Independent Assessment Committee Report

Constituted under Article 8.01 of the Collective Agreement between

Sault Area Hospital and

Ontario Nurses’ Association

April 4-6, 2016

Submitted: May 23, 2016
Independent Assessment Committee

Sault Area Hospital and
The Ontario Nurses’ Association

Heather Camrass
Director of Operations
Chief Nursing Officer
Sault Area Hospital

Jo Anne Shannon
Professional Practice Specialist
Ontario Nurses’ Association

The members of the Independent Assessment Committee Panel respectfully submit the attached Report with findings and recommendations regarding the Professional Responsibility Complaint presented by the Registered Nurses working on 3C Medicine of the Sault Area Hospital (SAH).

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, at a Hearing held April 4-6, 2016.

The Independent Assessment Committee Panel recognizes and appreciates the time, energy, transparency and thoughtfulness provided by representatives of the Sault Area Hospital, the Ontario Nurses’ Association and the Registered Nurses working on 3C Medical Short Stay Unit to prepare, sharing of their testimonials, present information regarding the Professional Responsibility Complaint, and to respond to the Panel’s questions. The attached Report contains unanimously supported recommendations which we hope will assist all parties to continue to work together, within the context of a quality practice environment that supports professional nursing practice and leadership, to provide effective and efficient patient care to the patients residing on 3C MSSU.

Respectfully submitted on Monday May 23, 2016.

Donna Rothwell, RN, BScN, MN
Chairperson, Independent Assessment Committee

Theresa Morris, RN, BScN, MN
Sault Area Hospital Nominee

Cindy Gabrielli, RN(EC), BScN, MSN
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 presents the IAC’s understanding of the PRC, including the development of the PRC, referral of the PRC to the IAC, and activities undertaken between the IAC referral and IAC Hearing, and presents the IAC’s understanding of the Association’s and Hospital’s perspectives regarding the PRC issues.

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

Section IV presents the IAC’s conclusions.

Section V contains the IAC’s summary of recommendations.

Section VI contains the Appendices referenced throughout the IAC Report.

1.2 Jurisdiction of the Independent Assessment Committee

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

Article 8.01 (a) sets 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, 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, and the College of Nurses of Ontario’s Professional Standards (2002)² RN workload is impacted by the inter-relationship of:

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² College of Nurses of Ontario: Professional Standards. ISBN 1-894557-33-6, Revised 2002, Publication # 41006
The IAC is responsible for examining the client, nurse and environmental factors impacting workload, and for making recommendations to address workload issues. Concerns outside of workload are beyond the jurisdiction of the IAC.

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

1.3 Referral to the Independent Assessment Committee

The Registered Nurses (RNs) working in the Acute Medical 3C Medical Short Stay Unit (MSSU), Sault Area Hospital have consistently identified ongoing serious practice and workload concerns as evidenced by the data submitted on numerous Professional Responsibility Workload Report Forms (PRWRFs) in 2015 and 2016.

Consistent documentation identifies that the practice, patient care and workload environment does not allow 3C MSSU RNs to meet College of Nurses of Ontario (CNO) standards; and they believe they are being asked to perform more work than is consistent with effective and efficient patient care. The employer is not providing effective supports and resources to respond to patient acuity and volumes, fluctuating workloads, unit activity, fluctuating staffing and professional practice issues.

These underlying serious practice and workload concerns have existed since 2010. ONA initially referred this file to an Independent Assessment Committee (IAC) hearing in January 2012. Both SAH and ONA agreed to put the hearing on hold in April 2012 as the Hospital was implementing changes to the medical units (3B and 3C) which both parties were hopeful would assist in resolving Professional Responsibility Complaints (PRC). These changes in bed mapping and model of care appeared to provide temporary relief at that time.

Unfortunately the underlying and unresolved practice and workload concerns re-escalated in 2013 and the parties have been meeting regularly since that time to attempt to reach agreement on resolution.

On October 2, 2014 the parties agreed to utilize Joan Cardiff in a pilot mediation role in February 2015 as an alternative to reconvening the Independent Assessment Committee process. The SAH unilaterally withdrew from the mediation process, stating that the Employer’s “efforts will be focused on planning the operational changes with comprehensive participation of all stakeholders.”
1.4 Proceedings of the Independent Assessment Committee

1.4.1 Pre-Hearing

1.4.1.1 Nominee Selection

In accordance with Article 8.01 (a) (viii), the Association and the Hospital identified their Nominees to the IAC. The IAC Chairperson received notification of the Association’s Nominee, Cindy Gabrielli, on January 5, 2016 (Appendix 2) and the Hospital’s Nominee, Theresa Morris, on January 6, 2016 (Appendix 3).

1.4.1.2 IAC Introductory Teleconference

The Chairperson contacted the Nominees on January 9 and 10th 2016 and provided copies of correspondence from both the Association and the Hospital as well as the draft agenda for the IAC hearing scheduled April 4, 5, and 6th, 2016 (Appendix 4). Several email exchanges occurred prior to the IAC Panel’s introductory teleconference held on Wednesday, March 23, 2016. The Chairperson reviewed the jurisdiction of the IAC within the Collective Agreement, discussed the role of the Nominees and Chairperson, reviewed the three phases of the IAC process, and discussed logistics associated with scheduling the Hearing and the process for review of the Hearing Briefs.

Following the teleconference, the Nominees discussed the need to hold an additional teleconference on Tuesday, March 29, 2016 at 1900 hrs to discuss any further documents required and a list of issues for review prior to the Hearing on April 4-6, 2016. As a result of this meeting a number of issues/questions were identified by the IAC and this list was developed by the IAC Chairperson and sent electronically to Heather Camrass, CNO at the SAH on Monday, March 28, 2016 (Appendix 5).

On April 3, 2016 the IAC met to review the agenda and have further dialogue regarding the documentation provided by the Association and the Hospital in preparation for the IAC Hearing on April 4-6, 2016.

1.4.1.3 Hearing Confirmation and Hearing Brief Distribution

The date for the Hearing was confirmed on Thursday, January 7, 2016. The location was simultaneously determined to be held at the Sault Area Hospital April 4, 5 and 6th, 2016. The IAC Chairperson wrote to the Hospital and the Association on January 9 and 10th, 2016 respectively to confirm the date and location of the Hearing and to provide the draft Hearing Agenda. Respecting the principle of full disclosure and to streamline the process of the Hearing by enabling the IAC to become familiar with the issues in advance, the IAC requested the Hospital and the Association to submit a Hearing Brief to the Chairperson by March 18, 2016.

The IAC Chairperson received and distributed the Hearing Briefs and supporting Exhibits as follows:
- Association Brief received and distributed to the IAC Panel and the Hospital on March 18, 2016;
- The SAH requested an extension for their submission to be submitted on March 21, 2016 and the IAC granted this
- Hospital Brief received March 21, 2016 and distributed to the IAC Panel and the Association on March 22, 2016; and
- Association submitted an additional Addendum to the IAC to supplement its Brief on March 30, 2016
IAC received additional information requested electronically from the Hospital as requested in their correspondence dated March 28, 2016.

1.4.1.4 IAC Pre-Hearing Meeting

The IAC held a Pre-Hearing meeting on April 3, 2016. The IAC reviewed the anticipated process of the Hearing, discussed the Hearing Briefs and identified key issues for exploration at the Hearing.

1.4.1.5 Confidentiality Issue

The Association was unable to agree with the SAH Confidentiality agreement. Through a series of emails and a teleconference held on Saturday April 2, 2016 with the IAC Chairperson, Heather Camrass, SAH CNO and Jo Anne Shannon, ONA Professional Practice Specialist, the SAH Confidentiality agreement was amended and approved by the SAH Privacy Officer. The Association and IAC Panel signed the Confidentiality Agreement in order to attend “bullet rounds” during the hospital tour on Monday, April 4, 2016.

1.4.1.6 Unit 3C Medical Short Stay Unit (MSSU) Tour: Monday April 4, 2016

On the morning of Monday, April 4, 2016, the IAC Panel conducted a Site Tour of 3C MSSU at 0800 hrs. In addition to the IAC Panel, the following individuals attended the Site Tour:

On behalf of the SAH:
- Jack Willett, Manager, 3C MSSU
- Heather Camrass, Chief Nursing Officer and Director of Operations

On behalf of the Association:
- Pauline Qupido, RN, 3C MSSU
- Monique Strorozuk, RN, 3C MSSU
- Jo Anne Shannon, ONA Professional Practice Specialist

The Tour was led by both Pauline Qupido and Monique Strorozuk. It included a comprehensive walk-around of all areas on 3C MSSU. The tour began with the IAC Panel, the Association and the Hospital participants attending “Bullet Rounds” at 0815 on Monday, April 4, 2016.

The Tour provided an opportunity to understand the complexity of the diverse patient population being cared for on 3C MSSU, the Physician model of care, the practice environment, care provision, medication administration processes, inter and intraprofessional communication and the geographical configuration of 3C MSSU.

1.4.2 Hearing

1.4.2.1 Hearing Schedule

The Hearing convened at 1130 hours in the Conference Room at the Sault Area Hospital. As indicated on the Hearing Agenda the Hearing was held over three days as follows:

- April 4, 2016: 08:00 – 16:30 hours
- April 5, 2016: 08:00 – 12:00 hours
  13:00 – 16:15 hours
April 6, 2016: 08:00 – 10:30 hours

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

1.4.2.2 Hearing Day 1: April 4, 2016

The IAC Chairperson opened the Hearing at 11:30 hours. Following introduction of the three IAC Panel members and round-table introduction of the Hospital and Association participants, the IAC Chairperson reviewed the following:

- the Hearing process, including anticipated flow and organization of each day;
- the jurisdictional scope of the IAC, including the purpose of the IAC and the nature of its non-binding recommendations;
- the role of Hearing participants, to promote clarity of understanding of the issues from their perspective; and
- the ‘ground rules’, to facilitate a respectful, collaborative, constructive and non-adversarial environment to promote discussion and professional dialogue.

The Association’s presentation to the IAC Panel and the Hospital was presented by Jo Anne Shannon, PPC. The presentation included an overview of Article 8.01, CNO Professional Standards, a historical overview, concerns identified by ONA members on 3C MSSU, and ONA’s thirty-one (31) recommendations. Following the presentation, the Association responded to questions of clarity related to the Association’s presentation from the Hospital and the IAC Panel members.

The Hospital presentation was presented by Lori Bertrand, Director, Clinical Programs. An overview of the SAH and Leadership team, Strategic Plan, Medical Program Goals and services, the current challenges, what is working well, improvement initiatives, and next steps. Following the presentation, the Hospital responded to questions of clarity related to the Hospital’s presentation from the Association and the IAC Panel members.

The IAC Chairperson adjourned the Hearing at 16:30 hours

1.4.2.3 Hearing Day 2: April 5, 2016

The IAC Chairperson opened the Hearing at 09:00 hours.

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

The Chairperson adjourned the Hearing at 16:00 hours.

1.4.2.4 IAC Intra-Hearing Meeting

The IAC Panel met during the evening of Monday, April 4, 2016 and the morning and evening of Tuesday, April 5, 2016 to review and synthesize the data collected during the Hospital tour of 3C MSSU and the wealth of information presented through the written submissions, supporting documents and
discussion during the Hearing, and to identify key questions to lead and engage in meaningful dialogue for the purpose of Hearing discussions on Wednesday, April 6, 2016.

1.4.2.5 Hearing Day 3: April 6, 2016

The IAC Chairperson opened the Hearing at 08:00 hours.

The IAC Chairperson once again reviewed with all those in attendance the ground rules for meaningful and professional discussions. The IAC Panel asked a series of questions related to the issues identified below:

- Standard work education provided to the 3C MSSU staff and staff preparation prior to September 2015
- Development of the 3C MSSU Admission Criteria and Exclusion Criteria
- Evaluation criteria for determining whether or not the Exclusion Criteria was still relevant
- Target “pull times” from the ED to 3C MSSU
- Metrics collected daily, weekly and monthly related to standard work and patient flow
- Escalation policies
- Staff empowerment
- Transfer of Accountability

All Hearing participants in attendance were provided with the opportunity to address the IAC Panel and actively participate in the discussion.

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

The IAC Chairperson’s closing comments referenced the following key points:

- Acknowledged the tremendous time and effort by both the Hospital and Association which was undertaken for the IAC Hearing and the excellent submissions and presentations to inform the IAC Panel and both parties of the issues;
- Thanked the staff who were in attendance and also acknowledged their active participation in the IAC Hearing;
- Thanked all those in attendance for their openness, honesty and willingness to share their personal testimonials, thoughts, patient experiences and concerns related to workload, professional responsibilities and accountabilities;
- Respecting the “ground rules” throughout the IAC hearing;
- Reconfirmed the IAC process is intended to provide an independent objective external perspective to aid in the resolution of outstanding issues, and that although the recommendations are non-binding, the IAC is hopeful the recommendations will provide a foundation from which both parties can move forward constructively; and
- Confirmed that the IAC Report would be submitted within a sixty (60) calendar day timeframe as per the approval by both the Hospital and Association. Although it is stipulated in Article 8.01 (a) (viii) of the Collective Agreement to submit the report in 45 days, permission was sought for an extension.

The Chairperson closed the Hearing at 10:30 hours on Wednesday April 6, 2016.
1.4.3  Post-Hearing

1.4.3.1  IAC Report Development

The initial draft of the IAC report was circulated on April 9, 2016 to the nominees to provide more detail of the proposed recommendations in preparation for an IAC teleconference to be held on April 18, 2016. The purpose of this call was to discuss the overall framework of the IAC report and recommendations.

Following the hearing the IAC met to discuss key themes and issues. Based on these themes the IAC developed initial recommendations in preparation for the development of the second draft of the IAC report.

The IAC conducted a teleconference on Monday April 18, 2016 to review the second draft of the IAC report and to prepare for the face to face meeting of the IAC scheduled for April 23, 2016.

The IAC met on April 23, 2016 to revise the second draft of the IAC Report.

Draft three of the IAC report was distributed on April 24, 2016.

An IAC teleconference was held on Wednesday April 27, 2016 at 1900 hrs.

Draft four of the IAC report was distributed on April 28, 2016.

An IAC teleconference was held to review draft five of the IAC report distributed on May 15, 2016 on Monday May 16, 2016.

1.4.3.2  IAC Report Submission

The IAC Report was submitted to the Association and the Hospital by email, in PDF format, on Monday May 23, 2016.
SECTION II

PRESENTATION OF THE PROFESSIONAL RESPONSIBILITY COMPLAINT

2.1 Development of the Professional Responsibility Complaint

2.1.1 Events Prior to Referral of the Professional Responsibility Complaint

On March 6, 2011 the move to the new hospital occurred. As a result of this move, the Medical Units were reconfigured into three (3) units: 1B – 25 beds – low acuity medical patients; 3B – 35 beds + 1 overflow which cared for moderate acuity general medical patients; and, 3C – 30 beds + 10 overflow high acuity medical patients that included telemetry, acute stroke, cardiology, oncology, peritoneal dialysis (PD), BiPaP and isolated patients. Given this patient population and their care requirements, staff identified learning needs related to telemetry monitoring, stroke training, PD and BiPaP education. Of importance, this was the initiation of the PRC process whereby staff began to file PRWRFs following the move to the new hospital on 3C.

The Hospital and ONA have worked together to address professional workload issues relating to the Medical Program since 2010, prior to the move to the new hospital. Due to an increase in the submission of Professional Responsibility Workload Report forms (PRWRF) beginning in January 2010, ONA and SAH representatives began to work locally on the identified issues, in order to resolve. The main themes of the workloads included:

- Overcapacity issues / patient flow
- Equipment and supplies (generally and due to increased demands with overcapacity)
- Inadequate base and relief staff
- Non-nursing duties
- Appropriate assignment of patients (Three Factor Framework)
- Communication

A comprehensive action plan was initiated in October 2010 and guided improvement work for 8 months, with a last update to that plan in June 2011. SAH moved to its new site in March 2011 and many of the issues were subsequently resolved based on new space, increased equipment and focus on new operational plans for each unit. Improvements included:

- Establishment of bed management policies, established guidelines for use of overcapacity beds in units
- Review of linen and supply quotas and procurement of equipment (such as BP cuffs, stethoscopes, vital signs monitors, suction regulators, thermometers, wireless phones, computers and keyboards)
- Review of base staffing and aggressive recruitment of outstanding positions
- Review of non-nursing duties (eg. resolution with increase in unit assistants, housekeeping)
- Education related to Three Factor framework

3 ONA Submission IAC Sault Area Hospital 3C MSSU and ONA p. 13
• Development of strategies for better communication (e.g. creation of SBAR between departments for transfer of patients, newsletter development, staff meetings, establishment of unit council, initiation of manager “rounding” with staff)

On January 13, 2012 ONA referred the evolving PRC on 3C to an IAC. Following this IAC submission the SAH developed a proposed plan and presented to the SAH Hospital Association Committee (HAC) in February 2012 “Medical Program Bed Reconfiguration – Draft for Discussion.” Based on this presentation and the options proposed, Option 4 was selected by SAH changing 3C to 30 medical beds including 16 telemetry beds. The patient population would remain the same except for oncology patients would move to 3B. As a result of this change, in March 2012, staffing changed by decreasing one RPN and increasing a RN 24/7. The IAC hearing was put on hold in April 2012 as a result of this change. Of note, the number of PRWRFs filed by 3C nurses decreased significantly.

In December 2012, plans were announced to consolidate the three medical units into two units effective January 2013. The units would be 3B and 3C each consisting of 40 beds. In May 2013, Plummer site closed and this meant that all the ALC patients were transferred to the new hospital. This change created an increase in the PRWRFs being filled out due to working short, inability to replace sick calls, lack of knowledge and skill for some nurses to care for telemetry patients, and high acuity care requirements.

On August 20, 2013, “Standards of Care for Admitted Patients to Medical Units” was implemented. This document clearly outlined care requirements that included a minimum of hourly rounding, health teaching, and clear assessment guidelines related to pain assessment, vital sign monitoring, and head to toe assessments. It was evident by the documentation reflected in the PRWRFs, that nurses were unable to meet these standards of care and still remains one of the fundamental issues for nurses to date.

December 12, 2013 the Association notified the employer they reserved the right to reconvene the IAC panel if necessary to review the workplace and practice environment on 3C. Following this notification the Manager forwarded an email to the 3C MSSU staff outlining the Interim Staffing Guidelines for 3CMSSU. At this point there was a decrease in the PRWRFs.

PRWRFs were increasing once again, so a document outlining issues and themes was developed as documented by the 3C RNs and submitted to the employer on August 12, 2014.

ONA proposed a mediation process in November 2014, and the Hospital agreed and this was scheduled for February 10-11, 2015.

In December of 2014, plans were made to convert 3C to a 20 bed Medical Short Stay Unit (MSSU) based on benchmarking with Windsor Regional and Southlake Hospitals. ONA was also notified the 3C Patient Care Coordinator would be replaced by a non-union Supervisor. On January 5, 2015, the Hospital notified ONA that the employer unilaterally decided to withdraw from the mediation process scheduled

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4 ONA Book of Exhibits IAC Sault Area Hospital 3C MSSU and ONA Exhibit 4
5 ONA Book of Exhibits IAC Sault Area Hospital 3C MSSU and ONA Exhibit 5
6 ONA Book of Exhibits IAC Sault Area Hospital 3C MSSU and ONA Exhibit 6
7 ONA Book of Exhibits IAC Sault Area Hospital 3C MSSU and ONA Exhibit 7
8 ONA Book of Exhibits IAC Sault Area Hospital 3C MSSU and ONA Exhibit 8
9 ONA Book of Exhibits IAC Sault Area Hospital 3C MSSU and ONA Exhibit 9
for February 2015. ONA then referred the PRC to IAC and the proposed dates would be scheduled in early 2016.

The first of four multidisciplinary meetings were conducted related to a planning committee for the transition to the 20 bed MSSU – this committee will be called the “Short Stay Planning Committee” (SSPC) for the purposes of this report. The membership included three (3) ONA representative and an ONA PPS with experience in the LEAN methodology. The discussion began with identifying its current state.

A second meeting was held on February 25, 2015. A subgroup of the SSPC did a site tour of Windsor Regional Hospital’s SSU. The outcome of this site visit resulted in a document entitled, “Short Stay Unit.” March 20, 2015 a third meeting was then held with the SSPC to review documents like Service Agreements with various departments and key stakeholders. At this time, the MSSU draft Admission Criteria was developed. On April 1, 2015, the Manager, Clinical Supervisor and the Physician Medical Director of the Medical Program presented to the SAH Senior Leadership Team – “Short Stay Unit.”

The fourth and final meeting of the SSPC was held on April 7, 2015. It was identified that the presentation made to the Senior Team was shared and that the Service Agreements were approved in principle by Senior Management, however, the Manager was not able to advise when these Service Agreements would be signed.

A small working group within the SSPC met five times to further review the admission and exclusion criteria and to review the Standard Work of the various roles over the month of April 2015 to May 19, 2015.

May 12, 2015, the PCC role was eliminated and was replaced by the non-union Clinical Supervisor ultimately resulting in the net reduction of 1 RN from 0700-1500 hrs/day Monday to Friday. May 19, 2015 a meeting of the SSPC was cancelled by the Clinical Supervisor, however, a small working group met instead. At that time the Clinical Supervisor verbally agreed to advocate to Senior Management that the RN with Added Responsibility (AR) would not have a patient assignment.

In June of 2015, email exchanges occurred related to concerns expressed by the RNs on 3C to lack of communication, schedules, nurse: patient ratios, standards of work, AR responsibilities, work flow education and transition to the new processes, metrics, and how the multi-disciplinary team members would support patient care. On July 5, 2015, two staff meetings were held with no agenda and an unclear implementation time frame for this change.

On September 1, 2015 a memo from SAH Human Resources was sent to ONA indicating the 3C MSSU would change to a 20 bed MSSU and have up to 20 overflow beds for medical patients. A number of PRWRFs were filed since the transition to MSSU. ONA developed a document entitled, “What’s Working Well- MSSU, What’s Not Working Well –MSSU on October 7, 2015.”

\[10\] ONA Book of Exhibits IAC Sault Area Hospital 3C MSSU and ONA Exhibit 11
\[11\] ONA Book of Exhibits IAC Sault Area Hospital 3C MSSU and ONA Exhibit 12
\[12\] ONA Book of Exhibits IAC Sault Area Hospital 3C MSSU and ONA Exhibit 13
\[13\] ONA Book of Exhibits IAC Sault Area Hospital 3C MSSU and ONA Exhibit 15
\[14\] ONA Book of Exhibits IAC Sault Area Hospital 3C MSSU and ONA Exhibit 18
On October 14, 2015, a MSSU meeting occurred with members of the SSPC, Director, Manager, Clinical Supervisor and several Physicians where they shared the above document. A summary of the discussions were identified by “Start, Stop, Change and Keep” processes.\(^{15}\)

The MSSU RN Working group reconvened for one final meeting on November 28, 2015. At this time the Director of the Medical program proposed that the nurse patient ratio be 1:5 with the RN –AR not having a patient assignment. On December 8, 2015, the Clinical Supervisor emailed staff to indicate that hourly rounding is mandatory and non-negotiable.\(^{16}\)

The first 3C Unit Council was held on December 15, 2015 where the terms of reference were discussed and no minutes were made available. It was noted that the 3C MSSU RNs were not able to conduct hourly rounding, administer medications timely and documentation was often entered late. The 3C MSSU RNs performed several non-nursing duties and the RN staff morale was very low. A second 3C MSSU Unit Council meeting was held on January 13, 2016, third meeting was held on February 10, 2016 and then again on March 9, 2016.

On January 6, 2016, it was confirmed the IAC hearing would be held on April 4-6, 2016.

On March 8, 2016 the Manager of 3C MSSU sent an email communication to all staff that effective March 14, 2016 the 3C MSSU would increase by 10 beds by reallocating 10 overflow beds to 3C MSSU. The RN –AR would not have a patient assignment on the day shift and on the night shift the RN (AR) had a 1:5 nurse patient ratio. The RN staff would have a nurse patient ratio of 1:5 on days and nights. The RN –AR daily checklist was also shared.\(^{17}\)

Since the change to 3C MSSU on March 14, 2016 the staff continue to raise concerns regarding patient acuity, multiple calls to the Critical Care Resource Team (CCRT) and admissions to ICU. The RN-AR is seldom able to fulfill their assigned role. Other RNs are finding it challenging to care for a 1:5 nurse patient ratio and they feel it is unmanageable and unsafe. There are numerous violations to standard work expectations. Staff is challenged also to attend bullet rounds and daily huddles.

\(^{15}\) ONA Book of Exhibits IAC Sault Area Hospital 3C MSSU and ONA Exhibit 19

\(^{16}\) ONA Book of Exhibits IAC Sault Area Hospital 3C MSSU and ONA Exhibit 21

\(^{17}\) ONA Book of Exhibits IAC Sault Area Hospital 3C MSSU and ONA Exhibit 25
2.1.2 Events Following Referral of the Professional Responsibility Complaint

In January 2013, SAH and ONA met to review a change in the configuration of the Medical Program units, planned for implementation for early 2013:

<table>
<thead>
<tr>
<th></th>
<th>Prior to April 2013</th>
<th>By April 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical 1B</td>
<td>20 beds; medical/palliative</td>
<td>Closed as medical beds; subsequently used for temporary overflow for ALC patients waiting for Nursing Home placement</td>
</tr>
<tr>
<td>Medical 3B</td>
<td>30 beds; medical</td>
<td>40 beds; medical / palliative</td>
</tr>
<tr>
<td>Medical 3C</td>
<td>30 beds; medical / cardiac, stroke</td>
<td>40 beds; medical / cardiac, stroke</td>
</tr>
</tbody>
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In 2013 / 2014, ONA acknowledged that the work environment on 3B was stable, and PRWRF were not being received any further from that area. There was concern expressed by ONA that progress on some of the issues on 3C had not been made, but also acknowledged the efforts on 3C to resolve issues related to the patient acuity, staff skill mix, assignment / role conflict and use of the Three Factor Framework. Ongoing training occurred related to the Collaborative practise tools, a Unit Council was implemented and the group created documents such as “Patient Assignment Guidelines, and “3C Work Ethics” to address issues, and focus continued on patient flow and overcapacity processes. Fifty interim long term care beds were due to open in the community in the fall of 2014 which would assist with pressure related to overcapacity, so there was a commitment to wait for that initiative to occur.

In October 2014, SAH and ONA met to review the status of issues on 3C. ONA proposed a new approach of mediation with a third party, in order to avoid referral to IAC. SAH committed to this process and plans were made to proceed in February 2015. As indicated earlier, SAH undertook the exercise in November 2014 to reshape care delivery for patients and subsequently confirmed a plan to operate a Medical Short Stay Unit. After consultation with the proposed Mediator and in light of the significant changes planned to the department, a decision was made not to proceed with mediation. While the mediation process proposed would have been beneficial to resolve outstanding issues had Medical 3C remained as is (staffing model and number of beds), the proposed process did not support an interdisciplinary approach that was required in making significant changes to this work environment. Using the LEAN principles to guide the work, an interdisciplinary team was identified to participate in the planning, including registered nurses, clerks, allied health professionals, physicians, CCAC representative, case reviewer, Diagnostic Imaging, Lab representatives, and Patient Advisors. In respect of the ongoing efforts between SAH and ONA to resolve issues, SAH agreed to invite ONA to the planning table to participate with the team.

There was a delay in implementing the changes to a Medical Short Stay unit on 3C due to the delayed opening of the community interim LTC beds and subsequent continued increased patient volume at SAH. Finally, on September 1, 2015, despite ongoing challenges with the inpatient volume, the 20 beds on 3C for operation under the Medical Short Stay Model were identified and the unit began operations with the RN staffing model and interdisciplinary team.

There have been challenges with operations of the unit, the majority of which relate to the full implementation of the physician model, staffing, and continued overcapacity at SAH.
• Physician model – initially, patients under the care of a Family Physician were not admitted to 3C as the physicians were not active participants in the model; a trial was initiated on Feb 19, 2016 to include Family Physicians into the care model. As a result of the additional patients expected to be admitted to the MSSU with the inclusion of this Physician group, the number of beds on 3C dedicated to MSSU has now increased to 30 on March 14, 2016 and will remain as such for the coming year.

• Staffing (number and role of staff) – within the available resources of the unit, a staffing model of all RN staff with 4 patients was trialed initially on day shift, including an AR with a patient assignment. This became a barrier to the AR being able to perform the accountabilities within the MSSU processes. A trial was initiated on March 14, 2016 to modify the assignment so that the AR does not have a patient assignment (and can focus on key accountabilities) while the remaining staff are accountable for 5 patients each.

• While the inpatient census has been reducing over time, SAH continues to experience some overcapacity, with overflow patients in medical beds (3B, and overflow co-located on 3C) and in ED

Notwithstanding the efforts and process initiatives undertaken since referral of the PRC to the IAC on December 9, 2015, the Hearing was to proceed on February 2-4, 2016 and needed to change and proceeded as scheduled on April 4-6, 2016.

2.2 Ontario Nurses’ Association and Sault Area Hospital Perspectives

The Hearing was structured such that:

• On April 4, 2016 the Association and the Hospital each provided an oral Submission presentation highlighting the key elements of their previously submitted written Brief.

• On April 5, 2016 the Hospital and the Association each provided an oral Response presentation, which included an opportunity for each party to clarify / discuss / challenge / question/rebut the information provided by the other.

• On April 6, 2016, the IAC posed a number of questions to both parties to obtain a more comprehensive understanding of the issues. All staff in attendance was given the opportunity to share their concerns, make statements and provide us with their own testimonials related to 3C MSSU.

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

2.2.1 Ontario Nurses’ Association

Accountability of RNs

The CNO Professional Standards states that RNs are accountable to advocate on behalf of their clients, to provide, facilitate, advocate for and promote the best possible outcomes for clients, to seek

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assistance in a timely manner, and to take action in situations where client safety and well-being is compromised. The RNs on 3C MSSU are meeting their CNO accountabilities by notifying their leaders of their care and practice concerns through documenting on PRWRFs.

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

Concerns regarding Process of Change to the Total Patient Care with RN Staffing Supported by a Collaborative Team of Dedicated Physicians and Allied Health

The Association believes that the change processes supporting the transition to a total patient care with RN Staffing model supported by a collaborative team of dedicated Physicians and Allied Health on 3C MSSU were inadequate to support the change, and thus negatively contributing to the current workload concerns.

Professional Responsibility Workload Report Forms

From January 1, 2015 – August 2015 the 3C Medical Unit consisting of 40 beds had 33 PRC forms submitted. From September 1, 2015 to current date 60 PRC’s have been submitted.

The key issues identified on the PRWRFs relate to:

- **Nursing Staffing Levels**: Insufficient base staffing levels for RNs result in nurse : patient ratios that are unsafe, unmanaged and dangerous. The collaborative and consultative RN-AR resource and Clinical Supervisor role is insufficient for RNs to work effectively, which is complicated by ongoing concerns regarding role ambiguity, responsibilities, accountabilities and role clarity. The RN –AR is having difficulty being a leader and resource to the rest of the nursing team. The RN-AR is also experiencing difficulty in assuming all admissions, discharges and transfers and managing patient flow on 3C MSSU. The lack of dedicated Educator resources results in lack of sufficient knowledge, skill and judgment and/or lack of evaluation of ongoing competencies for cardiac/telemetry patients, peritoneal dialysis and respiratory issues. There is an inability for the nurses to take meal and/or rest breaks resulting in an increased nurse fatigue and an increased risk of potential errors in the provision of patient care.

- **Model of Care Delivery**: Increasing pressure on the front line staff to implement a decreased patient length of stay and rapid patient turnover without proper processes/supports in place including allied health. There is a high level of patient activity on the unit with admissions, discharges and transfers. There is also a high level of patient acuity and complexity. GIMU locums are unfamiliar with MSSU workflow and processes.

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19 SAH Submission March 21, 2016 p. 10
• **Patient Factors:** The high level of patient acuity and complexity of 3C MSSU patient care needs, frequent changes in patient condition and high turnover of patients result in the utilization of the CCRT. With the implementation of Standard Work and Hourly Rounding, it is challenging for staff to meet patient needs consistently and comprehensively.

• **Gaps in continuity and consistency of Patient care:** Frequent interruptions, the need to assist colleagues with care provision, and the need to perform a range of non-nursing duties resulted in competing patient priorities. In tandem with Standard Work and Hourly Rounding, there were delays in medication administration, documentation, provision of patient care and patient assessments based on changes in patient’s condition.

• **Documentation:** Nurses are not able to document at point of care and in a timely manner in accordance with the Hospital Policy and the CNO standards due to the need to provide patient care based on acuity and complexity.

• **Medication administration:** Nurses are unable to complete medication administration in a timely manner in accordance with Hospital policy, CNO standards and experience many interruptions resulting in the potential for errors and delays as evidenced by the PRWRF reports.

• **Practice Environment:** Non-nursing duties are significant on 3C MSSU and relate to phone calls during evening and night shifts, stocking of supplies and linens, housekeeping responsibilities, processing Physician orders in the absence of the Unit Assistant.

**Analysis and Recommendations**

The Association identified 31 recommendations related to staffing, model of care/nursing workload, CNO standards and guidelines, SAH Policies, nursing leadership and the PRC process, application of the SAH Mission, Vision and iCare values, the *Excellent Care for All Act*. Key issues identified included the following:

**RN Staffing Levels:**

• The CNO 3 Factor Framework is intended to assist nurses and employers to make effective decisions regarding the required staff skill mix and daily patient assignment. A key element of the 3 Factor Framework is the ability of care providers to consult and collaborate with other members of the care team in situations where client safety is at risk. The current staff to patient ratio does not enable RNs to effectively collaborate as required by the 3 Factor Framework. This issue can be exacerbated by the number of Float Pool nurses, students and new staff on the unit, who are unfamiliar with the patients, the unit routines and the model of care.

**Model of Care/Nursing Workload:**

• The model of care adopted on 3C MSSU is Total Patient Care with RN staffing supported by a collaborative team of dedicated Physicians and allied health.

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20 ONA Book of Submissions IAC Sault Area Hospital 3C MSSU and ONA Exhibit 1 p. 69-91 and the ONA presentation April 4, 2016

21 SAH submission March 21, 2016 p. 10
The Hourly Rounding process requires RNs to rely on scripts, rather than critical thinking. Although RNs are present at the bedside, Hourly Rounding has eliminated the RNs of their ability to use professional judgement and their ability to prioritize, plan, individualize, implement and evaluate patient care needs. This has resulted in a potential for poor patient outcomes and lower patient and nurse satisfaction.

- Increased RN workload associated with the impacted RN morale, resulting in the RNs feeling burned out, stressed and overwhelmed by their work.
- Interruptions and fragmentation of care have been exacerbated, rather than lessened, by the Hourly Rounding. Lack of clarity regarding role responsibilities between the Clinical Manager and Clinical Supervisor has created blurred accountability related to reporting.

**CNO Standards and Practice Guidelines and SAH Policies:**
- The RNs are unable to meet their CNO Standards and Practice Guidelines and SAH Policies

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

**PRC Process**
- Resolutions are not timely to address nursing practice/workload/safety culture
- There is inconsistent or lack of required meetings with affected nurses by Manager or Supervisor within 10 calendar days
- There is an inconsistent written response from the Manager or Clinical Supervisor within the 10 calendar days.
- There is a blaming culture exhibited by the Director/Manager/Clinical Supervisor responses on PRWRFs and at HAC meetings

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

**Summary**

Patient care is enhanced when concerns relating to patient acuity, roles and responsibilities, and workload are addressed. The Association believes that while there have been, and continue to be, significant challenges associated with the implementation of the 3C MSSU care model, the key issue relates to the inadequate level of base staffing within the model. In addition, the support of the RNs, in terms of respect for their concerns and opportunities to provide quality and safe patient care has been insufficient. The Association is hopeful that with the development and fostering of a healthy practice environment, positive traction and momentum can be achieved.
2.2.2 Sault Area Hospital

Context of Discussion at the IAC

SAH remains committed to the operation of a Medical Short Stay unit. Despite challenges along the way, the operation of the unit has shown to have positive impact on patient flow and the patient experience.

Patient flow

Generally, the metrics reflective of effective patient flow have shown improvement on 3C:

- The number of ALC days is significantly reduced
- The percent of patients discharged within 72 hours from arrival to 3C is improving and currently at 70%
- The average length of stay has improved and conservative days have similarly been reduced
- The time to bed from ED showed some improvement initially, however the time has trended upward in recent months; this is most related to continued overcapacity at SAH and the number of beds available (20 beds)

Patient experience / outcomes

- Patient satisfaction (% Excellent), as measured by NRC (National Research Corporation Canada) Picker, has shown an increase as of September 2015. There have been enough submissions to provide results to SAH for the period of October – December, however it should be noted that responses will continue to be collected until the formal close which is June 2016. SAH also uses discharge phone calls to assess the patient experience; the calls were re-launched in January 2016 and results for that period indicate that of 19 calls made that month, 84% of patients identified the experience as either Very Good (16%) or Excellent (68%). The patients had most positive comments about nurses and physicians, and explanations regarding tests and medications.
- The number of reported falls is trending downward
- The number of reported medication errors is trending downward
- The pattern of incidences of Hospital acquired infection is unchanged. SAH has experienced a spike in the number of cases of C-diff; an analysis of the cases by SAH Infection and Prevention Control Physician has shown relation to antibiotic use and no relationship to transmission.

The planning and ongoing evaluation of this initiative has brought administrative and medical leaders, staff, physicians and the interdisciplinary team together in a positive and collaborative manner. SAH is committed to continued focus on the following:

- Recruitment of remaining RN staff for 3C MSSU
- Confirming commitment of all physician groups to the MSSU model as planned
- Complete trials regarding staff assignment, to confirm the most effective approach:
  - #1 – nurse-patient ratio 1:4, AR with patient assignment (complete)
  - #2 – nurse-patient ratio 1:5, AR with no patient assignment (in progress)
  - #3 – consider movement of staff between nights and days

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21 SAH IAC Submission March 21, 2016
• Improving efficiency of daily rounds at 0815 (Discharge) and 1400 hrs (Clinical)
• Ensuring consistent use of AIDET / key words by staff and physicians
• Ensuring consistent use of patient white boards in patient rooms
• Improving team work and relationships among staff, and between staff and leaders through:
  o providing education for all staff regarding our ICcare way (eg. ICcare conversations),
  assisting all to have crucial conversations with peers and physicians
  o providing consistent increased leadership presence
  o improved communication
• Improved communication with staff, physicians and key stakeholders regarding the functioning of the unit, and corporate / department metrics related to its operation
• Continuing to support the work of the Unit Council to evaluate progression of action items related to identified issues on the unit
• Implement a process to identify an Expected Date of Discharge (EDD) a Plan of Care trial (physician and nurse assess the patient at the bedside, identify EDD, treatment plan and evaluate ongoing).

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

Initiatives to Support Implementation of the 3C MSSU

The introduction of an all RN staff on 3C MSSU

SAH PROCESS IMPROVEMENT INITIATIVES

LEAN / staff involvement in planning:
  o creation of an interdisciplinary team to plan the operations of the MSSU prior to implementation, and evaluate the progress (includes staff, physicians, patients); the ongoing evaluation of changes in the department has been transitioned away from the initial planning team and is now the accountability of a more fulsome Unit Council
  o Medical leaders, including Medical Director and Chiefs of Hospitalist, Internal Medicine, and Family Practice are engaged in discussions and participate on a regular basis in evaluation with program leaders and staff
  o Unit council has been re-introduced in January 2016; there have been 3 meetings with new members thus far, and the group has addressed such things as a trial of extended ward clerk hours on weekends, strategies for better preparation of patients for discharge by 1100 hrs daily, and identification of metrics for the unit.
  o Assignment of a staff member to 3C, on February 1, for 4 months, who is certified in LEAN (Yellow Belt Certified), to assist the Leaders and staff with changes;
  o Review and refresh of MSSU processes due to the increased bed numbers and staff assignment change (eg. Standard work, Service agreements); review of relevant information occurs at daily huddles, so staff can give feedback
  o Review role / responsibility of AR (reviewed with staff for feedback at huddles), drafted work routine and checklist to trial daily
Investment in equipment:
- Over bed lifts – 26 of 30 MSSU beds have an over bed lift
- Purchase of walkers, rollators, thermometers
- Centralizing and assignment of IV pumps to all units, to improve access when required
- 2 portable “air mattresses” for patients for Medical Program use only
- Additional tower added to Accudose machine to increase capacity for medications
- Increase in number of computers on unit (3 new), for ease of access by staff, allied health and physicians
- iPad trial; unfortunately was not successful due to software issues with Meditech
- Ongoing review of quotas for supply rooms and linen

Other:
- Electronic Tracking board implemented (track patients waiting in ED for MSSU, in real time); this alerts the 3C staff to patients waiting for admission at any given time

Communication improvements:
- Communication survey was sent to all staff in February 2016 for input (12 responses); staff appreciates all the clinical tools (rounds, patient care discussions, information in chart and EMR) but also identified need for more consistent information regarding the functioning of the unit itself. Staff also identified that word of mouth is relied on too much and this causes misinformation
- Tools (Bullet Rounds Guide, Discharge Algorithm) have been developed to support discharge rounds flow and preparation for discharge, and posted
- Daily huddles resumed at 1500 hrs daily; the huddle board was updated and a log of discussion was started (binder kept on unit with huddle board) so that those not present can follow the discussion.
- Weekly email updates were initiated in March, to provide updates to staff on progress of items raised at huddles
- Metric board posted in multi-disciplinary room; includes reports and instructions regarding how to read some of the reports
- Unit council bulletin board is in place and contains previous minutes and an opportunity to add items for upcoming agenda
- Orientation package prepared for new physicians (Family Practice) on MSSU

Corporate initiatives related to patient flow:
- The Director of Transformation is leading a Patient Centered Flow Project until July 2016, in order to standardize the approach and reduce the overcapacity issues at SAH. Currently, 4 projects are underway: (a) Right Patient, Right bed, (b) Discharge Package, (c) Discharge Standard Work by Role, and (d) Role clarity for patient flow; staff representatives, including an RN from 3C and others from the medical program are involved in these projects
- Implementation of the Emergency Department Internal Medicine Consult Service, whereby an IM physician reviews all patients identified for admission to confirm, or create a discharge plan with support of outpatient and community services
Implementation of a Medical Follow up clinic, to provide timely follow up for patients from ED who might otherwise be admitted, and early follow up for those discharged from the medical units
- Creation of care pathways to support best evidence care for patient with identified CMGs (eg. CHF, COPD, Stroke)
- Implementation of an electronic order set database for physicians

Summary

The history of change on 3C MSSU requires the implementation of robust change management strategies and support.

The Hospital confirmed their change management model in September of 2015 with education led by the Hay Group. The model closely aligns with both the Kotter model and ADKAR model for change management. Although this change management model is in place, there is a lack of evidence to support whether or not this model was used to help prepare the 3C MSSU staff to prepare for the changes on this unit.

The Hospital is committed to working towards achieving a workplace with an appropriate and reasonable workload for all staff, with a highly-functioning team, amid good inter-personal relationships.

24 SAH submission on April 5, 2016 iCare Way (Change Management/Lean/Studer)
SECTION III

DISCUSSION AND ANALYSIS

3.1 Introduction

The IAC believes that the Panel has developed a comprehensive understanding of the professional responsibility concerns of the RNs working on 3C MSSU at the Sault Area Hospital. This understanding was achieved through:

• review and analysis of the written submissions, exhibits, oral presentations and discussions at the IAC Hearing held April 4-6, 2016;
• review of information provided by the Hospital and the Association during the IAC Hearing;
• review of literature available in the public domain regarding models of nursing care and the practice of Medical nursing, and;
• the IAC Panel’s collective practice experience, knowledge and expertise with similar professional practice issues.

3.2 Factors Impacting the Practice Environment

Discussion of professional responsibility within a Medical Short Stay Unit (MSSU) setting such as 3C must be considered within the context of the practice environment. The IAC’s analysis and recommendations are based on assumptions regarding:

• Sault Area Hospital Overview,
• Health Based Allocation Model (HBAM) funding,
• 3C MSSU geographical configuration,
• 3C MSSU patient population,
• 3C MSSU staffing resources,
• Nursing standards of practice, and
• Healthy work environments.

3.2.1 Sault Area Hospital Overview

Sault Area Hospital is a community Hospital currently consisting of 293 patient beds. Sault Area Hospital moved into a new location on March 6, 2011, replacing two separate facilities – General and Plummer. Prior to the move, the Medical Program was located in the General Site. The Medical Program consisted of three medical units: 2A Stroke Unit, 2Y Acute Medicine Unit and 3Y Assess and Restore Unit.

The new site is 20% larger than the old hospitals combined. The SAH operates with an annual operating budget of 171 million dollars. SAH provides primary, secondary and tertiary hospital services, serving a total catchment population of approximately 120,000 across the Algoma District.

On average, SAH encounters the following patient activity per month:

• 876 admissions into the hospital
• 872 discharges from hospital
• 58% (481 patients) of the hospital admissions come through the Emergency Department, with the next largest groups coming directly to the Maternal Child Program (18%), or Surgical Program (14%)
• Of those that come through the Emergency Department for admission, 55% or 265 patients require admission to a Medical Unit

3.2.2 SAH Operational and Capital Funding Overview

SAH has experienced a number of years of financial deficits; in the 2010/11 fiscal year, the Hospital ended the year with a working capital deficit of $76.2 million and a deficit in operations of $10.5 million. The Hospital conducted an extensive review in 2009 of current and planned operations for the new hospital and submitted a Hospital Improvement Plan (HIP) to the Northeast Local Health Integration Network (NLHIN) due to ongoing financial deficits. As well, SAH was the subject of a Peer Review in 2010/11 in order to confirm readiness to operate a new facility and the feasibility of the HIP recommendations.

Key recommendations made in both reviews that were relevant to the Medical Program included focus on:

- Expectation to operate at the 25 percentile
- reducing Sick time and Overtime costs
- reducing medical surgical supply costs
- reorganizing resources related to Patient flow
- reducing operation of beds through reduction of ALC and conservable days
- changing the culture including addressing lack of accountability at all levels, resistance to change and conflict avoidance

With the move to the new facility and focus on improvement and operating plans, the financial position of the Hospital improved over the subsequent years, compliant with expectations of the NLHIN and MOHLTC to achieve a balanced position. As the result of achieving a balanced position annually, the Hospital was provided with $14.8 million dollars in each of 3 years to address the working capital deficit. The expectation remains that the Hospital continues to achieve a surplus at year end in order to extinguish the remaining debt by 2026. If that does not occur, the Hospital may be required to return the total $44 million dollars provided for this purpose.

As the healthcare environment continues to change, there is an ongoing need for SAH to operate as efficiently as possible in the face of Health System Funding Reform. The financial pressures are driven by items such as:

- legislative requirement and a condition of Working Capital Relief funding to balance
- zero funding increase from MOHLTC for a number of years
- incremental compensation increases
- complexities of Health System Funding Reform (HBAM and QBP)

Based on these pressures, the financial shortfall identified in anticipation of the 2015/16 fiscal year was $10 million dollars. The Hospital undertook an initiative to reshape care delivery in order to provide quality care with less need for patients to be admitted or remain in a hospital bed rather than cut or

25 SAH Submission to IAC March 21, 2016 p. 9
eliminate services. It was through this process that investments for patient care were made in outpatient services (Medical Outpatient Clinic, Mental Health), utilization resources (improve patient flow to minimize unnecessary time spent in hospital), and creation of the Medical Short Stay Unit.

3.2.3 3C Geographical Configuration

SAH MEDICAL PROGRAM

The Medical Program, in its current state, provides the following services to adult patients of SAH:

- Medical Inpatient Units
  - 3B Medical Unit (40 beds)
  - 3C Medical Short Stay Unit (30 beds, as of March 14, 2016)
  - Medical Overflow (10 beds)
- District Stroke Program (includes inpatient care, Stroke Prevention and Stroke Clinic)
- Hospitalist Program and Nurse Practitioner inpatient services

3C Medical Unit

3C MSSU is currently located on the third floor of the Hospital, in the C wing; 30 beds have been designated for use by the MSSU. An additional 10 overflow beds are physically located within this wing. The beds are designated as Medical Overflow, and used when the capacity on inpatient units is exceeded and admitted patients remain in the Emergency Department. For the purposes of staffing, the beds are staffed with part time 3C staff and Float Pool RN and RPN staff, based on patient volume and acuity.

- 30 beds are staffed and in operation
- As a Short Stay unit, the unit is designed to move patients from ED in an expedited manner, providing rapid assessment, diagnostic testing and treatment, in order to facilitate discharge within 72 hours
- Designated as an isolation unit (has 6 isolation rooms and a satellite work station are for use in an outbreak)
- Model of Care: Total Patient Care with RN staffing supported by a collaborative team of dedicated physicians and allied health

3.2.4 3C MSSU Patient Population

- Provides care for patients with general medical diagnosis including those with cardiac, stroke, and peritoneal dialysis needs; the unit is designated for telemetry monitoring of medical patients who do not require the intensity of care provided in a Level 2 Intensive Care unit
- Designated as an isolation unit (has 6 isolation rooms and a satellite work station are for use in an outbreak)
- Model of Care: Total Patient Care with RN staffing supported by a collaborative team of dedicated physicians and allied health
3.2.5 Nursing Standards of Practice

The *Canadian Association of Medical and Surgical Nurses National Practice Standards (2008)* describe in detail the guiding beliefs and national practice standards based on core principles of nursing practice and were developed to encompass and support the uniqueness of medical-surgical nursing. They support the full scope of nursing practice and are applicable to all medical-surgical nurses as they move through their careers from novice to expert and in any of the nursing domains of practice.

Medical-surgical nursing is unique in that it is not limited to a disease or a body system but is holistic in nature and requires nurses to possess and maintain comprehensive and diverse knowledge and competencies. It is this generalist knowledge base that makes medical-surgical nursing the ideal place for foundational learning novice nurses. However, medical-surgical nursing is also the foundation for health care. The majority of clients in any health care system in Canada will receive care in a medical-surgical environment. As such medical surgical practice requires expert nurses that are leaders in practice, administration, research and education.

3.3 Analysis and Discussion

3.3.1 Introduction

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

The IAC believes as a result of their analysis there must be focused attention on the 3C MSSU Model of Care, its geographical configuration and patient demographics.

Secondly the IAC deems there must also be a focus on clinical leadership practices and quality nursing work life.

The IAC is confident that given the opportunity to openly express concerns and perspectives during the hearing, together with the external objective analysis and associated recommendations will assist both the SAH leadership team and the RNs to jointly commit to finding a common ground. This would allow both parties to move forward in resolving issues in the best interest of quality, safe patient care and a quality work environment.

In a Joint Position Statement *Practice Environments: Maximizing Client, Nurse and System Outcomes*, the Canadian Nurses’ Association (CNA) and Canadian Federation of Nurses Unions (CFNU) believe that

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26 The Canadian Association of Medical and Surgical Nurses National Practice Standards (2008). https://www.google.ca/#q=canadian+association+of+medical+surgical+nurses
quality practice environments maximize outcomes for clients, nurses and systems. They state that quality practice environments demonstrate seven sentinel characteristics:

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

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

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

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

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

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

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

It is the opinion of the IAC that these seven (7) fundamental characteristics are present but deficient in varying degrees on 3C MSSU and require a significant improvement based on the declarations shared during the IAC hearing April 4-6, 2016.

The IAC has developed its analysis and recommendations on the following key areas:

1. 3C MSSU Nursing Leadership and Governance Structure
2. 3C MSSU Nursing Care Delivery Model and Staffing
3. 3C MSSU Nursing Practice and Unit Processes

If appropriate commitment and actions are implemented within each of these key areas, the IAC believes that this will ultimately assist 3C MSSU to become a quality practice environment reflecting the seven sentinel characteristics as outlined above.

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28 Ibid
3.3.2 Leadership and Governance

The Registered Nurses Association of Ontario (RNAO) Best Practice Guideline *Developing and Sustaining Nursing Leadership* identifies five evidence-based transformational leadership practices which are fundamental for transforming nurses’ work settings into healthy work environments. These transformational practices, which apply to all roles and levels of leadership, including nurses providing direct care are\(^29\): 

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

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

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

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

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

The IAC believes that these transformational practices must be incorporated into the operational, clinical and point-of-care leadership positions including the Clinical Manager, Clinical Supervisors and RN (AR)s on 3C MSSU.

**Recommendations:**

1. A quality practice setting requires effective operational, clinical and point-of-care leadership.
2. The 3C MSSU Leadership team develop a strategy to implement the Registered Nurses Association of Ontario (RNAO) Best Practice Guideline Developing and Sustaining Nursing Leadership on 3C MSSU.
3. The Registered Nurses Association of Ontario (RNAO) Best Practice Guideline Developing and Sustaining Nursing Leadership becomes the framework utilized for leadership development for all 3C MSSU RNs.

3.3.2.1 Operational Leadership

3C MSSU’s operational leadership consists of a Director, Manager and Clinical Supervisor role. The Director of the Medical Program is a Registered Nurse and assumed responsibility for 3C in September 2012. At the same time the Clinical Manager also a Registered Nurse became the Manager of 3C. On

\(^{29}\)RNAO Healthy Work Environments: International Affairs and Best Practice Guideline *Developing and Sustaining Nursing Leadership*, 2\(^{nd}\) edition, 2013, pg 17
February 9, 2015, the Clinical Manager forwarded an email to the 3C staff announcing that he would be the Manager of both 3B and 3C and simultaneously informed the staff there would be the role of a Supervisor transitioning from 1B to 3C in this capacity.

The organizational structure of the Medical Program leadership team includes oversight by the Director of Clinical Programs, in conjunction with the Medical Director, a Patient Care Manager and Patient Care Supervisors. The leaders also work collaboratively with the Chiefs of Hospitalists, Family Practice and Internal Medicine.

In March 2015, SAH communicated a plan to revise the leadership structure, reducing the number of clinical Directors and Managers and increasing the number of front line Supervisors over a 12 month period. The change was in response to input from staff who desired better access to leadership in the work environment, including on more shifts of the day. The impact of this change in direction resulted in the decrease of one Patient Care Manager and the addition of four Patient Care Supervisors to the Medical Program. The first three supervisors were in place by June 2015 and the fourth supervisor has been hired this month, which completes the Medical Program leadership team.

Reporting to the Vice President, the Director of Clinical Programs provides vision, direction, leadership, support and guidance for the delivery of high quality, patient focused care within the program. The Medical Director provides medical leadership to the Chiefs, and works with the Clinical Director to provide oversight for operations and the delivery of care.

The Patient Care Manager is accountable for the daily operations of the department including management of human, financial and material resources, to ensure that quality of care is provided, the work environment is safe for all, and that the needs of the hospital and the patient are met.
The Patient Care Supervisor is accountable for the daily supervision of staff, ensuring that operational plans are observed, safety is maintained, and quality care is provided to the patients. The Supervisor is often the first point of contact for staff.

There are currently 23 full time registered nurses who rotate on a cyclic master of twelve hour day (1700-1900) and night (1900-0700) shifts. There are currently 10 part time registered nurses. With the recent addition of beds to the department (30 beds as of March 14, 2016), an additional 3 full time and 3 part-time RN staff are being recruited.

The IAC firmly believes that operational leadership of an inpatient unit like 3C MSSU with the volume and enormity of concerns expressed throughout the IAC hearings, submissions, presentations and testimonials from staff requires fundamental core nursing practice leadership competencies as articulated in the Registered Nurses Association of Ontario (RNAO) Best Practice Guideline Developing and Sustaining Nursing Leadership.30

3.3.2.2 Clinical Leadership

3.3.2.2.1 Clinical Manager Role

Simultaneously a greater presence of the Clinical Manager on the unit to be available to staff is also a key priority. The Clinical Manager must be able to focus attention on the issues that have been identified in the PRC and by staff to ensure quality and safe patient care as well as improving the quality of work life for staff on 3C MSSU. An important element to clinical leadership is to be able to actively engage with staff and to develop trusting collegial relationships to ensure staff is able to meet their professional standards. This requires a committed daily presence of the Clinical Manager to address issues, make informed decisions, problem solving and risk mitigation to ensure standards are met, adhered to and to facilitate effective change management strategies. 3C MSSU has undergone significant changes since September 2015 and requires consistent, dedicated clinical leadership to support staff.

Through staff testimonials the IAC heard that the Clinical Supervisor has a greater presence on the unit than the Clinical Manager and Director. Although the Clinical Supervisors are helpful, they are new to their roles and may not have the depth and breadth of clinical experience and expertise required to fully support the staff. Staff clearly indicated they wanted a greater presence of their Clinical Manager and Director of the Medical Program in order to clearly understand the ongoing issues and challenges staff are dealing with and the impact these decisions are impacting the staff and patient care.

Span of control for Clinical Managers is replete with evidence in the nursing literature. The role of the frontline Clinical Manager in healthcare has undergone significant changes in the past decade resulting in expanded role responsibilities including the supervision of staff across multiple units.31 Span of control has been defined as the number of people who are supervised by a manager. However, span of control is much more involved than just the number of direct reports. Meyer’s (2008) concept analysis of span of control includes:

- Number of employees per manager

30 RNAO Healthy Work Environments: International Affairs and Best Practice Guideline Developing and Sustaining Nursing Leadership, 2nd ed., 2013, pg. 17
• Degree of manager and staff interaction
• Manager role breadth and complexity
• The number and size of work groups under a manager’s authority
• And the availability of other managerial supports (educators, clinical specialists)32

The IAC recognizes that the Manager’s current portfolio, of two (2) units (combined bed total of 70 beds) and a District Stroke Program seems to be common practice in the acute care sector for front-line manager positions. However, given the vast amount and complexity of changes to 3C MSSU, the need for the Clinical Manager to be readily available to staff daily and manage the changes, the IAC recommends that effective immediately, the Clinical Manager must be completely dedicated to 3C MSSU for a minimum of six (6) months to evaluate the degree of change related to patient care, demographics, patient flow and staff issues that have arisen based on the recent changes implemented on March 14, 2016.

Recommendations:

4. **The 3C MSSU Clinical Manager must be responsible for 3C MSSU only, on a 1.0 FTE basis, for a minimum of a six-month period.**

5. **The Clinical Manager must be provided with the resources of a formalized leadership coach/mentor to foster professional leadership growth and development. The Clinical Manager will then be the coach/mentor to the Clinical Supervisors and the RN (AR)s.**

3.3.2.2.2 Clinical Supervisor Role

The SAH leadership model was implemented in September 2104. The major changes that occurred were the addition of several non-union Patient Care Supervisor positions and the elimination of the unionized patient care coordinators role. The leader standard work and job descriptions of the Clinical Manager and Patient Care Supervisor (PCS) roles were provided to the IAC. There are four (4) PCS for the medicine units (3C and 3B) with the fourth position just recently being filled.

In reviewing these job descriptions, listening to the staff and during the unit tour, it was clearly evident there was a lack of clarity related to these two roles.

**Clinical Supervisor Role Clarity**

The Clinical Supervisor (CS) is responsible for the supervision of the daily activities of 3C and 3B to ensure safe, high quality patient focused care is being provided. The CS provides supervisory, technical and clinical support to the staff. CS’s are responsible to develop work plans and develop productive work teams. The supervisor is the point of contact for the 3C MSSU staff. This makes it challenging for staff to clearly understand who they are accountable to – the CS or CM.

During the hearing it became evident to the IAC that there was role confusion between the Clinical Manager and Clinical supervisor role with the frontline staff. The staff was unclear as to who and how to escalate their concerns and daily work flow challenges.

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**Recommendations:**

6. **Dedicate two Clinical Supervisors to 3C MSSU for a minimum of a 6-month period during the hours of 0700-1500 and 1500-2300.**

7. **Develop and sustain the RNAO Best Practice Guideline Developing and Sustaining Nursing Leadership on 3C.**

8. **The patient assignment is completed by the RN (AR) using the College of Nurses of Ontario’s RN and RPN Practice: The Client, the Nurse and the Environment**

9. **The RN (AR) is responsible for all admissions to the unit and will go to ER for a complete report.**

10. **The 3C MSSU admission criteria must be reviewed by the ED leadership team to ensure there are appropriate and timely admissions to 3C MSSU.**

11. **The RN (AR) is empowered to call in additional staff based on her/his judgement of the unit activities/ acuity. If appropriate notify the Clinical Supervisor of this decision. This decision should not be questioned by the staffing office.**

3.3.2.2.3 RN Additional Responsibility (AR) Role

The 3C MSSU works within a total patient care model. There is a commitment to maintain continuity and consistency of the RN’s assignment during his/her tour of duty. Continuity of care has two elements; ‘care over time (past, present, future) and a focus on the individual patient’s health needs and personal context.

The Added Responsibility (AR) RN of the MSSU aides in this continuum by ensuring all admissions are complete, per standard work. It is also her/his responsibility to determine if the patient is suitable for admission to the unit, as it is her/his responsibility to receive report of all admissions. It became clear through the hearing nurses have disagreed with the appropriateness, but the patient would be admitted anyway. There does not appear to be a clear understanding of the admission criteria from the emergency department (ED) perspective.

The RN AR on 3C MSSU is responsible for several duties within the MSSU, his/her main duty is that of patient flow. The RN AR is provided a checklist by the hospital, to guide his/her through the day’s activities. They need to be aware of all the patients on the unit as well as their needs. In keeping with the primary care model it is important to be aware of nursing assignments. As the AR has no patient assignments she/he is able to provide the most appropriate and fair assignments to the remainder of the nurses. As he/she is a resource for the nursing staff, he/she aides in providing standards of care of the CNO, hospital, RHPA and other policies of the institution.

The Clinical Supervisor as well as the RN (AR) is responsible for the completion of the following day’s patient assignments. With a permanent RN (AR) in place, she/he is acutely aware of the acuity and

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33 College of Nurses of Ontario, *RN and RPN practice: The Client, the Nurse and the Environment* Pub. No. 41062

34 Registered Nurse Roles that facilitate continuity of care, September 2008, College and Association of Registered Nurses of Alberta

35 ONA Submission Exhibit 29
complexity and the geographical area of the patients based on report from off going AR or based on being there the previous day/night.

The RN (AR) has the overall accountability and responsibility of knowing the status of all the patients on 3C MSSU. As the RN(AR) he/she has the simultaneous responsibility of functioning as a resource to the nursing staff by ensuring nursing standards of practice, hospital policies and procedures are both interpreted and implemented correctly.

**Recommendations:**

12. The patient assignment is completed by the RN (AR) using the College of Nurses of Ontario’s RN and RPN Practice: The Client, the Nurse and the Environment Guideline.  
13. The RN (AR) is responsible for all admissions to 3C MSSU and will be responsible for obtaining a complete patient report from the ED nurse.  
14. The 3C MSSU admission criteria must be reviewed by the ED leadership team to ensure there are appropriate and timely admissions to 3C MSSU.  
15. The RN (AR) is empowered to call in additional staff based on her/his judgement of the unit activities/acuity. If appropriate notify the Clinical Supervisor of this decision. This decision should not be questioned by the staffing office.  
16. The IAC recommends the Hospital post four (4) permanent FTE RN (AR) positions with four relief RN (AR) positions for 3C MSSU which will cover 24 hrs/day 7 days/week.  
17. The RN (AR) positions will be posted as per the ONA collective agreement and to be posted immediately  
18. The RN(AR) on the 0700-1900 hr shift will NOT have a patient assignment  
19. The RN (AR) on the 1900-0700 hr shift will have a three (3) patient assignment – these patients should be those that are to be discharged within twenty-four hours and non-telemetry patients (please refer to the 3C MSSU Reconfiguration Model).

3.3.2.2.4 Educator Role

Continuing education supports the professional practice of nursing and the delivery of safe, evidence-based, high quality care of patients. The nurse educator plays a critical role in facilitating professional development needs of the nurses.

The CNO (2009) defines a learner as a person studying nursing, new nurse, an experienced nurse entering a new practice setting or a new health discipline. The Professional Standards (2002), states all nurses are expected to provide direction, collaborate and share knowledge and expertise with nurses working in new environments and nursing learners. Nurses who support learners should be available to the learner for assistance or consultation with assigned activities, advocate for an appropriate

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36 College of Nurses of Ontario, RN and RPN practice: The Client, the Nurse and the Environment Pub. No. 41062  
37 American Nurses Credentialing Center's Commission on Accreditation, September 2014. The Importance of Evaluating the Impact of Continuing Nursing Education on Outcomes: Professional Nursing Practice and Patient Care  
38 College of Nurses of Ontario. Practice Guideline: Supporting learners, 2009  
The nurses on 3C MSSU support learning but find difficulty with their own learning and those of others (students), due to the present workload of the unit.

The nurse educator, by developing educational activities designed to meet the learning needs of the nurses, positively impact the practice of nursing and patient outcomes. Those nurses who are in an educator role should be aware of the learner’s capabilities, maintain or facilitate access to the knowledge, judgement and skills relevant to the learners’ practice experience and be directly involved in the learning process through consultation with the learner, preceptor and/or administrator.

It was not clear during the IAC hearing whether there was purposeful interaction about learning needs of the staff. The IAC is aware the educator is on the unit at certain points of the day, as well available by phone. It is the understanding of the IAC, the educator is responsible for two medical units, Rehab and Complex Continuing Care. This large portfolio would provide little time to meet the needs of the 3C MSSU staff. In-services are also provided and posted for staff. Staff do however have some difficulties attending due to the patient acuity, activity and the overall work environment.

The CNO Supporting Learner’s Practice Guideline (2009), states “administrators will assess the workload of all nurses whose clients are cared for by learners and make ongoing workload adjustment so that nurses are available to support and communicate with learners.” Documented on the PRWRF’S, 3C MSSU is a learning environment for students from the local college/university. The staff has difficulty with mentoring/preceptor due to the workload of the unit. The preceptors should be able to guide the learners, facilitate learning experiences that address their goals. This has become a difficult task. Administrators will also provide systems and resources that support a learning environment.

**Recommendations:**

20. **The Hospital assigns a full time educator responsible for only 3C MSSU for a minimum of six (6) months and then re-evaluate the need for a fulltime educator for 3C MSSU.**

21. **The Hospital will review the workload of the nurses to grant time to attend relevant education**

22. **The Educator will be responsible for recertification, updates/refreshers, ie telemetry, peritoneal dialysis, stroke and any annual review of skills**

23. **The Educator will be a member of the 3C MSSU Unit Council**

24. **The Hospital will continue to post in-services and educational opportunities and allow for input for education sessions from staff**

25. **The hospital ensure adequate staffing on 3C MSSU when students are present on the unit, to ensure a positive learning environment**

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40 *American Nurses Credentialing Center’s Commission on Accreditation, September 2014. The Importance of Evaluating the Impact of Continuing Nursing Education on Outcomes: Professional Nursing Practice and Patient Care*

41 *American Nurses Credentialing Center’s Commission on Accreditation, September 2014. The Importance of Evaluating the Impact of Continuing Nursing Education on Outcomes: Professional Nursing Practice and Patient Care*

42 *College of Nurses of Ontario. Practice Guideline: Supporting learners, 2009*
3.3.2.2.5 RN (EC) Nurse Practitioner Role

The IAC understood that the Hospital has a RN (EC) within the Medical Program however, does not have any responsibility to 3C MSSU.

The Canadian Nursing Association recognizes the role of the nurse practitioner:

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

3C MSSSU cares for a variety of medical patients. This is accomplished with several standard work practices as well as service agreements. The IAC is aware not all service agreements are signed by those involved. The Short Stay unit committee when discussing roles, discussed the role of the Nurse Practitioner RN(EC) on this unit. It was decided at that time there was no requirement for a RN (EC) as the Physician is on the floor, and this unit is their priority.

The IAC reviewed the standards of work as well as service agreements for 3C MSSU. The standard work related to physicians/consultants identifies physicians are responsible for performing an admission assessment within sixty minutes of patient arrival to 3C MSSU. Also to ensure all the pertinent order sets, home medication or other pertinent information is reviewed and signed. If the physician is unable to do this initial assessment within sixty minutes of arrival, one must take into consideration this may delay the implementation of the plan of care and subsequently discharge. The physicians are responsible for several patients on the unit, and therefore being in the admission room with the RN (AR) is a rare occurrence.

As part of the discharge plan medication reconciliation is reviewed with the patient/family. The pharmacist, due to staffing issues, is unable to do this, but would be available for any questions the staff may require. As a result, the medication reconciliation is left up to the nurses on the unit.

Nurse Practitioners are authorized by the College of Nurses of Ontario (CNO), to perform controlled acts and activities outlined in the RHPA, and practice within their scope as outlined (College of Nurses, Practice Standards, 2016).

Nurse Practitioners also work collaboratively with other health care providers. This collaborative relationship on 3C MSSU would involve all other health care professionals who are involved in the patient’s care. This collaboration is to ensure all needs of the patient are met. The hospital is familiar with Nurse Practitioners including within the medical service.

The IAC believes that the role of the RN (EC) will support clinical nursing practice given the patient demographics in terms of acuity and complexity. The patients require more advanced assessment skills which having the RN (EC) available to support the nurses through teaching and mentoring will be a significant asset overall.

44 Nurse Practitioners are regulated as Registered Nurse Extended Care: RN(EC) in Ontario.
45 SAH submission March 21, 2016
Recommendations:

26. The Hospital must reassign the current RN (EC) within the Medical Program to 3C MSSU for a minimum of six (6) months. Responsibilities would include working collaboratively with the RN AR in the admissions room to perform admission assessments including medication reconciliation, use of order sets, discharge planning with the intent of ensuring medication reconciliation is complete and any other activities that would be deemed appropriate for this role.

27. Prior to the end of the six month trial an evaluation of the RN (EC) role must be conducted to determine if there is evidence to support this to be a permanent position.

28. The RN (EC) would practice to his/her full scope of practice as espoused by the College of Nurses of Ontario.

29. The hours the RN (EC) would work would be determined to facilitate early discharges and the multidisciplinary approach.

3.3.2.6 Role Clarity – Clinical Manager and Clinical Supervisor

The following are additional recommendations relating to role clarity for the Clinical Manager and Clinical Supervisor.

Recommendations:

30. The hospital to revise the leadership standard work and must provide clarity of these two positions within three (3) months.

31. At a staff meeting the role clarity will be presented and noted in the minutes so staff have a clear understanding of the roles and responsibilities of both the Clinical Manager and Supervisor.

32. Adopt the concept of 360 feedback reviews /evaluations for leaders on MSSU to offer anonymous frontline feedback to the leaders who manage and guide them. The 360-evaluation process will provide a balanced view of ones performance in all areas of leadership that will assist the professional growth of the organizations leaders.

3.3.2.3 Shared Governance Structures

Tim Porter O’Grady an influential nursing guru and leader in shaping shared governance began the discussions in the nursing literature in 1997. He describes shared governance as a “professional practice model, founded on the cornerstone principles of partnership, equity, accountability, & ownership that form a culturally sensitive & empowering framework, enabling sustainable & accountability-based decisions to support an interdisciplinary design for excellent patient care”. 46

Another definition of shared governance is defined as “a dynamic staff-leader partnership that promotes collaboration, shared decision-making and accountability for improving quality of care, safety and enhancing work life.”47 Shared governance models which enable staff nurses to collaborate on


decisions that impact patient care, quality improvement and nursing practice at the unit and/or program level have been found to be an effective way to improve the quality of the workplace environment. The outcome of an effective shared governance model is the sense of empowerment that comes from participating in decisions that directly impact one’s practice and the practice environment.

The IAC believes that shared governance models provide RNs with the opportunity to raise issues relevant to their nursing practice coupled with suggestions/recommendations and ideas to improve or enhance their practice. Shared governance encourages dialogue amongst staff leadership while assuming responsibility and accountability for not only identifying problems but developing solutions to resolve them. This also assists with the development of leadership attributes like critical thinking, therapeutic communication, conflict resolution and team building. Effective shared governance requires involvement and accountability from both management and staff.

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

The IAC believes that the SAH Medical leadership team has tried to implement a shared governance model through its approach of the Medical Short Stay Unit Work Group and its LEAN process improvement initiatives by engaging staff in both.

The 3CMSSU Working Group was initiated on February 7, 2015 and to date have held only four (4) meetings. This group focused on issues related to current state value stream mapping, site visit to WRH and a subsequent debrief, planning standard work and roles of those working on the unit, service agreements, unit configuration and admission criteria. A tremendous amount of work was completed by sub-groups of this working group.

In January 2016, an updated Project Charter was approved which reflected the revision to the plan to increase the number of beds on 3C MSSU for April 1/16.

With the MSSU already into the implementation and re-introduction of the 3C MSSU Unit Council in January 2016, the decision was made to move accountability for ongoing evaluation and “checking in” to this group. The Unit Council with eleven (11) staff representatives provides the ability for more staff to actively participate in and provide feedback and recommendations to the decisions about the unit’s work. The IAC would like to commend SAH leadership for re-introducing the 3C MSSU Unit Council in the spirit of shared governance.

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50 SAH submission – MSSU Working Group April 5, 2016
The IAC recognizes that the Hospital has embraced a LEAN philosophy, and that the 3C MSSU leadership is engaged and believes strongly with this approach. On February 1, 2016, a Registered Dietitian in the Renal Program and Professional Practice Lead for the Dietitian group started on 3C MSSU for a period of up to five months to assist with process improvements. The Association and staff are unclear of her day to day roles and responsibilities.

On February 19, 2016 a Communication Survey was sent out to all 3C MSSU staff by the Registered Dietitian (RD) now responsible for process improvements. Several issues were identified by one staff member which included 0815 rounds did not focus on discharges, more leadership being on board, 1400 rounds not focused on the plan of care or discharge plans, email communications from management was vague and not timely, failure of the MDs to read SBARS, Kardex not up to date and staff meetings too infrequent with vague information provided.

Then again on February 24/16 another email was sent to all staff regarding the daily huddles would not occur at 1500 hrs from the RD above. In the email it was stated that there would be a 10 minute opportunity to discuss and be updated on daily and weekly issues, projects and to track performance.

It is evident that the Hospital is actively engaged in the LEAN methodology to continuously identify opportunities for improvement. However, it is very important that staff clearly understand the role of the RD who is facilitating these initiatives and the expected outcomes. Given that shared governance is equally important and we now have a 3C MSSU Unit Council it is necessary to have members simultaneously engaged in order to facilitate the change and be part of the decision making process related to practice policy and procedures.

**Recommendations:**

33. The Hospital clearly defines the roles and responsibilities of the RD related to 3C MSSU process improvement initiative.

34. The RD become a member of the 3C MSSU Unit Council during her five month tenure to share results of the process improvement initiatives to enable effective decision making

35. The results of surveys sent out to staff based on process improvements be summarized and shared with all 3C MSSU staff. These results would then be discussed at Unit Council to effect change if required.

3.3.2.3.1 3C MSSU Unit Council

In the Hospital submission it was stated the 3C MSSU Unit Council was re-introduced in January 2016. There have been three meetings to date and the group has addressed issues like a trial of the extended ward clerk hours on weekends, strategies for better preparation of patients for discharge by 1100 hrs daily, and identification of metrics for the unit. There is also a “Unit Council” board in place and contains previous minutes and an opportunity for staff to add items for the upcoming meeting agenda.

There is a comprehensive Terms of Reference for the 3C MSSU Unit Council which identifies the Unit Co-Chairs. The IAC believes that to be effective, the Unit Council must have authority to make decisions within the scope defined in the Terms of Reference, which are then embraced and supported by the staff.

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51 SAH Submission March 21, 2016 p. 16
52 SAH Unit Council additional submission April 5, 2016
management team. The current terms of reference purpose indicate that the Unit Council will “provide input into decisions being made at the department, program or organizational level”\(^{53}\)

The IAC believes that the purpose of the Unit Council is to work collaboratively on decision-making relating to practice and procedures that enhance the quality of patient care, best practices, work environment and therapeutic relationships among staff. The Unit Council shall include all staff wishing to actively participate and not exclude anyone from being a member.

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

**Recommendations:**

36. *The 3C MSSU Unit Council revise the Terms of Reference to specify decision-making authority related to practice, procedures, guidelines and ground rules for action during and following meetings and membership to ensure inclusivity of staff wishing to participate.*

37. *The Hospital provide appropriate resourcing of the 3C MSSU Unit Council, to enable effective discussion and decision-making processes to occur.*

38. *The Hospital provide clerical assistance to ensure agenda and minutes are developed and circulated in a timely fashion for all 3C MSSU staff.*

3.3.2.3.2 3C MSSU Staff Meetings

The IAC heard repeatedly throughout the hearing the importance of having staff meetings that were facilitated by the Clinical Manager. SAH indicated that staff meetings are typically the accountability of the Manager/Supervisor to arrange. Historically staff meetings have been poorly attended in most areas of SAH due to staff’s inability to be relieved of their duties related to patient care.

The last staff meeting for this unit was held on July 2, 2015 where two meetings were scheduled at 1500 and 1900 hrs. A small number of staff was able to attend. The purpose of this meeting was to discuss the proposed staffing model of the MSSU. Staff was asked for their input. Based on staff feedback it was decided to pursue 1:4 nurse patient ratio.

The IAC notes that the Unit Staff meeting should be chaired by the Manager, and they provide an opportunity for information sharing and dissemination. The Staff Meeting is not, and should not be used as, an opportunity for discussion / debate / development of consensus on issues such as practice standards, model of care or unit operations. These are the purview of the 3C MSSU Unit Council.

It is important for staff to be able to have the opportunity to meet with their Clinical Manager to understand the broader issues that are occurring within SAH and the Medical Program. These meetings should occur at least weekly and be offered twice so that staff have the opportunity to attend at a time convenient to them. Staff must make the effort to attend these meetings and be active participants.

\(^{53}\) SAH Unit Council additional submission April 5, 2016 Short Stay Unit Council Terms of Reference
Recommendations:

39. Replace daily huddles with weekly staff meetings on the same day of the week at 7am (shift change) for a 6-month pilot led by the Clinical Manager. The Director of the Medical Program must attend one staff meeting per month.

40. Staff must be given the opportunity to submit agenda items.

41. Staff should make every effort to attend staff meetings that are planned and be part of the process to make improvements and provide suggestions. It is also the staff’s responsibility to read minutes of staff meetings that are posted or shared by email.

42. SAH should consider different options to engage staff in attending staff meetings for example arranging meetings to be conducted via teleconference so staff have the opportunity to bring issues forward.

3.3.2.3.3 Nursing Professional Practice Governance Model

The IAC was unable to learn in greater depth the upcoming changes related to Nursing Professional Practice Governance Model as shared by the Chief Nursing Officer. The IAC did learn that there are plans in May of 2016 that the Nursing Practice Council will be initiated. At the time of the IAC Hearing, detailed information was not available but the IAC was confident that plans are ready for implementation of a SAH Nursing Professional Practice Council.

Recommendations:

43. Implement the SAH Nursing Practice Council as planned and simultaneously seek broad engagement by all nurses throughout SAH to become actively involved in the professional opportunity.

44. Consider practice issues identified at the various SAH Unit Councils be shared at the SAH Nursing Practice Council to identify key themes and trends related to professional nursing practice.

3.3.2.3.4 3C MSSU Communication

It was evident that throughout the IAC proceedings the nursing demographics include a vast generational diversity of which, each generation has its own communication preferences. This was even more apparent throughout the IAC hearings when staff was asked their communication preferences. As a result of such a response it is evident that the leadership team needs to consider a variety of methods for staff communication.

Given the feedback also regarding staff’s inability to attend staff meetings or their desire to attend while on a day off, the forum for which sharing of information and obtaining feedback from staff moved to a “huddle” format daily. The huddles are currently held on the unit, in a team room, where staff are still accessible to other team member. The scheduled time for these huddles is at 1500 hrs each day. A “Huddle Log” was developed$^{54}$ to capture the essence of the discussion and available for those staff unable to attend. These logs are kept in a binder in the team room.

$^{54}$ SAH submission April 5, 2016 3C MSSU Staff meetings/communication
In February 2016, a survey was sent to all staff regarding communication. The survey was completed by 11/38 recipients. Results were made available to staff\(^{55}\).

Given the results of the communication survey there are still means to improve communication.

**Recommendations:**

45. Implement Recommendation 39 related to staff meetings.

46. Implement a weekly update from the Clinical Manager of issues, activities, decisions and/or changes via email on Fridays to ensure all staff are kept informed.

47. All staff be held accountable and responsible for reading their emails and ensure they are aware of unit updates.

3.3.2.3.5 Staff Rounding

Rounding for outcomes\(^{56}\) is a consistent practice of asking questions of key stakeholders -- leaders, staff, physicians and patients to obtain actionable information. SAH has partnered with Studer approximately eight years ago and have committed to implementing Studer’s evidence based practices to improve performance, patient satisfaction and engagement.

SAH has rebranded this approach to “our iCare way” using the Studer best practices and incorporating SAH’s values, which is a unique way to achieving excellence.\(^{57}\)

**The focus for questions during staff rounding is to**\(^{58}\):

► **Build relationships** (e.g. "How is your family?" ("Did your daughter graduate last week?")

► **Harvest "wins" to learn what is going well**, what is working, and who has been helpful (e.g. "Are there any physicians I need to recognize today?")

► **Identify process improvement areas** ("What systems can be working better?")

► **Repair and monitor systems** to ensure chronic issues have been resolved (i.e. "Do you have the tools and equipment to do your job?" or even more specifically: "How long did it take you to find an IV pump today?")

► **Ensure that key behavior standards in the organization are "hardwired"** (or being consistently executed) to reward those who are following the standards and coach those who are not.

Relationship-building questions during rounding build communication at all levels of an organization because they demonstrate to employees that leaders care about them as people a very important issue we heard during the IAC Hearings.

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\(^{55}\) SAH submission April 5, 2016 3C MSSU Staff meetings/communication  
\(^{56}\) Studer, Hardwiring for Excellence  
\(^{57}\) SAH submission April 5, 2016 3C MSSU Staff meetings/communication  
\(^{58}\) Studer, Hardwiring for Excellence
Because many health care employees tend to notice what is wrong or not working—instead of what is right and working—it’s particularly important to ask questions that look for the positive. While diagnosing what’s wrong is critical to ensuring quality clinical outcomes in patients, it serves as an obstacle in an organization’s effort to create a positive work culture, so we must build in opportunities to notice what’s right.

By identifying and preventing employee frustrations and delays, organizations increase staff productivity and communication. In this way, rounding can provide a quick return on investment by reducing medically unnecessary days due to inefficiencies.

Given the discussions throughout the IAC hearing related to staff not seeing their manager, lack of trust and poor communication, rounding for outcomes with staff is a meaningful way to develop trust, engage in meaningful dialogue with staff and to understand issues relevant to them.

**Recommendations:**

48. **The Clinical Manager implement staff rounding twice per week**

49. **The Clinical Manager must connect with all staff once a week between Monday and Friday for staff rounding.**

3.3.2.3.6 PRC Process with SAH and ONA

Article 8:0159 of the ONA Collective Agreement provides a process in which staff nurses as well as administration is to address workload issues. Article 8 specifies ‘at the time the workload occurs, discuss this issue within the unit/program to develop strategies to meet care needs using current resources’

It further states ‘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.

On 3C MSSU, the RN (AR) is used as a resource for the staff the staff work well as a team for their patients in times of need. This has been documented on the PRWRF by the hospital on several occasions. Using the RN (AR) as a resource and using the team staff attempt to resolve some of the issues immediately in real time.

The SAH has a Clinical Supervisor available Monday through Sunday, followed by an on call manager 7 days per week.

The collective agreement further states -Failing resolution 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 and the nurse are both working or within (10) calendar days, which ever is sooner. During the hearing, it became apparent meetings within this time frame were very few, the hospital felt challenged in meeting this 10 day turnaround.

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59 ONA Collective Agreement
The IAC understands there is a difference between a one-time situation and an ongoing issue. In a one-time situation, the nurses are expected to call the supervisor/manager to provide them with the opportunity to address or resolve the issue. However, if the workload is an ongoing issue, the RN’s are not required to contact the management staff at the time of occurrence. The hospital’s frustration is that they feel they cannot help if they do not know the issues at the time.

In the 3C MSSU, many of the workload issues have been ongoing for several years. This in itself provides evidence the RN’s have attempted to communicate their issues/concerns to the management staff. In some instances, the SAH has not responded or failed to meet, this gives the impression to the staff their concern about workload issues is not important. During the hearing the hospital expressed their beliefs in the importance of discussing the issues and does not disrespect the concerns of the nurses.

There appears to be frustration by both parties surrounding the PRC process.

**Recommendations:**

50. The IAC encourages the SAH and the local association to work together to improve the PRC process with the goal of implementing a collaborative approach to resolving workload concerns. This will include commitment on both sides to follow the steps in the collective agreement including time lines as set out.

51. The Hospital and the Association review the WRH presentation related to the Professional Responsibility Complaint and implement a similar process.60

### 3.3.2.4 Unit Culture and Change Management

The IAC noted two areas of concern relating to unit culture: staff’s reaction and response to change and a need for more support from the leadership team.

When managing change, two critical assessments are needed at the onset of the change. The first assessment is the change itself. This assessment examines the scope, depth and overall impact of the change. Specific items that should be addressed by this change assessment are as follows:

- Scope of the change (workgroup, department, division, enterprise);
- Number of stakeholders impacted;
- Type of change (process, technology, organization, job roles, merger, strategy);
- Amount of change from where we are today;

This assessment of the change and a thoughtful review of the nature of the change is essential to plan an organization’s change strategy.

The second evaluation is an organizational assessment. Each organization has unique characteristics that make change management either easy or challenging. These organizational attributes are important to understand so that one can educate the team and sponsors about potential barriers to change.

This assessment would cover areas such as:

- **Culture and value system**
  
  The culture and value system play a major role in how an organization reacts to change. Considering this factor, one is able to predict certain reactions in the group and plan accordingly.

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60 Windsor Regional Hospital Electronic Professional Responsibility Complaint Process – Blending Collaboration and Technology.
to deal with those reactions.

b) **Capacity for change (and how much change is already taking place)**
   Organizations have a limited capacity for change. If your organization is already experiencing a large degree of change, then implementing yet another change can be challenging.

c) **Leadership styles and power distribution**
   Leadership styles play an important role in change management planning. Because sponsorship and management support is a key success factor for change management, it is important that you take time to assess the leadership styles and power distribution in the organization;

d) **Residual effects of past changes**
   Past changes may have left a residual effect that could work in one’s favor, or make change management more challenging. The organization's history is part of the starting point when managing change;

e) **Middle management’s predisposition toward the change**
   In many organizations, there are middle managers who have a high degree of control over their peers and employees. These middle managers will play a significant role in the change process;

f) **Employee readiness for change**
   Employee readiness for change is a gauge of how prepared and able employees are for change, and whether one can expect high or low employee resistance, and why.\(^{61}\)

Given the depth and breadth of change within this unit, an effective change management strategy and support measures need to be integrated as part of this unit’s culture. Each individual responds to change differently.

The IAC believes that team-building support and change management from a source either internally or externally to the unit with change management and team building skills and expertise is required.

**Recommendations:**

52. *The Hospital engage either an internal or external expert to facilitate the development of a unit culture that is founded on the principles that underpin the Hospital’s code of conduct. This should include; change management, team-building, conflict resolution and communication activities involving active staff participation.*

3.3.3 3C MSSU Nursing Care Delivery Model and Staffing

3.3.3.1 Nursing Care Delivery Model

A nursing care delivery model is “a structured approach for organizing and providing nursing care to clients, informed by values and beliefs”.\(^{62}\) The goal of a nursing care delivery model is to:

- provide safe, competent, quality care that meets client needs and maximizes client outcomes across the continuum of care;
- utilize health-care providers effectively; and

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\(^{62}\) Invitational Round Table: Nursing Care Delivery Models and Staff Mix: Using Evidence in Decision-Making, pg 1, Canada Nurses Association, ISBN 978-1-55199-345-8, February 2011
• ensure meaningful work for health-care providers, thereby instilling in them a sense that their contributions are important.63

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

A nursing care delivery model details assignments, responsibility and authority to accomplish patient care, clearly identifies who is going to perform what care, who is responsible and who makes decisions, and matches the number and type of caregivers to patient care needs. The classic nursing care delivery models are total patient care, functional nursing, team nursing and primary nursing.

The model of care adopted at SAH for 3C MSSU is Total Patient Care with RN staffing supported by a collaborative team of dedicated physicians and allied health.64

3.3.3.2 Staffing

3.3.3.2.1 3C MSSU Unit Reconfiguration

3C MSSU is currently located on the third floor of the Hospital, in the C wing; 30 beds have been designated for use by the MSSU as of March 14, 2016. For the purposes of staffing, the beds are associated with 3C MSSU and staffed with part time 3C staff and Float Pool staff, based on patient volume and acuity.

• 30 operational beds
• Provides care for patients with general medical diagnosis including those with cardiac, stroke, and peritoneal dialysis needs; the unit is designated for telemetry monitoring of medical patients who do not require the intensity of care provided in a Level 2 Intensive Care unit
• As a Short Stay unit, the unit is designed to move patients from ED in an expedited manner, providing rapid assessment, diagnostic testing and treatment, in order to facilitate discharge within 72 hours
• Designated as an isolation unit (has 6 isolation rooms and a satellite work station are for use in an outbreak)
• Model of Care: Total Patient Care with RN staffing supported by a collaborative team of dedicated physicians and allied health

The IAC recommends this unit requires reconfiguration to a 28 bed unit – 16 beds dedicated for telemetry patients and a 12 bed MSSU. (See diagram). The IAC recommends the census of 3C MSSU be decreased from 30 to 28 beds for patient and staff safety and it would be left to the discretion of the Hospital to relocate bed 29 and 30 to the Overflow Unit if capacity warrants.

The Telemetry beds will be configured as follows:
  a) 12 beds will be located in stairwell 13

64 SAH Submission March 21, 2016 p.10
b) 4 beds will be located in stairwell 16 – these four beds can be used between telemetry/MSSU based on the utilization of telemetry patients and occupancy rates

The 3C MSSU patient admission criteria must be adhered to for quality and safe patient care

### 3.3.3.2 3C MSSU Staffing

It was clearly evident that the IAC Panel heard throughout the hearing that numerous attempts have been made since 2015 to staff 3C MSSU safely and effectively.

In March 2015, SAH communicated a plan to revise the leadership structure, reducing the number of Clinical Directors and Managers and increasing the number of front line Supervisors over a 12 month period. The change was in response to input from staff who desired better access to leadership in the work environment, including on more shifts of the day. The impact of this change in direction resulted in the decrease of one Patient Care Manager and the addition of four Patient Care Supervisors to the Medical Program. The first three supervisors were in place by June 2015 and the fourth supervisor has been hired this month, which completes the Medical Program leadership team.

There are currently 23 full time registered nurses who rotate on a cyclic master schedule of twelve hour day (1700-1900) and night (1900-0700) shifts. There are currently 10 part time registered nurses. With the recent addition of beds to the department (30 beds as of March 14, 2016), an additional 3 full time and 3 part-time RN staff are currently being recruited.

### September 1, 2015 3C Medicine Unit Changes

There was a delay in implementing the changes to a Medical Short Stay unit on 3C due to delayed opening of the community interim LTC beds and subsequent continued increased patient volume at SAH. Finally, on September 1, 2015, despite ongoing challenges with the inpatient volume, the 20 beds on 3C for operation under the Medical Short Stay Model were identified and the unit began operations with the RN staffing model and interdisciplinary team.

The following staffing pattern was developed for the changes to 3C Medicine as of September 1, 2015. Of note, when this staffing change was implemented there was a significant decrease in the number of PRWRFs related to a 1:4 nurse: patient ratio.
**Staffing Pattern – September 1, 2015 – March 13, 2016 (for 20 bed unit)**

<table>
<thead>
<tr>
<th>Role</th>
<th>Shifts</th>
<th>Notes</th>
</tr>
</thead>
</table>
| RN with Added Responsibility (AR) assignment | 0700-1900 (1) with patient assignment  
Nurse-patient ratio-1:4  
1900-0700 (1) with patient assignment  
Nurse-patient ratio-1:5 |                                            |
| RN                                  | 0700-1900 (4)  
Nurse-patient ratio-1:4  
1900-0700 (3)  
Nurse-patient ratio-1:5 |                                            |
| Unit Assistant                      | 0700-1900 (1), 0900-1700 (1), and 1700-2200 (1)  
0700-1900 (1), 1000-1800 (1) | Mon-Fri  
Sat-Sun |
| Patient Care Manager                | Mon-Fri, 0800-1600 hrs (1)  
Manager on call available after hours and weekends |                                            |
| Patient Care Supervisor             | Mon-Fri, 0800-1600 hrs;  
2 supervisors - 3C and Medical OF, 1 on 3B  
Sat-Sun, 0800-1600 hrs; 1 supervisor covering 3B / 3C  
)initiated in January 2016) | 3 of 4 weekends per month covered. |

**March 14, 2016 3C MSSU Medicine Program Changes**

On March 14, 2016, the 3C MSSU changed to a 30 bed unit with the following staffing assignments. Once this change was implemented there has been an increase in the submission of PRWRFs. A staffing model of all RN staff with 4 patients was trialed initially, including an AR with a patient assignment. This became a barrier to the AR being able to perform the accountabilities within the MSSU processes. A trial was initiated on March 14, 2016 to modify the assignment so that the AR does not have a patient assignment (and can focus on key accountabilities) while the remaining staff are accountable for 5 patients each.
### 3C MSSU Staffing Pattern – March 14, 2016 to Date (for 30 bed unit)

<table>
<thead>
<tr>
<th>Time and Days</th>
<th>Monday – Sunday</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>RN with Added Responsibility (AR) Assignment</strong></td>
<td></td>
</tr>
<tr>
<td>0700-1900 (1) <strong>without</strong> patient assignment</td>
<td></td>
</tr>
<tr>
<td>1900-0700 (1) with patient assignment</td>
<td>Nurse-patient ratio-1:5</td>
</tr>
<tr>
<td><strong>RN</strong></td>
<td>0700-1900 (6) Nurse-patient ratio-1:5</td>
</tr>
<tr>
<td>1900-0700 (5) Nurse-patient ratio-1:5</td>
<td></td>
</tr>
<tr>
<td><strong>Unit Assistant</strong></td>
<td>0700-1900 (1), 0900-1700 (1), and 1700-2200 (1) 0700-1900 (1), 1000-1800 (1)</td>
</tr>
<tr>
<td><strong>Patient Care Manager</strong></td>
<td>Mon-Fri, 0800-1600 hrs (1) Manager on call available after hours and weekends</td>
</tr>
<tr>
<td><strong>Patient Care Supervisor</strong></td>
<td>Mon-Fri, 0800-1600 hrs; * 2 supervisors - 3C and Medical OF and 1 on 3B** Sat-Sun, 0800-1600 hrs; 1 supervisor covering 3B / 3C</td>
</tr>
</tbody>
</table>

*Supervisors on 3C as of March 14/16 scheduled 0800-1600 and 1200-2000 hrs Mon-Fri to support changes  
**with addition of 4th Supervisor in March, 2 will be on 3B and expanded coverage will be 4/4 weekends for both units  

3 of 4 weekends per month covered.
### 3C MSSU Staffing Pattern – Proposed Staffing Changes (for 28 bed unit – 16 Telemetry Beds + 14 MSSU Beds)

<table>
<thead>
<tr>
<th></th>
<th>Monday – Sunday</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>RN with Added Responsibility (AR)</strong></td>
<td>0700-1900 (1) without patient assignment&lt;br&gt;1900-0700 (1) with patient assignment&lt;br&gt;Nurse-patient ratio-1:3 (assigned discharged patients)</td>
<td>RN-AR would have 3 patients from 1900-0700 hrs</td>
</tr>
<tr>
<td><strong>RN</strong></td>
<td>0700-1900 (7) Nurse-patient ratio-1:4&lt;br&gt;1900-0700 (5) Nurse-patient ratio-1:5</td>
<td>Increase of 1 RN from 0700-1900 hrs</td>
</tr>
<tr>
<td><strong>Unit Assistant</strong></td>
<td>0700-1900 (1), 1000-1800 (1), and 1800-2300 (1)&lt;br&gt;0700-1900 (1), 1700-2300 (1)</td>
<td>Mon-Fri (hours only change)&lt;br&gt;Sat-Sun (hours only change)</td>
</tr>
<tr>
<td><strong>Patient Care Manager</strong></td>
<td>Mon-Fri, 0800-1600 hrs (1) dedicated to 3C MSSU for a minimum of six (6) months&lt;br&gt;Manager on call available after hours and weekends</td>
<td>Manager dedicated to the unit for a minimum of six (6) months</td>
</tr>
<tr>
<td><strong>Patient Care Supervisor</strong></td>
<td>Mon-Fri, 0800-1600 hrs;&lt;br&gt;2 supervisors - 3C and Medical OF and 1 on 3B&lt;br&gt;Sat-Sun, 0800-1600 hrs; 1 supervisor covering 3B / 3C&lt;br&gt;*Supervisors on 3C as of March 14/16 scheduled 0700-1500 and 1500-2300 hrs Mon-Fri to support changes for at least six (6) months&lt;br&gt;**with addition of 4th Supervisor in March, 2 will be on 3B and expanded coverage will be 4/4 weekends for both units</td>
<td>3 of 4 weekends per month covered.&lt;br&gt;Clinical Supervisor on the unit from 0700-2300 hrs</td>
</tr>
<tr>
<td><strong>Housekeeping</strong></td>
<td>Maintain current hours however, reallocate responsibilities from nursing to housekeeping related to stocking supplies and linens</td>
<td></td>
</tr>
</tbody>
</table>

**Recommendations:**

53. The Hospital will maintain a 1:4 nurse patient ratio on days and 1:5 on nights for RN staffing

54. The RN (AR) will have no patients on days from 0700-1900 hrs and the RN (AR) will have 0-3 patient maximum on 1900-0700 hrs assigned to discharged patients and no telemetry patients.

55. This creates an increase the equivalent of one (1) RN on days equal to 2.5 FTEs

3.3.3.2.3 Scheduling Including Float Pool

The staff on 3C MSSU work a traditional 12hr master rotation. With the opening of 10 beds as of March 14, 2016 and the additional staffing requirements, the hospital has revisited the master rotation. There will be no changes to the majority of the RN’s schedule. The new rotation will include an additional 3 fulltime and 3 RPT RNs.
A new schedule of 2 days/2 nights with 5 off was proposed to the hospital by the ONA and the staff nurses which was denied at this time. The hospital felt there were several changes occurring and didn’t feel this was the appropriate time. However, the hospital did agree to revisit this type of schedule in the future.

Throughout the hearing the IAC heard from the nurses, the feeling of fatigue and low morale. This is caused as a result of several factors. Some of these include working overtime, working short, working through break times as well as a short turnover time within the master rotation. All of these factors have an influence on workload and nurse fatigue.

A complex definition by CNA/RNAO, 2010 nurse fatigue is a subjective feeling of tiredness (experienced by nurses) that is physically and mentally penetrative. It ranges from tiredness to exhaustion, creating an unrelenting overall condition that interferes with individuals’ physical and cognitive ability to function to their normal capacity. It is multidimensional in both its causes and manifestations; it is influenced by many factors; physiological (circadian rhythms), psychological (stress, alertness, sleepiness), behavioral (pattern of work, sleep habits) and environmental (work demand). Its experience involves some combination of features; physical and psychological (compassion fatigue, emotional exhaustion). It may significantly interfere with functioning and may persist despite periods of rest.

Fatigue is also accumulative as a result of lack of time for free self while at work. It has been documented on the PRWRF’s missing of meal breaks and/or rest breaks occurring on a regular basis on the 3C MSSU. Although overtime is not mandatory, the staff feels leaving the unit short is not good patient care, as well harmful to their co-workers. The nurses on the MSSU provide care to their patients within a department which is high acuity, fast pace with high patient turnover. Despite all these factors, the nurses on 3C continue to strive to meet their professional and organizational standards, and provide the best patient care they can.

The IAC believes to aide in reducing nurse fatigue on the MSSU, an innovative 2 day/2 night with 5 off rotation should not be deferred to a later date. This type of schedule provides for longer intervals away from work for staff to recover and regroup for their next shift.

Recommendations:

56. Staff need to ensure they take their scheduled breaks and seek appropriate relief to ensure they get their entitled break allotments and rest
57. If Float nurses are scheduled to 3C MSSU they must be fully trained to care for this patient population.
58. Begin dialogue between the Association and the Hospital to review the 2 day/2 night 5 day off schedule as per the staff request. The ONA local agreement outlines how a change to this type of schedule should occur, beginning with a vote of the nurses involved. If such vote is for this change in schedule, the hospital will draft the schedule and forward to the

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65 CNA/RNAO nurse Fatigue and Patient Safety Research Report, May 2010
scheduling committee within 6 weeks of the vote the hospital incorporates the RNAO best practice guideline Preventing and Mitigating Nurse Fatigue in Health Care

3.3.3.2.4 3C MSSU Unit Assistant

Unit Assistant

The IAC understood as outlined above in the charts regarding staffing resources that the Unit Assistant role is integral for the day to day operations of 3C MSSU. The Unit Assistant hours have remained unchanged throughout the changes to the unit. This is of concern to the IAC Panel members even though there have been significant issues identified in the PRWRF’s that nurses are assuming non-nursing responsibilities.

The IAC believes that the Unit Assistant coverage is a necessity seven (7) days/week and recommend that this remain constant. Given the patient activity related to admissions, transfers and discharges, the Unit Assistant should be available from 0700-2300hrs Monday to Friday and from 0700 -2300hrs Saturday/Sunday.

Recommendations:

59. Provide Unit Assistant coverage from 0700 – 2300 hrs Monday to Friday and on Saturday and Sunday from 0700-2300 hrs

3.3.3.3 Physician Model of Care

Although it is typically not in the domains of the IAC to comment on Physician practice or models of care, it is important to mention how the Physician schedule and the Physician Model of Care is impacting nursing practice and processes.

With the implementation of the MSSU model, plans were made for a dyad physician model within the interdisciplinary team covering the unit daily:

General Internal Medicine – (1) with 12 patients- assigned for one week at a time
Hospitalist Physician or Family Physician – management of 8 patients with consultation of IM as needed- assigned for one week at a time

Given the current model of the Family Physician Group (working out of Group Health) they were not initially involved in the plan for this model. This group works in a POD structure, meaning all GHC physicians are sorted into 3 PODS and a physician covering each of those three lists is at the hospital daily caring for inpatients of the Group Health Center (GHC). The group was not able to commit to one Family Physician being assigned to the MSSU and caring for any GHC patient on the unit, so from September 15 to February 2016 patients from Family Physicians were admitted to another medical unit unless they required telemetry.

In February 2016, a trial was implemented with the Family Physicians joining the model – this meant any patient who required admission to a medical unity could be admitted to MSSU. The POD model has not been revised which essentially means 3 physicians could essentially be caring for the same patient.

66 Preventing and Mitigating Nurse Fatigue in Health Care, 2011
This model of care creates fragmentation of care, increased communication for nursing depending on which Physician is caring for the patient on a given day. Simultaneously, the GIMU Physicians are not on call for their patients during the evening and night shift so nurses are having to consult with the Physician on call which that Physician has no history of the patient. This increases nursing workload for having to provide extensive information to on call Physicians for additional orders.

**Recommendations:**

60. A comprehensive external review be conducted on the Physician Model of Care at SAH to ensure continuity and consistency of quality patient care.

3.3.4 3C MSSU Nursing Practice and Unit Processes

The IAC believes that the workload of the RNs (and other staff) has been negatively impacted by the use of a number of practices and processes on 3C MSSU. Evaluating and revising these practices and processes will ultimately improve the workload of RNs and facilitate quality patient care. The IAC believes that the key practices / processes impacting workload relate to transfer of accountability at change of shift, use of the CNO 3 Factor Framework for staff/patient assignment, Bullet Rounds and Hourly Rounding expectations, and documentation.

3.3.4.1 Standard Work and Service Agreement Processes

The 3C MSSU unit is a 30-bed unit that has developed standard work for the following roles: physicians, AR, RN, Unit Clerk, Allied health partners, Case reviewer, Unit manager and supervisor which was shared with the IAC. The IAC reviewed the Standard Work processes for the admission, patient transfer and discharge. These documents were created during the initial planning of the MSSU. The MSSU working group used documents from other organizations as well as their observations during site visits to guide them in the creation of these documents.

SAH is in the process of reviewing and updating the Standard work, daily evaluations (AR checklist) and having ongoing discussions of key individuals (physicians).

Several service agreements were developed however, there are several which remain unsigned and not agreed to by the parties.

**Recommendations:**

61. The Hospital will review and finalize within three (3) months all Standard work/Service Agreements of each process and role and update with any/all changes.

62. The Unit Council will collaborate with the Hospital and participate in the decision making process of the Standard Work of all roles and processes for 3C MSSU.

63. The Standard will be presented to all 3C MSSU staff through an interactive education session on the standard work to ensure knowledge translation.
3.3.4.2 Transfer of Accountability (TOA) - Change of Shift Report

Communication of information between health care providers is a fundamental component of patient care. The information shared between providers who are changing shifts, referred to as “handover” helps plan patient care. Absent or inaccurate information can have deleterious effects on patient care.67

The IAC had the opportunity to hear from staff during the Hearing that TOA or shift report is done however is not performed consistently. There are some opportunities for improvement related to TOA even though there is a corporate clinical policy regarding communication of team members during transfers. The process and tools SAH has developed are in the form of an “SBAR”.68

The IAC believes that transfer of accountability report needs to reflect standardized requirements for patient information that is transferred from shift to shift. Multiple tools exist in the literature, such as the Mosby Nursing Skills Nursing Report69. Effective transfer of accountability requires the nurse/team from the previous shift to provide information directly to the incoming nurse/team in order to ensure an opportunity to discuss and clarify patient care information. The IAC understood that a nurse-to-nurse transfer of accountability format is currently in use on 3C MSSU. The IAC supports that this practice continue but the tool with which nurses use needs to be revised to reflect the patient demographics on 3C MSSU.

This should be the responsibility of the Unit Council to develop a TOA tool reflective of the patient population on 3C MSSU. Based on best practice, a five-step implementation plan should be considered:70

a) Develop a patient-population specific component of the TOA standards
b) Development of a written tool
c) Introduce and implement a bedside safety checklist
d) Introduce a face-to-face reporting strategy using the above tools
e) Evaluate the TOA process

Recommendations:

64. The 3C MSSU Unit Council assume responsibility and accountability for developing the TOA standards based on the patient population for this unit

3.3.4.3 Patient Care Rounds

3.3.4.3.1 Bullet Rounds

The 3C MSSU holds rounds at 0815 and 1400 each day. The IAC had the privilege to observe the morning 0815 rounds during the first day of the IAC. The supervisor led the rounds with the frontline

68 SAH Submission – Transfer of Accountability April 15, 2016 http://mns.elsevierperformancemanager.com/NursingSkills/Cont
nurses discussing their individual patients. The GIMU and the Hospitalist were present as well as the Unit Manager, Pharmacist and some allied partners.

The Association informed the IAC that this is not the normal attendance at morning rounds. It was shared it is very common for several of the key players to be absent which ultimately impacts the efficiency of the rounds. It was noted that the rounds start time had been changed from 0800 am to 0815 to support the requests from their allied health partners. (i.e. case reviewers, social workers and PT/OT).

**Recommendations:**

65. **The 0815 rounds will change to discharge rounds and the Case Reviewer, Clinical Supervisor (leads the rounds). The RN (AR) will represent the front line staff.**

66. **The purpose of the 1400 rounds will be for the purpose of identifying barriers to discharge so the team is able to collaborate on appropriate discharge planning. Attendance will be the AR RN staff, Physicians, Case Reviewer. The unit manager and Director will attend 1400 rounds once a week to demonstrate support to the 3C MSSU staff and evaluate the rounds for compliance to the standard process and attendance at these rounds.**

### 3.3.4.3.2 Hourly Rounding

Hourly rounds are to focus on the essential areas of pain, positioning, personal needs including toileting and possessions. The staff on 3C MSSU is required to use a detailed script while completing their hourly rounds. The Francis report stated that change couldn’t be implemented through a top down pronouncement, yet this does occur with the implementation of hourly rounding on the MSSU. A number of benefits have been cited from intentional rounding i.e. reduction in patient falls, reduction in pressure ulcers, and increase in patient satisfaction. However, there has been no systematic review completed and the evidence that does exist is weak and inconclusive Snelling, P. (2013).

The staff on MSSU reported that they are not able to complete hourly rounds on their patients. They are not able to meet the standard of hourly rounds and voice moral distress due to this inability to complete the expectations set out by the leadership.

**Recommendations:**

The US government response to the Francis report was that all hospitals would be urged to introduce rounding. It was not clear what type of rounding was being promoted: intentional rounding on all patients or rounding being introduced on those patients only in need of them. The Francis report also recommended that professional groups should work on creating evidence-based standard procedures whenever possible.

67. **The Hospital must review the current literature and evidence on hourly rounding within three (3) months and work in collaboration with the 3C MSSU Unit council to establish the unit standards on rounding that are evidence based while supporting the organizations mission and vision and creating a safe, quality work environment for the staff and patients on 3C MSSU.**
68. The Hospital will agree to allow patient rounding on a frequency of 1-2 hours until the work in Recommendation 67 is complete. This recommendation is grounded in the quality of rounding versus the frequency based on the current literature.\(^{71}\)

3.3.4.3.3 Huddles

MSSU holds a brief huddle after the 1400 round each day. The purpose of these huddles when they were started was to discuss what was working well and what was not working well. It is the opinion of the hospital and association that these huddles have become a venue for the frontline to voice their frustration and lack solution strategies attached to them and are not productive for either side.

Recommendations:

69. These daily huddles should be replaced with staff meetings as per recommendation 39

3.3.4.4 Critical Incident Debriefing

The 3C MSSU staff care for patients under the services of Internal Medicine and Family Medicine. The Association and staff informed the IAC that they call the CCRT frequently due to the high acuity of patients on 3C MSSU.

The CCRT data is collected for the medicine program and identifies the number of calls that were placed from 3C MSSU specifically. There were seventeen (17) CCRT out of twenty-nine (29) calls within one month to 3C MSSU.

Several frontline staff expressed nursing fatigue and moral distress regarding their feelings of not having the time to complete their nursing responsibilities, meet the standards and expectations set out by the SAH as well and voicing feelings of failure to rescue patients. No formal incident debriefing process/policy is in place on the 3C MSSU or at SAH.

Recommendations:

70. The 3C MSSU leadership team will develop and implement a critical incident debriefing policy to be used after all CCRT calls for 3C MSSU.
71. Staff fatigue and moral distress regarding these matters above should be a standing agenda item at the Unit Council to ensure CID is improving and decreasing these concerns.
72. Once this policy has been developed for 3C MSSU, this should be implemented throughout the Hospital. The critical incident debriefing policy/process should be a three-step process that has each of the following components:

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3.3.4.5 Escalation Process

The association and front line staff shared testimonies that demonstrated a lack of awareness of a standard process for escalation of patient safety issues.

**Recommendations:**

73. **Based on what he IAC heard and understood during the proceedings the hospital will increase frontline awareness, implement and adhere to the escalation policy for SAH.**

3.3.4.6 LEAN Practices

The SAH has chosen to apply LEAN methodology as an approach to quality improvement. SAH states they have made a commitment to ensure staff and physicians are leading change across the organization. The SAH change model aligns between the Kotter and ADKAR model. They informed the IAC they are committed to providing education to all staff and leaders regarding LEAN as well as invest in staff receiving LEAN methodology certifications. In February of this year a Yellow Belt LEAN certified staff member was assigned to the MSSU to assist and lead in the process improvement work on 3C.

**Recommendations:**

74. **The hospital must review the current knowledge of LEAN methodology and culture amongst the staff and leaders on MSSU.**

75. **The hospital review the roles and responsibilities of the Yellow Belt Lean certified team member:**
   - Duties should include ongoing LEAN methodology education to frontline staff and leaders to ensure all have a clear and common understanding of the principles of LEAN in a health care setting.
   - Ensure change is frontline led.
   - Ensure the organization’s change management model is being followed.

3.3.4.7 Work Environments

Tasks performed by the nurses on 3C MSSU, involve a multiple of activities. These activities include both direct and indirect patient care, coordination of team member, communication information, documenting and some non-nursing duties. Some of these tasks take the nurses away from their patients. These include looking for supplies, stacking of supplies in the rooms and having to look for the key for WOW’s as they are not holding a charge. All these add to the workload of the nurses on 3C. Documented on the PRWRF’s and noted during the tour, the WOW’s are continuously not working. They are not holding a charge for any length of time. If this occurs, the nurse must look for the key (in which there is only one), as well delaying care as no power to use the WOW. The hospital is aware of this issue.
and will look again into the reason for this lack of charge. This is very concerning if the staff need to use the WOW in a hurry.

The supply room is stocked four days per week by central supplies. If supplies run out, as was the case during the tour, nurses must find the supply somewhere else or contact the supplies department. This in itself takes time either for the nurse or the AR.

As part of the AR duties, restocking some of the supplies, ensuring linen carts are stocked, as well as the rooms are properly set up and supplies available. She is however able to delegate these duties. Delegating some of these duties would only increase the nurses workload, and would take away some of her/his own duties as the AR. The IAC believes such duties increase the workload of both the nurses and the AR and would be more appropriate for a non-professional, allowing the nurses to care for their patients.

**Recommendations:**

76. The supplies to be restocked daily by central supplies. This is a very high patient turnover unit

77. The stocking duties be removed from the AR checklist

78. The hospital hires a unit aide to manage the daily restocking of supplies, including patient rooms

79. The hospital to investigate the reasoning for the WOW’s not holding a charge

80. The nurses are to ensure the key for the WOW’s is returned following use

3.3.4.8 Staff Professional Development

Staff new to SAH receive 2 days of Hospital orientation and 4 clinical days. Any staff that join the 3C MSSU team receives orientation on the SAH competency checklist-Medical Unit Orientation. This orientation/education is completed through a combination of time with the Educator, partnered with a mentor on the unit and self-study. The lists of self-learning packages were given to the IAC for review. The Modules appeared to center on skills and documentation for SAH not specific skills or standard work for 3C.

The association expressed concerns to the IAC that the staff on 3C did not have the time allotted to them to complete self-learning modules and were not offered appropriate adequate professional development for their professional growth

**Recommendations:**

81. The Hospital will develop an orientation program specific for the 3C MSSU containing the following components; standard work, roles and responsibilities of all team members including leaders, LEAN Methodology, Service Agreements, metrics – what is being measured, why it is being measured, what we do with the results, rounds – 0830, 1400 hrs., the purpose and expectations of these rounds

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72 SAH Submission on April 5, 2016
73 SAH Submission April 5, 2016
82. The unit educator and clinical Manager will identify the key staff who will be assigned the mentor role for 3C and ensure these staff have a solid understanding of the above.

83. The staff need to be given the time to complete education during work hours.

3.3.4.9 Patient Criteria for 3C MSSU

A MSSU provides patient care to a specific population. These patients require brief hospitalization and discharge as soon as condition warrants. The MSSU should service the types of admissions that can target care requirements and subsequently discharge within 72 hrs. This is the goal at SAH MSSU.

Admission criteria was developed by a RN who was part of the working group for the unit which was presented to the Senior Management Team. These criteria provided specific guidelines for admission to the unit. Prior to the target opening of August 2015, the admission criteria was changed to exclusion criteria vs inclusion criteria. The exclusion criteria have lead to a very broad definition of types of patients who are appropriate to be admitted to the short stay unit.

Staff has reported and it was supported through the IAC tour, the population of 3C MSSU appears to be different from both the inclusion and exclusion criteria. The hospital believes there was a difference of understanding of what is appropriate and what is not and what types of patients would be discharged or transferred within the 72 hr guideline.

The IAC also understands the Intensive Care Unit (ICU), is a closed unit and as a result the cardiac and telemetry patients are to be admitted to 3C, with some exclusions. These patients in of themselves would be considered of higher acuity and complexity requiring more constant monitoring and a smaller nurse: patient ratio. The hospital also believes any patient would benefit from the MSSU as their overall LOS would be shorter.

The IAC commends the hospital in its implementation of a Critical Care Response Team (CCRT). This team provides an assessment in other areas of the hospital (not including ICU), when staff or physicians are concerned about a patient’s condition. This team has been utilized on MSSU as well as other areas. The concern of the IAC is the number of assessments by the CCRT, have been greater on 3C MSSU, than other units, supporting the premise of this unit being high acuity and further of the incidence of inappropriate admissions.

**Recommendations:**

84. The Hospital reviews the current exclusion criteria and revert back to admission criteria.

85. The hospital re-convene the working group, which included front line staff to develop specific guidelines for admission criteria based on what has worked and what has not worked over the past several months. There is a stress on what has not worked related to

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1. The Short Stay Unit as an option for hospitals: A review of the scientific literature. Medical Science Monitor v. 17(6)2011; SR15-SR19
   Gianfranco Damiani, Luigi Pinnarelli, Lorenzo Somella, Valentin Vera, Patrizia Magrini, Walter Ricciardi
types of patients on the unit. Part of this work would include reviewing the statistics related to diagnosis and their length of stay, utilization of CCRT and admission to ICU

86. Develop debriefing following each use of CCRT to ensure this was an appropriate admission. Include length patient has been on unit, as any patient can change condition following admission

87. Once admission criteria has been developed, all front line staff from MSSU, ED, ICU and any other unit who may be involved in the process be brought together to review and ensure understanding of the criteria

88. All management staff/physicians to have a clear understanding of the admission criteria

89. The criteria should also be posted on the units for clear viewing and circulated to all GIMU, hospitalists and family practice

90. The admission criteria must be adhered to by all staff and physicians at SAH

91. The hospital develop an escalation policy for the RN (AR)s, which provides support from management to move inappropriate admissions or patients who deteriorate off the MSSU in a timely manner.
SECTION IV

4.1 Conclusion

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

The IAC Panel completed a thorough analysis, which included an in-depth review of information received prior to and during the Hearing in relation to the literature relating to medical and short stay nursing, consideration of factors impacting the 3C MSSU practice environment, and integration of the Panel’s cumulative practice experience.

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

A ‘workload consistent with proper patient care’ requires an environment that supports quality practice. Robust existence of the seven sentinel characteristics of a quality practice environment identified by the CNU and CNFU\(^ {75} \) are required. The IAC believes that addressing issues relating to leadership and shared governance, model of care delivery and associated staffing and clinical practice / unit processes will enable 3C MSSU to become a quality practice environment and all staff, including the RNs, to experience a workload that supports proper patient care.

SECTION V

5.1 Summary of Recommendations

The IAC identified 91 recommendations, in the areas of leadership and shared governance, nursing delivery model of care and associated staffing, and clinical practices / unit processes, to address the issue of RN workload on 3C MSSU.

5.2.1 3.3.2 3C MSSU Leadership and Governance

1. A quality practice setting requires effective operational, clinical and point-of-care leadership.
2. The 3C MSSU Leadership team develop a strategy to implement the Registered Nurses Association of Ontario (RNAO) Best Practice Guideline Developing and Sustaining Nursing Leadership on 3C MSSU.
3. The Registered Nurses Association of Ontario (RNAO) Best Practice Guideline Developing and Sustaining Nursing Leadership becomes the framework utilized for leadership development for all 3C MSSU RNs.

5.2.2 3.3.2.2.1 3C MSSU Clinical Manager Role

4. The 3C MSSU Clinical Manager must be responsible for 3C MSSU only, on a 1.0 FTE basis, for a minimum of a six-month period.
5. The Clinical Manager must be provided with the resources of a formalized leadership coach/mentor to foster professional leadership growth and development. The Clinical Manager will then be the coach/mentor to the Clinical Supervisors and the RN (AR)s.

5.2.3 3.3.2.2.2 3C MSSU Clinical Supervisor Role

6. Dedicate two Clinical Supervisors to 3C MSSU for a minimum of a 6-month period during the hours of 0700-1500 and 1500-2300.
7. Develop and sustain the RNAO Best Practice Guideline Developing and Sustaining Nursing Leadership on 3C.
8. The patient assignment is completed by the RN (AR) using the College of Nurses of Ontario's RN and RPN Practice: The Client, the Nurse and the Environment.
9. The RN (AR) is responsible for all admissions to the unit and will go to ER for a complete report.
10. The 3C MSSU admission criteria must be reviewed by the ED leadership team to ensure there are appropriate and timely admissions to 3C MSSU.
11. The RN (AR) is empowered to call in additional staff based on her/his judgement of the unit activities/ acuity. If appropriate notify the Clinical Supervisor of this decision. This decision should not be questioned by the staffing office.

5.2.4 3.3.2.2.3 3C MSSU RN Additional Responsibility (AR) Role

12. The patient assignment is completed by the RN (AR) using the College of Nurses of Ontario’s RN and RPN Practice: The Client, the Nurse and the Environment Guideline.77
13. The RN (AR) is responsible for all admissions to 3C MSSU and will be responsible for obtaining a complete patient report from the ED nurse.
14. The 3C MSSU admission criteria must be reviewed by the ED leadership team to ensure there are appropriate and timely admissions to 3C MSSU.
15. The RN (AR) is empowered to call in additional staff based on her/his judgement of the unit activities/acuity. If appropriate notify the Clinical Supervisor of this decision. This decision should not be questioned by the staffing office.
16. The IAC recommends the Hospital post four (4) permanent FTE RN (AR) positions with four relief RN (AR) positions for 3C MSSU which will cover 24 hrs/day 7 days/week.
17. The RN (AR) positions will be posted as per the ONA collective agreement and to be posted immediately
18. The RN (AR) on the 0700-1900 hr shift will NOT have a patient assignment
19. The RN (AR) on the 1900-0700 hr shift will have a three (3) patient assignment – these patients should be those that are to be discharged within twenty-four hours and non-telemetry patients (please refer to the 3C MSSU Reconfiguration Model)

5.2.5 3.3.2.2.4 3C MSSU Educator Role

20. The Hospital assigns a full time educator responsible for only 3C MSSU for a minimum of six (6) months and then re-evaluates the need for a fulltime educator for both 3B an 3C.
21. The Hospital, review the workload of the nurses to allow time to attend relevant education
22. The Educator would be responsible for recertification, updates/refreshers, ie telemetry, peritoneal dialysis, stroke and any annual review of skills
23. The Educator would be a member of the 3C MSSU Unit Council
24. Continue to post in-services and allow for input for education sessions from staff
25. The hospital ensure adequate staffing on MSSU when students are on the unit, to ensure a positive learning environment

5.2.6 3.3.2.2.5 3C MSSU RN (EC) Nurse Practitioner Role

26. The Hospital must reassign the current RN (EC) within the Medical Program to 3C MSSU for a minimum of six (6) months. Responsibilities would include working collaboratively with the RN AR in the admissions room to perform admission assessments including medication reconciliation, use of order sets, discharge planning with the intent of ensuring medication reconciliation is complete and any other activities that would be deemed appropriate for this role
27. Prior to the end of the six month trial an evaluation of the RN (EC) role must be conducted to determine if there is evidence to support this to be a permanent position.
28. The RN (EC) would practice to his/her full scope of practice as espoused by the College of Nurses of Ontario
29. The hours the RN (EC) would work would be determined to facilitate early discharges and the multidisciplinary approach.

5.2.7  3.3.2.6 3C MSSU Role Clarity – Clinical Manager and Clinical Supervisor

30. The hospital to revise the leadership standard work and must provide clarity of these two positions within three (3) months.
31. At a staff meeting the role clarity will be presented and noted in the minutes so staff have a clear understanding of the roles and responsibilities of both the Clinical Manager and Supervisor.
32. Adopt the concept of 360 feedback reviews/evaluations for leaders on MSSU to offer anonymous frontline feedback to the leaders who manage and guide them. The 360-evaluation process will provide a balanced view of ones performance in all areas of leadership that will assist the professional growth of the organizations leaders.

5.2.8  3.3.2.3 3C MSSU Shared Governance Structures

33. The Hospital clearly defines the roles and responsibilities of the RD related to 3C MSSU process improvement initiative.
34. The RD become a member of the 3C MSSU Unit Council during her five month tenure to share results of the process improvement initiatives to enable effective decision making.
35. The results of surveys sent out to staff based on process improvements be summarized and shared with all 3C MSSU staff. These results would then be discussed at Unit Council to effect change if required.

5.2.8  3.3.2.3.1 3C MSSU Unit Council

36. The 3C MSSU Unit Council revise the Terms of Reference to specify decision-making authority related to practice, procedures and guidelines and ground rules for action during and following meetings.
37. The Hospital provides appropriate resourcing of the 3C MSSU Unit Council, to enable effective discussion and decision-making processes to occur.
38. The Hospital provides clerical assistance to ensure agenda and minutes are developed and circulated in a timely fashion for all 3C MSSU staff.

5.2.9  3.3.2.3.2 3C MSSU Staff Meetings

39. Replace daily huddles with weekly staff meetings on the same day of the week at 7am (shift change) for a 6-month pilot led by the Clinical Manager. The Director of the Medical Program must attend one staff meeting per month.
40. Staff must be given the opportunity to submit agenda items.
41. Staff should make every effort to attend staff meetings that are planned and be part of the process to make improvements and provide suggestions. It is also the staff’s responsibility to read minutes of staff meetings that are posted or shared by email.
42. SAH should consider different options to engage staff in attending staff meetings for example arranging meetings to be conducted via teleconference so staff can be engaged.
5.2.10 3.3.2.3.3 3C MSSU Nursing Professional Practice Governance Model

43. Implement the SAH Nursing Practice Council as planned and simultaneously seek broad engagement by all nurses throughout SAH to become actively involved in the professional opportunity.

44. Consider practice issues identified at the various SAH Unit Councils be shared at the SAH Nursing Practice Council to identify key themes and trends related to professional nursing practice.

5.2.11 3.3.2.3.4 3C MSSU Communication

45. Implement recommendation 39 related to staff meetings.

46. Implement a weekly update from the Clinical Manager of issues, activities, decisions and/or changes via email on Fridays to ensure all staff is kept informed.

47. All staff be held accountable and responsible for reading their emails and ensure they are aware of unit updates.

5.2.13 3.3.2.3.5 3C MSSU Staff Rounding

48. The Clinical Manager implement staff rounding twice per week.

49. The Clinical Manager must connect with all staff once a week between Monday and Friday for staff rounding.

5.2.14 3.3.2.3.6 3C MSSU PRC Process with SAH and ONA

50. The IAC encourages the SAH and the local association to work together to improve the PRC process with the goal of implementing a collaborative approach to resolving workload concerns. This will include commitment on both sides to follow the steps in the collective agreement including time lines as set out.

51. The hospital and ONA review the WRH presentation related to the Professional Responsibility Complaint and implement a similar process.78

5.2.15 3.3.2.4 Unit Culture and Change Management

52. The Hospital engages either in an internal expert to facilitate the development of a unit culture that is founded on the principles that underpin the Hospital’s code of conduct. This should include change management, team-building, conflict resolution and communication activities involving active staff participation.

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78 Windsor Regional Hospital Electronic Professional Responsibility Complaint Process – Blending Collaboration and Technology.
5.2.15 3.3.3.2.2 3C MSSU Staffing

53. The Hospital will maintain a 1:4 nurse patient ratio on days and 1:5 on nights for RN staffing.
54. The RN (AR) will have no patients on days from 0700-1900 hrs and the RN (AR) will have 0-3
patient maximum on 1900-0700 hrs assigned to discharged patients and no telemetry patients.
55. This creates an increase the equivalent of one (1) RN on days equal to 2.5 FTEs.

5.2.16 3.3.3.2.3 3C MSSU Scheduling

56. Staff need to ensure they take their scheduled breaks and seek appropriate relief to ensure they
get their entitled break allotments and rest.
57. If Float nurses are scheduled to 3C MSSU they must be fully trained to care for this patient
population.
58. Begin dialogue between the Association and the Hospital to review the 2day/2night 5 day off
schedule as per the staff request. The ONA local agreement outlines how a change to this type
of schedule should occur, beginning with a vote of the nurses involved. If such vote is for this
change in schedule, the hospital will draft the schedule and forward to the scheduling
committee within 6 weeks of the vote. The hospital incorporates the RNAO best practice
guideline Preventing and Mitigating Nurse Fatigue in Health Care\(^{79}\)

5.2.18 3.3.3.2.4 3C MSSU Unit Assistant

59. Provide Unit Assistant coverage from 0700 – 2300 hrs Monday to Friday and on Saturday and
Sunday from 0700-2300 hrs.

5.2.19 3.3.3.3 3C MSSU Physician Model of Care

60. A comprehensive external review will be conducted on the Physician Model of Care at SAH to
ensure continuity and consistency of quality patient care.

5.2.20 3.3.4.1 3C MSSU Standard Work and Service Agreement Processing

61. The Hospital will review and finalize within three (3) months all Standard work/Service
Agreements of each process and role and update with any/all changes.
62. The Unit Council will collaborate with the Hospital and participate in the decision making
process of the Standard Work of all roles and processes for 3C MSSU.
63. The Standard will be presented to all 3C MSSU staff through an interactive education session on
the standard work to ensure knowledge translation.

5.2.21 3.3.4.2 3C MSSU Transfer of Accountability (TOA) – Change of Shift Report

64. The 3C MSSU Unit Council assume responsibility and accountability for developing the TOA
standards based on the patient population for this unit.

\(^{79}\) Preventing and Mitigating Nurse Fatigue in Health Care, 2011
5.2.21  3.3.4.3.1 3C MSSU Bullet Rounds

65. The 0815 rounds will change to discharge rounds and the Case Reviewer, Clinical Supervisor (leads the rounds) the RN (AR) will represent the front line staff.

66. The purpose of the 1400 rounds will be for the purpose of identifying barriers to discharge so the team is able to collaborate on appropriate discharge planning. Attendance will be the AR RN staff, Physicians, Case Reviewer. The unit manager and Director will attend 1400 rounds once a week to demonstrate support to the 3C MSSU staff and evaluate the rounds for compliance to the standard process and attendance at these rounds.

5.2.22  3.3.4.3.2 3C MSSU Hourly Rounding

67. The Hospital must review the current literature and evidence on hourly rounding within three (3) months and work in collaboration with the 3C MSSU Unit council to establish the unit standards on rounding that are evidence based while supporting the organizations mission and vision and creating a safe, quality work environment for the staff and patients on 3C MSSU.

68. The Hospital will agree to allow patient rounding on a frequency of 1-2 hours until the work in Recommendation 67 is complete. This recommendation is grounded in the quality of rounding versus the frequency based on the current literature.80

5.2.24  3.3.4.3.3 3C MSSU Huddles

69. These daily huddles should be replaced with staff meetings as per recommendation 39.

5.2.25  3.3.4.4 3C MSSU Critical Incident Debriefing

70. The 3C MSSU leadership team will develop and implement a critical incident debriefing policy to be used after all CCRT calls for 3C MSSU.

71. Once this policy has been developed for 3C MSSU, this should be implemented throughout the Hospital. The critical incident debriefing policy/process should be a three-step process that has each of the following components:

• a defusing phase the day of the incident,
• a debriefing phase that occurs within 72 hours of the incident and a follow-up phase that occurs within one week of the incident.

72. Staff fatigue and moral distress regarding these matters above should be a standing agenda item at the Unit Council to ensure CID is improving and decreasing these concerns.

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5.2.26 3.3.4.5 3C MSSU Escalation Process

73. Based on what he IAC heard and understood during the proceedings the hospital will increase frontline awareness, implement and adhere to the escalation policy for SAH.

5.2.26 3.3.4.6 3C MSSU Lean Practices

74. The hospital must review the current knowledge of LEAN methodology and culture amongst the staff and leaders on MSSU.
75. The hospital will review the roles and responsibilities of the Yellow Belt Lean certified team member. Duties should include ongoing LEAN methodology education to frontline staff and leaders to ensure all have a clear and common understanding of the principles of LEAN in a health care setting. Ensure change is frontline led. Ensure the organization’s change management model is being followed.

5.2.27 3.3.4.7 3C MSSU Work Environments

76. The supplies to be restocked daily by central supplies. This is a very high patient turnover unit
77. The stocking duties be removed from the AR checklist
78. The hospital hires a unit aide to manage the daily restocking of supplies, including patient rooms
79. The hospital to investigate the reasoning for the WOW’s not holding a charge
80. The nurses are to ensure the key for the WOW’s is returned following use

5.2.28 3.3.4.8 3C MSSU Professional Development

81. The Hospital will develop an orientation program specific for the 3C MSSU containing the following components: Standard work, roles and responsibilities of all team members including leaders, LEAN Methodology, Service Agreements, metrics – what is being measured, why it is being measured, what we do with the results, rounds – 0830, 1400 hrs., the purpose and expectations of these rounds
82. The unit educator and clinical Manager will identify the key staff who will be assigned the mentor role for 3C and ensure these staff have a solid understanding of the above. The staff need to be given the time to complete education during work hours.
83. The staff need to be given the time to complete education during work hours.

5.2.29 3.3.4.9 Patient Criteria for 3C MSSU

84. The Hospital reviews the current exclusion criteria and revert back to admission criteria.
85. The hospital re-convene the working group, which included front line staff to develop specific guidelines for admission criteria based on what has worked and what has not worked over the past several months. There is a stress on what has not worked related to types of patients on the unit. Part of this work would include reviewing the statistics related to diagnosis and their length of stay, utilization of CCRT and admission to ICU
86. Develop debriefing following each use of CCRT to ensure this was an appropriate admission. Include length patient has been on unit, as any patient can change condition following admission
87. Once admission criteria has been developed, all front line staff from MSSU, ED, ICU and any other unit who may be involved in the process be brought together to review and ensure understanding of the criteria
88. All management staff/physicians to have a clear understanding of the admission criteria
89. The criteria should also be posted on the units for clear viewing and circulated to all GIMU, hospitalists and family practice
90. The admission criteria must be adhered to by all staff and physicians at SAH
91. The hospital develop an escalation policy for the RN (AR)s, which provides support from management to move inappropriate admissions or patients who deteriorate off the MSSU in a timely manner.
SECTION VI

Appendices

Appendix 1: Article 8.01: Professional Responsibility

Appendix 2: Nominee for the Association

Appendix 3: Nominee for the Hospital

Appendix 4: IAC Hearing Agenda and Hospital and Association Correspondence for IAC Hearing

Appendix 5: SAH Additional Information request

Appendix 6: Attendance Lists
January 13, 2012

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 3C Medical, Sault Area Hospital
(ONA File # 201103071)

The Registered Nurses (RNs) working in the Acute Medical (3C), Sault Area Hospital have consistently identified ongoing serious practice and workload concerns as evidenced by the data submitted on numerous Professional Responsibility Workload Report Forms (PRWRFs). We expect that this pattern will continue into the future.

The RNs working in 3C have documented that the current practice, patient care and workload environment does not allow them to meet College of Nurses of Ontario (CNO) standards; and 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 and unit activity, 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 that they care for, and remains very concerned regarding the impact on patient safety and 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 McMicking St.
Niagara Falls, ON
L2J 1W7
Cell: 905-329-3597
Home: 905-357-6276
E-mail: cagabrielli@cogeco.ca
Please provide written confirmation concerning the name, mailing address, home or cell and office phone numbers, fax number and e-mail address of your nominee.

As per my e-mail dated January 4th the Union recommends that the parties agree to invite Joan Cardiff as Chair of this IAC. Our rationale is that the issues are somewhat similar and overlap with the challenges in the ER, and it makes sense to utilize the knowledge and expertise that the ER IAC will gain during the ER hearing as a base for the 3C hearing. Therefore, if you are in agreement this hearing would occur on dates subsequent to the ER IAC. Please advise if you are in agreement with this recommendation.

Yours truly,

ONTARIO NURSES' ASSOCIATION

Jo Anne Shannon
Professional Practice Specialist

C: Linda Haslam-Stroud, President, Ontario Nurses' Association (ONA) (By Email)
  Glenda Hubley, Local Coordinator (By Email)
  David Cheslock, Labour Relations Officer, ONA (By Email)
  Cindy Gabricelli, ONA Nominee (By Email)
  Ron Gagnon, President and CEO, Sault Area Hospital (SAH)
  Marie Paluzzi, Vice President & COO, SAH
  Cynthia Johnson, Manager of 3C Medical (By Email)
  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 Haley, SAH Board of Directors
  Donna Hilsinger, SAH Board of Directors
  Gregory Peres, SAH Board of Directors
  Anthony P. Marrato, SAH Board of Directors
  Luisa 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. Greg Berg, Director of Medical Program
  Louise Paquette, CEO, NE LHIN
  Randy Kapashesit, Interim Chair of the Board of Directors, North East LHIN
January 6, 2016

Donna Rothwell
55 Carriage Road
St. Catharines, ON
L2P 1T1
donna.rothwell@stantec.com

VIA EMAIL

Re: Sault Area Hospital and Ontario Nurses’ Association: Professional Responsibility Complaint – Independent Assessment Committee (IAC) Referral – 3C Medical Unit

Dear Donna Rothwell,

I wish to inform you that the Sault Area Hospitals nominee for the IAC will be:

Theresa Morris
Director of Emergency Services
Windsor Regional Hospital
1995 Lens Avenue
Windsor, ON N8W 1L9

Telephone: 519-254-5577 Ext. 52407
Cell: 519-792-4468
Email: theresa.morris@wrh.on.ca

Please do not hesitate to contact me should you require additional information.

Sincerely,

[Lori Bertrand, RN BScN]
Director, Clinical Programs
(Medicine, ED, ICU, Stroke, Cardiac and Renal Programs)
Sault Area Hospital | 750 Great Northern Road | Sault Ste. Marie, ON | P6B 0A8
☎ 705.759.3434 ext. 5535 | bertrandl@sah.on.ca | www.sah.on.ca

C.C. Theresa Morris, SAH Nominee
Jo Anne Shannon, Professional Practice Specialist, ONA
Glenda Hubley, Local Coordinator, ONA
David Cheslock, Labour Relations Officer, ONA
Cindy Gabrielli, ONA Nominee
Heather Camrass, CNO, SAH
Jack Willet, Patient Care Manager, Medical 3C, SAH
David McCoy, Ontario Hospital Association
Kim Lemay, Director, HR, SAH

750 Great Northern Road, Sault-Ste-Marie (Ontario) P6B 0A8
Independent Assessment Committee (IAC)

Hearing

Ontario Nurses’ Association/Sault Area Hospital

Draft Agenda

Monday April 4, 2016

0800-0900 hrs  Independent Assessment Committee Meeting (Members only)
0900 - 1100 hrs  Tour of 3C Medical Unit – Tour Lead and Participants (TBD)
1100 - 1130 hrs  Break
1130 - 1200 hrs  Introductions and Review of the Proceedings by Chairperson
1200 – 1300 hrs  Lunch
1300 - 1430 hrs  Ontario Nurses Association Submission Presentation

  •  Response to questions of clarification by
    1.  Independent Assessment Committee
    2.  Sault Area Hospital

1430-1445 hrs  Break
1445-1615 hrs  Sault Area Hospital Submission Presentation

  •  Response to questions of clarification by
    1.  Independent Assessment Committee
    2.  Ontario Nurses Association

1615 - 1630 hrs  Review of Process for April 5, 2016 by Chairperson
1630 hrs  Adjournment
1630 - 1800 hrs  Meeting with the Independent Assessment Committee Members only
Independent Assessment Committee (IAC)

Hearing

Ontario Nurses’ Association/Sault Area Hospital

Draft Agenda

Tuesday April 5, 2016

0800-0900 hrs  
Independent Assessment Committee Meeting (Members only)

0900 hrs  
Continuation of the Hearing

0900-1200 hrs  
Sault Area Hospital Response to Ontario Nurses’ Association Submission

- Response to questions from:
  1. Independent Assessment Committee
  2. Ontario Nurses Association
  3. Discussion

1200-1300 hrs  
LUNCH

1300-1600 hrs  
Ontario Nurses Association Response to Sault Area Hospital Submission

- Response to questions from
  1. Independent Assessment Committee
  2. Sault Area Hospital
  3. Discussion

1600-1615 hrs  
Review of Process for April 6, 2016 by Chairperson

1615 hrs  
Adjournment

1615-2030 hrs  
Meeting with the Independent Assessment Committee Members only
Independent Assessment Committee (IAC)

Hearing

Ontario Nurses' Association/Sault Area Hospital

Draft Agenda

Wednesday April 6, 2016

0800 hrs  Continuation of the Hearing
0800-1200 hrs  Questions to both ONA and SAH by the IAC
               Closing Remarks
1200 hrs  Closure of the Hearing
January 9, 2016

Donna Rothwell
56 Carriage Road,
St. Catharines, ON
L2P 1T1

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

Dear Ms. Shannon

Re: Sault Area Hospital (SAH) and Ontario Nurses’ Association (ONA): Professional Responsibility Complaint 3C Medical Unit – Independent Assessment Committee Hearing

The purpose of this correspondence is to confirm the plans for the Independent Assessment Committee Hearing regarding the Professional Responsibility Complaint between the Sault Area Hospital 3C Medical Unit and the Ontario Nurses Association.

The Independent Assessment Committee (IAC) Hearing will be held on Monday April 4, Tuesday April 5, and Wednesday April 6, 2016 at the Sault Area Hospital. A “draft” agenda is attached.

On Monday April 4, 2016, the IAC would like to have a tour of the 3C Medical Unit at 0900 hrs prior to the Hearing. Please work in collaboration with ONA to arrange for the tour to begin at this time and jointly decide the following:

1. Determine three SAH and three ONA representatives who will accompany the three (3) IAC members on the tour; and who the representatives will be;
2. Determine if there are other areas in addition to the 3C Medical Unit that may be required to tour in order for the IAC to have a comprehensive understanding of the issues, and if so, which these will be; and
3. Determine who will lead the tour.

Please provide this information no later than Friday March 18, 2016.
The commencement of the hearing will then begin on Monday April 4, 2016 at 1300 hrs. As indicated in the draft Hearing Agenda, each of the SAH and ONA representatives will have one and a half (1.5 hours) to present their submission. The Hearing will adjourn for the day following the presentation of both submissions, in order that each party has the opportunity to prepare their Response for the following day.

The Hearing will commence on Tuesday April 5, 2016 at 0900 hrs. 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 the adjournment will depend on the extent of the discussion required. The IAC will meet following the day’s adjournment to determine areas/issues requiring further clarification.

The Hearing will recommence on Wednesday April 6, 2016 at 0800 hours with questions to both SAH and ONA by the IAC. The Hearing will close by 1200 hours; if additional time is required, arrangements will be made at that time for the 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 and beverages be made available for the ONA representatives.

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, attachments and/or supporting documents be provided no later than Friday March 18, 2016. Please send one (4) hard copies to me as Chair of the IAC via courier to the address at the beginning of my correspondence and an electronic version of your submission, attachments/supporting documents to drothwell9@gmail.com so I am able to send the ONA hard copy and electronic versions of all documentation to:

- ONA submission to Cindy Gabrielli (ONA Nominee) and Theresa Morris (SAH Nominee)
- ONA submission to SAH (attention to Heather Camrass)

In the event that ONA wishes to provide supplemental information after March 18, 2016, this will be accepted until Thursday March 24, 2016 and will be distributed as outlined above. Supplemental information may be sent via email but a hard copy must follow. Please note that supplemental information is information to support/clarify ONA’s submission; it is not to respond to the SAH submission.
The IAC will hold a Pre-Hearing Meeting the week of March 21, 2016 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 the development of the draft IAC report with, or seek feedback, comments, input from ONA while the report is being developed by the IAC committee, and will not share copies of the Report.

The IAC looks forward to working with ONA to address professional responsibility issues of concern with 3C Medical Unit. Should you have any questions please call me at 905-931-0204 or email me at drothwell9@gmail.com

Sincerely

Donna Rothwell

cc. Theresa Morris, SAH Nominee
   Cindy Gabrielli, ONA Nominee
   Jo Anne Shannon, Professional Practice Specialist, ONA
Monday March 28, 2016

Heather Camrass
Chief Nursing Officer
SAH

Donna Rothwell
IAC Chairperson

RE: SAH Follow-Up Information Required

Heather, the IAC Committee members have reviewed the extensive information provided by both the Association and SAH. However, we have identified the need for additional information as outlined below. Could you please have this information available on Monday April 4, 2016 (three hard copies) for the IAC Committee members? If you are able to provide this information prior to Monday can you please send it to me electronically by Friday April 1, 2016 please?

a) 3C MSSU Vacancy rate

b) 3C MSSU Overtime rates

c) 3C MSSU Absenteeism rates

d) 3C MSSU Master rotation

e) RN (AR) role description

f) Physician schedule for this unit

g) 3C MSSU Staff meeting agendas/minutes

h) Ongoing professional development/continuing education initiatives on 3C MSSU

i) 3C MSSU KPIs/quality indicators

j) Is SAH a “Studer” facility- what have they adopted in terms of the Studer model corporately?

k) SAH Change Management Philosophy – Kotter, ADKAR

l) Does SAH use an external staffing organization at all?
m) Role of the RRT on 3C MSSU

n) Model of Care – “Total Patient Care” Model – what does this mean? What education was provided to the staff?

o) Number of admissions per day, discharges per day and transfers per day.

p) Do they have targets for each of these to ensure/maintain flow on the 3C MSSU?

q) Is there an escalation process to follow when flow is impeded or targets are not met?

r) Do they have a transfer of accountability handoff tool and if so could we have a copy.

s) Is there standard work for pulling an admission out of ED, if so could you provide a copy of this?

t) Is there a tool for shift report - i.e. patient summary tool etc. If so can we have a copy?

u) Who makes the nursing assignments – AR, Operations manager?

v) How many hours of training/education did the frontline staff receive prior to opening of unit and ongoing education regarding Standard work and flow?

w) Were frontline staff involved in developing the Standard work development for the unit?

x) Does Decision support track metrics daily, weekly or monthly? Are these metrics posted and discussed with frontline staff?

y) Are there 3C MSSU staff meetings held? If so how often? Who is responsible for having staff meetings?

z) Could we have copies of the education material which the nurses use in the 3C MSSU, including the self-directed learning package? Also has there been any inservices for the MSSU staff, if so a copy of same. Included the sign in sheets for these education sessions. What percentage of the time is the educator on site for the staff?

i) Why was the 3C MSSU SSPC/RN working group stopped and what happened between June (when it was stopped) and September when unit opened? What is currently in place?

ii) Could we have a copy of the minutes for all these meetings of the above, including attendance?

iii) Unit Council meetings – could we have copies of the minutes of these meetings and a list of who attended?

iv) Copy of the admission criteria for the 3C MSSU effective March 14 2016

v) Copies of all the standard of work/service agreements
vi) Has there been an evaluation of the unit since it has opened? If so could you please share these minutes?

vii) Copy of the nurses rotation for a six (6) week period

viii) Why does the AR go to ER and what happens on the unit when she is gone? Does she have the authority to refuse a patient if feels does not meet the criteria? On average how long is she off the unit?

ix) Statistics of the amount of time the critical care response team is called to assist to MSSU including the number of transfers

x) The unit had a patient care coordinator in past which hospital changed to supervisors. There are 4 supervisors or in the process of hiring, so why are they only there until 2000hrs. What percentage of the time is the supervisor on the unit for assistance?

xi) The AR job description. Do all nurses rotate through this position?

xii) How often is the float pool used?

xiii) Now have 10 more beds but the extra staff not in place? How are these beds staffed?

xiv) Is pharmacy doing med reconciliation at discharge with the patient/family? If not who is doing this?
January 10, 2016

Donna Rothwell
56 Carriage Road,
St. Catharines, ON
L2P 1T1

Heather Camrass
Chief Nursing Officer
Director of Operations
Sault Area Hospital
750 Great Northern Road
Sault Ste. Marie, ON
P6B 0A8

Dear Ms. Camrass

Re: Sault Area Hospital (SAH) and Ontario Nurses’ Association (ONA): Professional Responsibility Complaint 3C Medical Unit – Independent Assessment Committee Hearing

The purpose of this correspondence is to confirm the plans for the Independent Assessment Committee Hearing regarding the Professional Responsibility Complaint between the Sault Area Hospital 3C Medical Unit and the Ontario Nurses Association.

The Independent Assessment Committee (IAC) Hearing will be held on Monday April 4, Tuesday April 5, and Wednesday April 6, 2016 at the Sault Area Hospital. A “draft” agenda is attached.

On Monday April 4, 2016, the IAC would like to have a tour of the 3C Medical Unit at 0900 hrs prior to the Hearing. Please work in collaboration with ONA to arrange for the tour to begin at this time and jointly decide the following:

1. Determine three (3) SAH and three (3) ONA representatives that will accompany the three (3) IAC members on the tour; and who the representatives will be;
2. Determine if there are other areas in addition to the 3C Medical Unit that may be required to tour in order for the IAC to have a comprehensive understanding of the issues, and if so, which these will be; and
3. Determine who will lead the tour.

Please provide this information no later than Friday March 18, 2016.
The commencement of the hearing will then begin on Monday April 4, 2016 at 1300 hrs. As indicated in the draft Hearing Agenda, each of the SAH and ONA representatives will have one and a half (1.5 hours) to present their submission. The Hearing will adjourn for the day following the presentation of both submissions, in order that each party has the opportunity to prepare their Response for the following day.

The Hearing will commence on Tuesday April 5, 2016 at 0900 hrs. 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 the adjournment will depend on the extent of the discussion required. The IAC will meet following the day’s adjournment to determine areas/issues requiring further clarification.

The Hearing will recommence on Wednesday April 6, 2016 at 0800 hours with questions to both SAH and ONA by the IAC. The Hearing will close by 1200 hours; if additional time is required, arrangements will be made at that time for the continuation of the Hearing at a mutually convenient date.

The IAC would prefer to conduct the Hearing at the SAH, if this is possible, and requests the following logistical arrangements. Please confirm whether these logistics will be possible no later than Tuesday March 1, 2016.

Hearing and IAC:

- A room capable of seating 23 people with the table configured in a “U” shape:
  - 3 seats at the front/top of the “U” for the IAC Committee Members and;
  - 10 seats on either side of the “U” shape for the SAH and ONA Hearing participants
  - Additional seating is required outside and around the “U” shaped table for staff and/or Physicians wishing to attend the Hearing and observe only
- Access to the Hearing Room by the IAC in the evening (beyond 2000 hrs) on the evening of Tuesday April 5, 2016
- Provision of the following:
  - An extension cord (s) if an electrical plug is not close to IAC seats and for both ONA and SAH participants
  - An LCD projector (Monday and Tuesday only)
  - A flip chart/white board with markers
  - Access to a photocopier if required
  - Telephone
  - Internet access
Caucus Rooms for both SAH and ONA:
  • A room capable of seating 10 people as close to the Hearing room as possible
  • Telephone and Internet access
  • Extension cords

Catering: Hearing Room:
  • Provision of:
    o Tea, coffee, juice, water, at all times the Hearing is in progress
    o Muffins for the morning breaks
    o Cookies and fruit for the afternoon breaks
  • Provision of a working lunch for the three (3) IAC members on all three days

Catering for both SAH and ONA:
  • Provision of tea, coffee and water for all three days

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, attachments and/or supporting documents be provided **no later than Friday March 18, 2016**. Please send four (4) hard copies for me as Chair of the IAC via courier to the address at the beginning of my correspondence and an electronic version of your submission, attachments/supporting documents to drothwell9@gmail.com so I am able to send the SAH hard copy and electronic versions of all documentation to:
  • SAH submission to Cindy Gabrielli (ONA Nominee) and Theresa Morris (SAH Nominee)
  • SAH submission to ONA (attention to Jo Anne Shannon)

In the event that SAH wishes to provide supplemental information after March 18, 2016, this will be accepted until Thursday March 24, 2016 and will be distributed as outlined above. Supplemental information may be sent via email but a hard copy must follow. Please note that supplemental information is information to support/clarify SAH’s submission; it is not to respond to the ONA submission.
The IAC will hold a Pre-Hearing Meeting the week of March 21, 2016 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, Theresa Morris, prior to the Hearing. In order to ensure integrity of the IAC process, following completion of the Hearing the Nominee will NOT discuss the development of the draft IAC report with, or seek feedback, comments, input from SAH while the report is being developed by the IAC committee, and will not share copies of the Report.

The IAC looks forward to working with SAH to address professional responsibility issues of concern with 3C Medical Unit.
Should you have any questions please call me at 905-931-0204 or email me at drothwell9@gmail.com

Sincerely

Donna Rothwell

cc. Theresa Morris, SAH Nominee
   Cindy Gabrielli, ONA Nominee
   Jo Anne Shannon, Professional Practice Specialist, ONA

Please send hard copies via courier to the address below:
56 Carriage Road
St. Catharines, ON
L2P1T1
<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Unit</th>
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<tbody>
<tr>
<td>H. C. O.</td>
<td>CX/Radio Ops</td>
<td>Medicine &amp; Stroke</td>
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<tr>
<td>Jack Willett</td>
<td>Patient Care Manager</td>
<td>Medicine &amp; Stroke</td>
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<tr>
<td>Vance Bayer</td>
<td>HR Supervisor</td>
<td>HR</td>
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<tr>
<td>Heather Becham (post 1 p.m.)</td>
<td>HR Consultant</td>
<td>HR</td>
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<tr>
<td>Kim Fisher</td>
<td>MSSU Secondment</td>
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<tr>
<td>Lee-Anne Jensen</td>
<td>ONA PCC Chair</td>
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<td>Andrea Jacky</td>
<td>ONA President</td>
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<tr>
<td>Rosie Bagni</td>
<td>ONA, Labour Relations Officer</td>
<td>ONA</td>
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<tr>
<td>Elliot Marlow</td>
<td>3C Registered Nurse</td>
<td>ONA</td>
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<tr>
<td>Courtney Gibbons</td>
<td>3CRN</td>
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<td>Pauline Cupido</td>
<td>3N RN</td>
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<td>Monique Stoczuk</td>
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<td>Joanne Shannon</td>
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<td>Meni Diolimos-Bryant</td>
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<td>Igor Bertrand</td>
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<td>Tam Mancuso</td>
<td>VP Region</td>
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<td>Kelly Macgregor</td>
<td>Renal RN</td>
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<td>Brian Dickson</td>
<td>Supervisor</td>
<td>3C</td>
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<td>David Bart</td>
<td>Medical Director</td>
<td>SAH</td>
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<tr>
<td>Matt Shier</td>
<td>RN Float Pool</td>
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<td>Marissa Scarrone-Gioca</td>
<td>RN</td>
<td>3C</td>
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<td>Stacy Pulinuk</td>
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<td>Arslan Irwin</td>
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<td>AM Court</td>
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<td>Brittany Hicks</td>
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<td>Christa Neble</td>
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<td>Dave Deck</td>
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<td>Rosal Basa</td>
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<tr>
<td>Yam Mancuso</td>
<td>VP Region 1</td>
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<td>Ken Taylor</td>
<td>RN 32</td>
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J. D. B. 
Alexi Oldfield

H. J. C. 
Alexi Oldfield

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Alexi Oldfield

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Alexi Oldfield

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Alexi Oldfield