Independent Assessment Committee Report

Constituted under Article 8.01 of the

Collective Agreement

Between

Southlake Regional Health Centre

And

Ontario Nurses’ Association

October 9, 2017
October 9, 2017

Ms. Susan Blair  
Professional Practice Specialist  
Ontario Nurses’ Association  
85 Grenville Street, Suite 400  
Toronto, Ontario, M5S 3A2

Ms. Annette Jones  
Vice President Patient Experiences and Chief Nursing Officer  
Southlake Regional Health Centre  
596 Davis Dr.  
Newmarket, ON, L3Y 2P9

Dear Ms. Blair and Ms. Jones,

The members of the Independent Assessment Committee have concluded our review and respectfully submit the Report of the Independent Assessment Committee that was constituted under Article 8.01 of the collective agreement between Southlake Regional Health Centre and the Ontario Nurses’ Association.

This report contains the Independent Assessment Committee’s findings and recommendations regarding the Professional Workload Complaint submitted by Registered Nurses from the Emergency Department at Southlake Regional Health Centre.

The process undertaken through an Independent Assessment Committee provides a unique opportunity for discussion and dialogue between all the parties regarding the complex issues and conditions that underlie a Professional Workload Complaint. The Committee has made 28 recommendations in five areas regarding issues that impact the workload of Registered Nurses.

The Members of the Independent Assessment Committee unanimously support all recommendations in this report. The Committee hopes that the recommendations will assist the Hospital and the Association to find mutually agreeable resolutions with regard to nursing workload issues in the Emergency Department.
Sincerely,

Leslie Vincent
Chairperson

Cindy Gabrielli
Nominee for the Ontario Nurses' Association

Derek McNally
Nominee for Southlake Regional Health Centre
# Table of Contents

1. Introduction ................................................................................................................................. 6  
   1.1. Organization of the Independent Assessment Committee Report ........................................ 6  
   1.2. Referral to the Independent Assessment Committee .......................................................... 6  
   1.3. Jurisdiction of the Independent Assessment Committee ..................................................... 7  
   1.4. Proceedings of the Independent Assessment Committee .................................................. 11  
      Pre-Hearing ............................................................................................................................... 11  
      Hearing .................................................................................................................................. 12  
      Post Closure of Hearing .......................................................................................................... 14  

2. Presentation of the Professional Responsibility Workload Complaint .................................... 15  
   2.1 Information on Southlake Regional Health Centre and the Emergency Department. 15  
   2.2 Current Staffing in the Emergency Department ............................................................... 17  
   2.3 Workload Concerns of Registered Nurses and Discussions at the Hospital Association  
      Committee ............................................................................................................................ 19  
   2.4 Meetings between Association and Hospital Prior to IAC .............................................. 29  

3 Discussion, Analysis, and Recommendations......................................................................... 31  
   3.1 Base Registered Nurse Staffing in the ED ................................................................. 31  
   3.2 Recruitment and Retention ................................................................................................. 33  
   3.3 Nurse Staffing in Various Areas of the Emergency Department ..................................... 34  
   3.4 Physician Navigators .......................................................................................................... 38  
   3.5 Physical Environment ......................................................................................................... 39  

4 Recommendations .................................................................................................................. 40  

5. Conclusion ............................................................................................................................... 43
Appendices

Appendix 2: Letter from Hospital to Association May 30, 2017
Appendix 3: Confirmation of Invitation to Chair
Appendix 4: Information Request
Appendix 5: Agenda for IAC
Appendix 6: Attendees at the IAC
1. Introduction

1.1. Organization of the Independent Assessment Committee Report

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

1. Introduction
   This section outlines the referral of the Professional Workload Complaint to the IAC, reviews the IAC’s jurisdiction as outlined in the Collective Agreement, and summarizes the Pre-Hearing, Hearing and Post-Hearing processes.

2. Presentation of the Professional Responsibility Workload Complaint
   This section presents the context of practice relating to the professional workload complaint in the Emergency Department at Southlake Regional Health Centre; summarizes the relevant history leading to the referral of the professional workload complaint to the IAC; and reviews the presentations by the Ontario Nurses’ Association (‘the Association’), Southlake Regional Health Centre (‘the Hospital’) at the IAC meeting.

3. Discussion, Analysis, and Recommendations

4. Summary and Conclusions

5. References and Appendices

The submissions and exhibits of the Ontario Nurses’ Association and Southlake Regional Health Centre are on file with both parties.

1.2. Referral to the Independent Assessment Committee

This Report addresses the professional workload complaints of Registered Nurses from the Emergency Department at Southlake Regional Health Centre. The Association stated the following in their pre-hearing submission:
“The RNs continue to struggle to meet their obligation to provide safe, quality patient care as a result of these high patient volumes and the hospital’s continuous state of overcapacity. This is supported by 104 Professional Responsibility Workload Report Forms (PRWRFs) completed from January 2016 to present.”

1.3. Jurisdiction of the Independent Assessment Committee

The IAC is convened under the authority of Article 8.01 on Professional Responsibility in the Hospital Central Hospital Agreement with the Ontario Nurses’ Association.

Article 8.01 states:

8.01 The parties agree that patient care is enhanced if concerns relating to professional practice, patient acuity, fluctuating workloads and fluctuating staffing are resolved in a timely and effective manner. This provision is intended to appropriately address employee concerns relative to their workload in the context of their professional responsibility. In particular the parties encourage nurses to raise any issues that negatively impact their workload or patient care, including but not limited to:

• Gaps in continuity of care
• Balance of staff mix
• Access to contingency staff
• Appropriate number of nursing staff.

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

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

1 Submission to the Independent Assessment Committee by Ontario Nurses’ Association, 2017, p.5
2 Collective Agreement Between the Hospital and Ontario Nurses’ Association, Article 8 – Professional Responsibility, March 31, 2018, p.19-21.
ii. If necessary, using established lines of communication as identified by the hospital, seek immediate assistance from an individual(s) (who could be within the bargaining unit) who has responsibility for timely resolution of workload issues.

iii. Failing resolution of the workload issue at the time of occurrence or if the issue is ongoing the nurse(s) will discuss the issue with her or his Manager or designate on the next day that the Manager (or designate) and the nurse are both working or within ten (10) calendar days whichever is sooner. When meeting with the manager, the nurse(s) may request the assistance of a Union representative to support/assist her/him at the meeting.

iv. Complete the ONA/Hospital professional Responsibility Workload Report Form. The manager (or designate) will provide a written response on the ONA/Hospital Professional Responsibility Workload Report Form to the nurse(s) within ten (10) calendar days of receipt of the form with a copy to the Bargaining Unit President, Chief Nursing Executive and the Senior Clinical Leader (if applicable). When meeting with the manager, the nurse(s) may request the assistance of a Union representative to support/assist her/him at the meeting.

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

vi. Failing resolution at the unit level, submit the ONA/Hospital Professional Responsibility Workload Report Form to the Hospital-Association Committee within twenty (20) calendar days from the date of the Manager’s response or when she or he ought to have responded under (iv) above.

vii. The Chair of the Hospital-Association Committee shall convene a meeting of the Hospital-Association Committee within fifteen (15) calendar days of the filing of the ONA/Hospital Professional Responsibility Workload Report Form. The Committee shall hear and attempt to resolve the issue(s) to the satisfaction of both parties and report the outcome to the nurse(s) using the Workload/Professional Responsibility Review Tool to develop joint recommendation).

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

ix. Failing resolution of the issue(s) within fifteen (15) calendar days of the meeting of the Hospital-Association Committee the issue(s) shall be forwarded to an Independent Assessment Committee.

x. Failing development of joint recommendation(s) and prior to the issues being forwarded to the Independent Assessment Committee, the Union will forward a written report outlining the issue(s) and recommendations to the Chief Nursing Executive.
xi. For professionals regulated by the RHPA other than nurses, the Union may forward a written report outlining the issue(s) and recommendations to the appropriate senior executive as designated by the Hospital.

xii. The Independent Assessment Committee is composed of three (3) registered nurses; one chosen by the Ontario Nurses' Association, one chosen by the Hospital and one chosen from a panel of independent registered nurses who are well respected within the profession. The member of the Committee chosen from the panel of independent registered nurses shall act as Chair. If one of the parties fails to appoint its nominee within a period of thirty (30) calendar days of giving notice to proceed to the Independent Assessment Committee, the process will proceed. This will not preclude either party from appointing their nominee prior to the commencement of the Independent Assessment Committee hearing.

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

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

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

xvi. The Chief Nursing Executive, Bargaining Unit President and the Hospital-Association Committee will jointly review the recommendations of the Independent Assessment Committee within thirty (30) calendar days of the release of the IAC recommendations and develop an implementation plan for mutually agreed changes. Such meetings will be booked prior to leaving the Independent Assessment Committee.

b)

i. The list of Assessment Committee Chairs is attached as Appendix 2. During the term of this Agreement, the central parties shall meet as necessary to review and amend by agreement the list of chairs of Professional Responsibility Assessment Committees. The parties agree that should a Chair be required, the Ontario Hospital Association and the Ontario Nurses' Association will be contacted. They will provide the name of the person to be utilized on the alphabetical listing of Chairs.
The name to be provided will be the top name on the list of Chairs who has not been previously assigned. Should the Chair who is scheduled to serve decline when requested, or it becomes obvious that she or he would not be suitable due to connections with the Hospital or community, the next person on the list will be approached to act as Chair.

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

The IAC’s jurisdiction thus relates to whether registered nurses are being requested and/or required to assume more work than is consistent with the provision of proper patient care. Workload is influenced by both direct factors (e.g. nurse-patient ratio, patient acuity/complexity of care requirements, patient volume) and indirect factors (e.g. roles and responsibilities of other care providers, physical environment of practice, standards of practice, and systems of care). The IAC is responsible for examining 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 findings and recommendations of the IAC provide an independent external perspective to assist the Association and the Hospital to achieve mutually agreeable resolutions to workload issues. The IAC is not an adjudicative panel, and its recommendations are not binding. In accordance with Professional Responsibility Article 8 of the Collective Agreement, the IAC was comprised of three Registered Nurses.

The members of the Independent Assessment Committee were:

**Chairperson**
Leslie Vincent

**For the Association**
Cindy Gabrielli

**For the Hospital**
Derek McNally
1.4. **Proceedings of the Independent Assessment Committee**

**Pre-Hearing**

On May 2, 2017 the Association notified the Hospital in a letter that the Association was forwarding the complaint to the Independent Assessment Committee; and confirming their nominee as Cindy Gabrielli (Appendix 1). On May 30, 2017 the Hospital notified the Association that their nominee would be Derek McNally (Appendix 2). On May 9, 2017, Leslie Vincent agreed to be the IAC Chair. This was confirmed in writing on June 1, 2017 (Appendix 3).

On July 27, 2017 the IAC proposed to the Hospital and the Association that the IAC be scheduled for September 27-29, 2017. The chair also informed both parties on July 27, 2017 that due to other obligations in October, the final report might be delayed beyond the prescribed 45 day period specified in the collective agreement. Both parties agreed to the dates for the IAC. On August 13, 2017, the IAC Chair requested that the submission briefs from both parties be received by September 8, 2017.

The IAC members met by teleconference on August 16, 2017 and discussed the following issues:
- Overview of the IAC process and timeframes;
- Agenda for the IAC;
- Information requirements for the committee to assist in the IAC’s process and deliberations.

On August 16, 2017 the IAC chair sent an information request to the Hospital and requested that the information be provided with their brief submission (Appendix 4).

On September 12, 2017 the IAC chair sent the agenda for the IAC (Appendix 5). The IAC also requested a tour of the Emergency Department on the first day of the IAC.

The following ground rules for conduct during the IAC were provided:
- Adhere to the agenda and the timeframes for presentation.
- Opportunity will be given to ask questions for clarity at the end of each presentation. If either party has a question, please indicate this to the Chair.
- Please speak from your own perspective and experience.
- Do not raise issues related to individuals; the IAC is not convened to address any concerns regarding individual performance.
- The proceedings of the hearing are confidential and not to be discussed outside the hearing except
for the purpose of preparing of the IAC meeting.

• The briefs, presentations, discussion and any distributed documents in this hearing are not to be shared with other parties.

On September 18, 2017 the IAC met by teleconference in preparation for the IAC meeting and to review the briefs submitted by both parties.

On September 22, 2107 the Hospital provided a copy of the Emergency Department Model of Care Report submitted by the Professional Practice Department at Southlake Regional Health Care Centre.

On September 25, 2017 the Hospital provided a supplementary brief outlining the hospital’s objection to the IAC taking jurisdiction of the Physician Navigator dispute between the parties.

On September 25, 2017 the Association provided an additional submission regarding their response to the Physician Navigator issue.

Prior to the hearing, both parties confirmed who would be in attendance at the hearing.

Hearing

Wednesday, September 27, 2017

The IAC met at the Hospital at 0830 hours on September 27, 2017 and were greeted by representatives of the Hospital and members of the Association. The IAC was provided with an extensive tour of the Emergency Department (ED). The tour served to familiarize the IAC with the work environment and physical layout of the unit. Marlene Wheaton-Chaston, Manager of the Emergency Department facilitated the tour.

The following individuals from the Association were on the tour:

• Susan Blair, Professional Practice Specialist
• DJ Sanderson, Bargaining Unit President, Local 124

Following a break, The IAC hearing convened at 1300 hour as per the agenda (Appendix 4). Participants and observers on the respective hearing dates are listed in Appendix 6.
Following introduction of the IAC Committee members and representatives of the Association and the Hospital, the IAC Chair reviewed the jurisdictional scope of the IAC, including the purpose of the IAC; and the ground rules for the Hearing procedure including confirmation that all participants understood and agreed.

The Chair of the IAC responded to the Hospital’s request that the IAC decline to consider the alleged workload complaints regarding Physician Navigators because of a grievance filed by the Association on the issue in July. The IAC panel discussed the issue and decided that the IAC would consider any workload complaints related to the Physician Navigators, as the issue is germane to the investigation of the workload issues in the ED.

At the request of the IAC panel, the Hospital provided a detailed description of the daily staffing schedule in the Emergency Department. The Association agreed that the description was accurate. The agreed upon staffing is provided in section 2.2.

Ms. Susan Blair, Professional Practice Specialist (PPS), presented on behalf of the Association. The Association’s presentation was based on their written pre-hearing submission and supporting exhibits as well as a summary of 104 Professional Responsibility Workload Report Forms (PRWRFs) submitted by the Registered Nurses of the Emergency Department between 2016 and the present. An additional 16 PRWRFs completed between September 4 and September 26, 2017 was provided during the presentation.

Kim Storey, Director of the Emergency Department and Patient Flow; Annette Jones, Vice President Patient Experiences and Marlene Wheaton-Chaston, Manager of the Emergency Department presented on behalf of the Hospital. The Hospital’s presentation was based on their pre-hearing submission, and additional information:

- The organizational approach to emergency care including not believing in having patients in an external waiting room, ‘keeping patients upright’ by utilizing chairs and exam tables as appropriate, and an engineered physician scheduling system based on volume and flexible start end times for shifts.
- The ED that was designed to care for 70,000 patients annually, but it is estimated that the unit will care for 120,000 patients this year. The hospital stated their concerns regarding infection control in the department and has commissioned a review by Dr. Kevin Katz.
- The Hospital stated they agreed that the Hospital needed to add additional staff to the ED and provided the most recent investments in staffing.
• The Hospital acknowledged the need to improve ED access to critical care beds.
• A recruitment plan for ED registered nurses.
• Plans to reduce agency and overtime by March 2018.

Thursday, September 28, 2017

The IAC Chair resumed the Hearing at 0900 hours. Dr. Steven Beatty, Chief of Staff, Marlene Wheaton-Chaston, Kim Storey, and Annette Jones provided the Hospital’s response to the Association’s submission. Members of the Hospital participated in the subsequent discussion. Ms. Blair provided the Association’s response to the Hospital’s submission. Other members of the Association also participated in the subsequent discussion. Following adjournment of the Hearing, the IAC met to review and synthesize the information provided, and to identify key issues requiring additional clarification and their respective questions for the final day of the hearing.

Friday, September 29, 2017

The IAC chair resumed the meeting at 0900 hr. Members of the IAC asked further questions in order to understand a range of issues in more detail and gaining further clarity of the issues arising from both parties’ presentations. The IAC Chair concluded the hearing by thanking Ms. Cindy Gabrielli, Association Nominee and Mr. Derek McNally, Hospital Nominee; as well as all the participants for their engagement and contributions in the Hearing process. The IAC Chair also communicated the hope that the parties will be able to move forward to seek resolution to the issues. The IAC Chair closed the Hearing at approximately 1200 hours.

Post Closure of Hearing

The IAC met by teleconference on October 5, 2017. At this meeting, the IAC had extensive discussion and reviewed the draft report and analysis. Following the meeting, all IAC members contributed to the next version of the report and recommendations. The IAC met by teleconference on October 7, 2017 and finalized the report on October 9, 2017.
2. Presentation of the Professional Responsibility Workload Complaint

2.1 Information on Southlake Regional Health Centre and the Emergency Department

The Emergency Department at Southlake Regional Health Centre is located in Newmarket, Ontario. Southlake Regional Health Centre is a large, regional full service hospital and serves a catchment area of more than 1,000,000 people in York Region, Simcoe County and as far north as Muskoka.

The hospital has approximately 384 beds, approximately 3,227 employees, a medical staff of approximately 589, and approximately 854 volunteers. There are 1092 Registered Nurses (RNs) employed by Southlake, and 265 Registered Practical Nurses (RPNs).[^3]

The Emergency Department is the third busiest ED in Ontario, and it is estimated that the ED will serve 120,000 by the end of the current fiscal year. The ED is divided into several areas:

- **Triage and Registration:** This area is adjacent to the external waiting room at the entrance of the ED. Ambulatory patients enter by the main door and if available, are met by the Pre-Triage nurse who completes the infection control screening. Patients then take a number and a seat in the external waiting room. Patients are then called to the triage desk. The Triage RN performs triage according to the Canadian Triage and Acuity Scale (CTAS) utilizing an electronic triage system then calls the patient. Registration clerks complete all patient registrations. Patients are then sent directly to the assigned care area. The main hospital security office is adjacent to the external waiting room and is staffed 24/7.

- **Acute Area:**
  - **EMS Triage/Transition Stretchers:** EMS patients arrive directly through the ambulance bay that is adjacent to the acute area. A triage nurse will triage the patient and if no appropriate space or bed is available, the patient will be placed on one of four transition stretchers in the hallway. EMS remains with any patient requiring cardiac monitoring if a monitored stretcher is not available. The hospital goal is to offload all patients within 30 minutes of arrival. This area is staffed by RN.
  - **Cardiac Monitored Stretchers:** Sixteen private stretchered rooms including 7 negative pressure rooms, and 3 resuscitation rooms (one of which is equipped for pediatric care). CTAS 1 and 2 patients are seen in this area. All rooms are equipped with cardiac monitoring. This area is staffed by RNs.

[^3]: Submissions on Behalf of Southlake Regional Health Care Centre, Volume 1, p.8.
- **Red Zone Telemetry**: An ambulatory area with recliner chairs that can provide telemetry for up to 6 patients. The area also includes two stretchers used for patient assessment and conscious sedation and is open 12 hours a day from 1100-2300. CTAS 2 patients are seen in this area and reassessment patients who have been transferred from the acute area. This area is staffed by an RN.

- **Sub-Acute/Ambulatory**:
  This area utilizes an RN/RPN model of care. The area is separated into two areas – Fast Track and Sub-Acute. There are 2 waiting areas. The Internal Waiting Room (IWR) is utilized for the Sub-Acute patients, and the other for Fast Track. Both waiting areas are located in hallways.
  - **Fast Track**: The patients sent to this area are CTAS 4 and 5 patients with presentations such as orthopaedic injuries, integumentary complaints such as lacerations, rashes, minor burns, cellulitis and patients who are returning for care such as CT scans, ultrasound and cellulitis assessment. The Fast track is open 12 hours a day and staffed by RPNs.
  - **Sub-acute**: The patients sent to this area are CTAS 2, 3, 4 and 5 patients with acute presentations including but not limited to medical, gynaecological and surgical nature. There are 5 pods with an exam room adjacent to a room with 6 chairs. Patients are taken from the internal waiting room (IWR) to one of the pods. If all the pods are full, then patients will continue to wait in the IWR. There is also access to one ENT room as well as another private room with a washroom. This area is staffed by RNs.

- **Yellow Zone**:
  This area can hold up to 14 consulted or admitted patients. Telemetry is available. Four of the spaces can be divided in to semis by curtains. This area is staffed by RNs.

- **Mental Health and Wellness Area (MHWA)**:
  A 5 stretcher area that is separate from all other areas and accessed through a badge swipe system and is monitored by CCTV. The area includes two separation rooms. There are inclusion/exclusion criteria for patient entry. The nursing station is adjacent but separate from the care areas. The area provides care to adult mental health patients. This area is staffed by RNs and Psychiatric Emergency Nurses (PENs). The PENs are assigned to the MHWA by the psychiatric unit and are not part of the ED budget. There is also a security guard 24 hours a day stationed in the unit.

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4 Submissions on Behalf of Southlake Regional Health Centre, Volume 1, p.8-11.
2.2 Current Staffing in the Emergency Department

Currently the ED is staffed by:

- One Manager who works Monday to Friday. One Permanent Charge Nurse on days and one on nights. One Clinical Coordinator who works 4-10 hours shifts a week on weekdays.
- Registered Nurses, Registered Practical Nurses and Psychiatric Emergency Nurses (PEN), who all work 11.25 hours shifts on days, evenings or nights. The nursing staff is allocated to a specific function or area or to the role of float nurse. The day shift is normally 0730-1930. The evening shift is normally 1100-2300. The night shift is 1930-2330. There are a few evening shifts that start at different times.
- Staffing was increased in 2016 because of an increase of $950,000 to the ED budget. The increase in budget was utilized for:
  - Two 11.25 RN shifts: 1 evening shift for EMS offload/hallway, and 1 shift in the sub-acute area.
  - One 11.25 RPN shift in fast track to replace an RN, and the RN shift was reallocated to the internal waiting room and reassessment pod in the sub-acute area.
  - Two 11.25 clerical staff: one evening/night in sub-acute area and one in the Yellow Zone (admits/consults).
- On September 11, 2017 a phlebotomist was added to the staffing to do the morning blood work on all admitted patients in the ED;
- In fiscal 2018-19, an additional $450,000 will be added to the budget for:
  - One RPN 24/7 in the yellow zone, which will increase nurse staffing in the yellow zone to 3 nurses per shift and free up an RN shift to be reallocated to the internal waiting room in the sub-acute area.
- Pharmacy technician hours were increased to 7 days a week, on days and evenings.
- The hospital also utilizes agency nurses and nurses from the hospital’s Virtual Nursing Team (VNT) to replace shifts that are vacant, sick calls and for surge.
- ED physicians employ Physician Navigators (PN) to work with them on their shift. Physician Navigators assist physicians with non-clinical tasks and are not to be engaged in direct patient care or to touch patients. PNs are utilized in order to increase physician efficiency.
- Currently there are 38 RN and 2 RPN shifts per day. The allocation of shifts is shown in Table 1.
Table 1: Allocation of Nursing and Clerical Shifts in a 24-hour period.

<table>
<thead>
<tr>
<th>Assignment</th>
<th>Days</th>
<th>Evenings</th>
<th>Nights</th>
<th>Notes</th>
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<td>1</td>
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<tr>
<td>Float</td>
<td></td>
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<td>1400-1930</td>
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<tr>
<td>Clerical Float</td>
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<td></td>
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<tr>
<td>Triage</td>
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<td>1</td>
<td>1</td>
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<tr>
<td>Pre-Triage</td>
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<td></td>
<td></td>
<td>0900-2100</td>
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<tr>
<td>EMS Triage/Transition</td>
<td>2</td>
<td></td>
<td>1</td>
<td></td>
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<td>Acute 1-3; Resus B</td>
<td>1</td>
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<tr>
<td>Acute 9-12</td>
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<td>Acute Floats</td>
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<td>Red Zone</td>
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<tr>
<td>Sub Acute Reassess and IWR</td>
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<td></td>
<td></td>
<td>1000-2200</td>
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<tr>
<td>SA Pod 17/18</td>
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<tr>
<td>SA Pod 27</td>
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<tr>
<td>SA Float</td>
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<td>0.5</td>
<td>1930-0200</td>
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<td>SA Fast Track</td>
<td>1 RPN</td>
<td>1 RPN</td>
<td>1000-2200</td>
<td>D shift</td>
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<tr>
<td>Clerical for Sub-Acute/FT</td>
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<td></td>
<td>1</td>
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<td>Yellow Consult/Admit</td>
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<td>Days is 0900-2100</td>
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<tr>
<td>Clerical for Yellow</td>
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<td>1</td>
<td>Plus 1 PEN Days &amp; Nights</td>
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<td>MHWA</td>
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<td>MHWA Security</td>
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<td>Total RN Shifts</td>
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<td>9.5</td>
<td>13.5</td>
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<td>Total RPN Shifts</td>
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<td>3</td>
<td></td>
</tr>
</tbody>
</table>
2.3 Workload Concerns of Registered Nurses and Discussions at the Hospital Association Committee

There have been 120 Professional Responsibility Workload Responsibility Forms (PRWRFs) submitted between January 2016 and September 26, 2017.

During the presentation, the Association stated that the nursing workload problems are as a result of eight issues – the primary issue being a lack of adequate RN staffing resulting in the significant challenges for the RNs to meet the College of Nurses of Ontario practice standards for RNs, and specialty standards set by the National Emergency Nurse Association. The eight issues are:

- Skill mix of RNs and RPNs in the sub-acute/fast track area.
- Insufficient RN staffing in the sub-acute/internal waiting room
- Insufficient RN staffing in the acute area/red zone
- Insufficient RN staffing in the yellow zone/consult/admit
- Insufficient RN staffing in the triage/EMS off load area
- Mix of PENs and ED RNs in the MHWA
- Role and responsibilities of physician navigators
- Frequent use of agency RNs, vacant shifts on the posted baseline schedule, communication with management

The Association provided the following recommendations:

- **Skill mix in fast track area:**
  - Although CTAS 4 and 5 patients are cared for in this area, the Association states that CTAS is based on the chief complaint, and does not preclude that the patient can have unpredictable and complex needs. Conscious sedation is also conducted in this area, requiring that an RN provide care, and therefore an RN must be reassigned from another area for a period of time. If an RPN determines that a client is too complex, they consult an RN and this may result in a transfer of care, usually requiring that the patient be moved to sub-acute.
  - Therefore the Association recommends that:
    - The RPNs are replaced with RNs.
    - The fast track remains open 24 hours/day, an increase of 11 hours a day.

- **Insufficient RN staffing in the sub-acute/internal waiting room (IWR)**

\[5\] Submission to the Independent Assessment Committee by Ontario Nurses’ Association, p.9.
The Sub-acute/IWR area sees a large number of patients per day, and is open 24 hours a day. The area is often congested with patients and family members. The Reassessment pod and the adjacent hallway serves as the IWR, and is staffed between 1000-2200 by a RN who is also managing the reassessment pod. When fast track closes at 2300, any remaining patients must be cared for, and often are moved to sub-acute if there is no other nurse that can be reassigned to fast track. The nurses state that this occurs frequently although there is no data available to assess the frequency of occurrence.

Fifty-one (51) of the PRWRFs were related to workload issues in this area related to excessive nurse patient ratios, delays in care, concerns regarding lack of monitoring of the IWR and the reassessment pod.

Therefore the Association recommends:
- An additional RN in Pod 27 at night
- An additional RN in the IWR to provide 24/7 coverage.
- An additional float RN in the evening.
- A surge protocol for the IWR when census is >10, to include additional RN staffing and housekeeping.

**Insufficient RN staffing in the acute area/red zone**

The Association stated that the acuity of patients in this area warrants a decrease in patient/nurse ratio to 3:1 from 4:1. Due to the challenges in accessing critical care beds, patients may be held in the ER for many hours before transfer.

Twenty-nine of the PRWRFs were related to workload issues in the acute area/red zone related to patient acuity, care delays, the care of ICU patients, patient volume, and triage overload.

The Association therefore recommends:
- Increasing the RN staff to 5 on days and nights from the current level of 4.
- Keeping the red zone open 24 hours a day, an increase of 12 hours a day.

**Insufficient RN staffing in the yellow zone/consult/admit**

The yellow zone is staffed with two nurses on days and nights and one on evenings. The desired patient/nurse ratio is 5:1 ratio. On a regular basis the census in the area exceeds 10, and the ED policy is to add a nurse when the census is over 10.

Approximately 17 of the PWRFs were generated from the yellow zone related to high volumes of patients, delays in care, and working short of staff.

The association acknowledged that recent changes made by the Hospital have improved the situation;
• A pharmacy technician completes the Best Medication Reconciliation Records for patients.
• An audit of the most common medications resulted in an updating of the Accudose medication dispenser, allowing the RNs to give medication in a timelier manner.
• An additional ward clerk was assigned to the area on the night shift.
• As of September 11, 2017, phlebotomist is doing all regular blood work from 0600-0900 on all admitted patients in the ED.
  o The Association therefore recommends:
    ▪ Adding an additional RN on Days and Nights to ensure sufficient staff to maintain a patient/nurse ratio of 5:1.

• **Insufficient RN staffing in the triage/EMS off load area**
  o Approximately 12 PWRFs were generated from the triage/EMS area related to delays in patient care and patient volumes. Frequent delays in triage were documented.
  o The Association therefore recommends:
    ▪ Adding an additional RN to EMS offload on the day shift.

• **Mix of PENs and ED RNs in the MHWA**
  o The MHWA is staffed by one ER RN and one PEN on days and nights, plus a security guard.
  o There were 11 PWRFs generated from the MHWA in 2017 related to violence, patients with exclusion criteria being placed in the MHWA, use of VNT staff in the unit to replace the PEN.
  o The association therefore recommends:
    ▪ Replacing the ED RN with a PEN on days and nights.

• **Role and responsibilities of Physician Navigators**
  o PNs were introduced to the ER in 2012 to increase physician efficiency and are not to be engaged in direct patient care.
  o Five PRWRFs were completed related to PNs functioning outside the scope of the role; communication issues that cause and removing patients from the patient tracker when the RN still has care to provide causing confusion as to the location of the patient and the patient record.
  o On July 14, 2017 the Association filed a grievance regarding the PNs with regard to the inappropriately contracting out the work of RNs to unregulated persons.6
  o The Association therefore recommends:

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6 Supplemental Brief on Behalf of Southlake Regional Health Centre: Objection to Physician Navigator Issue. p.3.
- Ensuring that PNs do not engage in patient care
- Ensuring that physicians are communicating directly with RNs on patient care matters.

**Frequent use of agency RNs, vacant shifts on the posted baseline schedule, communication with management**

- The Association stated that there is frequently insufficient staffing in the ED because of vacant shifts in the schedule, therefore not meeting baseline requirements, which may result in working short or being replaced with agency or VNT. The association is concerned that the majority of agency and VNT nurses are not ED trained nurses, therefore impacting on quality of care and the workload of the ED nursing staff.

- The Association therefore recommends:
  - Ensuring the ED is staffed with ED trained nurses at all times.
  - Increasing the baseline RN staffing
  - Increase the ED RN pool.
  - Ensuring all ED RNs have Advanced Cardiac Life Support (ACLS); Pediatric Advanced Life Support (PALS); Trauma Nursing Core Courses (TNCC); Canadian Triage and Acuity Scale-Combined Adult/Pediatric Component Educational Program
  - Financially support RN continuing education in Emergency Nursing Pediatric Course (ENPC); Course on Advanced Trauma Nursing (CATN II); Emergency Nursing Certification Canada (ENCC).

The Association stated that the increasing patient workload requires Registered Nurses (RNs) to perform more work than is consistent with proper patient care. During and following the presentation, the Association responded to questions of clarification from both the Hospital and IAC.

Kim Storey, Director of the Emergency Department and Patient Flow; Annette Jones, Vice President Patient Experiences and Marlene Wheaton-Chaston, Manager of the Emergency Department presented on behalf of the Hospital. The Hospital’s presentation was based on their written pre-hearing submissions. The presentation addressed ED performance, innovations and approach to care, the current limitations of the physical environment, staffing in the ED, access to critical care beds, model of care, reduction of agency and overtime, recruitment, and replacement of RNs in the ED and for surge, education of staff, and physician navigators.
• **Performance, innovation and approach to care in the ED:**
  - The hospital takes pride in being a top performer in ER care in Ontario, and having developed novel approaches to ED care. The organizational approach to emergency care is based on not keeping patients in an external waiting room, but sending patients directly to the appropriate care area after being triaged, ‘keeping patients upright’ by utilizing chairs and exam tables as appropriate, and on an engineered physician scheduling system based on volume and flexible start end times for shifts.
  - The average length of stay for non-admitted high acuity patients is 6.7 hours and 3.5 hours for non-admitted low acuity patients.\(^7\)
  - The average time to see a physician is 40 min., and 1.2 hours at the 90\(^{th}\) percentile.
  - The percentage of patients who leave without being seen YTD is 0.6%, well below the provincial average of 3.2%, and other EDs in the Central LHIN at 2.0%.
  - The hospital has reviewed return visits to EMS as per the Health Quality Ontario requirement that hospitals monitor return visits as an efficient way to identify adverse events and quality issues. The indicators are:
    - **Number and percentage of ED return visits within 72 hours of discharge from the initial ED non-admit visit, to the same or a different hospital, and resulting in an admission to an inpatient unit on the second visit.**\(^8\)
      - Southlake rate is 0.89%, Ontario average is 0.98%
    - **Number and percentage of ED return visits within 7 days of discharge from the initial ED non-admit visit, to the same or a different hospital, resulting in an admission to an inpatient unit in the second visit with a sentinel diagnosis (subarachnoid hemorrhage [SAH], acute myocardial infarction [AMI], and paediatric sepsis) and with a relevant diagnosis documented in the initial ED non-admit visit.**\(^8\)
      - Southlake rate is .86%, Ontario average is 0.98%.

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\(^7\) Submissions on Behalf of Southlake Regional Health Centre, Volume 1, p.11.

There was a recent implementation of process changes in EMS offload based on a recent LEAN initiative to reduce the transfer of care time.

The Hospital Standardized Mortality Ratio is 71.

- **Limitations of the physical environment:**
  - The current ED was originally designed to care for 70,000 patients annually. It is expected that this year the ED will serve 120,000 patients.
  - The hospital stated their concerns regarding the limitations on clinical space and infection control related to overcrowding in the department and has commissioned an IPAC review by Dr. Kevin Katz.

- **Staffing in the ED**
  - The hospital stated that they agreed that they needed to add additional staff to the ED and provided the most recent investments in staffing which are provided in detail in section 2.2.
  - There are 131 positions in the ED for RNs, but not all are filled. The current head count is 115. The distribution of the 131 positions is outlined in Table 2.

### Table 2: Distribution of RN positions by FT, PT and Casual Status

<table>
<thead>
<tr>
<th>Position</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>FT</td>
<td>91 (3 are job share positions)</td>
</tr>
<tr>
<td>PT</td>
<td>21</td>
</tr>
<tr>
<td>Casual</td>
<td>19</td>
</tr>
<tr>
<td>Total</td>
<td>131</td>
</tr>
</tbody>
</table>

The hospital does not agree with the amount of increase in staff recommended by the Association.

The hospital provided their rationale for staffing in each area.

- **EMS Offload:** The hospital states that EMS patient volumes are relatively stable and not increasing at the same rate as ambulatory patients, and therefore an additional EMS offload nurse is not necessary. EMS volumes for the past 3 years are:
  - 2014-2015: 16,077
  - 2015-2016: 16,834
  - 2016-2017: 16,508
- 2017-2018: YTD 9,008 (annualized volume estimate of 13,512)
  - The hospital stated that they believe the projected reduction in EMS transfers is due to improvements being made by EMS and partners to reduce emergency transfers to hospitals.
  - **Acute Area:** The hospital does not agree that additional nurses are required to care for critically ill patients, stating that in the last year there were 510 patients who were admitted to critical care from the ED, an average of 1.4 per day. Additionally, there have been 89 critically ill patients who were transferred by Criticall from the ED since April 1, 2017. Based on 89 patients in 5 months, the estimated annual volume of Criticall patients is 213. Therefore there are approximately 723 critically ill patients a year. This is an average of 2 per day. The hospital agrees that it needs to improve access to critical care beds.
  - **Red Zone:** The hospital does not see a need to keep this area open for more than 12 hours a day based on the decrease in patient volumes during the night hours. The space is utilized for admitted patients when the Yellow Zone is full, and they will use VNT staff to care for the patients if they do not have sufficient ED nursing staff.
  - **Fast Track:** The hospital states that 98% of fast track patients are discharged home, and concedes that it frequently stays open until 0100 or 0200, but does not think that there is sufficient patient volume to keep the area open 24/7. Although conscious sedation does take place in this area and requires an RN, the Charge Nurse the discretion to decide on the timing of the procedures based on availability of staff and the acuity of the patient.
  - **Sub-Acute/IWR:** The hospital acknowledges the concerns of the nurses, and plans to reallocate one 11.25 hour nursing shift to the IWR when the RPNs are hired to work in the Yellow zone.
  - **MHWA:** One PEN and 1 ER RN currently staff the MHWA. The hospital stated that the psychiatry unit is currently struggling to staff the unit with PEN nurses due to challenges in recruitment and retention. They have been supplementing the staffing with VNT staff that has additional training in mental health. The hospital stated that they believe it is safer for patient care to have the mix of a PEN and ER RN. The total number of Code White in the ED year to date is 21, 12 of which were in the MHWA. Given the current staffing challenges with PENs and the preference to maintain the 1PEN/1 ED RN model, the hospital does not agree with moving to an all PEN model of care.
- **Yellow Zone/Admitted Patients:** The ED admits an average of 30 patients a day. The hospital monitors the number of admitted patients in the ED and this is reported at several data points during the 24-hour period. The hospital provided data on admissions in the ED at 0800 for the last few months (Table 3).

<table>
<thead>
<tr>
<th>Timeframe</th>
<th>Number of Admits at 0800</th>
</tr>
</thead>
<tbody>
<tr>
<td>April to June 2017</td>
<td>12</td>
</tr>
<tr>
<td>April YTD</td>
<td>16</td>
</tr>
<tr>
<td>Last 7 days</td>
<td>27</td>
</tr>
</tbody>
</table>

- **Access to critical care beds.**
  - The hospital stated the need to improve access to critical care beds from the ED.
  - Currently the average time for an admitted critical care patient in the ED is 10.03 hours, and 24.06 hours at the 90\(^{th}\) percentile. The goal is to reduce the 90\(^{th}\) percentile time to 8 hours.
  - The average time from decision to admit to admission to a critical care unit is 6 hours, and 18.13 hours at the 90\(^{th}\) percentile.
  - The average time from triage to decision to admit is 4.03 hours and 5.93 at the 90\(^{th}\) percentile.
  - The hospital provided the current initiatives to improve access through process improvements:
    - Changing the current referral process to remove the General Internal Medicine consult before consulting an intensivist (only possible in day shift)
    - Adding an additional bed in the medical/surgical ICU for a total of 14 beds
    - Changing the practice of holding a bed open in case of a cardiac arrest.
    - Having the Charge Nurses in ED and ICU work together to improve the transfer process between units.

- **Access to inpatient beds**
  - The hospital has several initiatives in process to try and improve access to inpatient beds and reduce the number of admitted patients in the ED.
  - Bed optimization at Southlake: the Hospital is currently realigning beds by repatriating 10-12 patient rooms currently being utilized as lounges or offices.
The Hospital is seeking approval to open an additional 66 beds by December including 30 sub acute beds at the Southlake Residential Care Village and 30 beds at the old Humber Hospital Finch site.

- Ten hospice beds will open in November 2017.

- **Model of care**
  - RPNs were introduced to the ED in 2009 in a support role in the yellow zone. In 2011 a professional practice review was conducted on the model of care in the hospital. The goals of the review were to maximize the scope of practice of nurses and to increase “hands-on care of patients”.
  - In 2013, RPNs started to work to full scope of practice in fast track in collaboration with an RN.
  - In March 2017, a RPN only model in fast track was initiated.
  - The hospital’s view is that a CTAS 4-5 patient is appropriately cared for by a RPN, and that RNs are available in the adjacent acute area for consultation and/or transfer of care if necessary.
  - The Professional Practice Department conducted a model of care review over the summer of 2017 and submitted a report in September 2017. A number of opportunities were identified in the report including:
    - Review of the charge nurse role. The competing challenges of the role may be limiting the ability or the charge nurse to be a resource to novice staff.
    - Revising the RN position guide to include Coronary Care II as a preferred requirement to hire given that performance of a 12 lead EKG is a basic competency for an ED nurse.
    - Review the RPN role to consider expanding the role into the consult/assessment area to provide care to admitted patients as the unit generally has medicine admitted patients, and the inpatient units utilize a RN/RPN model of care.\(^9\)

- **Plans to reduce agency and overtime by March 2018.**
  - The year to date utilization of agency (Apr-Aug) is 2,925 hours and overtime is 4,765 hours. This annualizes to 18,456 hours or 9.5 FTEs.
  - The Hospital is focused on eliminating the use of agency nurses by March 2018, primarily through the recruitment of more nurses.

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\(^9\) Nursing Model of Care Review Emergency Department, Southlake Regional Health Care Professional Practice Department, p.26-27.
The hospital plans to reduce unplanned overtime by 50% by March 31, 2019.
The hospital is also increasing the size of the VNT in an effort to offset overtime and agency. Training in cardiac, ER, and intensive care is being offered.

**Replacement of RNs in the Emergency Department and surge**
- The hospital utilizes casual/part time staff, overtime, VNT, and agency to replace RNs and to respond to surge.
- VNT staff are supposed to care for admitted patients.

**Recruitment plan for ED Registered Nurses.**
- The ED does not have sufficient baseline staffing (as shown by the number of vacant positions), resulting in the utilization of high levels of agency, overtime and VNT.  
  - Turnover is approximately 8%. In the last year there have been a total of 6 departures from the ED: 5 resignations (3 located outside of the geographic area), 1 for family reasons, 1 unknown) and 1 termination. There were 7 transfers out of the unit: three to critical care, two returned to their previous unit, one new graduate took a permanent position in Medicine, and one took an advanced practice position. There were no retirements.
- The ED has created 10 additional Regular Part Time (RPT) positions.
- The Hospital has held career fairs and the Manager of the ED has conducted 75 interviews. The corporate efforts have resulted in 45 RNs being hired to the hospital, but only one to the ED.
- An incentive program is planned to provide a monetary reward if a nurse is hired based on the referral of a nurse already employed at Southlake.
- Historically the hospital has relied on being able to hire experienced ED nurses, but are now unable to hire sufficient experienced RNs to meet the staffing needs.
- The hospital has developed a Graduated Development Plan to support the training of novice ED nurses. The plan will provide new nurses with the orientation and training to facilitate their successful transition from novice to competent ER RN. The program includes 360 hours of orientation and 62 hours of education +/- CC2. To date there are 5 FT RNs enrolled in this program.  

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10 Submissions on Behalf of Southlake Regional Health Centre, Volume 1, p.20

11 Submissions on Behalf of Southlake Regional Health Centre, Volume 1, p.20.
o Previously, there was an Internship Program to support the training of RNs who transferred to the ED from other units in the hospital, but the program was not found to be successful, and most of the nurses eventually transferred back to their previous department.

**Orientation and education of RNs**

- The ED has a full time educator.
- All ED nurses receive 1 paid education day per year. The day focuses on topics the nurses wish to learn about and any additional training considered necessary by the hospital. It is offered once per month except during the summer. Seventy one percent of the ED nurses have attended the education day this year.
- Any training considered mandatory is paid for by the hospital. e.g. Non Violent Crisis Intervention (NVC).
- Nurses may also access up to $1,200 per year for other courses from a professional development fund.

**Physician Navigators**

- Dr. Steven Beatty, Chief of Staff at Southlake Regional Health Centre, addressed the issue of physician navigators during the September 28 meeting. Dr. Beatty stated that when the PN role was approved at the Medical Advisory Committee, a set of regulations and a role description were developed. PNs must declare in writing that they will adhere to the role. In addition, references and a criminal check are conducted. PNs sign a confidentiality agreement. Dr. Beatty stated that he is aware of the concerns raised by nurses including PNs functioning outside the role description, and perceived as being obstructive. He stated that he asked Dr. Duic, (Physician Head in the ED) to review the PN role and to ensure that there was no role creep or obstructive behavior occurring.

### 2.4 Meetings between Association and Hospital Prior to IAC

The Hospital Association Committee (HAC) is the forum where PWRFs are discussed. For a period of time there was a sub-HAC to address the ED issues, but this was dissolved after establishing a Labour Management Committee to discuss policy issues; therefore allowing the HAC to focus on workload issues. The minutes of HAC meetings that addressed ER issues were provided to the IAC panel. The meetings took place on:

- October 4, 2016
- November 1, 2016
- December 6, 2016
By February 2017, an action tracker document for the ED had been developed and this formed the basis for further discussion regarding issues and resolutions at subsequent meetings. In the minutes of the April 18, 2017 meeting, it was noted that on eight of the sixteen issues related to the ED, the parties had either reached agreement, had a work in progress or there were opportunities for joint recommendations and collaboration.  

In the minutes of the June 6, 2017 meeting, it was noted that the Association had informed the Hospital that the workload issues in the ED were being referred to an Independent Assessment Committee. In the meeting the Hospital commented that it would be helpful for the Hospital to have a “clearer picture of which items have gone to settlement and which would proceed to the IAC.”  

In the meeting ONA agreed to create a separate document to clearly identify the items in Agreement. In the June 20, 2017 meeting a “comprehensive, collaborative discussion regarding each item in the ED Action Template document occurred. Strategies, dates and timelines are documented in the ED Action template as attached.”  

It was further stated in the June 20 minutes that the Association and the Hospital would meet to update the document accordingly and bring it forward for review and approval at the next meeting.  

The Hospital was also asked about their interest in mediation. The Hospital declined mediation.

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12 Hospital Association Committee (HAC) Minutes, April 18, 2017. Data Requests from the IAC, Tab 6.

13 Hospital Association Committee (HAC) Minutes, June 6, 2016, Data Requests from the IAC, Tab 6.

14 All minutes were marked as Approved with the exception of the minutes from June 6 and 20, 2017.
3 Discussion, Analysis and Recommendations

Five issues that impact on nursing workload in the Emergency Department were identified by the IAC. The issues are:

1. Base Registered Nurse Staffing in the ED
2. Recruitment and Retention
3. Nurse Staffing in Specific Areas of the ED
4. Physician Navigators
5. Physical Environment

3.1 Base Registered Nurse Staffing in the ED

Adequate nurse staffing is an essential component to ensure patient safety and quality of care. Ongoing evaluation of nurse staffing and outcomes related to patient safety and quality is essential. The current base number of positions is 131 (91 FT, 21 RPT of which 9 are currently vacant, and 19 casual), designed to meet a need for 38 shifts per day. The current headcount of nurses is 115. The utilization of nurse staffing in the last two years is as per Table 4.\(^\text{15}\)

<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Hours</td>
<td>FTEs</td>
<td>Hours</td>
</tr>
<tr>
<td>Full time</td>
<td>152,264</td>
<td>78.08</td>
<td>59,714</td>
</tr>
<tr>
<td>Regular Part time</td>
<td>29,754</td>
<td>15.26</td>
<td>9,576</td>
</tr>
<tr>
<td>Casual</td>
<td>11,421</td>
<td>5.85</td>
<td>1,135</td>
</tr>
<tr>
<td>Agency</td>
<td>7,557</td>
<td>3.87</td>
<td>2,295</td>
</tr>
<tr>
<td>Total</td>
<td>200,996</td>
<td>103.07</td>
<td>72,720</td>
</tr>
</tbody>
</table>

\(^{15}\) Total Paid Hours in FTES for Full Time, Part Time, Casual, Agency RNs for YTD 17/18, IAC Data Request, Item 3b
• There is excessive use of overtime shifts to fill staffing requirements. The use of overtime has increased every year since 2015 (Table 5).

Table 5: Overtime Utilization 2015-2017

<table>
<thead>
<tr>
<th>Year</th>
<th>Overtime Hours</th>
<th>FTE equivalent</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015</td>
<td>6,382</td>
<td>3.3</td>
</tr>
<tr>
<td>2016</td>
<td>10,508</td>
<td>5.4</td>
</tr>
<tr>
<td>2017 YTD</td>
<td>13,671</td>
<td>7.0</td>
</tr>
</tbody>
</table>

• VNT staff Utilization for April to August 2017, is 3,659.08 hours. This would annualize to 8,781 hours or 4.5 FTEs or an average of 2.1 VNT shifts per day in the ED.

• Sick time has also increased over the same time period (Table 6)

Table 6: Sick Time Utilization 2015-2017

<table>
<thead>
<tr>
<th>Year</th>
<th>Sick time Hours</th>
<th>FTE Equivalent</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015</td>
<td>7,109</td>
<td>3.6</td>
</tr>
<tr>
<td>2016</td>
<td>10,910</td>
<td>5.6</td>
</tr>
<tr>
<td>2017 YTD</td>
<td>11,513</td>
<td>5.9</td>
</tr>
</tbody>
</table>

• The Hospital provided data on weekly staffing for the periods of January 1 to April 1 2017, and June 25 to September 23 2017. The summaries provide a daily breakdown on the number of shifts of vacation, vacancies on the posted schedule, sick time, emergency LOA, no shows, regular time relief, VNT, overtime, agency, and actual staffing. Although the planned staffing is now 38 RN shifts per day (it was 36 during the Jan-April time period), there were many days when the unit staffing exceeded this number. Presumably the additional staff was in response to patient volumes, patient acuity and or surge requirements, as there was consistent sick time, vacation, and EMLOAs throughout the period that would not have been if patient care demands were not an issue.
During the Jan-April period when the baseline staffing was 36, the average actual staffing on most weeks was 37-40, and one week was 43.

During the June to September period, when the baseline staffing was 38, the average was 39-40, with one week at 37, and one week at 43.

During the period of January to April, there were 38 days when there was a vacancy on the schedule, and a total 122 shifts.

During the period of June to September, there were 60 days when there was a vacancy on the schedule, and a total of 269 shifts.

Throughout both time periods, there was consistent use of VNT, overtime and agency to replace shifts, and during the summer months, to respond to workload increase. During the June to September period, there were 75 days and 187 shifts when additional staff was utilized to respond to workload increases.

Based on the current staffing of 38 shifts a day, the unit requires a minimum of approximately 100 FTEs (assuming replacement of 20 days of vacation, 12 statutory holidays and 7 sick days). The sick time that exceeds 7 days a year/FTE, and there are additional replacement requirements for paid education time, other replacements needs (e.g. long term illness) and the constant need to surge.

There are an insufficient number of nurses employed in the ED at Southlake Regional Health Centre to ensure the unit is staffed on a regular basis with ED nurses. There is an immediate need to stabilize the nurse staffing in the ED, particularly in light of the constantly increasing patient volumes, workload levels, and excessive reliance on overtime, agency and VNT.

3.2 Recruitment and Retention

The ED has historically been able to recruit experienced ED nurses, but is now experiencing significant challenges. The unit has had limited experience in hiring, orienting and retaining new graduates and or nurses who are not ED trained. The unit has been unsuccessful in retaining nurses who transfer from other units to the ED. According to the data provided to the IAC, there are only Temporary Full Time (TFT) and Regular Part Time (RPT) positions posted.\(^\text{16}\) Given the competitive labour market that the Hospital now finds itself in, it would seem prudent to offer more permanent full time positions rather than agency and VNT.

\(^{16}\) Number and Type of Nurse Positions Posted in the Current Year, IAC Data Request, Item 3d.
than part time or temporary. The risk of this strategy is low given the constant growth in volume and the regular turnover that is normal in any unit. Staff nurses are not currently engaged in recruitment efforts.

The hospital recognizes that a new recruitment and retention approach is necessary and has taken steps to increase recruitment efforts and by designing a new orientation program to support the hiring of nurses without ED experience. Given that the unit has historically hired few novice ED nurses, it is advised that those who will be preceptors/mentors have education in effective mentoring and coaching practices. The engagement of the senior staff in retaining new hires will be critical. Both management and staff need to commit themselves to collaborating on this important task.

3.3 Nurse Staffing in Various Areas of the Emergency Department

Hospital Data on ER Functioning and Patient Volumes/Acutity
The hospital has data on the usual ED measures such as volume, acuity, admissions, quality outcomes and so forth. A corporate dashboard of key indicators is sent out several times a day, but notably not at night. It was the observation of the IAC panel, that while management has access to considerable data to assist in decision making, it lacks information on information to measure the impact on nursing workload in the ED particularly during the night period, such as the volume of patients in specific areas and how long some areas are open past planned closure times. In addition, there did not seem to be data collected on important aspects of nursing workload such as numbers of transfers of care between RPNs and RNs, number of times there are concurrent critically ill patients requiring care, time spent on moving patients from one area to another to provide care, average admits during the night, or how often RNs are being reassigned from one area to another to respond to care needs.

Nurse Scheduling
Nurses are scheduled to start shifts at 0730, 1100, or 1930. There are three shifts with other start times, one at 0900 in triage, one at 1000 in sub-acute, and one at 1400 that is a split shift between floating and sub-acute. The RPNs start at 1000 and 1100 in fast track. The purpose of the evening shift starting at 1100 is to ensure adequate relief for day and evening staff for breaks, as well as to match staffing to the patient volume throughout the 24-hour period; however, this means that the staffing is lowest during the night period of 2300-0730. There was frequent mention in the PWRFs and in the IAC meeting of the late closure problems in fast track and red zone during the period of 2300-0200, plus the buildup of admitted patients in the department. Therefore consideration might be given to whether the start times on some evening shifts should be later than 1130, and whether there is sufficient night staffing.
Triage/EMS Offload

The Emergency Department is expecting to see 120,000 patients this year. This is an average of 328 patients a day who must be triaged by a nurse. The pattern of registrants by hours shows that the number of patients arriving is lowest after midnight, and climbs quickly starting at 0900 and remains steady until 2100, before dropping again during the night period. This pattern is consistent over the last 3 years. Based on this pattern the triage and EMS staffing is staggered to peak during the afternoon and evening hours, leaving one nurse to triage between 0730-0900, and from 2300-0730. One shift is designated to “pre-triage”, but in reality the shift is usually allocated to triage. There is also a morning reduction in staffing in the EMS triage/offload, often requiring the Charge Nurse to cover in this area, as the lone triage nurse cannot effectively cover both areas. During the latter part of the evening shift, there can be up to 6 nurses between the two areas. Recent data would indicate that there might be a significant decrease in EMS volume in the current year.

The time to triage a patient is minimally 5 minutes, and can certainly take longer given any complexities, communication challenges, interruptions and so forth. Therefore it can be estimated that the minimal amount of triage time for nurses based on 120,000 patients is 600,000 minutes or 10,000 hours a year or an average of 27.39 hours per day. Given that nurses receive 90 minutes of paid and unpaid break, the available direct nursing time for care is 10.5 hours per 12-hour shift. Therefore the available triage nursing time on any given day is 4 shifts x 10.5 hours or 42 hours. Therefore it would seem that the pressure points the staff are experiencing in triage/EMS offload may be more related to the distribution of staff over 24 hours, rather than the absolute number of staff assigned on a daily basis to the area. This may be compounded by the fact that the overall number of staff is lowest during the 2300-0730 period, which results in reduced capacity to respond to surges in workload demand in the various areas of the ED by reassignment of staff.

However, given the steady annual increase in patient volume, and despite a projected decrease in EMS volume, it is the opinion of the IAC that this area will require close monitoring regarding nurse workload over the next year to determine when additional triage RN resources should be added.

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17 Year over year Registrations by Hour of Day and Day of Week (Year 14/15, 15/16, 16/17, Data Requests from IAC Panel, Item 1a.
Fast Track
Starting in March 2017, the model of care in the fast track area was changed to be RPN only. At the IAC, the nurses identified that the utilization of an RPN model in fast track was their biggest concern. The hospital is supporting the autonomous functioning of RPNs in this area, supported by RNs who work in the adjacent sub-acute area. But it should also be noted that there was only 1 PWRF that directly stated a concern over RPN staffing. Other PRWFs submitted from the sub-acute area did speak to the fast track not closing on time, conscious sedation needs, or the movement of patients from fast track to sub-acute.

The only formal evaluation of this model change was the professional practice review completed over the summer, which examined selected data/information on unit functioning, staff interviews, and 16 hours of job shadowing. Data collected and assessed as part of the review included:

- Unit profile assessment tool (adapted for population)
- Review of daily access reporting tool (DART)
- Review of position guides
- Review of patient outcome data including incident reports and patient satisfaction
- Review of daily staffing complement
- Review of overtime/agency use data
- Human resource data vacancy/positing/demographics

Given the recent establishment of an all RPN model in the area, and the level of concern by RNs about the current utilization of RPNs in the area, it is advised that a more in depth evaluation of the practice of RPNs and RNs in the fast track/sub-acute area be conducted. While RPNs can function autonomously, they do not function in isolation.

The College of Nurses of Ontario Practice Guideline on RN and RPN Practice: the Client, the Nurse and the Environment\(^\text{18}\) utilizes three factors (the client, the environment and the nurse) to guide decision making on care-provider assignments and the need for consultation and collaboration. Effective and timely consultation and collaboration between RNs and RPNs is essential in the provision of safe care. RNs must care for those patients who are less stable, less predictable and at higher risk of negative outcomes. The RNs view the RPNs as their colleagues and understand their professional accountability and responsibility to support the RPNs through consultation, collaboration and/or transfer of

\(^\text{18}\) College of Nurses of Ontario. *RN and RPN Practice: the Client, the Nurse and the Environment*, 2014
accountability. This was described by the RNs as challenging given the high volume of patients being seen in both the fast track and sub-acute areas, and the fact that conscious sedation can occur in the fast track area that requires the presence of an RN. The practice of conscious sedation in an area only staffed by RPNs necessitates that an RN provide care. The Hospital should evaluate the current practice of conducting conscious sedation in fast track with regard to patient safety and nursing workload, and whether it is feasible/desirable to only perform conscious sedation in areas normally staffed by RNs.

Based on discussion at the IAC, it was clear that the RPNs do consult RNs, but there has been no evaluation of the degree/frequency of consultation/collaboration or monitoring of transfer of accountability. While the Professional Practice Review did examine the fast track area, it was not a fulsome evaluation of RPN/RN functioning since the major change in model of care.

In addition, it was reported in the PWRFs and acknowledged by the hospital that the fast track area frequently does not close on time at 2300, necessitating that an RN(s) take over the care of these patients in addition to her/his current patient assignment(s).

**Sub-Acute Area**

The sub-acute area is a very busy area of the ED and is frequently congested with patients and family members. During the IAC, the nurses were asked if there was one ‘mission critical’ area where they would increase staffing, the response was sub-acute. The hospital has committed to adding one additional shift to the IWR, as soon as the RPNs are hired to work in the Yellow Zone. The nurses in the sub-acute area are also the closest support to fast track, and therefore are the most likely to be consulted and to assist with any additional care requirements in this area. The efficient functioning of the sub-acute area is critical to maintain flow in this ED for the less acute/ambulatory population of patients. The current complement of staff does not allow for the effective management of patients in the IWR, the reassessment area, and pod 27.

**Yellow Zone**

The yellow zone census has been consistently at 14 patients for some time, requiring additional nursing staff. The hospital plans to introduce one RPN shift around the clock in the near future, to meet the current staffing requirements of 3 nurses per shift. This will be an additional shift above the current allocation of 2 nurses on days and nights. One 12-hour RN shift is to be reallocated to the sub-acute area. Given that the Yellow Zone has primarily admitted patients, the Hospital should consider whether inpatient medical and/or surgical units could staff this area rather than utilizing ED nurses.
Acute Area

The main pressure point in the acute area is the unpredictable care needs of critically ill patients and delays in the disposition of critically ill patients to an inpatient area. Other critical care nursing resources in the hospital, such as the CCRT, are not called upon to assist with care. The hospital is making considerable efforts to improve access to critical care beds and to reduce the LOS in the ER. The relationship between the nurses in the ED and nurses in critical care is less than ideal, and there is little evident collaboration. While management can improve access and policies of care, only the staff nurses can improve the current working relationships.

Mental Health Wellness Area

The hospital stated that they believe the model of one PEN and one ED RN is optimal given the patient population and their view that there are occasions when the knowledge and skill of the ED RN is important because changes in the patient’s non-mental health status. It was not clear to the IAC whether the ER nurses, despite the direction from management to do so, consistently follow the inclusion/exclusion criteria because of volume pressures throughout the department. Management is also concerned about the challenges the psychiatry unit is currently having in recruiting and retaining PENs. However, it is the view of the IAC that moving to an all PEN model would be optimal, given the capacity of the psychiatry unit to improve recruitment and retention. This would free up the ED RNs currently assigned to work in this area, to move back into the pool of nurses for the rest of the ED (but not to increase daily staffing).

Overall ED Staffing

Beyond the incremental staffing recommended in specific areas, the IAC seriously considered whether an additional shift should be added in order to respond to whichever area might be experiencing an increase in patient volume and/or workload. If the planned measures to increase flow to inpatient beds do not significantly decrease the volume of admitted patients in the ED within 6 months, then the Hospital needs to ensure sufficient staffing for patient volumes and maintain an appropriate ratio of admitted patients to nurse. (i.e. five to one).

3.4 Physician Navigators

There were a small number of PWRFs related to the issues of physician navigators. The nurses have identified concerns that some PNs are functioning outside their role description, as well as concerns about communication challenges between PNs, RNs and physicians regarding patient care issues. The view of the IAC is that issues regarding PNs are not so much a workload issue; but are rather issues of
role clarity and communication. While there have been evaluations of the positive impact of the PN on physician efficiency\(^{19}\), it was noted that none of the 3 studies evaluated the impact on the efficiency or workload of other team professionals such as RNs. Management seems to function as the ‘go-between’ between physicians and nurses when issues are raised. While it was important for the Chief of Staff to come to the IAC to directly address PN issues, it would seem that more direct communication and collaboration between nurse, physicians and PNs at the unit level are necessary.

3.5 Physical Environment

The ED is currently providing care to 120,000 patients a year (and their families/care providers) in a space designed for 70,000. The multidisciplinary staff is to be complimented on the excellent quality of care being provided to patients in this constrained environment. While a long term redevelopment plan is underway, the ED is many years away from having a significant larger space suited to the current volumes. Therefore any intermediate opportunities to expand clinical space are essential.


4 Recommendations

The Independent Assessment Committee makes the following recommendations regarding workload issues in the Emergency Department at Southlake Regional Health Centre.

Related to Baseline Staffing and Scheduling

1. Create a minimum of five (5) permanent full time positions in order to increase the unit’s capacity to effectively respond to relief requirements and any increased workload, and thereby decreasing the dependency on agency, overtime and VNT. This augmentation in positions is not meant to increase the daily minimum complement (currently set at 38), but to provide a larger pool of nurses to meet the daily minimum staffing.
2. Continue the efforts to reduce overtime and agency through hiring additional ED staff, ensuring that the department is primarily staffed by ED Nurses.

Related to Recruitment and Retention

3. Increase the number of permanent full time positions rather than trying to hire temporary, permanent part time or casual positions.
4. Engage the nursing staff in recruitment efforts such as attending the job fairs with management and interviewing candidates.
5. Establish a mentorship program and offer education to the nurses in preceptorship/mentorship in order to support their important role in teaching and supporting novice nurses in the department.

Related to Nurse Staffing

6. Review the current staggering of evening shifts and consider whether more shifts should start after 1100 in order to increase nursing staff during the 2300-0200 time period. e.g. an evening shift from 1500-0300.
7. If the planned measures to increase flow to inpatient beds do not significantly decrease the volume of admitted patients in the ED within 6 months, then the Hospital needs to ensure sufficient staffing for patient volumes and maintain an appropriate ratio of admitted patients to nurse. (i.e. five to one).

In the Triage/EMS Offload area:

8. If the function of pre-triage is desired, consider whether a non-health care person could conduct the infection control screening in the waiting room.
9. Realign the shifts in triage and EMS offload to three on days, 3 on nights, and 1 on evenings (1000-2200 or 1100-2300) to provide more even coverage across the 24-hour period.

10. Given the steady annual increase in patient volume, the Hospital must closely monitor conditions for when an additional triage RN resources should be added to daily staffing.

**In the Fast track area:**

11. Have an independent evaluation of the RPNS/RN model of care in fast track/sub-acute conducted within 6 months to evaluate whether the current RPN only model is adequate to meet patient needs. The evaluation to minimally include:
   a. Whether RPNs are functioning within their scope of practice and consistent with the 3-factor framework.
   b. How often RNs are consulted by RPNs and if there are any times when they should have been but were not.
   c. Number of occasions of transfer of care from RN to RPN or vice versa.
   d. Number of occasions that a patient assigned by triage to fast track is found on further assessment not to be appropriate for this area.
   e. Number of conscious sedations being conducted.

12. Evaluate the frequency of the following issues in fast track by measuring occurrence on a daily basis for a minimum of one month:
   a. How often fast track remains open past the planned closure time of 2300.
   b. If it remains open, then who takes over care of the patients and for what period of time. How many patients are still in fast track at closing time. Do they remain in fast track or are they moved to another area for their remaining care.
   c. How often is conscious sedation performed in the area, and where does the RN comes from to provide care, and for how long.

13. Evaluate the current practice of conducting conscious sedation in this area in terms of patient safety and nursing workload and whether it is feasible/desirable to only perform conscious sedation in other areas normally staffed by RNs.

14. At the end of the period of evaluation and the independent review whether there should be a RPN model at all, or whether returning to a RN/RPN model in fast track is warranted.

15. Keep the fast track open from 2300-0300 and add an additional 4 hours of staffing to the daily complement.

16. Continue with current operational plans to find alternative care options for patients returning for issues such as diagnostic imaging and intravenous medications.
In the Sub-Acute area:
17. In addition to the 11.25 hours to be re-allocated from the Yellow Zone, it is recommended to add another 11.25 hours of RN care (for a total of 22.5 hours) to provide for the care requirements in the Sub-Acute area and ensuring coverage for IWR.

In the Yellow zone:
18. The IAC supports the addition of an RPN shift to this area 24/7, and the reallocation of one 11.25 hour RN shift to the sub-acute area.
19. The change to RN/RPN staffing mix in the area should be evaluated using the 3-factor framework within a 6-month time frame to evaluate whether RPNs are functioning effectively in this area and being assigned appropriate patients.
20. When the change is made to an RN/RPN model in the Yellow Zone, ensure that replacement of RNs is by RNs, and RPNs by RPNs.
21. Given that the Yellow Zone has primarily admitted patients, the Hospital should consider whether inpatient medical and/or surgical units could staff this area rather than utilizing ED nurses.

In the Acute Area:
22. The IAC supports efforts to increase access to critical care beds by opening of a 14th ICU bed, process improvements in medical/intensivist consultation, and eliminating the code bed hold.
23. Implement a solution to resolve the surge requirements for 1:1 care issues through options such as:
   a. If the patient is to be admitted to a Southlake intensive care area, additional critical care staff supports are sent to the ER to manage these patients such as the CCRT or a critical care nurse if sufficient resources are not available in the ER.
   b. Consider establishing an on-call system in the ED for critical care surge requirements.

In the Mental Health and Wellness Area:
24. Establish a PEN only nursing model in the MHWA.

Related to Physician Navigators
25. Conduct a prospective audit on physician navigator functioning to evaluate whether they are consistently functioning within their role description.
26. Immediately establish a time limited working committee between RNs, PNs and physicians to work on improving communication and collaboration.
Related to the Physical Environment

27. Any administrative space within or contiguous to the ED should be converted to additional clinical space.

28. Conduct a LEAN event on the ED Unit focusing on amount, type, utility, storage of equipment and supplies, in order to standardize such materials, in order to reduce congestion, clutter and unnecessary materials.

5. Conclusion

This report contains the Independent Assessment Committee’s findings and recommendations regarding Professional Workload Complaint submitted by Nurses from the Emergency Department at Southlake Regional Health Centre.

The process undertaken through an Independent Assessment Committee provides a unique opportunity for discussion and dialogue between all the parties regarding the complex issues and conditions that underlie a Professional Workload Complaint. The Committee has made 28 recommendations in five areas regarding issues that impact the workload of Registered Nurses.

The Members of the Independent Assessment Committee unanimously support all recommendations in this report. The Committee hopes that the recommendations will assist the Hospital and the Association to find mutually agreeable resolutions with regard to nursing workload issues in the Emergency Department.
Appendix 1: Letter from the Association May 2, 2017.

May 2, 2017

Annette Jones
Vice President, Patient Experiences and Chief Nursing Officer
Southlake Regional Health Centre
596 Davis Dr
Newmarket, ON L3Y 2P9

Dear Annette Jones,

Re: Refer Professional Practice and Workload Issues at the Southlake Regional Health Centre Emergency Department (ONA File # 201106114) to Independent Assessment Committee (IAC)

The Registered Nurses (RNs) working in the Emergency Department (ED) at Southlake Regional Health Centre (SLRHC) have consistently identified ongoing practice and workload issues as evidenced by the data submitted on over 65 Professional Responsibility Workload Report Forms (PRWRFs) since January 2016.

The RNs have documented that their current workload and practice environment does not allow them to meet the College of Nurses of Ontario (CNO) Standards of Practice and Practice Guidelines and Canadian Triage and Acuity Scale (CTAS) guidelines among others; and they believe they are being asked to perform more work than is consistent with proper patient care.

The parties have attempted to resolve the issues as evidence in the proposed resolutions/or recommendations that are outlined in our action plans. Despite this, a number of the workload and practice issues identified by ONA members remain unresolved including but not limited to issues related to patient acuity, patient volumes, fluctuating workloads, fluctuating staffing and professional practice.

The Union is extremely concerned with regards to the potential of negative patient outcomes. We are seeking resolution of the practice and workload issues on behalf of our members, the patients, and community for which they provide care. 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 (IAC) as per Article 8 of the Hospital Central 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

Provincial Office: Toronto
Regional Offices: Ottawa • Hamilton • Kingston • London
Oshawa • Sudbury • Thunder Bay • Timmins • Windsor
Please provide written confirmation concerning the name, mailing address, home or cell and office phone number, fax number and e-mail address of your nominee.

I have contacted David McCoy of Ontario Hospital Association to determine the next IAC Chair rotation in accordance with Appendix 2 will be Leslie Vincent. I will confirm with Ms. Vincent that she is available to Chair this hearing and will document this by a separate letter to her.

The parties have collaborated and attained resolutions to address some of the practice and workload issues in the ED. The Union is open to continue to work with the Hospital to further resolve the outstanding issues and believe that many dollars spent on the IAC could be better utilized to improve the practice and workplace environment for our members and patients.

Sincerely,

ONTARIO NURSES' ASSOCIATION

[Signature]

Susie Blair
Professional Practice Specialist

C:  DJ Sanderson LC/BUP
    Silvanna Petersen Servicing LRO
    Dr. Dave Williams President and CEO, Southlake Regional Health Centre
    Linda Haslam-Stroud  ONA President
    Vicki Mckenna ONA Vice-President
    Andy Summers ONA Regional VP
Appendix 2: Letter from Hospital to Association May 30, 2017

May 30, 2017

Susan Blair
Professional Practice Specialist
Ontario Nurses’ Association
85 Greenville St., Toronto, ON M5S 3A2
416-964-8833 ext 2301
Toll Free - 1-800-387-5580
susanb@ona.org

Dear Ms. Blair:

Re: Professional Responsibility Complaint in the Emergency Department – Proceeding to an Independent Assessment Committee

Thank you for your letter dated May 2, 2017 notifying that the union is forwarding the Professional Responsibility Complaint in the Emergency Department to an Independent Assessment Committee.

As per your request, please consider this our written confirmation of the Hospital’s Nominee for the Independent Assessment Committee. Southlake nominates Derek McNally. Please find his contact information below:

Derek McNally, Executive Vice President Clinical Services & Chief Nursing Executive
Niagara Health
derek.mcnelly@niagarahealth.on.ca
W: (905) 378-4647 x52100 I Fax: (905) 321-3800 I Mobile: (905) 329-1679
1200 Fourth Ave, St. Catharines, ON L2S 0A9
Executive Assistant: Karen Wilson. karen.wilson@niagarahealth.on.ca Ext 32112

Should you have any questions, please feel free to contact me at 905-895-4521 ext. 2146.

Sincerely,

Annette Jones, RN, MScN
Vice President Patient Experiences and Chief Nursing Officer

Cont’d Page 2

tradition is cherished, change is welcomed
June 1, 2017

Leslie Vincent
716 Windermere Ave.
Toronto, ON, M6S 3M1

Dear Leslie Vincent,

Re: Southlake Emergency IAC Hearing - Confirmation of Invitation to Chair

Thank you for accepting the nomination to chair an Independent Assessment Committee (IAC) investigating a Professional Responsibility Complaint in the Emergency Department at Southlake Regional Health Centre. I have consulted with Mr. David McCoy, at the Ontario Hospital Association and both parties have agreed to you chairing this IAC.

In order to move forward on resolving workload issues ONA is requesting that a date be set for an IAC investigation and hearing. ONA remains committed to working with the Employer until such time as a date is set for the IAC. The contact details for ONA’s nominee are as follows:

Cynthia Gabrielli
6285 McMicking Street Niagara Falls, ON L2J 1W7
Tel: 905-357-6276 (home)  Tel: 905-329-3597 (cell)
Email: cgabrielli@co.ge.ca

Please feel free to contact our Nominee directly for dates in proceeding. Furthermore, should you have any additional questions please do not hesitate to contact me by telephone or email.

Sincerely,

ONTARIO NURSES’ ASSOCIATION

Susan Blair
Professional Practice Specialist

C: Linda Haslam-Stroud, RN, President, ONA
Vicki McKenna, RN, First Vice-President, ONA
Andy Summers, RN, Region 3 Vice President, ONA
DJ Sanderson, ONA Local Coordinator and Bargaining Unit President, ONA
Todd Davis, Labour Relations Officer, ONA
Athena Brown, Manager, ONA
Cynthia Gabrielli, ONA nominee
Dr. Dave Williams, President and CEO, Southlake Regional Health Centre
Annette Jones, Chief Nursing Officer, Southlake General Hospital

Provincial Office: Toronto
Regional Offices: Ottawa • Hamilton • Kingston • London
Orillia • Sudbury • Thunder Bay • Timmins • Windsor
Appendix 4: Information Request

1. Patient Information (for past 2 fiscal years)
   a. Volumes; by year, day of week and by hour of day
   b. Distribution by CTAS level; by year, by day of week
   c. Ambulance volumes and offload times
   d. Admissions by CTAS level (including admission rate)
   e. Number of Admits with no bed, by hour of day
   f. Performance indicators
   g. ED LOS by day of week

2. Unit Organization/Functioning
   a. Organizational chart for nursing in emergency department
   b. Description of how ER is organized; zones and functions.
   c. Job descriptions for Registered Nurse, Team Leader/Charge Nurse and Triage Nurse
   d. Copy of typical chart format for Emergency Department
   e. Charting guidelines and /or policies for ED
   f. Policies regarding gridlock/overcapacity in the ER and actions to be taken if volumes/admissions exceeds capacity; including any procedures/policies regarding calling in additional staff because of high volumes/admissions
   g. Changes or initiatives that have impacted ER in last two years:
      i. External issues that impact patient flow/volumes in ER
      ii. Major process changes, model of care changes, technology implementations, special projects in ER

   a. Budgeted FTEs for all staff categories in the ER
   b. Total paid hours in FTEs for full time, part time, casual, agency RNs (YTD for 17/18)
   c. Number of FT, PT, Casual RNs (i.e. head count)
   d. Number and type of RN positions posted in the current fiscal year;
   e. Sick time, overtime in FTEs for RNs (YTD); and a comparison for the last 3 years
   f. Current vacancies for RNs;
   g. Turnover rate RNs;
   h. Experience profile - Average years of experience in ER; number of junior staff (less than 2 years experience)
      i. Number of nursing staff on modified work; or have permanent accommodations
   j. Copy of local collective agreement;
   k. Master Schedule; copy of last two posted schedules; copy of a daily assignment sheet

m. Number of Educators, Advanced Practice Nurses, Nurse Practitioners who work in ER

n. If utilized for ER: size and utilization of organizational float pool

4. **Budget and Performance Indicators (for last 3 years)**
   a. Total planned and expended budget for ER – labour, supplies etc.
   b. PFR performance and allocation for ER
   c. P4R indicators and results

5. **Quality of Care/Performance Indicators**
   a. Patient satisfaction results for last two fiscal years
   b. Number of type of critical incidents in ER for last two fiscal years
   c. Results of triage audits for last year
   d. Program quality minutes or program minutes related to staffing and change process
   e. Reports on any other indicators being utilized to evaluate efficiency and effectiveness of the ER.

6. HAC agendas and minutes from 2016, 2017 and any other agendas/minutes of meetings regarding workload complaints in ER

7. Staff meeting minutes for the last year
# Appendix 5: Agenda for IAC

## Agenda

**Park Inn by Radisson**  
555 Cochrane Drive, Markham, ON, L3R 8E3

**Wednesday, September 27, 2017**

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<tr>
<th>Time</th>
<th>Item</th>
<th>Participants</th>
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<tr>
<td>08:30–11:00</td>
<td>Tour of Emergency Department</td>
<td>IAC, SRHC and ONA</td>
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<tr>
<td>11:00—13:00</td>
<td>Transit to Park Inn, Lunch and IAC Panel Meeting</td>
<td>IAC</td>
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<td>13:00—13:15</td>
<td>Introduction and Review of Proceedings by Chairperson</td>
<td>IAC Chair</td>
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<td>13:00—14:30</td>
<td>Ontario Nurses’ Association Submission Presentation</td>
<td>IAC, SHRC and ONA</td>
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<td>Response to questions of clarification from:</td>
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<td>• Southlake Regional Health Centre</td>
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<td>14:30—14:45</td>
<td>Break</td>
<td>All</td>
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<td>15:15—16:45</td>
<td>Southlake Regional Health Centre Submission Presentation</td>
<td>IAC, SRHC and ONA</td>
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<td>• Ontario Nurses’ Association</td>
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<td>16:45—17:00</td>
<td>Review of Process for Thursday, September 28, 2017</td>
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<td>17:00</td>
<td>Adjournment of Hearing</td>
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## Agenda
### Thursday, September 28, 2017

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<td>Southlake Regional Health Centre</td>
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<td>Response to</td>
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<td>12:00-13:00</td>
<td>Lunch</td>
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<tr>
<td>13:00-16:00</td>
<td>Ontario Nurses’ Association Response to Southlake Regional Health Centre</td>
<td>IAC, SRHC and ONA</td>
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<td></td>
<td>Response to questions from</td>
<td></td>
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<td></td>
<td>• Independent Assessment Committee</td>
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<td>• Southlake Regional Health Centre</td>
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<td></td>
<td>• Discussion</td>
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<tr>
<td>16:00 – 16:15</td>
<td>Review of Process for Friday, September 29, 2017</td>
<td>IAC Chair</td>
</tr>
<tr>
<td>16:15</td>
<td>Adjournment of Hearing</td>
<td>IAC Chair</td>
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<td>16:15 onwards</td>
<td>Independent Assessment Committee Meeting</td>
<td>IAC</td>
</tr>
<tr>
<td>Time</td>
<td>Item</td>
<td>Participants</td>
</tr>
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<tr>
<td>09:00 — 12:00</td>
<td>Questions to both Parties by Independent Assessment Committee</td>
<td>IAC, SRHC and ONA</td>
</tr>
<tr>
<td>12:00 — 12:30</td>
<td>Closing Remarks and Identification of Next Steps by Chairperson</td>
<td>IAC Chair</td>
</tr>
<tr>
<td>12:30</td>
<td>Closure of Hearing</td>
<td>All</td>
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<tr>
<td>12:30 — 14:00</td>
<td>Independent Assessment Committee Meeting</td>
<td>IAC</td>
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</tbody>
</table>
Appendix 6: Attendees at the IAC

Association Attendees:

Susan Blair, Professional Practice Specialist, Ontario Nurses’ Association
Lorrie Daniels, Professional Practice Specialist, Ontario Nurses’ Association
Kelly Farrugia, Manager II/Professional Practice, Ontario Nurses’ Association
Cathryn Hoy, Vice President, Ontario Nurses’ Association Board
Nicole Butt, Legal Counsel, Ontario Nurses’ Association
Jill Moore, Staff Nurse, Southlake Regional Health Centre
DJ Sanderson, Bargaining Unit President, Local 124
Rebecca Sanderson, Staff Nurse, Southlake Regional Health Centre
Adam Castelli, Staff Nurse, Southlake Regional Health Centre
Lori Mellett, Staff Nurse, Southlake Regional Health Centre
Katie Anne Norris, Staff Nurse, Southlake Regional Health Centre

Hospital Attendees:

Annette Jones, Vice President, Patient Experiences and Chief Nursing Officer
Marlene Wheaton-Chaston, Manager, Emergency Department
Kim Storey, Director, Emergency Department and Patient Flow
Helena Hutton, Executive Vice President, and Chief Operating Officer
Sandra Smith, Vice President, Our People and Corporate Services and Chief Human Resources Officer
Leah Martuscelli, Director, Human Resources
Lorrie Reynolds, Director, Maternal Child and Professional Practice, Deputy Chief Nursing Officer
Dr. Steven Beatty, Chief of Staff, Southlake Regional Health Centre