump Policy by:**
   a. clarifying when IV pumps are and are not required for safe patient care,
   b. allocating a specific number of IV pumps to each unit/department, and
   c. assigning responsibility for management of the allocated IV pumps to the unit/department.

**3.3.4.3 Telemetry**

The IAC was confounded by the evident difficulties surrounding the use of telemetry packs at SAH. Although the extent of telemetry resources has increased substantially from the old to the new Hospital, the demand for telemetry-monitored beds appears to be consistently higher than the available resources, both within the ED and within the inpatient units. The IAC understood that the Hospital is adding four additional telemetry channels to the acute medical unit, and that a Telemetry Utilization Review Process was implemented in January 2012 to ensure daily reassessment regarding the ongoing need for patient monitoring. The IAC encourages the Hospital to stringently monitor the q24-hour review to ensure that the policy is being consistently implemented, and to ensure that guidelines regarding the requirements for telemetry are current.

**3.3.4.4 Triage Zone Reconfiguration**

The IAC strongly supports the Hospital’s plans to reconfigure the Triage Zone area, particularly the two workstations, in order to support the health and safety of nurses, and to avoid situations such as the assault on a Triage RN which occurred in January 2012, and to increase the confidentiality of nurse/patient discussions during the CTAS assessment. The IAC understood that the reconfiguration plans were developed in concert with the ED RNs, and that the cost proposal of $40 - $50K, approved in principle, is awaiting final endorsement for funding. The Security Office is located beside the Triage Zone, and a Security Officer is expected to be within the ED (optimally within the Triage Zone) at all times. The Hospital is arranging for televisions to be placed within the Triage Waiting Room, to

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54 The IAC understood that if a Code White is called elsewhere in the Hospital, the Security Officer posted to the ED leaves the ED to respond to the Code.
increase “white noise” and decrease the ability of patients/family in the Waiting Room overhearing discussions at the Triage workstations. Finally, the Triage RNs have “screamers” which they can activate to notify staff within the Acute Zone that they are facing safety challenges. The IAC commends all of these actions.

In the meantime, until the renovations are complete, the IAC encourages the Hospital to install a “panic button” which can be clearly heard within the Acute Zone.

**Recommendation:**

35. *Move forward expeditiously with the approved renovations of the Triage Assessment area. In the meantime, install a “panic/code” button in the Triage Assessment area which can be clearly heard within the core ED.*

3.3.4.5 Clinical Diagnostic Unit

The IAC was impressed with the Hospital’s efforts to create a CDU, in terms of its intended impact on avoiding unnecessary hospital admissions, and enhancing the flow of CTAS 2 – CTAS 4 patients within the Subacute Zone. However, the IAC was disappointed with the apparent low patient numbers in this area. The IAC believes that two strategies may assist to ‘populate’ the CDU.

The first relates to ensuring that the ED Tracker is continuously updated. The Triage RN must be aware when patients move from either the Acute or Subacute Zones to the CDU, so she/he can then move a patient from the Triage Waiting Room into the vacated exam/treatment room. The IAC recognizes that this requires an additional ‘step’ for the RN/Unit Assistant, but emphasizes that it will result in a more effective allocation of patient care responsibilities among all the RN staff, and believes it needs to be a non-negotiable expectation.

The second relates to the admission criteria for the CDU. The IAC understood that patients with abdominal pain/renal colic, allergic reaction and anaphylaxis, chest pain/angina/syncope, vomiting/dehydration, asthma (adult and pediatric) or who require blood transfusions are eligible for admission. The IAC questions whether these admission criteria could be broadened, similar to those in use successfully in hospitals in the US and the UK\(^55\), including issues such as congestive heart failure, back pain, headache without fever or neurological abnormality, cellulitis, diabetic ketoacidosis, short term therapy such as seizure disorder requiring anticonvulsant loading, sickle cell pain crisis, etc. The IAC encourages the Hospital to continue to explore effective use of the CDU with both ED physicians and medical specialists, in order to gain maximal benefit of this valuable (in terms of space and nursing staff) resource.

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\(^{55}\) E.g.: [http://www.ena.org/SiteCollectionDocuments/Position%20Statements/ObservationUnits.pdf](http://www.ena.org/SiteCollectionDocuments/Position%20Statements/ObservationUnits.pdf)  
SECTION IV

CONCLUSIONS AND RECOMMENDATIONS

4.1 Conclusion

Article 8.01 of the Collective Agreement between the Ontario Nurses’ Association and the Sault Area Hospital requests the Independent Assessment Committee to specifically address the issue of whether or not the RNs in the Emergency Department 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 during a 2-1/2 day Hearing, extensive Committee discussion and deliberation prior to and following the Hearing, and a literature review regarding appropriate standards of practice and staffing for Emergency Departments, the IAC concluded that additional staffing resources are required. However, the IAC believes that addition of one additional RN shift per 24 hours, and addition of a Unit Aide position 24/7 will not, in isolation, address the level of discontent that the RNs are experiencing. The IAC believes that other factors, relating to a sense of trust and empowerment, involvement in and accountability for clinical practice and ED operational decisions, and corporate issues beyond the scope of the ED, are also impacting the RNs’ ability to find an appropriate balance between patient care needs and workload requirements. The IAC therefore believes that the recommendations outlined below need to be considered in entirety.

4.2 Recommendations

The IAC identified 35 recommendations, in the areas of leadership and empowerment, practice, staffing and workload and corporate initiatives, to address the issue of workload of the RNs in the ED.

4.2.1 Leadership and Empowerment

First-line leadership roles are sentinel to the health and functioning of a nursing unit/department. The SAH ED is currently without a Manager, and has only part-time Educator support. At least until a permanent Nurse Manager is recruited, and optimally after that, the ED requires the support and leadership of a full-time Educator.

1. Appoint the Educator to the ED on a full-time basis. If this is not corporately possible, appoint the Educator to the ED on a full-time basis until the permanent ED Nurse Manager has been recruited and in place for six months, and thereafter ensure the Educator is available to the ED on a clearly defined basis (minimum 2.5 days per week).

2. Focus the Educator’s role on practice and education issues, including implementation of medical directives, and integration of newly hired RNs into the ED, with active involvement in clinical practice issues within the ED.

The philosophical approach regarding funding for emergency services in Ontario is moving towards a ‘pay for performance’ model, which requires consistent improvement in ED wait times and patient length
of stay for funding to be maintained. The RNs must now manage the competing priorities of patient care and funding requirements, and without opportunities to discuss the impact of this dissonance and discuss/develop strategies to effectively address it, are feeling disempowered. Resurrection of the Unit Council, enabling RNs to assume leadership and accountability for practice issues and decisions, and implementation of formal communication mechanisms are required.

3. **Resurrect the ED Nursing Unit Council**, to provide a venue for discussion of and resolution of issues relating to operational functioning of the ED and clinical practice issues relating to the provision of patient care.

   Terms of Reference to include:
   a. **Purpose**: to make collaborative decisions regarding practices and procedures that enhance the quality of patient care and practice environment
   b. **Chair**: co-chaired by ED Educator and an ED RN selected by nomination
   c. **Membership**: defined membership, including 4 RNs and 1 RPN selected by nomination, one allied health team member, ED PCC, ED Educator and ED Nurse Manager, with a defined membership term of two years
   d. **Meetings**: held biweekly until firmly established, then monthly
   e. **Agenda**: developed jointly by the co-chairs and published in advance of the meeting
   f. **Minutes**: adopt the format used by SAH HAC
   g. **Distribution of Minutes**: by email and in Communication Book

Facilitate RN involvement by ensuring that RNs are relieved from patient care assignment during Unit Council meetings, and are remunerated as per discussion at HAC.

4. **Implement a Communication Book which is**
   a. located in a central location within the ED that enables easy access by all working RNs and RPNs,
   b. maintained by the ED Nurse Manager, and
   c. the responsibility of the RNs and RPNs to read.

5. **Maintain regular Staff Meetings**, held monthly and chaired by ED Nurse Manager.
   a. **Purpose**: ensure communication of corporate and program issues, initiatives and outcomes, including quality assurance indicator outcomes.
   b. **Minutes**: posted online and in Communication Book

The opportunity to participate in a leadership position, such as Charge Nurse and Triage Nurse, provide RNs with both a sense of ownership of the ED and a more comprehensive understanding of the complex inter-relationships required for smooth and effective departmental functioning. In order to balance available nursing resources with required patient care needs, the Charge Nurse needs to have authority to revise the patient assignment as required.

6. **Implement revised role responsibilities for the Charge Nurse**, specifying the expectation that the Charge Nurse will have authority to revise the patient assignment to ensure nurses are located in the areas within the Department with the greatest patient volumes/care needs.

7. **Confirm in policy that RPN independent patient assignments will remain within the Fast Track Zone. RPNs may assist with the care provision in the Subacute and Acute Zones in collaboration with RNs, but should not assume an independent patient assignment.**
8. Continue the practice of rotating the AR and Triage RN roles among ED RNs who have 2-3 years ED experience and/or demonstrate leadership qualities.

9. Continue the practice of ‘shadow assigning’ the Triage RN role.

A formal mentorship relationship is of tremendous benefit and support to RNs. The previously developed Mentorship Program needs to be synthesized to increase its effectiveness for mentors, mentees and Nursing Management, and then revitalized across the Hospital.

10. Revise the existing Mentorship Program Workbooks to synthesize the key elements for mentors and mentees, and formally re-implement the Program in the ED (and elsewhere).

In order to effectively support workload concerns, and to provide RNs with confidence that those relating to ‘ongoing issues’ will be addressed, the clinical Administrator-on-Call requires an understanding of the issues impacting the functioning of all programs, to enable consistent decision-making by everyone assuming the clinical Administrator-on-Call role.

11. Develop a comprehensive education/guideline binder, to facilitate consistent decision-making among all Administrators-on-Call.

12. Re-communicate the process for notification of the Clinical Administrator-on-Call, the Service Administrator-on-Call, and the Senior Administrator-on-Call to all SAH nursing staff.

4.2.2 Practice

CTAS triage assessment provides an indication of the acuity of the patient presenting to the ED, and provides a guideline regarding the required timeframe for nursing and physician assessment. Documentation of the initial CTAS triage assessments must remain unchanged.

13. Cease the practice of altering the initial documented CTAS category, as determined at the time of initial patient presentation to the ED, during the patient’s visit in the ED.

Consistent implementation of the ‘fax and go’ policy will require changes in practice on the part of both ED and inpatient unit RNs, but is required to support timely movement of admitted patients from the ED to the designated inpatient bed.

14. Communicate expectation that patient transfer from the ED to inpatient units uses the ‘fax and go’ policy, and take appropriate action to address issues as required.

The number of medical directives in use in the ED will expand significantly within the next several months, as the 13 new medical directives currently in process are approved and implemented. Effective implementation will require clarity regarding where and by whom medical directives are to be implemented, a defined education and competence evaluation process, and evaluation of their effectiveness.
15. **Develop a policy regarding implementation of medical directives which will optimize patient flow within the ED and will enable implementation of the directives at a time and location that is in the best interest of the patient.**

16. **Nurse Educator, Nurse Manager and Medical Director** jointly develop a defined process for evaluation of competence of all RNs to implement medical directives, which includes a formal delegation of authority for competence evaluation from the Medical Director to the Nurse Educator.

17. **Evaluate the implementation of the new medical directives, following six months of use, by means of:**
   - **a.** a random audit of 500 ED patients who did / did not have medical directives, and
   - **b.** RN staff survey to determine appropriateness of implementation and requirements for revisions of content, and addition/discontinuation of specific directives.

Clarity regarding the requirements for constant care attendant support is required, to ensure a balance between patient safety and nursing workload.

18. **Re-evaluate the constant care policy to identify guidelines for determination of when constant care is and is not required on a 1:1 basis for patients for whom safety of self or others is a concern.**

Provision of effective patient education and discharge teaching is a challenge within a busy ED. Clarification of the scope/content of required education/discharge instructions, together with support for RNs to gain required knowledge base and use of relevant standardized teaching tools, will greatly enhance the consistent provision of patient education by all RNs.

19. **The ED Educator, ED Nurse Manager and Unit Council research standardized teaching tools, including those available through the Meditech system, from other EDs within the Northeast LHIN, from the Provincial Clinical Educators Group, and on the public domain on the internet, and select those with specific relevance for implementation in the SAH ED.**

20. **Continue to work with Meditech to implement an automatic referral to community agencies.**

21. **Survey the ED nursing staff regarding their perception of the scope, adequacy and content of patient education in 12 months.**

The Fast Track Zone is very effectively caring for almost 45% of the SAH ED patients. However, review of patient volumes and pace of flow of patients through Fast Track is required by 1800 each evening, to ensure that all patients have received treatment when Fast Track closes at 2200.

22. **SAH implement a formal policy whereby the Charge RN/Charge MD implement a resource allocation plan each evening by 1800, including the reassignment of nursing and/or physician resources to Fast Track from the Acute or Subacute Zones, and/or the integration of CTAS 4 and 5 patients into the Subacute Zone as required to ensure closure of the Fast Track Zone by 2200.**
4.2.3 Staffing and Workload

Appropriate staffing is essential to the delivery of safe and effective patient care, and helps to ensure efficient throughput processes in the ED. Baseline nursing staffing needs to reflect the Zone configuration within the ED, the volume and acuity of patients presenting to and remaining within each Zone for treatment, and the nursing skill mix providing patient care. The current baseline staffing provides a total of 21 RN shifts (236.25 hours), 2 RPN shifts (22.5 hours) and 1 RN(EC) shift (7.5 hours) over a 24-hour period.

The RPN and RN(EC) staffing in the Fast Track Zone is appropriate, and should be maintained.

23. Maintain the current nursing staff mix and nursing staffing pattern in the Fast Track Zone.

The RN staffing within the Acute, Subacute and Triage Zones requires rebalancing to ensure that the nursing resources relate to the volume and care needs of patients within each Zone, and requires the addition of one 11.25 hour RN shift per 24-hour period.

24. Alter the baseline RN staffing complement within the ED as follows:
   
   i. Reassign one (1) RN from the Acute Zone to the ‘See and Treat’ area of the Subacute Zone on the day (0700 – 1900) and night (1900 – 0700) shifts to provide two (2) RNs in ‘See and Treat’ on a 24/7 basis.
   
   ii. Revise the current 1000 – 2200 shift to 1100 – 2300, and assign this RN to the Acute Zone, to provide five (5) RNs in the Acute Zone during the ‘surge’ period.
   
   iii. Assign one (1) RN in the ‘See and Treat’ area as a ‘shadow assignment’ for the Triage RN between 2400 – 1200.
   
   iv. Add one (1) RN midshift, 1200 – 2400, and assign this RN as a float to “See and Treat”, with the following as criteria for reassignment to the Triage Zone:
      a. more than two (2) patients awaiting initial CTAS assessment, and/or
      b. Triage RN unable to complete CTAS reassessments of patients in the Triage Waiting Room within the time frames specified by the CTAS Standards, and
      c. lunch and supper break coverage for the Triage RN.

The key element which tips the balance of patient census, patient flow and nursing staffing resources is the number of admitted patients waiting in the ED for inpatient bed placement. Admitted patients place a very significant pressure on ED resources. A clearly defined approach, which articulates consistently applied criteria and decision-making authority, is required to ensure appropriate nursing resources to care for admitted patients.

25. Develop and implement a decision-tree which determines when additional staff, above the RN baseline, is required to effectively care for patients presenting to the ED and admitted patients waiting in the ED for an inpatient bed and clarifies decision-making authority.
In an active ED such as SAH, nursing resources need to be focused away from non-nursing tasks such as stocking and ordering supplies, drawing blood and calling in additional staff.

26. Implement a Unit Aide position within the ED on a 24/7 basis.

27. Conduct a cost-benefit analysis to determine the most efficient and effective way to provide phlebotomy and ECGs within the ED.

28. Educate the ED Unit Assistants to develop the shift-by-shift Call Sheet, seeking clarification as required from the Charge Nurse.

29. Assign responsibility for calling in additional RN staff, in the order identified on the Call Sheet, to the Unit Assistants.

The RNs currently work a range of 11.25 hour schedules, including a ‘traditional’ (days only) schedule worked by the PCCs, a day-evening schedule worked by 4 RNs, a ‘weekend worker’ schedule worked by 4 RNs, and an ‘innovative’ (4-on / 5-off) schedule worked by 27 RNs. Rebalancing the schedule to provide a more even balance of baseline shift coverage among the full-time RNs, together with ongoing evaluation of scheduling options, will be of long-term benefit.

30. Include both qualitative (anonymous RN survey) and quantitative (sick time and overtime) analysis when evaluating the current ‘4-on / 5-off innovative schedule’.

31. Revise the current master rotation, within the requirements of the Letter of Understanding, to ensure more consistent coverage of the baseline staffing requirements by the full-time staff.

32. Explore flexible/innovative approaches to RN scheduling, including but not limited to exploration of an 1860 hour rotation, inclusion of more than 27 RNs in the ‘innovative schedule’ currently being piloted, to support RN work/life balance.

4.2.4 Corporate Initiatives

Several issues are outside of scope of the ED, but impact on the functioning of the ED. Addressing the placement of ‘orphan’ patients, clarifying and managing the IV pump policy, and implementing the approved changes in the Triage Assessment area will be of benefit.

33. The Hospital determine the most appropriate location of ‘orphan’ patients, and provide appropriate staffing resources to support the required care needs in the unit/department selected.

34. Manage the IV Pump Policy by:
   a. clarifying when IV pumps are and are not required for safe patient care,
   b. allocating a specific number of IV pumps to each unit/department, and
   c. assigning responsibility for management of the allocated IV pumps to the unit/department.
35. Move forward expeditiously with the approved renovations of the Triage Assessment area. In the meantime, install a “panic/code” button in the Triage Assessment area which can be clearly heard within the core ED.

The IAC encourages the Hospital and the Association to work together to address these 35 recommendations within the ED. The IAC believes that implementation will have a positive impact on the quality of RNs’ worklife, workload and satisfaction, and the quality of patient care.
Appendix I

2011 – 2014 Collective Agreement between the Hospital and the Association

Article 8.01: Professional Responsibility

8.01 The parties agree that patient care is enhanced if concerns relating to professional practice, patient acuity, fluctuating workloads and fluctuating staffing are resolved in a timely and effective manner.

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

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

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

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

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

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

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

vii) Any settlement arrived at under Article 8.01 (a) iii), iv), or v) shall be signed by the parties.
(Article 8.01 (a), (viii), (ix) and (x) and 8.01 (b) applies to nurses only)

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

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

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

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

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

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

(b) i) The list of Assessment Committee Chairs is attached as Appendix 2. During the term of this Agreement, the central parties shall meet as necessary to review and amend by agreement the list of chairs of Professional Responsibility Assessment Committees.

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

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

ii) Each party will bear the cost of its own nominee and will share equally the fee of the Chair and whatever other expenses are incurred by the Assessment Committee in the performance of its responsibilities as set out herein.
December 5, 2011

Johanne Messier-Mann
Chief Nursing Officer
Sault Area Hospital
750 Great Northern Road
Sault Ste Marie, ON P6B 0A8

Dear Ms. Messier-Mann

RE: Professional Responsibility Complaint Emergency Room, Sault Area Hospital
(ONA File # 201002466)

The Registered Nurses (RNs) working in the Emergency Room (ER), Sault Area Hospital have consistently identified ongoing serious practice and workload concerns as evidenced by the data submitted on two hundred and twenty-nine Professional Responsibility Workload Report Forms (PRWRFs) from January 2010 to today's date. We expect that this pattern will continue into the future.

The RNs working in the ER have documented that the current practice, patient care and workload environment does not allow them to meet College of Nurses of Ontario (CNO) standards or Canadian Triage and Acuity Scale guidelines; and they believe they are being asked to perform more work than is consistent with proper patient care. Effective supports have not been provided to respond to patient acuity and volumes, fluctuating workloads, fluctuating staffing and professional practice issues.

The parties have been meeting regularly to attempt to resolve the issues. Despite this, the employer has been unable to propose or agree to sufficient measures to resolve the very serious practice and workload concerns identified by ONA members. The Union is seeking resolution of the concerns on behalf of our members and the patients they care for, and remains very concerned regarding the potential for catastrophic negative patient outcomes.

Timely and effective 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:

Cindy Gabrielli, RN (EC), BScN, MSN
6285 McMillen St.
Niagara Falls, ON
L2J 1W7
Cell 905-329-3597
Home 905-357-6276
e-mail cgabrielli@cogeco.ca

Provincial Office: Toronto
Regional Offices: Ottawa • Hamilton • Kingston • London
Orillia • Sudbury • Thunder Bay • Timmins • Windsor
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 invited from the list in Appendix 2, pending confirmation from the Ontario Hospital Association.

Yours truly,

ONTARIO NURSES’ ASSOCIATION

Jo Anne Shannon
Professional Practice Specialist

C: Linda Haslam-Stroud, President, Ontario Nurses’ Association (ONA)
   Glenda Hubley, Local Coordinator
   David Cheslock, Labour Relations Officer, ONA
   Cindy Gabrielli, ONA Nominee
   Ron Gagnon, President and CEO, Sault Area Hospital (SAH)
   Marie Paluzzi, Vice President & COO, SAH
   Vanda Cooper, Director of Critical Care
   Robin Joanisse, Manager of Emergency Department
   Elaine Pitcher, Chair, SAH Board of Directors
   Jamie Melville, 1st Vice Chair and Treasurer, SAH Board of Directors
   Dr. Malcolm Brigden, SAH Board of Directors
   Dr. Doug Bignell, SAH Board of Directors
   Lorne Carter, SAH Board of Directors
   Joy Halley, SAH Board of Directors
   Donna Hilsinger, SAH Board of Directors
   Gregory Peres, SAH Board of Directors
   Anthony P. Marrato, SAH Board of Directors
   Luise Martone, SAH Board of Directors
   Debbie Romani, SAH Board of Directors
   Frank Sarlo, SAH Board of Directors
   Reg St-Amour, SAH Board of Directors
   Laurel Young, SAH Board of Directors
   Connie Witty, SAH Board of Directors
   Dr Alan McLean, Chief of Staff (Physician Group)
   Dr. Donald MacIntosh, Medical Director of Emergency Program
   Dr. Heather O’Brien, Chief of Anaesthesia, Interim Medical Director of Critical Care
   Louise Paquette, CEO, NE LHIN
   Randy Kapasaheit, Interim Chair of the Board of Directors, North East LHIN
   Sam Mandelbaum, Ontario Hospital Association
December 7, 2011

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

Dear Joan Cardiff,

RE: Sault Area Hospital and Ontario Nurses’ Association: Professional Responsibility Complaint – Emergency Room – Independent Assessment Committee – ONA File # 201002466

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

The attached letter provides the Association’s nominee name and contact information. The Hospital will forward you their nomination letter. Please set up dates with nominees, who will confirm with their respective parties. ONA is available on February 22-24, 2012.

Yours truly,

ONTARIO NURSES’ ASSOCIATION

Jo Anne Shannon
Professional Practice Specialist

Encl.

C: Glenda Hubley, Local Coordinator
Craig Watson, Bargaining Unit Professional Responsibility Representative
David Cheslock, Labour Relations Officer, ONA
Cindy Gabrielli, ONA Nominee
Johanne Messier-Mann, Chief Nursing Officer, Sault Area Hospital
Sam Mandelbaum, Ontario Hospital Association

Sault Area Hospital / Ontario Nurses’ Association
Independent Assessment Committee Report
June 2012
December 29, 2011

Appendix 4

416 Lakeshore Road
White Lake, Ontario
K0A 3L0

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

Dear Ms. Shannon:

Re: Sault Area Hospital (SAH) and Ontario Nurses’ Association (ONA): Professional Responsibility Complaint Emergency Department – 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 Emergency Department and the Ontario Nurses’ Association.

The Independent Assessment Committee (IAC) Hearing will be held on Tuesday May 1st, Wednesday May 2nd and Thursday May 3rd, 2012 at the Sault Area Hospital. A draft agenda for the Hearing is attached.

On Tuesday May 1st, the IAC would like to tour the Emergency Department in the morning, prior to the Hearing. Please work with the SAH to arrange for the Tour to begin at 1000 hours, and jointly decide:

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

Please provide this information by Friday April 13th, 2012.

The Hearing will begin at 1300 hours on Tuesday May 1st, 2012. As indicated on the draft Hearing Agenda, each of the ONA and the SAH will have one and one half (1-1/2) hours to present their submission. The Hearing will adjourn for the day following presentation of both submissions, in order to enable each party to prepare their Response.

The Hearing will commence at 0900 hours on Wednesday May 2nd, with the Response from SAH, followed by the Response from ONA. The Hearing will adjourn for the day following presentation of both Response submissions; the time of adjournment will depend on the extent of discussion required.
The IAC will meet following the day's adjournment to determine areas/issues requiring further clarification.
The Hearing will recommence at 0830 hours on Thursday May 3\textsuperscript{rd}, with Questions to both ONA and SAH 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.

Specific arrangements regarding the location of the Hearing and caucus rooms will be made closer to the date of the Hearing. The IAC will request that a caucus room, with telephone and internet access, be made available for the ONA.

In order to support the principle of full disclosure, and to enable the IAC to effectively prepare for the Hearing, the IAC requests that individual, independent written submissions be provided by Friday April 13\textsuperscript{th}, 2012. Please submit five copies of your submission and attachments/supporting documents in hard copy to my address. Please note that this is a rural address, with courier service only once daily. As Chair of the IAC, I will retain one (1) copy of each submission, and will distribute the remaining four (4) submissions with attachments/supporting documents by courier on Monday April 16\textsuperscript{th}, 2012 as follows:

- One (1) copy of the SAH submission and one (1) copy of the ONA submission to each of Diane Baigrie (SAH Nominee) and Cindy Gabrielli (ONA Nominee);
- Two (2) copies of the SAH submission to the ONA (attention Jo Anne Shannon;
- Two (2) copies of the ONA submission to the SAH (attention Johanne Messier-Mann)/

In the event that ONA wishes to provide supplemental information after April 13\textsuperscript{th}, 2012, this will be accepted until Friday April 28\textsuperscript{th}, 2012 and will be distributed as above. Supplemental information may be sent by email, with hard copy to follow. Please note that supplemental information is information to support/clarify ONA’s submission; it is not information to respond to the SAH submission.

The IAC will hold a Pre-Hearing Meeting the week of April 23\textsuperscript{rd}, 2012, to review the submissions in detail. If the IAC requires additional information in order to understand the key issues prior to the Hearing, this will be requested immediately following the Pre-Hearing Meeting.

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

The IAC looks forward to working with ONA and the Emergency Department RNs to address professional responsibility issues of concern. I will be in contact to finalize the logistical details of the Hearing in February 2012. In the meantime, if you have any questions, please contact me by phone at 613-622-7743 or by email at jcardiff@cheo.on.ca after January 27\textsuperscript{th}, 2012.

Sincerely

Joan Cardiff

cc. Diane Baigrie, SAH Nominee
    Cindy Gabrielli, ONA Nominee
    Johanne Messier-Mann, Chief Nursing Officer, SAH
December 29, 2011

416 Lakeshore Road
White Lake, Ontario
K0A 3L0

Johanne Messier-Mann
Chief Nursing Officer
Director Maternal Child & Medical Program
Sault Area Hospital
750 Great Northern Road
Sault Ste. Marie, Ontario
P6B 0A8

Dear Ms. Messier-Mann:

Re: Sault Area Hospital (SAH) and Ontario Nurses’ Association (ONA): Professional Responsibility Complaint Emergency Department – 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 Emergency Department and the Ontario Nurses’ Association.

The Independent Assessment Committee (IAC) Hearing will be held on Tuesday May 1st, Wednesday May 2nd and Thursday May 3rd, 2012 at the Sault Area Hospital. A draft agenda for the Hearing is attached.

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

Please provide this information by Friday April 13th, 2012.

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

The Hearing will recommence at 0830 hours on Thursday May 3rd, with Questions to both ONA and SAH 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 IAC would prefer to hold the Hearing at the SAH, if this is possible, and requests the following logistical arrangements. Please confirm whether these will be possible by February 3rd, 2012.

Hearing and IAC:
- A room capable of seating 23 people, with the table configured in a U-shape:
  - 3 seats at the top of the “U” for the IAC members, and
  - 10 seats on either side of the “U” for the SAH and ONA Hearing participants.
- Access to the Hearing Room by the IAC into the evening (beyond 1800 hours) on the evening of Wednesday May 2nd.
- Provision of:
  - An extension cord if an electrical plug is not close to the IAC seats,
  - An LCD projector (Tuesday and Wednesday only), and
  - A flip chart with markers.

Caucus ONA:
- A room capable of seating 10 people, as close to the Hearing Room as possible
- Telephone and internet access

Catering: Hearing Room:
- Provision of:
  - tea, coffee, juice and water in the Hearing Room for all times the Hearing is in session.
  - muffins for the morning breaks on Wednesday May 2nd and Thursday May 3rd.
  - cookies and fruit for the afternoon breaks on Tuesday May 1st and Wednesday May 2nd.
- Provision of a working lunch for the three IAC members on Tuesday May 1st, Wednesday May 2nd and Thursday May 3rd

Catering: ONA Caucus Room:
- Provision of tea, coffee and water from 0800 Tuesday May 1st to 1500 Thursday May 3rd.

In order to support the principle of full disclosure, and to enable the IAC to effectively prepare for the Hearing, the IAC requests that individual, independent written submissions be provided by Friday April 13th, 2012. Please submit five copies of your submission and attachments/supporting documents in hard copy to my address. Please note that this is a rural address, with courier service only once daily. As Chair of the IAC, I will retain one (1) copy of each submission, and will distribute the remaining four (4) submissions with attachments/supporting documents by courier on Monday April 16th, 2012 as follows:

- One (1) copy of the SAH submission and one (1) copy of the ONA submission to each of Diane Baigrie (SAH Nominee) and Cindy Gabrielli (ONA Nominee);
- Two (2) copies of the SAH submission to the ONA (attention Jo Anne Shannon);
- Two (2) copies of the ONA submission to the SAH (attention Johanne Messier-Mann).
In the event that SAH wishes to provide supplemental information after April 13\textsuperscript{th}, 2012, this will be accepted until Friday April 28\textsuperscript{th}, 2012 and will be distributed as above. Supplemental information may be sent by email, with hard copy to follow. Please note that supplemental information is information to support/clarify SAH’s submission; it is not information to respond to the ONA submission.

The IAC will hold a Pre-Hearing Meeting the week of April 23\textsuperscript{nd}, 2012, to review the submissions in detail. If the IAC requires additional information in order to understand the key issues prior to the Hearing, this will be requested immediately following the Pre-Hearing Meeting.

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

The IAC looks forward to working with SAH to address professional responsibility issues of concern in the Emergency Department. I will be in contact to finalize the logistical details of the Hearing in February 2012. In the meantime, if you have any questions, please contact me by phone at 613-622-7743 or by email at jcardiff@cheo.on.ca after January 27\textsuperscript{th}, 2012.

Sincerely

Joan Cardiff

cc.  Diane Baigrie, SAH Nominee
     Cindy Gabrielle, ONA Nominee
     Jo Anne Shannon, Professional Practice Specialist, ONA
Appendix 5

Independent Assessment Committee Hearing

Ontario Nurses’ Association / Sault Area Hospital

Agenda

Tuesday May 1, 2012
Batchewana (E3460) / Goulais (E3461) Room

09:00 – 10:00  Independent Assessment Committee Meeting (Committee Members only)

10:00 – 12:00  Tour of Emergency Department
• Attending:
  • Independent Assessment Committee
  • For SAH: Vanda Cooper, Robin Joanisse, Vance Boyd
  • For ONA: Jo Anne Shannon, Carol Thorold, Tammy Marsh

13:00  Commencement of Hearing

13:00 – 13:30  • Introduction and Review of Proceedings by Chairperson

13:30 – 15:00  • Ontario Nurses’ Association Submission Presentation
  • Response to questions of clarification from
  • Independent Assessment Committee
  • Sault Area Hospital

15:00 – 15:15  Break

15:15 – 16:45  • Sault Area Hospital Submission Presentation
  • Response to questions of clarification from
  • Independent Assessment Committee
  • Ontario Nurses’ Association

16:45 – 17:00  • Review of Process for May 2, 2012 by Chairperson

17:00  Adjournment of Hearing
Independent Assessment Committee Hearing

Ontario Nurses’ Association / Sault Area Hospital

Agenda

Wednesday May 2, 2012
Batchewana (E3460) / Goulais (E3461) Room

07:30–08:30  Independent Assessment Committee Meeting (Committee Members only)

08:30  Continuation of Hearing

08:30–11:30  •Sault Area Hospital Response to Ontario Nurses’ Association Submission
  •Response to questions from
    •Independent Assessment Committee
    •Ontario Nurses’ Association
  •Discussion

11:30–12:30  Lunch Break

12:30–15:30  •Ontario Nurses’ Association Response to Sault Area Hospital Submission
  •Response to questions from
    •Independent Assessment Committee
    •Sault Area Hospital
  •Discussion

15:30–15:45  •Review of Process for May 3, 2012 by Chairperson

15:45  Adjournment of Hearing

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

Note: The timing of the agenda is ‘fluid’. If the 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 May 3, 2012
Batchewana (E3460) / Goulais (E3461) Room

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
13:00 Closure of Hearing
13:00 – 15:00 Independent Assessment Committee Meeting (Committee members only)
# Hearing Participants and Observers

**Tuesday May 1, 2012**

**Hearing Participants:**
- For the Association:
  - Glenda Hubley: Local 46 Bargaining Unit President
  - Tammy Marsh: RN, Emergency Department
  - Kierston Miron: Local 46 PRC Representative
  - Jennifer Moodie: RN, Emergency Department
  - Jo Anne Shannon: Professional Practice Specialist, ONA
  - Carol Thorold: RN, Emergency Department
  - Linda Walsh: RN, Emergency Department
- For the Hospital:
  - Vance Boyer: HR Consultant
  - Vanda Cooper: Director, Emergency, Critical Care, Access
  - Robin Joanisse: Manager, Emergency Department
  - Johanne Messier-Mann: Chief Nursing Officer

**Hearing Observers:**
- For the Association:
  - Sharon Abrams: RN, Emergency Department
  - Brianna Bardel: RN, Emergency Department
  - David Cheslock: Labour Relations Officer, ONA
  - Adele Churchill: Labour Relations Assistant, ONA
  - Sherri Huard: RN, Renal Unit
  - Catherine Maccarone: RN, Renal Unit
  - Kelly Macgregor: RN, Renal Unit
  - Jewel Porter: RN, Renal Unit
  - Justine Rodgers: RN, Emergency Department
  - Tricia Scornaiencki: RN, Emergency Department
  - Stephen Smith: MD, Emergency Department
- For the Hospital:
  - Lori Bertrand: Director, Surgical Program

**Wednesday May 2, 2012**

**Hearing Participants:**
- For the Association:
  - Glenda Hubley: Local 46 Bargaining Unit President
  - Tammy Marsh: RN, Emergency Department
  - Kierston Miron: Local 46 PRC Representative
  - Jo Anne Shannon: Professional Practice Specialist, ONA
  - Carol Thorold: RN, Emergency Department
  - Linda Walsh: RN, Emergency Department
- For the Hospital:
  - Vance Boyer: HR Consultant
  - Vanda Cooper: Director, Emergency, Critical Care, Access
  - Robin Joanisse: Manager, Emergency Department
  - Johanne Messier-Mann: Chief Nursing Officer

**Hearing Observers:**
- For the Association:
  - Sharon Abrams: RN, Emergency Department
  - Barbie Blair: RN, Critical Care Float Pool
  - Mike Bodnar: MD, Emergency Department

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*Sault Area Hospital / Ontario Nurses’ Association  
Independent Assessment Committee Report  
June 2012*
Rachel Campbell  RN, Emergency Department
David Cheslock  Labour Relations Officer, ONA
Adele Churchill  Labour Relations Assistant, ONA
Wendy Galey  RN, Emergency Department
Leanne Givens  RN, Emergency Department
Amanda Lepera  RN, Emergency Department
Catherine Maccarone  RN, Renal Unit
Diane McAuley  RN, Emergency Department
Julie McEachern  RN, Emergency Department
Karen Saindon  RN, Emergency Department
Tricia Scornaiencki  RN, Renal Unit
Stephen Smith  MD, Emergency Department
Paula Vincent  RN, Emergency Department

For the Hospital:  Lori Bertrand  Director, Surgical Program

May 3, 2012:

Hearing Participants:
For the Association:  Glenda Hubley  Local 46 Bargaining Unit President
Tammy Marsh  RN, Emergency Department
Kierston Miron  Local 46 PRC Representative
Jo Anne Shannon  Professional Practice Specialist, ONA
Carol Thorold  RN, Emergency Department
Linda Walsh  RN, Emergency Department

For the Hospital:  Vance Boyer  HR Consultant
Vanda Cooper  Director, Emergency, Critical Care, Access
Robin Joanisse  Manager, Emergency Department
Johanne Messier-Mann  Chief Nursing Officer

Hearing Observers
For the Association  Sharon Abrams  RN, Emergency Department
Carla Bertolissi  RN, Emergency Department
Barbie Blair  RN, Critical Care Float Pool
Mike Bodnar  MD, Emergency Department
Rachel Campbell  RN, Emergency Department
David Cheslock  Labour Relations Officer, ONA
Adele Churchill  Labour Relations Assistant, ONA
G. Denneny  RN, Renal Unit
Julie Favaro  RN, Emergency Department
Amanda Lepera  RN, Emergency Department
Catherine Maccarone  RN, Renal Unit
Kelly Macgregor  RN, Renal Unit
Diane McAuley  RN, Emergency Department
Katherine McGuire  RN, Emergency Department
Carrie Perra  RN, Emergency Department
Brenda Polnich  RN, Emergency Department
Jewel Porter  RN, Renal Unit
Justine Rodgers  RN, Emergency Department
Jennifer Sandana  RN, Emergency Department
Tricia Scornaiencki  RN, Emergency Department
Nicole Sizer  RN, Emergency Department

For the Hospital:  Lori Bertrand  Director, Surgical Program
Ontario Nurses’ Association Recommendations

Professional Practice

1. The Nursing Unit Practice Council will meet monthly and minutes shall be posted for all ER nursing staff.
2. The long term recommendations of the Joint Health and Safety Committee to enhance nurse safety in the ER will be implemented in a timely manner.
3. 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
   - Preventing and Managing Nurse Fatigue in Health Care
   - Workplace Health, Safety and Well-Being of the Nurse
   - Developing and Sustaining Effective Staffing and Workload Practices
   - Developing and Sustaining Nursing Leadership

Fluctuating Workload

4. The employer and the union shall jointly evaluate the new medical program model of care within four months of implementation for the impact on the quality of care to cardiac/monitored patients, availability of monitored inpatient beds and monitored bed/telemetry capacity in ER.
5. Reopen and properly staff the closed ER stretchers.
6. 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.
7. Hire and train an adequate number of support staff to eliminate or greatly reduce time spent on non-nursing duties. In particular, RNs should not be required to call in staff, stock and clean rooms, or porter patients.
8. Provide an adequate number of available/prescheduled constant care attendants or assign one PSW to ER 24/7.
9. There shall be an adequate number of IV infusion pumps to provide safe care to ER patients and a hospital policy strictly enforced to ensure such pumps remain immediately available in the ER.

Patient Acuity / Fluctuating Staffing

10. Increase the base RN staffing by adding full-time lines to increase by one RN 24/7 to provide 12 RNs on days and 12 RNs on nights. Included in the enhancement of night shift is the change of the 1000 – 2200 hour shift to 1900 – 0700. This increase will provide flexibility to respond to activity such as meeting CTAS standards of assessment/reassessment, providing a second triage RN on nights when needed, providing a second RN in See & Treat, accepting ambulance off-loads, reopening the closed RN stretchers and caring for virtual/hallway patients etc.
12. Staff the See & Treat area with an additional Nurse Practitioner when a dedicated physician is not available.
13. Part-time RN staffing levels shall ensure that baseline nursing staff is maintained, and such that, there are sufficient resources to respond to requests for statutory holiday and vacations, replace vacant shifts such as sick time and prevent the pre-assigning of the float pools.
14. The Hospital will collaboratively develop and implement a comprehensive strategy for recruitment and retention in the ER, with the goal of filling all vacant positions as soon as possible.
15. The Float Pools shall not be pre-assigned to nursing units and shall be large enough to regularly cover incidental shift vacancies.
16. Develop an improved staffing/contingency plan to be put in place when the activity and/or acuity exceed the numbers of RNs available to provide care.
17. Amend the overcapacity policy to include safe staffing plans to care for hallway patients for the duration of such overcapacity.
18. RN staffing levels shall ensure that the time and resources required are available to allow the provision of safe, ethical and competent patient care.
Sault Area Hospital Recommendations

Recommendation 1:
Optimization of nursing and physician resource allocations with the implementation of formal Charge Nurse and Charge Physician roles and responsibilities specific to the reassignment of human resources from low volume zones to higher volume zones.

Recommendation 2:
Optimization of the Emergency Department Information Tracker to improve quality of patient tracking and monitoring of zone activity.

Recommendation 3:
Revision of ED zone criteria with education roll-out to nursing staff.

Recommendation 4:
Continued optimization of patient flow to Clinical Decision Unit.

Recommendation 5:
Reduce non direct patient care activities presently being performed by nurses. Introduce ED aids and hours of work to replenish exam room supplies, carts and special procedure rooms.
NENA Standards of Emergency Nursing Practice

PROFESSIONALISM

STANDARD I - Qualification
The Emergency Nurse shall be competent and current, adhering to established Standards of Nursing Practice.

1.1 The Staff Emergency Nurse shall meet specified qualifications for employment:
- Minimum TWO years acute care, medicine/surgery experience in an active treatment setting is preferred.
- Emergency nursing recognizes the need to develop and train new graduates in the skills and knowledge needed to become specialized as an Emergency Nurse.
- Competence in:
  - Basic Cardiac Life Support (BCLS) procedures
  - Advanced Cardiac Life Support (ACLS) protocols
  - Pediatric Advanced Life Support (PALS) protocols
- Additional Courses recognized by NENA Inc.:
  - Trauma Nursing Core Course (TNCC),
  - Emergency Nursing Pediatric Course (ENPC),
  - Course on Advanced Trauma Nursing (CATN II),
  - Emergency Nurse Certification Canada (ENC(C))
- Current registration (RN) with Provincial/Territory Body
- Successfully completes a comprehensive orientation program to ensure competency in the care of the patient

1.2 The Triage Nurse shall meet specified qualifications for employment: (in addition to 1.1 above include)
- Minimum TWO years recent Emergency Nursing Practice
- Demonstrated competence in Emergency Nursing Practice
- Displayed acquisition of Advanced Assessment, Interviewing and Interpersonal skills
- Trained in current CTAS (Canadian Triage and Acuity Scale)

1.3 The Clinical Nursing Educator shall meet specified qualifications for Employment: (in addition to 1.1 and 1.2 above include)
- THREE years recent Emergency Nursing Experience
- Experience in instructional methods
- Baccalaureate Degree-Nursing is preferred.
- Demonstrated comprehension of specific needs of the Adult Learner

1.4 The Unit Manager shall meet specified qualifications for employment:
- Minimum of 5 years Emergency Nursing Experience
- Maintains a working knowledge of and supports the dissemination of same in the work environment:
  - NENA endorsed courses
  - Demonstrate comprehension of Nursing Management Strategies
  - Demonstrated leadership skills
  - Baccalaureate Degree-Nursing is preferred.

STANDARD II: Professional Status
The Emergency Nurse shall engage in a variety of activities and behaviors that characterize professionals.

2.1 Ethics: The Emergency Nurse shall provide nursing care that demonstrates compliance with the Canadian Nurses Association Code of Ethics.
2.2 Autonomy: The Emergency Nurse shall function autonomously to the extent that knowledge, skill, judgment, and scope of practice allows.
- Actions are congruent with the Provincial Nursing Associations
- Actions are congruent with institutional policy and procedures
- Participates in case and peer review to evaluate autonomous practice

2.3 Professional Identity: The Emergency Nurse shall promote understanding of their role and responsibilities.
- Clearly identifies self to patient and significant others (as responsible for patients nursing care).
- Clearly identifies self to colleagues and other health care providers
- Seeks the opportunity to be involved in activities relevant to Emergency Nursing Practice

2.4 Authority: The Emergency Nurse shall exercise authority congruent with their role and responsibility in accordance with their respective regulatory body Acts.
- Practices in accordance with their respective regulatory body Acts, provincial publications/documents that define an describe the scope of nursing practice.
- Practices in accordance with the policies and procedures of the agency in which they are employed
- Practices within the confines of one’s knowledge, skill, judgment and expertise coordinates the delivery of care given to patients for whom they are responsible

2.5 Legislation: The Emergency Nurse shall be aware of current legislation that influences emergency care and the practice of nursing.

2.6 Accountability: The Emergency Nurse shall be accountable for his/her actions
- Utilizes self-evaluation and evaluations from peers, supervisors and patients to modify their practice accordingly
- Assumes responsibility for actions
- Participates in the formulation and revision of policies, procedures and protocols related to all aspects of Emergency Care

2.7 Professional Image: The Emergency Nurse shall foster a professional image of nursing
- Articulates and demonstrates the crucial role of Emergency Nursing within the Health Care System, to other professionals, the media and the public
- Act as a role model to encourage entry into Emergency Nursing

2.8 Preceptor: The Emergency Nurse shall foster a supportive relationship with graduate nurses and new staff in Emergency departments:
- Act as a resource to new learners
- Promote understanding of policies and procedures that govern their practice as defined by their legislative bodies and institutional practices.
- Assists to identify learning needs of new staff

PRACTICE

STANDARD I: Triage
The Emergency Nurse must triage every patient entering the Emergency Care System and determine priorities of care based on physical, psychosocial and spiritual needs, as well as factors influencing patient flow through the system

1.1 Assessment: Triage assessment shall include rapid, systematic collection of data related to the patient’s chief complaint. The Patient is triaged according to the urgency of his/her presenting problem within the following categories: resuscitative, emergent, urgent, less urgent and non-urgent
- Performs symptom analysis of chief complaint on all patients entering the emergency care system collecting subjective and objective data
- Evaluates the patient in a timely manner according to the Canadian Triage and Acuity Scale
- Reassesses the patients in the waiting area based on triage acuity guidelines and recategorize as necessary
- Documents triage assessments in succinct, complete fashion, according to agency guidelines

1.2 Analysis/Plan: Triage assessment shall be analyzed to determine acuity, patient care area, and any appropriate interventions based on triage protocol
- Assigns patients to appropriate patient care area and staff, based on triage assessment and acuity categorization
• Informs emergency care team of the patient’s arrival and communicate pertinent information
• Communicates with administration regarding workload, potential/actual problems based on assessment and/or ongoing care of the patients within the emergency care setting

1.3 Intervention: The Triage Nurse shall function independently within the scope of practice established for Professional Nurses by Provincial/Territorial Regulatory Bodies.
• Initiates nursing interventions according to triage protocols
• Facilitates the flow of patients through the emergency care system
• Communicates pertinent information to families/significant others as appropriate
• Mobilizes all resources and clinical guidelines as needed for patient or family

1.4 Collaborative Intervention: The Triage Nurse shall function collaboratively to facilitate timely care of the patients
• Ensures prompt initiation of resuscitative measures, if indicated
• Initiates diagnostic testing, if indicated
• Initiates treatment, if indicated in accordance with hospital policy and procedure

1.5 Evaluation: Quality monitoring shall be developed and implemented to ensure timely, appropriate triage.
• Demonstrates complete documentation and consistency with triage protocol (e.g. Random Chart Audits, Case Review, Adherence to Computer based Triage etc.)

STANDARD II: Assessment
The Emergency Nurse shall initiate accurate and ongoing assessment of physical, psychosocial and spiritual needs of patients within the Emergency Care System.

2.1 Initial Assessment: Initial assessment shall include systematic and pertinent collection of data based on the chief complaint.
• Obtains initial focused subjective and objective data through history taking (inclusive of patient/family/EMS, other care providers, etc.), physical assessment, and review of records.
• The patient assessment shall reflect a holistic approach

2.2 Ongoing Assessment: Continuing reassessment shall be performed to include systematic and pertinent collection of data that reflect the current health status of the patient.
• Performs ongoing patient assessment in a timely manner based on acuity
• Records significant data as appropriate to the nature and severity of the illness or injury
• Communicates significant data to appropriate persons promptly
• Communicates with patients and families regarding waiting times

STANDARD III: Analysis/Planning
The Emergency Nurse shall formulate a comprehensive plan of care for the emergency patient based on the subjective/objective data.

3.1 Plan of Care: The Emergency Nurse shall develop and utilize a plan of care as a systematic, uniform, and consistent method to provide safe and effective patient care.
• Identifies priorities for nursing actions, affecting patient outcomes and goals
• Reflects environmental, physical and psychosocial stress factors affecting the patient
• Bases the plan on current nursing knowledge, professional standards and agency policy
• Incorporates teaching and learning principles into the plan of care

3.2 Supplies and Equipment: The Emergency Nurses shall ensure that supplies and equipment necessary for the care and safety of the Emergency patient are available
• Ensures that supplies necessary for provision of emergency care are readily available and fit for use
• Ensures that the equipment necessary for provision of emergency care is readily available and in working order

3.3 Safety: The Emergency Nurse shall take measures to ensure the safety of colleagues, patients, significant others and themselves in the emergency care setting
• Identifies and rectifies sources of potential accidents through daily or periodic inspection
• Is familiar with standardized safety procedures
• Implements safety procedures for each patient in accordance with the patient’s specific requirements
• Practice reflects a knowledge and use of infection control measures.
• Demonstrates knowledge, skill and judgment necessary to implement the protocol to be followed in the event of an internal/external disaster or threat
• Ensures that the supplies and equipment necessary for the implementation of universal precautions are available and utilized
• Participates in the development of a security plan to assure the safety of all and the protection of property
• Identifies actual/potential security risks on an ongoing basis and act accordingly to ensure the safety of all

3.4 Legal Responsibilities: The Emergency Nurse shall demonstrate an awareness of current federal, provincial and municipal laws governing the delivery of care to the emergency patient.
• Follows written agency policy and procedure surrounding medical/legal issues
• Follows the HIPPA/FOIP guidelines when providing any information

STANDARD IV: Intervention
The Emergency Nurse shall implement a plan of care based on nursing/medical assessment and diagnosis
4.1 Independent Functions: The Emergency Nurse shall function independently within the scope of Professional Nursing Practice established by their respective regulatory body.
• Independently performs continuous patient monitoring and alters the plan of care accordingly
• Independently provides patient education
• Independently performs life/limb and function saving measures within the scope of professional nursing practice

4.2 Collaborative Function: The Emergency Nurse shall function collaboratively with other health care providers to implement the plan of care within the scope of professional nursing practice.
• Individualizes a plan of care for each patient
• Implements a plan of care for each patient

STANDARD V: Evaluation
The Emergency Nurse shall evaluate and modify the plan of care based on observable responses and attainable goals of patient centered outcomes
5.1 Evaluation: Emergency Nursing Care shall be evaluated on a continual basis to determine attainment of patient centered outcomes.
• Records and uses current patient data to measure progress
• Utilizes data from the patient, primary care giver, and members of the health care team
• Documents reassessment of the patient and revises the plan of care accordingly

5.2 Initiatives Development: The Emergency Nurse shall be involved in mechanisms to regularly evaluate and monitor the quality of emergency care.
• Participates in the development of continuous quality improvement (CQI) plans
• Participates in the implementation of the quality improvement plan through patient outcome reviews and patients surveys
• Participates in the development of actions, resolutions, and ongoing monitoring activities designed to improve emergency care practice

STANDARD VI: Ethics
The Emergency Nurse shall provide care based on the Canadian Nurses Association, Code of Ethics for Nursing.
6.1 Ethics: The Emergency Nurse shall provide care that demonstrates ethical beliefs and respect for the patient’s rights in accordance with the Canadian Nurses Association, Code of Ethics for Nursing.
• Respects the individuality and human worth of the patient regardless of age, sexual orientation, socioeconomic status, cultural or ethnic background or spiritual beliefs
• Respects the health and well-being, choice, dignity, confidentiality, fairness and privacy of the patient
• Promotes and utilizes principles of equity and fairness in assisting the patient
• Takes actions which are consistent with their professional responsibilities and standards of practice
STANDARD VII: Communication
The Emergency Nurse will communicate with the emergency patient, significant others, and other health care providers openly, honestly, and timely following the HIPPA/FOIPPA guidelines.

7.1 Liaison with the patient and significant others: The Emergency Nurse shall provide sufficient information to allow the patients and significant others to participate in the patients care.
   • Involves the patient in education and decision-making processes related to their care
   • Involves significant others in education and decision-making processes related to the patients care

7.2 Liaison with community: The Emergency Nurse shall participate in educational endeavours related to the provision of emergency care within the community.
   • Participates in formal/informal community teaching regarding Emergency Nursing and Emergency Care Systems

7.3 Interdisciplinary Relations: The Emergency Nurse shall effectively communicate, in order to facilitate effective and comprehensive emergency health care.
   • Functions as liaison between/among members of the health care team
   • Collaborates in health care decisions related to patient care
   • Communicates quality of care concerns to other members of the health care team
   • Communicates nursing expertise to other disciplines to address issues relevant to provision of emergency health care

7.4 Documentation: The Emergency Nurse shall accurately document pertinent patient data, nursing interventions and patient outcomes.
   • Documents thoroughly, chronologically and continuously, based on the nursing process and patient outcomes
   • Utilizes agency specific documentation systems

7.5 Public Relations: The Emergency Nurse shall demonstrate skill in interacting with the public to foster the provision of respectful patient centered care.
   • Facilitates communication between patient and emergency care team
   • Promotes open communication
   • Follows HIPA/FOIPPA guidelines when communicating with outside agencies, family members and the public.

7.6 Interactions: The Emergency Nurse shall interact as team members of the Emergency Medical System, respecting the limits, capabilities, and responsibilities of all members.
   • Participates in multidisciplinary patient care conferences and collaborate in team decisions
   • Participates in critical incident stress management on both a formal and informal basis

EDUCATION

STANDARD I: Provision of Information
The Emergency Nurse shall assist the patient and significant others to obtain knowledge about health, wellness/illness and injury prevention/treatment

1.1 Patient and Significant other teaching: Teaching shall be an ongoing process that includes provisions of information about the condition, responsibilities, options, and recommendations for appropriate follow-up.
   • Offers information about the condition to the patient and significant others in a way that is consistent with their intellectual and emotional capabilities
   • Offers explanations about interventions before initiation whenever possible
   • Involves the patient and significant others in the decision-making process related to therapeutic intervention whenever possible
   • Ensures an explanation is provided for medications, treatments, self-care, follow-up and/or referral
   • Participates in development and use of written discharge instructions
   • Evaluates patient educational materials

1.2 Prevention: Epidemiological trends shall serve as a basis for identification of individuals at risk of illness or injury.
   • Assists the patient and significant others in the identification of factors and place them “at risk” for illness or injury
   • Explains methods for illness or injury prevention
   • Explains early detection and intervention strategies

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1.3 Public Education: The Emergency Nurse will participate in public education regarding the Emergency Care System.

1.4 Health Promotion: The Emergency Nurse will participate in the dissemination of health information as it is related to identified needs of the patient.

**STANDARD II: Education**

The Emergency Nurse shall maintain their professional competency based on their provincial governing bodies.

2.1 Continuing education: The Emergency Nurse shall obtain progressive, ongoing education.
- Determines professional learning needs and identifies short and long-term education goals relevant to practice
- Plans/implements activities to achieve educational goals
- Shares newly gained knowledge from relevant educational programs with peers and colleagues
- Demonstrates enhanced clinical practice as a result of continuing education
- Has knowledge of and participates in professional groups that impact on the practice of Emergency Nursing

2.2 Nursing Education: The Emergency Nurse shall facilitate learning experiences for professional peers and nursing students.
- Acts as a teacher, preceptor, mentor, and role model to nursing students
- Teaches professional peers about the roles and responsibilities of the Emergency Nurse

2.3 Emergency Medical System: The Emergency Nurse shall facilitate learning experiences for members of the health care team and students.
- Participates in the orientation of health care team members and students regarding policies, procedures, roles, and responsibilities
- Participates in the teaching and supervision of health care team members and students during clinical practice

2.4 Orientation: Orientation shall be based on the function which the Emergency Nurse is expected to assume in the Emergency Setting.
- Knowledge of employer approved written policies and procedures
- Knowledge of the physical set-up of the emergency facility and the utilization of all client care equipment
- Knowledge of the utilization of documentation system
- Knowledge of the roles and functions of other emergency personnel as described according to legal statues, job descriptions, policies and procedures
- Knowledge of the emergency communication network and its operation
- Knowledge of nursing procedures and psychomotor skills within the emergency situation
- Knowledge of ethical and legal considerations which impact patient care in the emergency setting

**RESEARCH**

**STANDARD I: Research**

The Emergency Nurses shall recognize and utilize research findings to advance emergency nursing practice.

1.1 Application to Practice: The Emergency Nurse shall use information from research literature to improve practice.
- Possesses an awareness of research in Emergency Nursing
- Implements changes in clinical practice through evidence based research
- Disseminates research findings to peers

1.2 Collaboration: The Emergency Nurse shall collaborate with colleagues in other disciplines who are engaged in research in the practice setting.
- Participates in and supports interdisciplinary research
- Assists in identification of research subjects

1.3 Administrative Support: The Emergency Nurse in leadership roles shall facilitate research in the practice setting when agency guidelines governing research have been fulfilled.
• Provides administrative support for research conducted in settings for which they are responsible
• Includes research activities as a component in performance evaluations

1.4 Ethics: The Emergency Nurse shall adhere to ethics that govern research.
  • Protects the subject’s rights to privacy and confidentiality
  • Protects the subject’s rights to voluntary/informed consent without coercion
  • Demonstrates knowledge of and participates in the mechanisms available to address violation of the rights