

INDEPENDENT ASSESSMENT COMMITTEE REPORT SUMMARY

ONA File: 201300678

Employer: Rouge Valley Health System, 3 Margaret Birch Wing

Board: Chair, Joan Cardiff; ONA Nominee, Glenda Hubley; Employer Nominee, Carol Anderson

Decision Date: February 14, 2014

Professional Practice Specialist: Jo Anne Shannon

The Independent Assessment Committee (IAC) did conclude that the RNs working in the 3 Margaret Birch Wing (3MBW) have been required to perform more work than is consistent with proper patient care. Significantly, the IAC concluded that 'a workload consistent with proper patient care' requires an environment that supports quality nursing practice.

3MBW is a Post Acute Care Unit consisting of geriatric treatment and assessment, complex continuing care and alternate level of care beds. The Hospital implemented a model of care and skill mix change in September 2011 whereby half of the RNs and RPNs on the day and evening shifts were replaced by unregulated care providers (UCPs). They called this new model of care "Collaborative Care".

The IAC stated "From the IAC's perspective, the Hospital 'lost focus' with regards to the initiatives undertaken to support the implementation of the Collaborative Care Model."

The Hospital used LEAN methodology to develop rigid "Hour by Hour Accountability" schedules which contained tightly scripted periods of time varying from 15 minutes to an hour in which the RNs, RPNs and UCPs were required to perform specific tasks or activities. This included a Four "P" Rounding (4PR) schedule requiring a scripted hourly or two hourly brief assessments of patients (pain, personal needs, positioning and presentation).

It was ONA's position that this requirement for 4PR caused frequent, significant and dangerous interruptions of the RNs taking them away from patient care and resulting in delays and omissions in patient care. In addition, ONA submitted that the 4PR stripped the RNs of their ability to use critical thinking and professional judgement and their ability to prioritize, plan, individualize, implement and evaluate patient care needs.

The IAC supported ONA's position stating "The IAC believes that the prescriptive nature of this document (X to be done at 0800, Y to be done at 0930) does not recognize the normal ebb-and-flow of activity on an inpatient hospital unit". The IAC strongly disagreed with the concept of mandated scheduling of nursing activities and recommended the discontinuation of the formal 4PR approach.

They further recommended the implementation of Standards of Care to be executed by regulated health care professionals who use their autonomy and judgement to implement. These Standards of Care would include regular assessment and intervention as required, effectively replacing the need for an "overly-structured 4P Rounding approach".

Considerable attention was focused by the IAC on the erosion of the leadership role of the RNs and the Unit Coordinator (charge nurse). The IAC recognized that the implementation of the new model of care had decreased the role and professional respect of the RN as clinical leaders on the unit and commented on the need for the UCPs to understand the clinical relationship and

accountability of nurses as leaders of the collaborative care team. “The Hour by Hour Accountability schedule has placed all members of the interprofessional team on an equal footing, with no-one person defined as having the accountability for the supervision, direction or leadership of the team”.

Further, the IAC noted the obvious resentment and frustration on the part of all members of the care team describing “a very negative cycle that must be broken”. The IAC recommended a focus on the skills of RNs “to provide clinical direction to and supervision of UCPs, and collaborative consultation with RPNs. A model of care that clearly delineates this leadership role vis-à-vis the other members of the care team would be advantageous”.

The IAC recommended that the role of the Unit Coordinator also be revised to recognize her role as an expert nurse providing integral mentorship, learning and evaluative support to the care team, and be readily available to step into clinical situations to ensure patient and staff safety.

The IAC also focused considerable attention to the model of care. The IAC stated that the term ‘collaborative care’ is not, in itself, a care delivery model and they described the current model of care as a ‘functional care delivery model’. They further stated “The RN in the role of team leader was not evident”. Significantly, “The IAC believes that a model of care which maximizes the leadership capabilities and responsibilities of the RN, enables the RPN to work at full scope, and provides a mechanism to monitor and supervise the UCP, is required.”

Recommendations include the implementation of a ‘modular nursing model’ which the IAC described as regulated and non-regulated staff co-operating in care for patients under the leadership of the RN. “As team leader, the RN is actively involved in planning and coordinating care.” The IAC recommended the addition of an RPN to the day shift. This would result in the 2 staff RNs not carrying a regular direct-care patient assignment on the day shift, freeing them up to be responsible for overall leadership of the team, care planning, managing family issues, complex discharges and new admissions. As well, the RN would be able to function as a resource to the RPN/UCP dyads.

The IAC questioned the extent to which the RN in the current model of care is able to provide “effective, timely and knowledgeable consultative support” to RPNs as required by the College of Nurses Three Factor Framework. The IAC also commented that “the Hospital failed to recognize and acknowledge the impact of removing 55% of the full-time RN positions.” In addition, the RNs’ workload was accentuated by the fact that the RPNs were not required by the Hospital to practice at full scope for a full 18 months following the model of care change.

The IAC was “amazed” and concerned by the low number of full-time positions across each category of care provider, significantly contributing to the staffing instability being experienced by 3MBW. The IAC commented on the “astoundingly high use of agency staff” at more than 50% of budgeted shifts for UCPs as an example. A recommendation was made to increase the base number of full-time RN, RPN and UCP positions to cover the majority of the base line schedule with full-time employees. Further, “The IAC believes that in light of the current issues on 3MBW, external agency resources should be used as minimally as possible”.

The IAC was critical of the lack of a day to day presence of strong nursing practice leadership and recommended the implementation of a new Advanced Practice Nurse role to provide consistent, day-to-day, on the spot leadership regarding clinical practice standards. “Given that neither the Manager nor Program Director are nurses and the Clinical Practice Leader has

responsibilities beyond 3MBW, the IAC believes that strong clinical nursing leadership is required from another member of the unit leadership team.”

The Hospital has recently implemented a Unit Council that at the time of the IAC hearing was co-chaired by the Unit Coordinator and a UCP, which caused great concern for ONA given the mandate of the Unit Council to review evidence-based nursing and interdisciplinary research and integrate best practices into the practice environment . The IAC supported ONA’s concerns by recommending that the Unit Council be co-chaired by two regulated staff members, and that it be “properly resourced” by including paid time for staff to attend on their day off, or relieved of patient care responsibilities if working.

The IAC noted that there is no front line nursing representation on the Program Council and recommended that both the Unit Coordinator and a front line staff member be appointed. The IAC also commented on the lack of front line RN representation on the corporate Professional Nursing Practice or Professional Nursing Standards Committees. While prefacing their comment that this is beyond the scope of the current PRC, they urged the Hospital to reconsider this issue.

The IAC Panel concluded that “the manner in which the care delivery model and associated staffing and unit processes have been implemented has resulted in the RNs being unable to provide proper patient care. This has been accentuated by a number of clinical unit practices which have not supported effective care provision.”

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

The IAC identified in total 50 recommendations, focusing in the areas of leadership and governance, nursing care delivery model and associated staffing, and clinical practice/unit processes.

IAC Recommendations

4.2.1 Leadership and Shared Governance

A quality practice setting requires effective operational, clinical and point-of-care leadership.

The 3MBW Manager is a novice leader, and requires mentoring support and skills development to provide effective leadership in light of the current instability on 3MBW. Assignment to 3MBW on a full-time basis, for a defined period, will be of benefit.

1. The 3MBW Manager be responsible for 3MBW only, on a 1.0 FTE basis, for a six-month period.

2. *The Vice President accountable for Post-Acute Care Program organize and implement a formal management mentorship relationship for the 3MBW Manager with an external expert leader.*

3. *The 3MBW Manager successfully complete a comprehensive Leadership Development Program.*

Clinical leadership will be more optimally provided by a Clinical Nurse Specialist (CNS) than an Nurse Practitioner (RN(EC)). The Advanced Practice Nurse in a CNS role is more suited to provide clinical leadership with respect to practice standards and competencies than is the RN(EC) role, which is more oriented to provision of patient care.

4. *The Post-Acute Program replace the budgeted RN(EC) position with an Advanced Practice Nurse CNS position, and take action to hire this position as soon as possible.*

The Unit Coordinator is the 'oil' that enables smooth functioning of an inpatient unit, and as such, requires flexibility to address issues impacting staffing and patient care.

5. *Discontinue the current Standard of Work document for the UC.*

6. *Implement a Unit Coordinator role profile which identifies the key elements supporting the smooth functioning of 3MBW, including:*

- *timely problem-solving of patient and staff issues;*
- *assessing patient eligibility for transfer to 3MBW;*
- *determining staffing requirements in advance;*
- *providing mentorship, learning and evaluative support to new and/or temporary unit staff; and*
- *leading the Bullet Discharge Planning Rounds..*

College of Nurses of Ontario (CNO) regulatory standards include the requirement for RNs to assume a leadership role in the provision of patient care. The current care delivery model has been implemented in a manner which has not supported or facilitated RN leadership.

7. *Develop and implement a role profile for the RN working in a leveled practice environment that clearly articulates her/his leadership practice expectations, including (but not limited to):*

- *meet with the dyad team at the beginning of each shift to discuss and coordinate care provision;*
- *update client care plans (Kardex) as required to ensure content is correct and comprehensive;*
- *oversee the care provided by UCPs.*

Effectively implemented shared governance models provide staff at all levels with a sense of empowerment resulting from participating in decisions that directly impact professional practice

and one's practice environment. Although 3MBW has resurrected the Unit Council, front-line staff members do not participate in the Program Council, and the accepted mechanism for decision-making has remained with the leadership team. Clarity regarding responsibility for decision-making regarding unit operational processes and clinical practices is required.

8. The Unit Council revise the Terms of Reference to specify chairmanship, membership, boundaries of decision-making and ground rules for action during and following meetings.

9. The Hospital provide appropriate resourcing of the Unit Council, to enable effective discussion and decision-making.

10. The Hospital provide clerical assistance to ensure agenda and minutes are developed and circulated in a timely fashion.

11. Professional Practice mentorship be provided by the ONA RVHS Professional Responsibility Representative and the 3MBW CNS.

12. The Unit Coordinator from each of the four inpatient units within the Post-Acute Program sit as a decision-making member of the Post-Acute Program Council.

13. Front-line staff members from the Unit Council (in addition to the Unit Coordinator) participate on the Program Council.

Unit culture impacts intra-team communication, collaboration and beliefs about practice. The 3MBW culture of tolerance for a lack of inter-collegial respect and unprofessional behaviour has not been effectively addressed, leaving issues to fester. The 3MBW practice culture does not embrace evidence-based practice.

14. The Hospital engage an external expert (such as an Organizational Effectiveness specialist) to facilitate the development of a unit culture that is founded on the principles that underpin the Hospital's code of conduct. This should include team-building, conflict resolution and communication activities involving active staff participation.

15. The Hospital take direct action, up to and including discipline, in instances where staff members violate the Hospital Code of Conduct and Values. This will require the consistent presence and observation by the Manager in the short term.

16. The Hospital engage in a partnership with an external body (community college, Regional Geriatric Program etc.) to develop and provide a curriculum for the 3MBW staff that will assist with the transfer to a restorative care / enablement philosophy, the development of rehabilitation and gerontological nursing competencies and implementation of senior-friendly best practices on the unit.

17. The CPL implement a support group to assist RNs to explore preparation for CNA Certification in Gerontology or Rehabilitation Nursing.

4.2.2 Nursing Care Delivery Model and Associated Staffing

Although a team nursing care delivery model was envisioned when the collaborative care approach was implemented, this quickly evolved to a functional care delivery model. A move to a modular nursing model of care will maximize the leadership capabilities and responsibilities of

the RN, enable the RPN to work at full scope, and provide a mechanism to monitor and supervise the UCP.

18. 3MBW implement an even staff allocation across all shifts to enable balanced regulated/unregulated care teams. The allocation be:

- *day shift: 2 RNs, 4 RPNs, 4 UCPs*
- *evening shift: 2 RNs, 2 RPNs, 2 UCPs*
- *night shift: 2 RNs, 2 RPNs.*

19. Reallocate current budget from the third UCP on evenings and the weekend Unit Clerk coverage to support the creation of a fourth RPN position on the day shift.

20. Implement a professional nursing care delivery model, preferably modular nursing, that is based upon teamwork, geographic distribution of patients, shared accountability, continuity of patient care provider and maximizes utilization of the scope of practice of RNs, RPNs and UCPs.

21. Until modular nursing is implemented, assign one RN to each of 3 West and 3 East on the day shift (i.e. discontinue the current 'float' role).

3MBW has suffered significantly from a low number of full-time unit-based RN, RPN and UCP staff. The consequent assignment of part-time staff to their committed hours to meet baseline schedule needs has resulted in a heavy reliance on the SRT pool and external agency resources to cover unanticipated and anticipated vacancies and 'up-staffing' in response to patient care needs. This has, in turn, had a negative impact on continuity of patient care, effective point-of-care leadership (and followership), and cost. An increase in the proportion of full-time to part-time staff is required.

22. The Hospital increase the number of full-time RN, RPN and UCP positions to enable better coverage of the base-line schedule with full-time staff.

Although the 3MBW RNs have utilized a self-scheduling system for a number of years, the majority of RNs self-schedule into a regular schedule and/or permanent shifts. Opportunities are available to meld scheduling autonomy with the scheduling consistency available through implementation of a master rotation.

23. Create a master schedule that covers the base-line staffing with full-time RNs, working 7.5 hour and/or 11.25 hour tours, with the potential for permanent shift assignment. Develop, as indicated in Article 13.03, a Letter of Agreement(s) to protect current the permanent shift schedules permitted under the 3MBW Self-Scheduling Guidelines.

24. Implement a corporate Scheduling Committee which will be responsible to annually review (a) all unit master schedules to ensure compliance with the Collective Agreement and (b) all new or revised unit master schedules prior to implementation and to provide guidance and advice regarding challenging scheduling issues and innovative schedules.

The SRT pool provides an important resource to meet short-notice staffing requirements. To function as an effective team member within the 3MBW care delivery model, SRT staff

members require an orientation to the 3MBW care delivery model prior to assignment to the unit. Assigning SRT staff to a home unit, rather than a corporate resource pool, will assist with this integration.

25. Provide all SRT pool staff (RN, RPN and UCP) with a one-shift orientation to 3MBW prior to being assigned. The RN orientation include shadowing with an experienced 3MBW RN to enable understanding of the RN's responsibilities for direction and supervision of UCPs within the 3MBW model of care.

26. The 3MBW Manager, CPL and UC develop an Orientation to 3MBW document, for use during SRT staff orientation and to enable evaluation of understanding of the 3MBW care delivery model by non-core staff.

Unit Clerk coverage is required on a consistent basis during the day shift on both 3 West and 3 East. The funding currently allocated for weekend Unit Clerk coverage would be better applied to support direct care provision by a regulated provider (RPN).

27. Provide Unit Clerk coverage from 0800 – 1600 Monday to Friday on each of 3 West and 3 East.

28. Re-allocate budget for weekend clerical coverage to direct care (RPN on day shift).

4.2.3 Clinical Practice / Unit Processes

The workload of the RNs (and other staff) on 3MBW has been impacted by a number of clinical practices and unit processes relating to medication administration, transfer of accountability at change of shift, use of the 3 Factor Framework for staff/patient assignment, Bullet Rounds and 4P rounding expectations, and documentation.

The time required for medication administration will be eased when an electronic Medication Administration Record is implemented, medication transcription incidents are addressed at the time they are identified, and medication administration practices are standardized and adhered to by all staff.

29. The Hospital implement an electronic Medication Administration Record as soon as possible.

30. 3MBW Manager ensure that the Unit Clerks meet the minimum qualifications to support the transcription of physician orders (e.g. a Medical Terminology course) and attend a unit in-service to reinforce medication transcriptions standards as indicated in Hospital Policy M-0120. The 3MBW Manager must continuously monitor these practices to ensure competency.

31. Regulated staff self-monitor to ensure adherence to CNO "Medication" standards of practice and Hospital policy "Preparation, Administration and Documentation of Medication" with respect to IRIS reporting.

32. The Professional Practice Committee establish, articulate and implement clear parameters for practice regarding medication administration.

33. All RNs and RPNs on 3MBW adhere to the medication administration parameters identified by the Professional Practice Committee, with managerial follow-up as required.

34. *The Unit Council and the 3MBW management team jointly identify tools and resources that will assist in timely and efficient medication administration, included but not limited to additional medication carts, unit dose bundling and implementation of standard medication administration times.*

The requirements for professional staff to transfer accountability for patient care at change of shift report are unclear and inconsistent. There is no direct interaction between the outgoing and incoming staff, and no standardized expectations for patient information transferred from shift to shift, both of which are required. Information on the Patient Assignment Board is not consistently updated throughout the day, limiting its utility.

35. *Remove the requirement that change of shift report for 20 patients be completed within 15 minutes.*

36. *Discontinue use of the Change of Shift Report sheet. Implement a change of shift report process whereby the outgoing nurse (RN or RPN) provides report for the 10 patients within her/his dyad⁸¹ in accordance with a standardized format, and using the Care Plan / Kardex as the base.*

Following implementation of a modular care delivery model, the outgoing RN will provide report for the 10 patients within the module to the incoming module team.

37. *The Unit Council develop a standardized reporting format tool, which identifies the key information to be provided, in concert with the care plan as identified in the Kardex.*

38. *Discontinue the use of the Patient Assignment Board. Post the daily staff assignment at the nursing station for access by the multi-disciplinary team.*

The current approach of using the 3 Factor Framework to colour-code a patient as green, yellow or red is inappropriate, as it is the triangulation of the patient, nurse and environment factors, not the patient, which leads to the green/yellow/red colour allocation. Replacement of the colour coding of patients with RN nursing judgement on a shift-by-shift basis to determine the most appropriate care provider will be beneficial.

39. *Continue to utilize the 3FF philosophy when making staff : patient assignment decisions, but discontinue the practice of colour-coding patients on the patient assignment sheet..*

Patient care rounds on 3MBW include inter-professional rounds, Bullet Rounds, held in the morning Monday to Friday, and 4P Rounding, held throughout the 24-hour day. Bullet Rounds currently involve all members of the care team (RN, RPN and UCP) as well as the UC and allied health staff, and appear to provide a general status update on each patient, rather than a focus on factors impacting discharge.

40. *Participation in the 3 East and 3 West Bullet Rounds include the UC, two RNs leading the modular care team and the allied health team members only.*

41. *The UC be exclusively responsible for maintaining the Bullet Rounds Board, and in so doing, use the green/yellow/red system (marker or magnet) to correspond with the patient's anticipated discharge status.*

42. Limit the Bullet Rounds Board information to that required to facilitate discharge, such as room, patient name, diagnosis, service, admission date, discharge location, estimated discharge date and barriers to discharge.

The current mandated schedule for 4P Rounding ensures that all patients are seen on a regular basis, but does not allow for individual accommodation of patient needs. While the concept of 4P Rounding is appropriate, successful implementation will require the regulated staff member's judgement regarding the frequency with which assessment and intervention are required for each patient. Rounding expectations must recognize that each patient is unique, and requires assessment and/or intervention tailored to his/her specific situation.

43. Discontinue use of the Hour by Hour Accountability Schedule.

44. Discontinue the formal 4P Rounding approach, including use of the laminated Rounding Log.

45. Each RN assume accountability to ensure that patients within her/his module are assessed at the beginning of each shift by the modular team, and that assessments and interventions are completed as required by the patient's care needs and by the minimum unit standard for patient observation.

46. Develop Standards of Care that outline the minimum expectations for the provision of patient care unique to this unit, team functioning, including regular patient assessment, intervention as required, and documentation of care provided.

Documentation of patient care needs is currently referenced in the Care Plan / Kardex, on the Bullet Rounds Board, and on the white boards in patient rooms. This approach has diluted the efficacy of the care plan / Kardex as "the" go-to resource, and has increased the risk of incorrect patient care being provided. This risk is increased when documentation of care needs are duplicated in multiple locations. The patient room white board should be reserved for communication between the patient/family and the health care team.

47. In concert with Recommendation 42, RNs and RPNs self-monitor accountability to update their patients' Care Plan / Kardex on a regular basis to ensure currency with the patient health record. In the short term, until it has become standard practice, Care Plans / Kardexes should be monitored by the Manager to ensure validity and currency.

48. Utilize the patient room white boards as a communication tool with patients/families by including the date, name of current care providers on that shift, and estimated discharge date only.

49. Update the white board during the modular team round immediately after change of shift report.

Accountability for documentation of patient care provision on the *Assessment and Routine Care Flowsheet* requires clarification, to ensure that UCPs are providing comprehensive documentation of personal care provided, and that differentiation between care provided by regulated vs. unregulated staff members is evident.

50. Review and revise policies regarding Documentation to ensure compatibility with the care delivery model on 3MBW.