

INDEPENDENT ASSESSMENT COMMITTEE REPORT SUMMARY

**Employer: Kingston General Hospital, Critical Care Program - Kidd 2 and Davies 4
Board: Chair, Leslie Vincent; ONA Nominee, Cynthia Orlicki; Employer Nominee, Ella Ferris.**

Decision Date: May 15, 2013

Professional Practice Specialist: Lorrie Daniels

This Professional Responsibility Complaint arose as a result of the Kingston General Hospital ("Hospital") assigning a number of patients and a workload to the RNs working in the Critical Care Program, such that the RNs had cause to believe that they were being asked to perform more work than was consistent with proper patient care. As a result, between January 2012 and March 2013, 106 Professional Responsibility Workload Report Forms (PRWRFs) were completed by the RNs on Kidd 2 and Davies 4. The main issues identified in the PRWRFs included insufficient staffing levels, multiple and increasing numbers of vacant shifts on the posted schedule, inability to replace vacant RN shifts, being required to perform non-nursing duties, lack of support and inability to take or complete rest breaks.

Prior to the commencement of the Independent Assessment Committee (IAC) Hearing ("Hearing"), it was identified that the issues brought forward regarding the Davies 4 ICU would not be the primary focus of the Hearing as many of the issues had been resolved.

The Hearing commenced on April 8th and concluded on April 10th. Following the Hearing, the Independent Assessment Committee prepared a detailed report wherein it made 56 recommendations that related to 12 areas, including staffing, scheduling, retention, assignments, leadership, education, culture and communication. The recommendations were made unanimously by all members of the IAC with the goal of resolving the workload issues on the Kidd 2 and Davies 4 units within the Critical Care Program.

While the IAC is not an adjudicative panel and its recommendations are non-binding, the IAC emphasized that there were a number of issues impacting the RNs in the critical care program at the Hospital and in order to recover from the place of unrest and low staff morale, a number of changes would need to be implemented, as highlighted below.

1. Staffing

The IAC acknowledged that there was a considerable turnover of staff in the ICU over the past two years. As a result, the combination of increasing bed capacity and turnover of staff resulted in continuous hiring and orientation of new staff. The IAC also highlighted that, as a result of this high turnover, the Hospital was unable to consistently staff the unit to planned levels. These issues were further compounded by construction and frequent bed moves.

The IAC did a detailed analysis of the Hospital's budget and concluded that the Hospital had some budget flexibility which would allow the Hospital to staff to a higher level for a period of time in order to stabilize the unit staffing and assess workload, especially following the planned bed openings in September of this year.

Recommendations:

1. The Hospital should continue to benchmark staffing to comparable critical care units to support decision making regarding nurse-to-patient ratio and hours per patient day for D4 and K2.
2. The Hospitals should implement the Registered Nurses' Association of Ontario (RNAO) Healthy Work Environment Best Practice Guideline on Developing and Sustaining Effective Staffing and Workload Practice.
3. The Hospital should evaluate the adequacy of the number of full- and part-time registered nurses to meet established staffing levels and replacement requirements on a regular basis (minimum twice a year), utilizing the forecasting tool published in the Building Capacity in Nursing Human Resource Planning: A Best Practice Resource for Nursing Managers.
4. The Hospital must ensure that an adequate staffing complement of full- and part-time registered nurses is hired to meet the established staffing levels of the unit, including predictable replacement requirements such as vacation, statutory holidays, maternity leaves and sick time.
5. The Hospital must ensure that K2 is staffed to planned levels on a consistent basis in order to stabilize staffing on this unit and to support improved staff retention and morale, and to ensure proper work assignments.
6. The Hospital should establish a mechanism to identify future staffing gaps; and establish an objective measure of staffing gaps by regularly monitoring the actual gap between desired and actual staffing.
7. The Hospital should staff K2 at 95 per cent occupancy levels for a minimum period of three months after the opening of the final four PCOP beds in September 2013. The recommended staffing for 95 per cent occupancy is two Charge Nurses and 28 RNs. If during this period, occupancy and acuity for a shift(s) is lower than expected, the unit can staff down as necessary. Evaluate the cost effectiveness of this approach including use of overtime and sick time.
8. The Hospital should monitor the staffing resources, occupancy, ventilator rate, avoidable day rate and other measures as appropriate on a monthly basis to determine if and/how staffing can be adjusted.
9. The Hospital should monitor the ability to increase staffing when required.
10. The Hospital should ensure that an adequate number of support staff is scheduled and present for each shift. Improve the schedule for Patient Care Assistants to ensure consistent staffing across all shifts and days by considering a different master such as a 2/3 schedule or hybrid of the two.

2. Scheduling

During the Hearing, the Hospital admitted that scheduling had been a challenge due to increased demand for staff during the renovations of the critical care units and the increase in the number of patients due to opening of newly funded beds. As a result, the RN vacancy rate resulted in high patient-to-nurse ratios and increased workload.

Recommendations:

1. The Hospital must ensure that staff schedules are posted without holes. If this cannot be done at time of posting, every effort should be made to fill in any gaps at least one week before the shift.
2. The Hospital should review if there is a more effective schedule that could be developed for the K2 and D4 in order to create more balance across shifts and days of the week in order to support full staffing on every shift.
 - a. Schedule should be done respecting the rights of the nurses to take their vacation within the terms and conditions of the Collective Agreement.
 - b. Schedule should be reviewed and appropriate changes made as necessary by the Hospital to ensure that there is an appropriate range of skill mix from novice to expert on each line, while not resulting in increased expenditures.
 - c. If the 2D2N schedule creates gaps that cannot be met by part-time or casual staff, the Hospital should determine how many traditional schedules (2/3) would be required to minimize the plus and minus days in the current master schedule. The traditional schedule should then be offered to new hires and the 2D2N offered only when there is a vacant line.
3. The Charge Nurse should be given the autonomy to make staffing decisions on a shift-by-shift basis to ensure safe, quality patient care. The Charge Nurse should be able to increase staff as needed and decrease staff by not replacing sick-time or offering a vacation day or a leave of absence if all staff is not needed. The Charge Nurse should consult with the Manager or the Administrative Coordinator, as required by Hospital policy.

3. Retention

The Hospital and ONA agreed that the turnover of staff in the ICU was higher than desired and needed to improve. While the IAC did identify some strengths in support of recruitment and retention, the IAC also noted that there were a number of negative issues, such as inconsistent staffing. The IAC concluded that the successful integration of new staff is the key to retention to both existing and new staff and therefore made the following recommendations.

Recommendations:

1. The Critical Care nursing leadership and the unit staff nurses should collaborate to develop a unit-specific plan to address staff retention.
2. Continue to utilize a variety of innovative scheduling practices in order to meet both patient care requirements and to support staff retention.

3. The Hospital needs to review the vacation quota calculation and revise as necessary to ensure that an accurate vacation quota is established to allow for vacation entitlements as per the collective agreement.
4. The Hospital should implement a mentorship education and development program for nursing staff who act as mentors to support the orientation and integration of new staff. Include educational material in the program on providing constructive feedback, role modeling and information on developing critical thinking skills in novice critical care nurses.

4. Assignments

The IAC highlighted a shortfall with the Hospital's Guideline for Alternative Assignments in the ICU. While the Guideline detailed a number of factors to consider when assigning more than one patient to an RN, the Guideline failed to consider how the mentoring of staff would impact patient assignments. In its report, the IAC stated that it would be prudent to avoid assigning a mentor a doubled patient assignment as this would impact on the ability of the mentor to provide support to the mentee while completing care for his or her own patients.

Recommendations:

1. Staffing of the unit must take into consideration the coverage needed to safely and appropriately provide for breaks. This may require the decision to staff above base in order to provide sufficient consultative support to mentoring of new staff and novice critical care nurses who are no longer on orientation.
2. Review the criteria for double assignments and include considerations for patient assignments of staff who are mentoring new hires on orientation and support consistent implementation by the Charge Nurse group.
3. Room 18 should not be utilized for critically ill patients. It is most appropriate for patients who require palliative care or are being discharged from the unit and do not require frequent interventions or close visual monitoring.

5. Unit Morale and Staff Engagement

Following the Hearing, the IAC concluded that it was "evident that there were issues of low morale within the K2 unit that [were] related to the quality of the relationship between management and staff." During the Hearing, staff made a number of suggestions for the improvement of morale, which were incorporated into the IAC's recommendations below.

Recommendations:

1. Continue with regular staff meetings and post minutes electronically and in hard copy to increase access to staff.
2. Re-establish the unit council with staff nurse leadership.
 - a. Provide leadership support to the staff nurse leaders in their new roles.

- b. Consider establishing representative membership from the unit staff to council rather than it being open to all staff.
 - c. Encourage the council to take on only a few key initiatives in their first year.
 - d. Provide remuneration to staff who are members of the unit council for time spent in unit council meetings.
3. Establish other methods to improve the relationship between staff and management.
- a. Establish a town hall type meeting three to four times a year in the ICU for all staff and invite senior management (Director and VP/CNE) to attend and provide an update from a Hospital leadership perspective and to engage in active dialogue with unit staff. These meetings can be used to communicate corporate messages about external pressures, government priorities, budget, etc. and should be used for staff to bring forward their concerns and together, management and staff should determine win-win solutions.
 - b. Establish unit manager rounding on staff to support staff engagement, relationship building, and to model approachability.
4. Make a commitment to review the staff engagement survey results and to create corrective action plans to address gaps as identified by staff.

6. Culture and Communication

Regarding culture and communication, the IAC noted that the challenges on the units resulted in a breakdown of trust and communication between management and the nurses, nurses and physicians and in some cases, nurse to nurse. The IAC emphasized that trust needed to be re-established in order to maximize an individual and professional contribution by staff towards the Hospital's mission and strategy. In developing the high trust environment, the IAC recommended that RNAO's Best Practice Guidelines be implemented and that the orientation for new staff be strengthened.

Recommendations:

1. Implement the RNAO Best Practice Guideline on Collaborative Practice Among Nursing Teams. Timelines for implementation and evaluation metrics must also be established.
2. The unit management and nursing staff in the critical care program (K2, D4 and ICCN) should review the Hospital "Get Real" program to determine relevance and implementation strategies at a local level in critical care. This strategy must address code of conduct and behavior expectations to support professionalism and mutual respect.
3. Publicly post indicators of a healthy work environment – reduced absenteeism, reduced turnover, improved staff satisfaction. Post safety and patient satisfaction outcomes.
4. Unit management and nursing staff should both commit to improving formal and informal two-way communication.
 - a. Informal face-to-face communication should be used daily by management, Charge Nurses and nurses to build relationships. All parties should commit to

active listening skills, be aware of good non-verbal communication techniques, and take responsibility for what is said and how it is said.

- b. Nurses should bring their questions and concerns directly to management to be addressed and for resolution.
5. The Hospital should help employees understand the Hospital's overall business strategy and communicate to the staff how their work contributes to the unit and overall Hospital success.
6. Unit management should commit to responding to staff emails and/or voicemails within 72 hours unless away from the Hospital.
7. If not already in use, implement a standardized method of communication by all staff in the ICU like Situation-Background-Assessment-Recommendation (SBAR).
8. The Hospital should ensure that the use of Vocera is consistent among all team members working in the ICUs in order to support timely access to team members and resources. Provide formal education/review of Vocera communication system to all staff expected to use Vocera with scenarios of when it would be useful to use the communication device. Ensure that all medical learners receive Vocera training as part of their orientation to the ICU; and expectation of its use at KGH.

Scenario examples: RN calling PCA to assist with patient boost in bed; RN to Pharmacy regarding missing medication; RN to PT to plan getting patient up in chair; RN to RT for assist with desaturation of patient after a turn or new STAT order for ABG or planned bronchoscopy; UCC to RN to inquire about visitor; UCC to RN to inquire about picking up a shift the next day; MD to RN to inform about new orders written.

9. In order to support effective and efficient teamwork, all medical and other professional learners must attend a K2 ICU orientation session. This session should be led by the Nurse Manager outlining expectations of medical and other health professional learners in the K2 ICU.

7. Leadership

According to the IAC, it was evident that there was unwillingness from both Hospital management and the RNs to move the critical care program forward from a place of unrest and low staff morale. The IAC encouraged both parties to demonstrate leadership competencies to move to a place of mutual respect. To encourage this transition, the IAC made the following recommendations.

Recommendations:

1. The Hospital should also focus its leadership on enhancing teamwork so that nurses see their unit leadership as part of the team. Working together, management can assist all staff to reach their full potential and achieve common personal, professional, unit and Hospital goals.

2. Unit staff must be open to working with unit leadership to move forward, and align their skills and knowledge to meet the needs of the unit and the Hospital, while also meeting their personal and professional goals.
3. The Hospital should determine the leadership development needs of the Managers, Charge Nurses, Clinical Educators and Nurses on K2, D4 and ICCN. Job descriptions should be current and relevant to the practice environment. The RNAO best practice guideline on Developing and Sustaining Nursing Leadership can be used as a resource.

8. Education

Recommendations:

1. Orientation should be not be scheduled more than every two months to allow time for clinical educators to follow up and evaluate new hires; provide some time for new staff to integrate with the ICU Team, and for mentors to have a break between mentoring new staff.
2. In line with best practices in other organizations with critical care programs, new graduate nurses should be hired to the ICU under the New Graduate Guarantee.
3. Consistently utilize the “Nursing Self-Appraisal” tool with all new hires.
4. Augment the transfer of accountability process at shift handover by ensuring that novice nurses consistently utilize the systems-based approach taught during orientation.
5. Establish an annual education day for all critical care nursing staff with financial support for attendance.
6. Redefine the Circulating Clinical Educator (CE) role and expectations within the ICU. Ensure that all staff understand the role and how the circulating clinical educator can be effectively utilized.
7. The Hospital should support the ongoing professional development of the Clinical Educators.

9. Model of Care

During the Hearing, it was acknowledged by the Hospital that combining the closed medical model and open medical model in the ICU was problematic and it was eventually deemed unsuitable. At the time of the Hearing, the models were separated by Kidd 2 functioning as a closed medical unit and Davies 4 as an open model; the IAC emphasized that this separation should continue.

Recommendation:

1. Maintain the closed medical model on K2.

10. Patient Flow and Bed Management

The IAC made a number of recommendations to improve patient flow in order to bring down the avoidable ICU days, which was noted to be “very high.”

Recommendations:

1. Continue with current corporate efforts to improve patient flow and to decrease the avoidable days in critical care.
2. Extend the daily Charge Nurse meeting to include the Nurse Managers of the critical care units on a consistent basis.
3. Establish a mechanism for collaboration between the critical care program and other programs with regard to patient flow. This will help to inform critical care Charge Nurses to anticipate bed flow in and out of the K2 and D4 ICU.

11. CCIS Data Management

The Critical Care Information System (CCIS) was developed to provide data on every patient admitted to Level 3 and 2 critical care units in Ontario. It was noted that at KGH, clerical staff are entering the data into the system. Given the importance of the CCIS data, the IAC indicated that best practices would be to have a Registered Nurse entering the data, as outlined below.

Recommendations:

1. The Charge Nurses on K2 and D4 should collect and enter the CCIS data or at a minimum, review the CCIS data prior to entry by a clerical staff member.
2. To ensure the highest quality of CCIS data, implement an audit system when the new audit tools are available from CCIS.
3. Include a review of CCIS data results in staff meetings/town halls on a regular basis so that staff is aware and informed on the data, the interpretation by the Hospital and how it is being used to support decision making.

12. Hospital Association Committee

During the Hearing, the Hospital acknowledged that the Hospital Association Committee would benefit from review and improvement. The IAC agreed and made a number of recommendations to support a well functioning HAC and HAC-PRC process.

Recommendations:

1. The Hospital and the Association should jointly Review the articles and language in the Central and Local Collective Agreements with regard to the Hospital Association Committee and revise the Kingston General Hospital Association Committee Terms of Reference as necessary.

2. The Association and the Hospital should jointly develop rules of conduct for joint meetings that address issues such as: respectful engagement; processes for inviting guests to the HAC; determining for each party who is the designated contact person if there is a request for information;
3. The Hospital and the Association should develop a template for agendas and minutes that both parties utilize on a consistent basis to support effective meeting preparation and management.
4. The Association and the Hospital should, on an annual basis, develop and agree to the annual schedule of HAC meetings.
5. The Hospital should offer education to all Clinical Managers as necessary on the processes for effective management of PRWRFs and management response.
6. The Hospital and the Association should jointly develop a system for tracking PRWRFs.

Conclusion:

The IAC concluded by stating that it unanimously supported all recommendations contained in the report. The IAC was hopeful that the recommendations in the report would assist the Hospital and ONA to find mutually agreeable resolutions to the nursing workload issues on Kidd 2 and Davies 4.