Handing over the Torch to Very Good Hands!

This is my last column for *Practice Matters* as your First Vice-President with the portfolio of professional practice (along with political action). In January, I assume the role of ONA President and it is an honour that members have entrusted me to lead our union for the next two years. I take that responsibility very seriously, and I promise to not let you down.

When I first took over this important portfolio several years ago, I knew that ONA members were patient advocates through and through. But I have been absolutely overwhelmed by the lengths you go to each and every day to ensure your patients receive the very best care, often under challenging circumstances, and that your standards aren't compromised. Workload is now, as it was then, our members’ number one concern and your advocacy to ensure appropriate changes are made is nothing short of inspiring.

It’s thanks to you filling out your workload forms when you experience workload issues and other areas of concerns in your workplaces that we are making those meaningful changes – and more and more with settlements at the Bargaining Unit level and during mediation. While an Independent Assessment Committee (IAC) hearing is the last step in the professional responsibility complaints process, we are often breaking new ground there as well. You’ll read about one such story in this issue. While we didn’t get everything we wanted, the 28 recommendations handed down by the IAC panel are a good starting point for implementing meaningful changes.

Issues began to escalate about five years ago, with RNs reporting that due to a lack of adequate staffing, it was challenging to meet their professional standards in addition to the standards established by the National Emergency Nurses Association. In the past year alone, more than 100 professional responsibility workload forms were filled out.

“Our ED has been growing faster than it can be contained,” said Southlake Bargaining Unit President DJ Sanderson. “It was only meant for 70,000 visits per year and we’re set to break 120,000 this year alone. You will find patients in every nook and cranny, and any meeting space where tables and chairs can be pulled out. It takes high-
ly-skilled, highly-trained nurses to complete the work in this area. We’ve also had a number of violent incidents in our ED and are working hard to implement strategies, but the workload has continued to climb and the banks have broken.”

While the employer agreed to changes to improve RNs’ working conditions after several meetings with ONA – most significantly, adding a phlebotomist to free up nurses from blood work and conducting an independent Infection Control Risk Assessment – many outstanding issues remained, and members continued to fill out workload forms.

“We very easily identified eight themes that are unaddressed issues members are dealing with regularly,” said Sanderson. “It wasn’t just a lack of staff and overcrowding, but lack of process, the way the department is designed, and the way the patients flow through. I wish I could tell you that I’m kidding when I say we heard from management there’s always someone keeping an eye on patients, whether that person is a nurse, a doctor, a clerk or a member of housekeeping staff.”

When it became evident these serious issues would not be addressed, ONA referred the matter to an IAC, which took place from September 27 - 29.

“More than 30 nurses attended,” noted Sanderson. “We heard from the employer that our workload forms are just a snapshot in time, and that they have the real statistics and the real picture of the ED. But we expressed that we are constantly working in crisis mode and cannot continue at this level. I appreciate that in this relationship we look at things a little bit differently, but our ultimate goal is to make things better for our nurses and, therefore, our patients.”

Within two weeks, the IAC panel issued its report, which contained 28 recommendations, addressing every one of ONA’s eight areas of concern (see sidebar). While we argued for increased RN base-line staffing, the panel was not comfortable recommending significant increases, and instead urged the parties to conduct audits and continue to evaluate.

“Our members were really happy to see that a light is finally being shone on infection control, and one of the biggest achievements was the one-to-one staffing process needed for the acutely ill patients,” concluded Sanderson, adding they are working with the employer on next steps, which he accepts won’t happen overnight or all at once. “I think the nurses were hoping for an all-RN model, but asking for an assessment of the RN/RPN role in the ED and a review of the model of care by an independent party sends a very clear message. Just because the IAC report didn’t give us 10 more nurses a day, there is value in what’s written here. If we can leverage it the way I hope we can with the employer, there are going to be some big wins.”

What Was Achieved

Key highlights of the IAC recommendations include:

- Adding at least five permanent full-time positions to the roster.
- Conducting an independent evaluation on whether the current staffing model meets patient needs.
- Conducting an audit on the nature of patients and care provided in this area.
- Moving to an all Psychiatric Emergency Nurses’ model in the Mental Health Wellness Area.
- Increasing RN hours in yellow zone by 11.25 additional hours and reallocating an additional 11.25 hours from sub-acute care.
- Maintaining 1:1 care for critically ill patients during surge.
- Increasing the number of permanent full-time positions, rather than hiring permanent part-time or casual positions.

I can’t thank ONA enough for the time, resources and energy they put into this IAC. It was a show of strength for our members, and I still walk down the hall and get high fives!” —Southlake Bargaining Unit President DJ Sanderson
First Vice-President Vicki McKenna. “For regulated health professionals, the term ‘restrictions’ carries strong negative connotations and suggests the member has done something wrong or has fallen short in some aspect of her or his practice.”

We repeatedly raised this issue with the Ministry of Health and Long-Term Care and the CNO while our members sent letters and emails and posted comments on social media. We raised similar concerns about labeling RNs as having restrictions if they choose not to complete the education required for independent prescribing beginning in 2018.

In September, Minister of Health and Long-Term Care Eric Hoskins wrote to the CNO, telling them not to label these NPs or RNs as having restrictions and instructing them to work with ONA to find another way to convey this information – a huge victory for NPs and RNs!

As a result of ONA’s advocacy, nurse practitioners (NPs) in Ontario who choose not to prescribe controlled substances will no longer be labelled as having “restrictions” on their license by the College of Nurses of Ontario (CNO)! The same will be true for RNs who choose not to expand their scope by engaging in independent prescribing when this rolls out in the new year.

Regulations under the Nursing Act changed in the spring of 2017, allowing NPs with CNO-approved training to prescribe controlled substances. ONA has always supported this change because it will improve access to health care for thousands of patients. However, we did not support the CNO’s decision to label all NPs who chose not to receive the required education and expand their practice as being “entitled to practice with restrictions.”

“An NP can choose not to engage in prescribing controlled substances for any number of reasons and should be able to make that decision without attracting a negative label,” said First Vice-President Vicki McKenna. “For regulated health professionals, the term ‘restrictions’ carries strong negative connotations and suggests the member has done something wrong or has fallen short in some aspect of her or his practice.”

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Local 83 certainly has the right idea when it comes to engaging members in the professional responsibility complaints (PRC) process!

First-Coordinator/Vice-Bargaining Unit President of The Ottawa Hospital Kelly Johnston said they have created an online game that has members using their own cell phones and other electronic devices to test their PRC knowledge after an in-service is delivered.

The game, available through www.kahoot.it, is fun, interactive and competitive, allowing members to play as an individual or as a team. There is even a prize for the highest score – a $5 Tim Horton’s card, always a big hit!

We encourage you to take a look at the kahoot website and consider developing a game for your Local.
Fighting Bill 87 Changes

IN WINTER AND SPRING OF 2017, ONA fought hard against parts of Bill 87, an omnibus health bill that included proposed changes to the Regulated Health Professions Act.

We met with the Ministry of Health and Long-Term Care and also presented arguments to the Provincial Standing Committee. While the government did not follow all of ONA’s recommendations, it did heed our advice on one crucial issue.

In Bill 87, the government was proposing a change that would require regulatory colleges to post on the public register results of all decisions of the Discipline Committees and Fitness to Practice Committees. That would include not just decisions where there were findings against members, but also decisions where there were “no findings” (i.e. Discipline Committee decisions that a member was not guilty of misconduct and decisions of the Fitness to Practice Committee that the member was not incapacitated.)

ONA argued that posting this type of information would not clear our members’ names, it would do the opposite: taint members’ reputations because people might still believe there must be some truth to the allegations. We argued that the only way to avoid damaging a member’s reputation was to have noth-

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ment made some concessions to these “not guilty” findings. The legislation that was passed, the Putting Patients First Act, does two things that are an improvement on what was proposed in Bill 87:
1. When the Discipline Committee makes a ruling that there is “no finding” against a member, that decision will be posted on the register if there was no support for the allegations.
2. When the Fitness to Practice Committee makes a ruling that a member is not incapacitated, that decision will not be posted on the register at all.

Coroner’s Inquest Recommends “Sufficient Nursing Staff”

A CORONER’S INQUEST looking into the death of a 65-year-old man while in restraints in a psychiatric facility has issued a verdict which includes several recommendations proposed by ONA.

ONA had standing at the Mpelos Inquest, which took place in October, and brought our expertise to deal with systemic issues, such as the use of restraints, training of staff, patient violence, use of security and staffing issues. Through the Legal Expense Assistance Plan (LEAP), we also provided legal representation to two RN members who cared for the patient in question.

The inquest verdict came down on November 7, and included a key recommendation, which had been proposed solely by ONA, that “sufficient nursing staff be assigned to care for patients in mental health units.”

CONTINUES ➔
ONA Fights against Interim Suspensions

ONA’S LEGAL EXPENSE ASSISTANCE PLAN (LEAP) TEAM has been hard at work defending members who are in danger of having their licenses suspended.

In June, the government enacted changes to the Regulated Health Professions Act (RHPA), giving new powers to regulatory colleges, including the College of Nurses of Ontario (CNO). One of those new powers? When the CNO receives a complaint or report about a member, the Inquiries, Complaints and Reports Committee (ICRC) can move to suspend that member’s license on an interim basis if it feels patients are at risk.

To date, we have avoided suspensions in every case.

Previously, the ICRC had lesser powers: it could impose an interim suspension only after it referred a matter for a discipline hearing or a Fitness to Practice hearing, the matter had been investigated, and the member had a chance to review documentation and defend her or himself. However, the new legislation allows the CNO to push for a suspension as soon as it receives a complaint or report, even before it begins an investigation.

ONA advocated against these and other changes to the RHPA. While we met with officials from the Ministry of Health and Long-Term Care and presented our arguments at Queen’s Park before a Provincial Standing Committee, the government passed the changes.

Almost immediately, LEAP began receiving notices from the ICRC, seeking to exercise this new power and asking for our response on very short notice. The CNO also began more frequently invoking its traditional power to push for suspensions after referring a matter to discipline or Fitness to Practice.

LEAP received several notices of proposed suspensions. In each case, LEAP provided submissions explaining why an interim suspension was not necessary for public protection and detailing the financial and career hardships our members would face if they were not able to work in their profession.

To date, we have avoided suspensions in every case – a success for our members! However, the ICRC has imposed interim conditions on members, requiring them to notify their employers of the ongoing CNO investigation and, in some cases, not allowing them to practice independently.

Coroner’s Inquest Recommends “Sufficient Nursing Staff”

Other recommendations of interest to our members include:

- All clinical staff providing care in mental health units should have specific education and training in providing care to mental health patients.
- Training for clinicians and security guards should be provided in-house and, where applicable, to health-care providers and security guards as a team, particularly regarding restraints.
- All front-line staff working in the emergency department should have annual training on the prevention and management of aggressive behaviours and non-violent crisis intervention, including the use and avoidance/minimization of restraints; falls; patient and staff safety; and effective communications.
- All clinical staff in mental health units should have a personal alarm.

The purpose of a Coroner’s Inquest is to improve public safety and make recommendations to prevent death in similar circumstances. ONA has been involved in high-profile inquests in the past, including the Lori Dupont Inquest, which ultimately resulted in improvements to the Occupational Health and Safety Act regarding workplace harassment and violence.