# Independent Assessment Committee Report

## Constituted under Article 8.01 of the Collective Agreement between

# Campbellford Memorial Hospital (CMH)

# and

# Ontario Nurses' Association (ONA)

**June 26th, June 29th, and June 30th, 2023**

# Independent Assessment Committee

## Campbellford Memorial Hospital
## and
## The Ontario Nurses' Association

Heather Campbell
Vice President of Patient Care and Chief Nurse Executive
Campbellford Memorial Hospital

Andrea Cashman/Tanya Beattie
Professional Practice Specialist (s)
Ontario Nurses' Association

The members of the Independent Assessment Committee Panel respectfully submit the attached Report with findings and recommendations regarding the Professional Responsibility Complaint presented by the Registered Nurses working in the Medical/Surgical Unit at the Campbellford Memorial Hospital.

The Professional Responsibility Complaint was presented to the Independent Assessment Committee, in accordance with Article 8.01 of the Collective Agreement between the Campbellford Memorial Hospital and the Ontario Nurses' Association, at a Hearing held June 26th, June 29th and June 30th, 2023.

The Independent Assessment Committee Panel recognizes and appreciates the time, energy, and thoughtfulness provided by representatives of the Campbellford Memorial Hospital, the Ontario Nurses' Association and the Registered Nurses working in the Medical/Surgical Inpatient Unit (IPU) to prepare and present information regarding the Professional Responsibility Complaint, and to respond to the Panel's questions. The attached Report contains unanimously supported recommendations, which we hope will assist all parties to continue to work together, within the context of a quality practice environment which supports professional practice, provide quality and safe patient care to the patients presenting in the Medical/Surgical Unit.

Respectfully submitted on August 14th,2023.

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

Stephanie Pearsall, BScN, MHS
Guelph General Hospital Nominee

Rozanna Haynes, RN
Ontario Nurses' Association Nominee

# Table of Contents

# SECTION 1

# INTRODUCTION

## 1.1 Organization of the Independent Assessment Committee Report

The Independent Assessment Committee (IAC) Report is presented in five (5) sections.

**Section I** reviews the IAC's jurisdiction as outlined in the Collective Agreement between the Campbellford Memorial Hospital ('the Hospital') and the Ontario Nurses' Association ('the Association'), reviews the process of referral of the Professional Responsibility Complaint ('the PRC') to the IAC, and presents the Pre-Hearing, Hearing and Post-Hearing processes.

**Section II** presents the IAC's understanding of the PRC, including the development of the PRC, referral of the PRC to the IAC, and activities undertaken between the IAC referral and IAC Hearing, and presents the IAC's understanding of the Association's and Hospital's perspectives regarding the PRC issues.

**Section III** presents the IAC Panel's analysis and discussion of the issues relating to the Professional Responsibility Complaint (PRC).

**Section IV** presents the IAC Panel's conclusions and recommendations.

**Section V** contains the Appendices referenced throughout the IAC Report.

## 1.2 Jurisdiction of the Independent Assessment Committee

**ARTICLE 8 – PROFESSIONAL RESPONSIBILITY**[1]

(Article 8.01 applies to employees covered by an Ontario College under the *Regulated Health Professions Act* only.)

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 issues 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.

If 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.

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 their 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 them 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

[1] Collective Agreement Ontario Nurses Association Expires March 31, 2023

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 them 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 they 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 recommendations (Appendix 9).

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 issues through the development of joint recommendations within fifteen (15) calendar days of the meeting of the Hospital Association Committee the issue shall be forwarded to an Independent Assessment Committee.

x) Failing development of joint recommendation(s) and prior to the issue(s) 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.

(Article 8.01 (a), (x), (xiii) and (xiv) and 8.01 (b) applies to nurses only)

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.

A copy of the Procedural Guidelines contained in Appendix 8 shall be provided to all Chairpersons named in Appendix 2.

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, relevant Clinical Leaders, 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 meeting(s) will be booked prior to leaving the Independent Assessment Committee hearing.

(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 they would not be suitable, 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.

NOTE: It is understood and agreed that the provisions of Article 3 have application to conduct pursuant to this provision.

8.02 The delegation of Controlled Acts shall be in accordance with the *Regulated Health Professions Act*, Medical Directives, and related statutes and regulations and in accordance with guidelines established by the College of Nurses of Ontario from time to time, and any hospital policy related thereto, provided that if the Union is of the opinion that such delegation would be detrimental to quality patient care, the Union may refer the issue to the Hospital-Association Committee.

NOTE: Where an employee is in a position other than in a registered nursing position with duties and responsibilities which are subject to the *Regulated Health Professions Act*, they shall be treated in a manner consistent with this Article.

8.03 The Hospital will notify the nurse when it reports them to the College of Nurses of Ontario and refer them to the Union as a resource.

8.04 Should an employee, who is a Health Professional under the *Regulated Health Professions Act,* be required to provide their Regulatory College with proof of liability insurance, the Hospital, upon request from the employee, will provide the employee with a letter outlining the Hospital's liability coverage for Health Professionals in the Hospital's employ.

## 1.3 Referral of Professional Responsibility Complaint to the Independent Assessment Committee (IAC)

The Registered Nurses (RNs) working in the Medical Surgical Unit at Campbellford Memorial Hospital have consistently identified ongoing nursing practice and workload issues as evidenced by the information and data submitted from the Ontario Nurses Association (ONA) as outlined in their brief since April 25, 2017. The data reported on seventy-seven (77) PRWRF's received by the IAC Chairperson and Committee June 5th, 2023**.** [2] There was an additional ONA Brief Volume III- List of PRWRFs submitted on June 5, 2023.[3]

ONA followed up with emails to the OHA (January 2023) and a letter (January 23, 2023) naming the IAC Chair and naming ONA's nominee to the IAC Panel. The Employer responded in writing to confirm their nominee, on February 27, 2023[4]

Donna Rothwell RN, BScN, MN was identified as the Chair of the IAC as per the ONA/Hospital Central Agreement list of Committee Chairs on January 23, 2023, and this correspondence to the Chair, naming ONA's nominee, Rozanna Haynes, RN, and Campbellford Memorial Hospital named their nominee for the IAC, Stephanie Pearsall, BScN, MHS on February 27, 2023.[5]

[2] ONA Submission to IAC Volume 1: ONA Brief and PRWRF Tracking Report June 5, 2023.
[3] ONA Submission to IAC Volume III: ONA Brief and PRWRF Tracking Report June 5, 2023.
[4] ONA Submission to IAC Volume 1: ONA Brief and PRWRF Tracking Report June 5th, 2023
[5] Appendix 3

## 1.4 Proceedings of the Independent Assessment Committee

### 1.4.1 Pre-Hearing

#### 1.4.1.1 Nominee Selection

In accordance with Article 8.01 (a), (x), (xiii) and (xiv) and 8.01 (b) applies to nurses only the Association and the Hospital identified their Nominees to the IAC. The IAC Chairperson received notification of the Association's Nominee, Rozanna Haynes RN, on January 23, 2023 (*Appendix 2*) and the Hospital's Nominee, Stephanie Pearsall, BScN, MHS on February 27, 2023. (*Appendix 3*).[6]

#### 1.4.1.2 IAC Introductory Teleconference

The IAC Chairperson contacted the Nominees March 11th and 13th, 2023, and provided copies of correspondence related to IAC Guidelines and Nominee Role. ONA's correspondence related to Campbellford Memorial Hospital's overview of the issues and a list of items for Campbellford Memorial Hospital's to submit as requested for the upcoming IAC for the Nominees to review.

On March 16th, 2023, both the Association and Campbellford Memorial Hospital received a draft agenda for the IAC hearing scheduled for June 26th, 29th and 30th, 2023 and correspondence from the IAC Chairperson and both nominees were copied on this correspondence.

Several email exchanges occurred prior to the IAC Panel's introductory teleconference held on May 18th, 2023. The Chairperson reviewed the jurisdiction of the IAC within the Collective Agreement, discussed the role of the Nominees and Chairperson, reviewed the three phases of the IAC process, and discussed logistics associated with scheduling the Hearing and the process for review of the Hearing Briefs.

It was then decided that the IAC Panel members would meet on Saturday June 10th, 2023, following receipt of the Association's and Campbellford Memorial Hospital submissions to discuss any issues or concerns. The meeting occurred with the IAC Chairperson and the Nominees.

#### 1.4.1.3 Hearing Confirmation and Hearing Brief Distribution

The date for the Hearing was confirmed on March 16th, 2023. The Hospital requested their preference would be to conduct the IAC in person however, ONA was not able to support this.

It was mutually decided by the Association and Campbellford Memorial Hospital, the IAC scheduled for June 26th, June 29th and 30th, 2023 to be held virtually. The Chairperson secured a third party to support the virtual meeting held between the IAC Chairperson, Nominees, the Association and CMH.

The IAC Chairperson wrote to the Hospital and the Association on March 16th, 2023, respectively to confirm the date of the Hearing and to provide the draft Hearing Agenda. Respecting the principle of full disclosure and to streamline the process of the Hearing by enabling the IAC to become familiar with the issues in advance, the IAC requested the Hospital and the Association to submit a Hearing Brief to the Chairperson Monday June 5th, 2023.

[6] As noted, above.

The IAC Chairperson received and distributed the Hearing Briefs, scheduled meetings and supporting Exhibits as follows:

- Association Brief and Hospital Brief received on June 5, 2023, and distributed to the IAC Panel, ONA and the Hospital on June 5, 2023.
- IAC Panel held an initial call to review materials and respond to any questions in preparation for the IAC hearing June 10th, 2023.
- IAC Panel met again to review the responses and review data on Sunday June 18th, 22nd and June 25th. 2023, for the upcoming sessions at the IAC Hearing.

#### 1.4.1.4 IAC Panel Pre-Hearing Meetings

The IAC Panel held Pre-Hearing meetings as outlined above to review the anticipated process of the Hearing, Hearing Briefs and identified key issues for exploration at the Hearing.

#### 1.4.1.5 Virtual Meeting and the Campbellford Memorial Hospital Tour

The Association, Hospital and IAC Chairperson discussed how best to proceed with the tour given the IAC hearing was going to be held virtually. The agenda ensured there was adequate time on day one for the entire panel and those in attendance to preview the virtual video.

#### 1.4.1.6 Campbellford Memorial Hospital Tour: Day One IAC Hearing Monday June 26th, 2023

On the morning of Monday June 26th, 2023, the IAC Panel and those in attendance observed a Site Tour of Campbellford Memorial Hospital developed in collaboration with ONA representation. All those in attendance of Day One of the IAC Hearing watched the video of the Hospital tour.

The Tour provided an opportunity to understand the complexity of the diverse patient population being cared for in the Medical Surgical Program Campbellford Memorial Hospital, the practice environment, care provision, supplies, equipment inter and interprofessional communication and the geographical configuration.

### 1.4.2 IAC Hearing

#### 1.4.2.1 IAC Hearing Schedule

The Hearing convened via Zoom for all participants at 0830 hours. The Hearing was held over three days as follows utilizing Zoom as our virtual platform.

Monday June 26th, 2023: 08:30 – 13:50 hours

Thursday June 29th, 2023: 08:30 – 1215 hours

Friday June 30th, 2023: 08:30 – 1015 hours

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

#### 1.4.2.2 Hearing Day 1: Monday June 26th, 2023

The IAC Chairperson opened the Hearing at 0830 hours. Following introduction of the three IAC Panel members and round-table introduction of the Hospital and Association participants, the IAC Chairperson reviewed the following ground rules and IAC Chair Responsibilities:

- Welcome and Introductions
- I would like to begin by acknowledging the tremendous time and effort that has been undertaken for this week's IAC Hearing by both Campbellford Memorial Hospital and ONA.
- Both parties have provided excellent submissions and briefs to inform our hospital nominee Stephanie Pearsall, our ONA nominee Rozanna Haynes, myself as your Chair of the IAC Panel, and both parties of the issues at the Campbellford Memorial Hospital Medical Surgical Unit.
- The IAC Hearing is to be confidential and private and is not to be discussed outside of the hearing.
- As the IAC Chair I want to ensure those staff attending should feel safe sharing their stories without any negative repercussions following the hearing.
- It is important for both parties to be reassured that your IAC panel has read and reread in detail all your submissions and supporting documents prior to today's meeting.
- It is my responsibility as your Chair to ensure throughout this week's hearing we have an environment where both parties can fully participate and be engaged in this process.
- My role is to ensure we stay focused on the issues.
- I will be adjusting our timelines throughout the IAC hearings if either party finishes their presentations earlier than the allotted timeframes as outlined in the agenda. However, we will not exceed the timelines that have been allocated for these presentations.
- The goal is to permit both parties to feel heard, respected, and treated equally throughout this process so the IAC panel can develop some key recommendations based on the issues presented.

The Association's presentation to the IAC Panel and the Hospital was presented by Andrea Cashman, ONA Professional Practice Specialist. The presentation included an overview of Article 8.01, CNO Professional Standards, a historical overview, concerns identified by ONA members in the Medical Surgical Unit at Campbellford Memorial Hospital and recommendations.
Following the presentation, the Association responded to questions of clarity related to the Association's presentation from the Hospital and the IAC Panel members.

A break was held between the Association and Hospital presentations.

The Hospital presentation began at 1215 hours and was presented by Heather Campbell, Vice President and Chief Nurse Executive, Campbellford Memorial Hospital. An overview of the Campbellford Memorial Hospital Medical/Surgical Unit, Program Goals and services, the current challenges, what is working well, improvement initiatives, and next steps.
Following the presentation, the Hospital responded to questions of clarity related to the Hospital's presentation from the Association and the IAC Panel members.

The IAC Chairperson adjourned the Hearing at 1350 hours.

#### 1.4.2.3 Hearing Day 2: Thursday June 29th, 2023

The IAC Chairperson opened the Hearing at 0830 hours. Lorrie Daniels, ONA Manager introduced Tanya Beattie Professional Practice Specialist will be presenting today and Friday June 30th IAC Hearing in the absence of Andrea Cashman.
Heather Campbell, supported by members of the Hospital IAC Hearing team, provided the Hospital's response to the ONA Hearing Submission. Following a break, Tanya Beattie supported by members of the Association IAC Hearing team, provided the Association's response to the Hospital Hearing Submission. Both the Hospital and the Association teams participated in active discussion.

The Chairperson adjourned the Hearing at 1215 hours.

#### 1.4.2.4 IAC Panel Intra-Hearing Meeting

The IAC Panel met, June 29th, 2023, prior to and after the meeting. The intent was to review and synthesize the data collected and the wealth of information presented through the written submissions, supporting documents, presentations, and discussion during the Hearing, to identify key questions to lead and engage in meaningful dialogue for the purposes of Hearing discussions on Day 3 of the Hearing.

#### 1.4.2.5 Hearing Day 3: Friday June 30th, 2023

The IAC Chairperson opened the Hearing at 08:30 hours and was adjourned at 1020 h.
The IAC Panel asked a series of questions of Heather Campbell VP and CNE on behalf of the Hospital, and Tanya Beattie, Professional Practice Specialist on behalf of the Association prior to the conclusion of the IAC Hearing.

All CMH staff participants in attendance were provided the opportunity to address the IAC Panel. Staff shared their lived experiences, personal stories in person, and through correspondence shared by Tanya Beattie. ONA PPS for those staff not able to attend in person.

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

- Acknowledged the tremendous time and effort by both the Hospital and Association that was undertaken for the IAC Hearing and the excellent submissions and presentations to inform the IAC Panel and both parties of the issues in the Medical Surgical Unit.
- Thanked the staff who were in attendance and acknowledged their active participation in the IAC Hearing and their willingness to bring forward important issues related to quality and safe patient care.
- Thanked all those in attendance for their openness, honesty, and willingness to share their personal stories, thoughts, patient experiences, and concerns related to workload, professional responsibilities, and accountabilities.
- Respecting the "ground rules" throughout the IAC hearing

- Reconfirmed that the IAC process is intended to provide an independent objective external perspective to aid in the resolution of outstanding issues, and that although the recommendations are non-binding, it is hoped they will provide a foundation from which both parties can move forward constructively; and
- Confirmed the IAC Report would be submitted within forty-five (45) calendar day timeframe as stipulated in Article 8.01 (a) (viii) of the Collective Agreement.
- I hope everyone who participated in this process will reflect on discussions held these past two- and one-half days to understand the importance of how both parties can move forward in a positive, professional, and collegial manner to bring about the required changes in the best interest of quality, ethical and safe patient care.
- I also want to thank the IAC Panel – Rozanna and Stephanie for your contributions, knowledge, and expertise as we have collaborated over the past several weeks and as we move forward with the development of the key recommendations for the IAC Report

### 1.4.3 Post-Hearing

#### 1.4.3.1 IAC Report Development

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

The IAC conducted a series of teleconferences during July and August 2023 to review the recommendations, various drafts of the IAC report and finalize the final ONA and CMH IAC Report.

The initial draft of the IAC report framework was circulated on June 29th, 2023, with a teleconference that was held on Sunday July 2nd, July 9th, July 16th, July 23rd, July 30th, and August 2nd, August 5th, and August 13th, 2023.The purpose of these calls was to discuss the overall framework of the IAC report, to develop the key recommendations and finalize the IAC report.

#### 1.4.3.2 IAC Report Submission

The IAC Report was submitted to the Association and the Hospital by email, in PDF format, on August 14th, 2023.

# SECTION II

# PRESENTATION OF THE PROFESSIONAL RESPONSIBILITY COMPLAINT (PRC)

## 2.1 Development of the Professional Responsibility Complaint (PRC)

### 2.1.1 Events Prior to Referral of the Professional Development Complaint (PRC)

**About the Hospital**

Campbellford Memorial Hospital (CMH) is a 34-bed health care facility located in Trent Hills. It serves approximately 40,000 Northumberland, Peterborough, and Hastings County residents, as well as a large seasonal population of cottagers and tourists enjoying the beautiful Kawartha Lakes Region and the Trent River System.

As the only hospital located between Belleville and Peterborough, Ontario, CMH provides a comprehensive array of acute care services including a Medical/Surgical Unit, a Special Care Unit, Endoscopy Surgical Suite, Diagnostic Imaging Department, Laboratory, numerous Out-Patient Clinics, 24/7 Emergency Department and numerous community programs including Mental Health, GAIN, and Supportive Housing.

To ensure comprehensive, coordinated, patient and family-centred care that meets local needs, the Campbellford Memorial Hospital's community health care campus partners include Trent Hills Family Health Team; Campbellford Memorial Health Centre; Campbellford Memorial MultiCare Lodge; as well as other area hospitals and community agencies. These partners ensure you receive the right care in the right place at the right time.[7]

Campbellford Memorial Hospital is committed to providing high quality health care to the community. The aging building has its challenges and expanding the current site is not possible. CMH has applied for a capital planning grant to redevelop the facility as part of a Campus of Care that will create one location for a continuum of health services in Campbellford. Once complete, the redevelopment project will bring together the Hospital, a new Long-Term Care Home, Community Mental Health Clinic, a Geriatric Assessment and Intervention Network, and future to build. Portions of CMH are nearly 70 years old and have had minimal upgrades since it was first built. Private rooms were not considered necessary at that time. CMH is currently facing $25 million in facility repairs as well as replacements that will be required over the next 25 years (this amount is expected to increase). The pandemic has also underscored significant infection prevention and control gaps (e.g., lack of negative pressure areas, limited private rooms, and insufficient air filtration) that have stymied the flow of admissions during outbreaks because of the inability to cohort patients. Finally, the hospital faces ongoing capacity pressures in the Emergency Department and the Inpatient Medical unit, which will continue to worsen due to population growth and changing demographics. A new and expanded facility will mitigate these pressures. A new hospital as part of a Campus of Care will also significantly help strengthen the community's physician recruitment efforts by providing a modern facility that has the adequate capacity, and optimal environment for high-quality patient care.[8]

Until recently, the medical surgical unit was identified as the East, West, and South Wings, which divided the medical and surgical patient areas from the day surgery area of the unit. The Employer renamed the three

[7] Campbellford Memorial Hospital Brief June 5, 2023, p. 3
[8] Campbellford Memorial Hospital Brief June 5, 2023, p. 4

wings, announcing the change in a memo March 20, 2023 (Exhibit 1). The three wings have been renamed the Trent River, Ranney Gorge, and Ferris Lane wings. The Ranney Gorge wing, previously the West Wing, houses medical patients predominantly. The Ferris Lane wing, previously the East Wing, is predominantly where surgical patients are cared for, and the Trent River wing, previously called the South Wing, is designated for the Day Surgery and Endoscopic Procedure area. [9]

Each wing of the medical and surgical unit has four private patient rooms. The medical wing (Ranney Gorge) has six semi-private rooms and one three-bed wardroom identified above, as the overcapacity space. The surgical wing (Ferris Lane) has five semi-private rooms and the four-bed area, the SCU. The unit census is almost always at full capacity and frequently at overcapacity more than 34 patients. There are no negative pressure rooms or any appropriate isolation rooms with an ante room within the unit. For patients on isolation precautions, they are housed in a private room or cohorted in a semi-private room, regardless of the type of isolation based on available space. [10]

**Campbellford Memorial Hospital Medical Surgical Unit Overview**

The inpatient unit at CMH is funded for 34 beds plus 4 surge beds as needed. There are 30 beds as part of the main unit and 4 beds which are identified as a Special Care Unit (SCU). It is important to note that the Special Care Unit is **not** designated by Critical Care Services of Ontario (CCSO) as a Level 2 Critical Care Unit. Patient level data from patients in the SCU beds is not inputted into the Critical Care Information system (CCIS).

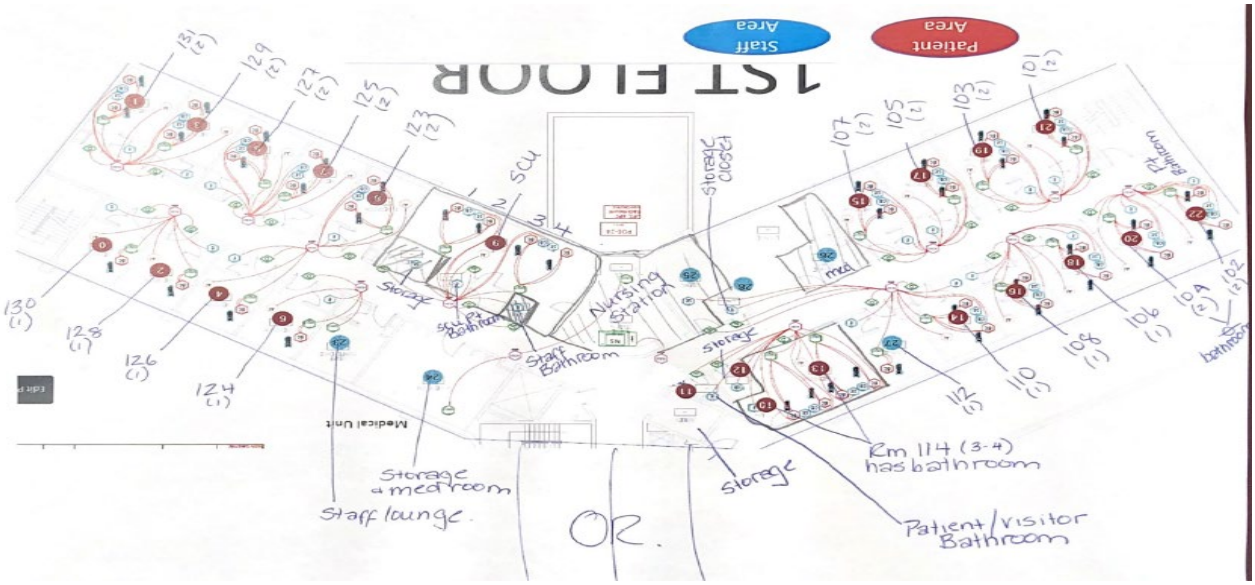
The Critical Care Information System (CCIS) is a key component of Ontario's Critical Care Strategy which is overseen by Critical Care Services Ontario (CCSO). The CCIS provides near-real time data on every patient admitted to level 3 and level 2 critical care units in Ontario's acute care hospitals. The system also provides information on bed availability, critical care service utilization and patient outcomes through the 'Reports' functionality. The system provides an important medium for monitoring and managing the province's critical care resources more effectively, and for highlighting opportunities to implement quality improvement initiatives at individual hospitals and across regions.

The CCIS Bed Availability Tool (BAT) automatically transfers critical care bed information to CritiCall Ontario's PHRS critical care resource screens. This information is used in real time by CritiCall Ontario agents and Provincial partners to help make informed decisions about placement of patients when hospitals experience a capacity issue (e.g., Moderate surge, Natural Disasters, Pandemic, major events, etc.), or patients need a higher level of care (e.g. 'Life or Limb').

The SCU beds are not monitored by CCIS, therefore Critical Care patients will not be transferred into these beds. The beds may be utilized if a CMH patient condition deteriorates, and transfer is being arranged.[11]

[9] ONA Submission to IAC Volume 1: ONA Brief and PRWRF Tracking Report June 5th, 2023, p. 7,
[10] ONA Submission to IAC Volume 1: ONA Brief and PRWRF Tracking Report June 5th, 2023, p. 6.
[11] Campbellford Memorial Hospital Brief June 5, 2023, p. 4-5

**Unit Map of Campbellford Memorial Hospital Medical Surgical Unit**[12]




**Campbellford Memorial Hospital's Medical Surgical Inpatient Unit (IPU) Nursing Model of Care**

CMH's IPU nursing model of care includes Registered Nurses (RN) and Registered Practical Nurses (RPN). Collaboration is essential to improving healthcare delivery and a strengths-based approach leverages knowledge and skills of team members.

The IPU adheres to the College of Nurses of Ontario (CNO) three-factor framework professional practice model of care that has the following guiding principles:

> (a) Registered Nurses (RNs) and Registered Practical Nurses (RPNs) study from the same body of nursing knowledge. RN's study for a longer period, allowing for greater foundational knowledge in clinical practice, decision making, leadership, research utilization and resource management. It is because of these differences that the level of autonomous practice of RNs differs from that of RPNs.
>
> (b) The stability and complexity of a patient's condition influences the nursing knowledge required to provide the level of care the patient needs. A less stable, more complex patient situation creates an increased need for consultation and collaboration, and/or the need for an RN to provide the full range of care requirements.
>
> (c) Respecting and understanding the expectations and contributions of all members of the health care team facilitates appropriate utilization of nurses, enhances collaboration, and leads to improved patient outcomes.

The IPU Team leader works in conjunction with the multidisciplinary care team and is responsible for the achievement of optimal clinical outcomes by effectively managing care, work assignments, resources, and length of stay.

[12] Campbellford Memorial Hospital Presentation June 26,2023.

The Acute Medicine Nurse Practitioner is a member of the Acute Medicine Multidisciplinary Health Care Team and has a unique role in providing medical care to our acute medical population. She/he provides patient centred care within the scope of the College of Nurses Practice Standards for Nurse Practitioners.

A Nursing Float Pool was created to support the IPU. This pool would replace short notice sick calls and could be utilized for transfer of patients to other centers and/or booked appointments.

CMH is currently utilizing agency nurses in the IPU. There are currently 4 agency nurses working full time hours as a short-term strategy as the organization continues to actively recruit.[13]

The daily staffing on the medical surgical unit, until February 8, 2023, by shift, was three RNs on the day shift, one RN Team Leader (TL) and five Registered Practical Nurses (RPNs). Personal Support Workers (PSWs) were not members of the baseline staffing complement. One ward clerk was scheduled over two shifts, from 0730 to 2330 hours Monday to Friday, while the weekend hours for ward clerk coverage were 1000 to 1800 hours. On the night shift there were three RNs scheduled and three RPNs. The staffing changes are depicted in the Figure below. The intended nurse-to-patient ratio on the day shift was one to five. The nurse-to-patient ratio on the night shift was one to seven.[14]

**Staffing Chart**

| Previous Staffing | | |
|---|---|---|
| **Day** | **Monday to Friday** | **Saturday to Sunday** |
| RN - D (0730-1930) | *3 | *3 |
| RN - TL (0730-1530) | 1 | 0 |
| RPN - D (0730-1930) | 5 | 5 |
| **Night** | | |
| RN - N (1930-0730)<br>*One of the three RNs is the CN and SCU RN assignment. | *3 | *3 |
| RPN - N (1930-0730) | 2 | 2 |

| Current Staffing | | |
|---|---|---|
| **Day** | **Monday to Friday** | **Saturday to Sunday** |
| RN - D (0730-1930) | *2 | *2 |
| RN - TL (0730-1530) | 1 | 0 |
| RPN - D (0730-1930) | 5 | 5 |
| **Night** | | |
| RN - N (1930-0730)<br>**One of the two RNs is the CN and SCU RN assignment. | *2 | *2 |
| RPN - N (1930-0730) | 4 | 4 |

The Employer enhanced staffing during the summer 2022, by adding seven PSWs to the staffing complement, on a temporary basis. The goal was to provide support to the staffing model and assist with nursing staff vacations. The employer stated that they would share the changed team model plan with ONA;

[13] Campbellford Memorial Hospital Brief June 5, 2023, p. 10.
[14] ONA Submission to IAC Volume 1: ONA Brief and PRWRF Tracking Report June 5th, 2023, p. 9-12.

however, they did not. PSWs were scheduled temporarily for full time hours, with one PSW scheduled per shift (Exhibit 3).[15]

The model of care change resulted in the Employer reducing the baseline RN staffing complement. The Employer eliminated four full time RN positions, reducing the number of RN full time equivalents (FTEs) from 12 RNs to eight RNs. Two RN positions were vacant at the time, and two FT RNs received layoff notice, on October 3, 2022 (Exhibit 4). The Employer informed CMH staff on October 6, 2022, of the layoffs, by letter, (Exhibit 5) stating they were implementing a model of care change based on their evaluation of the patient acuity and volume. The first phase of the model of care change occurred in September of 2022 as a change to the RPNs schedule, moving from eight hour to 12-hour tours for all RPNs. Prior to this the RPNs worked a mix of eight- and 12-hour tours. The second phase was the realignment of the RN staffing, decreasing RN coverage to two RNs on days and nights. The RN staffing change was implemented in February 2023. The change was based on the employer's perspective that their staffing was not aligned with the patient population, and the volume of patients, along with their perspective of the patient acuity on the unit. The employer's goal was identified to be stabilization of the daily RN staffing, organizationally, rather than a focus on the needs of the inpatient medical surgical patients. The employer continues to struggle with RN recruitment and difficulty filling vacant RN positions. The employer also failed to provide ONA with written notification of the layoff letter shared with staff, as a requirement of the collective agreement. [16]

**Professional Responsibility and Workload Process**[17]

The Professional Responsibility and Workload (PRW) process was developed to assist Registered Nurses (RNs) through the difficult and often stressful process of raising and resolving issues related to professional practice, patient acuity, fluctuating workloads, and fluctuating staffing; and resolving these concerns in a timely and effective manner.

The PRW process was designed not only to promote the safety and best possible care of patients, but also for the protection of the Ontario Nurses' Association (ONA) members who may identify that patients and staff are at risk because of improper staffing, skill mix, practice, and workload issues. The collective agreement specifies the process for documenting these issues in writing on the Professional Responsibility Workload Report Form (PRWRF), and thus implementing a process that facilitates employers to work with ONA and its members to mutually resolve issues in the best interest of safe, ethical, and proper patient care.

The College of Nurses of Ontario (CNO) has Standards of Practice that registrants are expected to meet to provide safe, ethical, and quality patient care within their scope of practice. RNs have a professional obligation to ensure nursing practices are carried out according to the CNO Standards of Practice. If nurses cannot meet these standards, it is up to individual nurses to report these concerns to the employer and attempt to resolve the issues. The employer, on the other hand, has an obligation to respond to the reported concerns, and to provide a quality practice environment that facilitates and permits nurses to meet CNO standards. The Professional Responsibility Clause is designed to assist both frontline and administrative RNs in meeting their professional obligation to the CNO and to enhance and promote safe, quality patient care.

The Professional Responsibility Workload Report Form is a documentation tool to identify and demonstrate ongoing trends, barriers to the provision of safe, competent, and ethical care and any contributing workplace problems; and provides a process and forum for RNs to make recommendations to the employer to address the issues. The PRWRF promotes a problem-solving approach by means of facilitating discussion with, and requiring a written response from, the Manager. Once the employer has been made aware of the

[15] ONA Submission to IAC Volume 1: ONA Brief and PRWRF Tracking Report June 5th, 2023, p. 9-12
[16] ONA Submission to IAC Volume 1: ONA Brief and PRWRF Tracking Report June 5th, 2023, p. 12.
[17] ONA Submission to IAC Volume 1: ONA Brief and PRWRF Tracking Report June 5th, 2023, p.13-14.

Professional Responsibility and Workload Issue(s), it is the administrative nurses' accountability to their own CNO Standards to advocate for and pursue resolution.[18]

### 2.1.2 Events Following Referral of the Professional Responsibility Complaint [19]

The Hospital-Association Committee (HAC) at Campbellford Memorial Hospital is scheduled to meet bimonthly and at times more often, as necessary, in accordance with Articles 6.03 and 8.01. The key professional responsibility issues reported by the RNs working on the medical surgical unit include staffing and serious and significant health and safety concerns. CMH and ONA Labour Relations Officer (LRO) and PPS staff met at HAC meetings to discuss unresolved PRWRFs every two months, in 2022. Meetings occurred bimonthly, in January, March, May, September and November. The parties were unable to achieve any meaningful resolution at these meetings. In addition, discussions regarding the HAC terms of reference identified that the hospital does not have in effect any current terms of reference. The only terms of reference document are dated 2009, however, it does not contain a specific date or authorizing signatures enacting them (Exhibit 10). The current employer parties, working with ONA were unaware of any past or current terms of reference document for the HAC (Exhibit 11).

Professional Practice issues for the medical surgical unit were first discussed at HAC on May 6, 2022, and a subsequent email was sent on May 11, 2022 (Exhibit 12). A Professional Practice Specialist supported the bargaining at the employer meeting. Unsuccessful discussions deemed ongoing support from PPS would be required, and a Professional Practice Specialist was assigned to the file. The employer was notified by letter sent via email on May 9, 2022 (Exhibit 13). A request for information disclosure was exchanged between ONA and the Employer, with a request for receipt of information dated May 30, 2022. The employer failed to comply with the collective agreement, and on May 30, 2022, were notified of their violation of the process in Article 8 (Exhibit 14). Subsequent email correspondences were shared on June 6, 2022 (Exhibit 15) to obtain the required information requests. The Professional Practice Specialist provided the employer on June 14, 2022, with an updated version with embedded notes for the meeting on June 6, 2022 (Exhibit 16). The Employer followed up with pieces of disclosure information via email on June 30, (Exhibit 14) July 4 and July 6, 2022, however, not all requested disclosure was provided (Exhibit 14a, 17).

ONA's efforts to resolve the issues involved four meetings of the sub-HAC, with the employer. Meetings occurred on May 6, 2022, June 6, 2022, July 19, 2022, and August 16, 2022. The discussion during these meetings as captured in the action plans/meeting notes (Exhibits 12, 16, 18, 19, 20, 21, 22) outline the multiple PRWRFs reporting the employer's failure to maintain baseline staffing or replace vacant shifts created because of sick calls, unfilled vacancies, and other leaves of absence. Additional issues reported and discussed included negative patient outcomes due to insufficient staffing and resulting in delayed care, delayed treatments, missed or delayed ability to aid with activities of daily living, delayed medication administration, patient assessments, postponed transfer for tests, and unsafe nurse-to-patient ratios. The inability of RNs to take appropriate rest periods or breaks was also reported as an issue. The sub-HAC meeting scheduled for September 26, 2022, was cancelled due to illness of an ONA team member. Communication with the employer failed to reach an alternative date or time to reschedule the meeting. ONA proposed to meet for a fourth meeting on November 18, 2022, (Exhibit 23) and proposed to utilize a mediation process to attempt mutually agreeable resolutions. The employer did not reply with follow up.

Action plan documents were presented at the sub-HAC meetings with the employer and updates were shared with the employer after each meeting. The employer failed to provide any responses to the action plan; or provide any additional information or report any actions or strategies being taken to achieve resolution. While the ONA team documented meeting minutes (Exhibit 20, 21, 22), no joint meeting minutes

[18] ONA Submission to IAC Volume 1: ONA Brief and PRWRF Tracking Report June 5th, 2023, p.13-14.
[19] ONA Submission to IAC Volume 1: ONA Brief and PRWRF Tracking Report June 5th, 2023, p.16-21.

were shared. ONA recommended and provided an acuity and workload tool to the Employer, as requested; however, the employer refused to consider or implement the tool or investigate other appropriate acuity measurement tools (Exhibit 12). ONA proposed a validated acuity tool as a strategy to support improved staffing and safer nurse to patient ratios, however, the employer was not agreeable, nor did they propose or suggest alternative solutions to resolve the issues.

Following the breakdown of effective meetings and communication with CMH, ONA proposed mediation as an alternate dispute resolution strategy, on August 16, 2022, and again on November 18, 2022. The employer did not engage or respond to ONAs verbal recommendation, or subsequent written request, and additional proposal for mediation on December 14, 2022 (Exhibit 24). ONA's efforts to engage the employer in a process of mediation was futile, as the employer simply did not respond. Simultaneous to proposing mediation, ONA forwarded an Items of Agreement document proposing some items could be resolved and signed by the parties (Exhibit 24). The employer also failed to respond to these proposals. As such, ONA was obligated to proceed, as per the collective agreement and advance the workload issues to the Independent Assessment Committee, in a letter sent on January 19, 2023 (Exhibit 25).

The Employer realigned the laid off RN staff to create a resource team to, in their opinion, assist with staffing needs in both the medical surgical unit and the emergency department, by decreasing the baseline RN staffing per shift on the medical surgical unit. The employers' changes to the staffing model, in September 2022 resulted in one less RN being scheduled on both the day and night shift, and an additional RPN being scheduled per shift. The new baseline staffing model resulted in a significant change in the balance of nursing skill mix on the unit, with 75 per cent of the staffing on both shifts being RPNs. As such, the RNs report they struggle to meet their professional standards of practice and the care needs of their highly acute patients and provide the necessary supports and expert resource needed to the remaining nursing staff (Exhibit 26).

The RNs on the IPU at CMH have been reporting on their PRWRFs, their workload and practice issues since April 25, 2017. The data reported on 77 PRWRFs submitted to date relate to inadequate baseline staffing, worsened by sick calls and vacancies, an unstable RN and RPN skill mix, gaps in staffing when an RN must take a patient on transfer to another facility, and the impact on staffing and patient care when already insufficient staffing resources are further depleted, as well as when an RN is required to respond to all hospital-wide codes. Other issues reported include high patient acuity, a lack of or malfunctioning equipment and supply issues, a lack of adequate and or effective orientation and education, especially pertaining to the lack of training for SCU. Staff and patient safety concerns such as the lack of panic alarms, and nonexistent negative pressure rooms and non-nursing duties were also noted as ongoing issues.

Further, the members report that the manager has not met the requirements of the collective agreement to discuss the PRWRF issues at the unit level. Often the management response provided merely acknowledges an issue exists. Furthermore, the manager has stated at a HAC meeting that she uses the unit council (Exhibit 27a) to discuss the PRWRFs, which is not the appropriate forum as per the collective agreement and fails to provide the required efforts and communication necessary to understand the issues (Exhibit 27).

A letter forwarding the unresolved issues to the IAC was submitted by the Union to the IAC Chairperson on January 23, 2023 (Exhibit 28). As indicated in the Union's Letter of Referral, ONA respectfully requests that the IAC assess the nursing practice and workload concerns put before them from the perspective of being able to provide safe, ethical, competent, and professional quality patient care in a quality practice setting, according to relevant professional and specialty standards, and supporting research and literature, including the following CNO Practice Standards and Guidelines:

1. Code of Conduct (Exhibit 29)
2. Professional Standards Revised 2002, 2018 (Exhibit 8)

3. RN and RPN Practice – The Client, the Nurse and the Environment, 2018 (Exhibit 30)
4. Therapeutic Nurse-Client Relationship Revised 2006, 2019 (Exhibit 31)
5. Authorizing Mechanisms, 2020 (Exhibit 32)
6. Decisions about Procedures and Authority Revised, 2020 (Exhibit 33)
7. Confidentiality and Privacy – Personal Health Information, 2019 (Exhibit 34)
8. Ethics, 2019 (Exhibit 35)
9. Documentation Revised 2008, 2019 (Exhibit 36)
10. Medication Revised 2008, 2019 (Exhibit 37)
11. Conflict Prevention and Management, 2018 (Exhibit 38)
12. Consent, 2017 (Exhibit 39)
13. Directives, 2020 (Exhibit 40).

## 2.2 Ontario Nurses' Association and Campbellford Memorial Hospital Perspectives

The Hearing was structured such that:

- On June 26th, 2023, the Association, and the Hospital each provided an oral Submission presentation highlighting the key elements of their previously submitted written Brief.
- On June 29th, 2023, the Hospital, and the Association each provided an oral Response presentation, which included an opportunity for each party to clarify / discuss / challenge / question/rebut the information provided by the other.
- On June 30th, 2023, the IAC Panel posed several questions to both parties to obtain a more comprehensive understanding of the issues. All staff in attendance were given the opportunity to share their concerns, make statements and provide us with their own testimonials related to CMH Medical/Surgical IPU.

From the Hearing Briefs and supporting Exhibits submitted prior to the Hearing, the presentations, discussion, and response to questions at the Hearing, and analysis of information following the Hearing, the IAC Panel understands the Association's and Hospital's perspectives related to professional practice issues, staffing and workplace safety issues.

### 2.2.1 Ontario Nurses' Association

The Association identified seventy-four (74) recommendations based on seventy-seven (77) PRWRF's submitted, relating to staffing, patient acuity, fluctuating workloads, and missed care, education, leadership and communication, morale and poor work environment and non-professional duties.[20]
The following are ONA's recommendations:

**Staffing**

1. The employer will increase Team Leader coverage to provide 16 hours per day of coverage, seven days per week. The TL role is responsible for overseeing staffing and assignments and providing expertise and support to the staff. When the TL is off, the role will be backfilled with an RN who has been trained to cover the Charge Nurse role.

2. The employer will increase daily RN staffing, in addition to the team leader, to achieve four RNs on the day shift and four RNs on the night shift. The employer will maintain the current RPN staffing levels. This staffing model would provide for two RNs to be scheduled in the SCU and one RN on each wing of the medical and surgical unit, in addition to the team leader. This staffing model would support a nurse-to-patient ratio of one RN for two patients in SCU.

[20] ONA Submission to IAC Volume 1: ONA Brief and PRWRF Tracking Report June 5th, 2023, p. 117-126.

3. The employer will increase RN staffing above to support the transport of patients to regional hospitals when an RN escort is required. The employer will schedule a transport RN daily, 24/7.
4. The employer will increase RN staffing as described above to ensure the RN staff are available to support novice RN and RPN staff as required as per CNO's RN and RPN Practice Guideline: The Client, The Nurse, and The Environment, based on patient acuity and complexity needs, not only the number of patients.
5. Where the employer cannot safely staff the unit, they must take meaningful actions to ensure the safety of patients, including but not limited to; closing or blocking of beds, and prevention of admissions and transfers where they are unable to provide safe and adequate staffing.
6. The employer will create and implement an algorithm and policy outlining the available auxiliary staffing supports and resources when RN coverage options have been exhausted.
7. The employer will develop a comprehensive nursing recruitment and retention strategy for the Medical Surgical Unit to retain staff and reduce staff turnover.
8. The employer will make every effort to fill vacancies proactively prior to any RN or RPN embarking on a known leave.
9. Recruitment and Retention will be a standing agenda item at all HAC meetings.
10. The employer will implement a standardized exit interview process and engage all RNs leaving the unit.
11. Immediately hire a full-time Nurse Practitioner (NP) who will be available on the unit to conduct patient assessments and provide orders.
12. Ensure there is adequate on-call physician or NP coverage for RNs for emergent or urgent situations.
13. Reduce and limit the use of agency RNs, while working towards the elimination of agency staffing.
14. Immediately recruit a nurse educator. In the interim, provide nursing staff with access to educational opportunities through external education resources and during working hours or paid time.

**Acuity**

1. Increase the RN staffing complement per shift to include four RNs on the day shift and four RNs on the night shift, to ensure nursing staff can meet the goal of providing safe, quality patient care for all acuity levels.
2. Implement and evaluate the use of an approved acuity tool, with nursing input and participation, to establish appropriate admission criteria and safe patient assignments.
3. Adjust patient assignments to ensure that the nurse-to-patient ratio for the RN assignment supports the RN to have time for providing consultation and collaboration with all RNs and RPNs, as required.
4. Establish a bed management policy, in consultation with the RNs on the unit, that includes a bed allocation and assignment matrix to ensure appropriate patient admission to the medical surgical unit.
5. Ensure organizational policies support RN and RPN practice to be in alignment with the CNO Practice Guideline: RN and RPN Practice: The Client, the Nurse and the Environment, and ensure nursing education addresses scope of practice during orientation and annually.
6. The employer will conduct an RN and RPN self-assessment of competencies using Benner's Theory of Novice to Expert and align schedules to ensure a balanced mix of staff skill and experience on all shifts.
7. The employer will replace RN vacancies with an RN, to ensure the appropriate nursing category is assigned to match the patient needs considering the three factors, in accordance with the CNO practice guideline: RN and RPN practice: The Client, the Nurse and the Environment.
8. The employer will develop an electronic incident reporting system to facilitate the reporting, collection, review, and analysis of patient safety incidents, especially those related to missed care.

**Education**

1. The employer will recruit a Nurse Educator with a fulsome knowledge and experience in medical, surgical, and emergency nursing care.
2. The employer will establish and implement a fulsome and complete orientation program for all new staff in the medical surgical unit using the Canadian Nurses' Association (CNA) Medical-Surgical Nursing – List of Competencies, to support a safe quality transition of new nurses to the organization and the department.
3. The employer will establish and implement a mentorship program for all new staff, which will include a minimum of 12 supernumerary buddied shifts with a single consistent mentor and a balanced split between day and night shifts. Additional mentored shifts will be offered as deemed necessary for the new nurse, and in consultation with the mentor and the educator. Effective mentorship will promote staff retention and job satisfaction.
4. The employer will ensure new hires, after at least six months on the unit, have all the necessary training complete with four buddy shifts with an expert RN in the Special Care Unit (SCU) before being assigned to work independently in the unit. The training curriculum will be informed by expert SCU RNs, along with feedback from recent hires.
5. The employer will provide and support all RN staff to attend, on employer-paid time, a mandatory annual in-house educational skills/competency day, combined with annual mandatory training on all additional nursing skills to care for patients in the medical surgical unit, including but not limited to: advanced cardiovascular life support (ACLS), non-violent crisis intervention training (NVCI) and other hospital core education programs.
6. The employer will institute a formal charge nurse (CN) education program, that will clearly outline the role, responsibilities, and accountabilities. This education will be developed in consultation and collaboration with the RNs on the unit, specifically the RN who has primarily been fulfilling the role.
7. The employer will conduct an RN self-assessment of competencies using Benner's Theory of Novice to Expert and will align schedules to ensure a balanced skill mix of RNs on all shifts.

**Leadership**

1. The employer will increase daily RN staffing to have four RNs on the day shift and four RNs on the night shift, immediately.
2. Implement an organizational leadership training and development program. Include all nursing leadership and promote authentic and transformational leadership practices at CMH.
3. Implement regular and consistent staff meetings, with nursing input into the agenda. The agenda to be posted one week in advance, with notice of meeting dates one month in advance. Meeting minutes to be printed and posted on the unit bulletin board.
4. Manager communication should be clear, effective, timely and transparent at all times.
5. Nursing Leadership will engage positively in the Professional Responsibility Process to create a dynamic and positive culture, to establish collaboration, problem-solving and open, effective communication at all times, with a solution focus and problem-solving perspective to achieve mutually agreeable resolutions.
6. The manager must ensure each staff member is provided an opportunity for union representation at every meeting regarding a workload or practice issue, as per the collective agreement. The manager will not conduct such meetings in the absence of a union representative unless the member willingly waives their right.
7. Network with RNAO to become a Best Practice Spotlight Organization to promote improvements in staffing, retention, recruitment, sustainability of staff, and improved leadership practices at CMH to name a few.
8. Implement the Registered Nurses Association of Ontario (RNAO) Best Practice Guideline: Developing and Sustaining Nursing Leadership on the medical surgical unit.

9. Make every effort to promote, support and sustain management and senior leadership stability by providing robust leadership orientation and peer support.
10. Ensure all leadership are trained in the Occupational Health and Safety Act (OHSA) and understand their roles and responsibilities as competent supervisors under this legislation.
11. Hire a full-time occupational health and safety RN. The RN members' report they feel intimidated and propose a conflict of interest exists, where a non-medical HR director, not bound by ethical and professional standards holds this dual role with access to their confidential medical information.

**Morale and Work Environment**

1. The employer will confirm the appropriate care provider for one-to-one patient observation based on the patient's needs and risk, in consultation with the Team Lead and RN. ONA recommends the highest level of trained security guard for violent patients and a PSW for patient observation for confused patients or patients that are high risk for elopement.
2. The employer will revise their patient flow, surge and overcapacity policies and plans, to ensure appropriate staffing to support patient care needs, and new admissions to the medical surgical unit. For every three patients above the baseline of 34 the employer will bring in an additional RN staff.
3. The employer will develop a process to ensure there are four sets of functional Pinel restraints and keys always available on the unit.
4. One security guard will be scheduled and available 24 hours per day, seven days a week, and will round hourly on the inpatient unit. Should security be unavailable, the employer will ensure the unit is informed immediately and alternative support is provided for safety. All security guard staff will be trained to the highest level of training and skilled to safely de-escalate and support the management of aggressive behaviours.
5. The employer will hire and train PSWs to provide care and support to patients requiring close observation due to cognitive concerns, behavioural conditions, or risk of elopement.
6. The employer will hire organizational security guard staff and schedule 24/7 security coverage. All security guard staff will be trained to the highest level of protection, including use of force and baton use.
7. All unit staff will be trained in Non-Violent Crisis Intervention. This will be mandatory and paid time training, reviewed and updated annually. Training will include didactic, hands on, and demonstration training sessions. The employer will monitor annual training to ensure compliance.
8. Immediately rectify the functioning of the code white system by instituting a proper code white response, including training, and personal panic alarms. In the interim, provide a reasonable alternative to ensure safety (e.g., placing security on each unit).
9. The employer will develop and implement a policy to conduct debriefs with all affected staff involved in a code white, within 72 hours. The JHSC worker rep and co-chair will participate in such debriefs. This will be included as a step in the code white policy.
10. All staff will be provided with GPS locator personal safety alarms, immediately.
11. The employer will conduct annually and as required, a risk assessment with an external company specializing in risk assessments. The JHSC ONA member will be present during the risk assessment. Risk assessment findings will be shared with the JHSC as well as an action plan to resolve any safety concerns identified.
12. The employer will implement an updated electronic incident reporting system and ensure timely follow-up for all safety issues. Purchase an established external incident reporting system that will ensure stakeholders receive copies of the report, appropriately and timely, including the writer of the incident report and the JHSC. This shall be an organizational priority to be completed in the quickest possible timeframe.
13. Immediately allow the ONA bargaining unit to post an expression of interest for JHSC representation to all RNs on the medical surgical unit to give the opportunity for medical surgical RNs to actively participate in this committee.

14. Develop a violence prevention policy that will be reviewed by the JHSC prior to finalization, with membership engagement and input, to be completed by December 31, 2023.
15. The employer will develop a process for creating and implementing behavioural care plans for patients with responsive behaviours in collaboration with the RNs and interdisciplinary team. The process will include collaborating with the privacy officer to identify patients who have a current behavioural care plan, thus mitigating risk to all care team members. The BSO RN should be included in the development of the care plans.
16. Management will conduct daily safety huddles with staff. They will be scheduled during the day shift at a time deemed most suitable for the unit staff, and include standing items for discussion, including but not limited to; staffing, patient flow, patient safety concerns, support staffing, safety concerns, and workload concerns, etc.
17. The employer will immediately establish a committee for the purpose of reviewing incident reports with a focus on solutions; and that incorporates a just culture approach. Ensure medical surgical RN staff are engaged to participate.
18. The employer will ensure all nursing leaders and managers receive supervisor training as determined under the OHSA, as well as all Charge Nurse and Team Leader roles. The employer will be responsible for maintaining the training records.
19. The employer will provide appropriate and sufficient equipment to meet the patient care needs on the unit and will continue to monitor and replace or update as necessary, any deficient equipment.
20. The employer will create and implement a process for monitoring and maintaining adequate supplies and functional equipment. These duties are to be completed by non-RN personnel.
21. The employer will ensure all patient rooms, in particular, room 107 as well as any other room without wall suction, be equipped with appropriate and safe access to effective suctioning equipment (wall suction is ideal). Each room should be equipped with wall mounted suction and with appropriate safety device/covers that can be applied and removed as deemed appropriate, based on the patient risk assessment. The current environment is deemed to be a hazard.
22. Develop a lift and transfer policy that identifies safe practices to promote injury prevention. Ensure front line RN staff are given the opportunity to provide input and JHSC participation is sought for development and review, prior to policy finalization.
23. All RNs must be trained and competent to conduct inpatient glucose testing, glucometer use and interpretation of results to ensure safe, timely and appropriate patient assessment and care.
24. All SCU RNs must be educated and upskilled to conduct and interpret ECGs to promote and support timely patient assessment and intervention.

**Non-Nursing Duties**

1. The employer will ensure all ward clerk vacancies are filled and scheduled hours will be maintained 0730 to 2330 hours, Monday to Friday and 1000 to 1800 hours, Saturday, and Sunday to provide adequate support on the unit.
2. The employer will staff the unit with one permanent PSW for the day and the evening shift seven days a week. To achieve this, the employer will create two full time and three part time PSW positions.
3. The employer will increase inpatient physiotherapy coverage to be from 0800 to 1700 hours daily, including weekends. To achieve this, the employer will hire one full-time and two part-time physiotherapists.
4. The employer will provide additional PSW support as required, 24/7, to provide one to one observation for patients with responsive behaviors or as ordered by a physician or designate.
5. The employer will increase housekeeping services to include overnight coverage for the medical surgical unit and the emergency department (ED). This will require the employer to recruit an additional one point five FTE housekeeper to provide coverage from 2300 to 0700 hours daily.

6. The employer will increase portering services to provide coverage on the day shift from 0700 to 1500 hours and on the evening shift from 1500 to 2300 hours, seven days per week. All porters will be provided with appropriate and adequate orientation and training to transfer patients.
7. The employer will ensure the permanent medical surgical unit NP vacancy is filled immediately and will maintain NP coverage for the unit of at minimum, 40 hours per week.
8. The employer will ensure the NP GAIN clinic vacancy is filled immediately to ensure continuity of care for patients requiring specialized care.
9. The employer will ensure the Social Worker role is redefined to help the patients in the medical surgical unit achieve optimum psychosocial and social functioning.
10. The employer will redefine the Discharge Planner role to be filled by a Registered Nurse to ensure patient needs are met and discharge planning can be completed successfully with all the necessary patient supports in place. This will ensure safe and timely care, as well as appropriate disposition of patients.

### 2.2.2 Campbellford Memorial Hospital

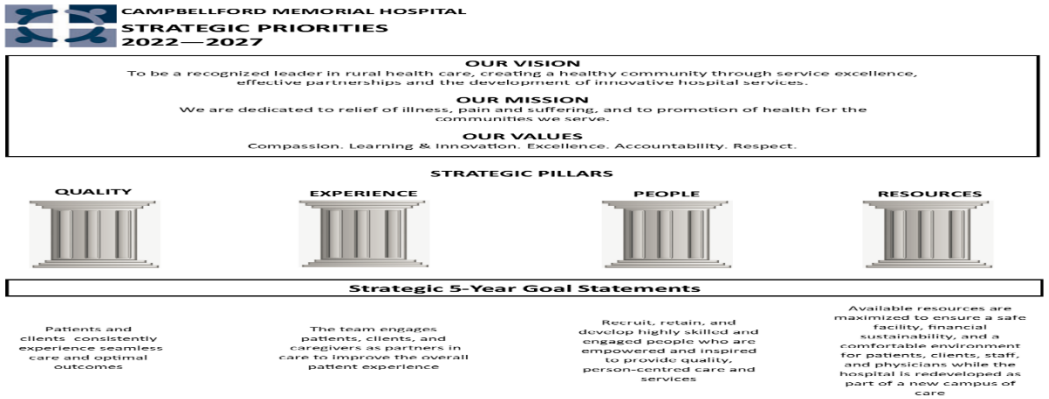
*Context of Discussion at the IAC*

## About the Hospital[21]

Campbellford Memorial Hospital (CMH) is a 34-bed health care facility located in Trent Hills. It serves approximately 40,000 Northumberland, Peterborough, and Hastings County residents, as well as a large seasonal population of cottagers and tourists enjoying the beautiful Kawartha Lakes Region and the Trent River System.

As the only hospital located between Belleville and Peterborough, Ontario, CMH provides a comprehensive array of acute care services including a Medical/Surgical Unit, a Special Care Unit, Endoscopy Surgical Suite, Diagnostic Imaging Department, Laboratory, numerous Out-Patient Clinics, 24/7 Emergency Department and numerous community programs including Mental Health, GAIN, and Supportive Housing.

To ensure comprehensive, coordinated, patient and family-centred care that meets local needs, the Campbellford Memorial Hospital's community health care campus partners include Trent Hills Family Health Team; Campbellford Memorial Health Centre; Campbellford Memorial Multicare Lodge; as well as other area hospitals and community agencies. These partners ensure you receive the right care in the right place at the right time.




[21] Campbellford Memorial Hospital Brief p. 3-5, June 5, 2023.

CMH initiated a strategic priority-setting exercise with the objective to re-focus the organization's work for the next five years, from 2022 to 2027, and to align all members of the workforce in a collective effort toward a common purpose.

This priority-setting activity was conducted with CMH's vision, mission, and values statements underpinning the work.

Campbellford Memorial Hospital is committed to providing high quality health care to the community. The aging building has its challenges and expanding the current site is not possible. CMH has applied for a capital planning grant to redevelop the facility as part of a Campus of Care that will create one location for a continuum of health services in Campbellford. Once complete, the redevelopment project will bring together the Hospital, a new Long-Term Care Home, Community Mental Health Clinic, a Geriatric Assessment and Intervention Network, and future plans to build. Portions of CMH are nearly 70 years old and have had minimal upgrades since it was first built. Private rooms were not considered necessary at that time. CMH is currently facing $25 million in facility repairs as well as replacements that will be required over the next 25 years (this amount is expected to increase). The pandemic has also underscored significant infection prevention and control gaps (e.g. lack of negative pressure areas, limited private rooms, and insufficient air filtration) that have stymied the flow of admissions during outbreaks because of the inability to cohort patients. Finally, the hospital faces ongoing capacity pressures in the Emergency Department and the Inpatient Medical unit, which will continue to worsen due to population growth and changing demographics. A new and expanded facility will mitigate these pressures. A new hospital as part of a Campus of Care will also significantly help strengthen the community's physician recruitment efforts by providing a modern facility that has the adequate capacity, and optimal environment for high-quality patient care.

## Campbellford Memorial Hospital Medical/Surgical Unit Overview[22]

The inpatient unit at CMH is funded for 34 beds plus 4 surge beds as needed. There are 30 beds as part of the main unit and 4 beds which are identified as a Special Care Unit (SCU). It is important to note that the Special Care Unit is **not** designated by Critical Care Services of Ontario (CCSO) as a Level 2 Critical Care Unit. Patient level data from patients in the SCU beds is not inputted into the Critical Care Information system (CCIS).

The Critical Care Information System (CCIS) is a key component of Ontario's Critical Care Strategy which is overseen by Critical Care Services Ontario (CCSO). The CCIS provides near-real time data on every patient admitted to level 3 and level 2 critical care units in Ontario's acute care hospitals. The system also provides information on bed availability, critical care service utilization and patient outcomes through the 'Reports' functionality. The system provides an important medium for monitoring and managing the province's critical care resources more effectively, and for highlighting opportunities to implement quality improvement initiatives at individual hospitals and across regions.

The CCIS Bed Availability Tool (BAT) automatically transfers critical care bed information to CritiCall Ontario's PHRS critical care resource screens. This information is used in real time by CritiCall Ontario agents and Provincial partners to help make informed decisions about placement of patients when hospitals experience a capacity issue (e.g. Moderate surge, Natural Disasters, Pandemic, major events, etc.), or patients need a higher level of care (e.g. 'Life or Limb').

[22] Campbellford Memorial Hospital Brief p. 3-5, June 5, 2023.

The SCU beds are not monitored by CCIS, therefore Critical Care patients will not be transferred into these beds. The beds may be utilized if a CMH patient condition deteriorates, and transfer is being arranged. Most recently, the April 2023 Performance Scorecard indicates that the IPU has met, exceeded or is close to target on all key performance indicators.

CAMPBELLFORD MEMORIAL HOSPITAL

**Inpatient Performance Dashboard April 2022 - March 2023**

| Target/Benchmark Key |
|---|
| Target Met or Exceeded |
| Close to Target |
| Performance Standard not yet Met |

| Performance Indicators | Alignment to Standards | Driver or Watch | Target | Q1 | | | Q1 Total | Q2 | | | Q2 Total | Q3 | | | Q3 Total | Q4 | | | Q4 Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | Apr | May | June | | July | Aug | Sept | | Oct | Nov | Dec | | Jan | Feb | Mar | |
| **Safe** | | | | | | | | | | | | | | | | | | | |
| Number of workplace violence incidents overall | P | Driver | 0 | | | | | 1 | 4 | 2 | 7 | 2 | 1 | 1 | 4 | | | | |
| BCMA Compliance - Perentage Compliance | A, P | Driver | 80 | 84.6 | 84.2 | 82 | 83.6 | 83.8 | 82.3 | 82.2 | 83 | 84.6 | 83.9 | 82.7 | 83.7 | 83.8 | 84.7 | 85 | 84.5 |
| Number of patients who had a fall in hospital that are rated level 3 or highter | A, P | Driver | 0 | | | | | | | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 2 |
| Number of hospital acquired infections per month | A, P | Watch | 0 | 4-C | 0 | 0 | 4 | 0 | 0 | 0 | 0 | 8-C | 2-C | 2-C/1-D | 4 | 1 | 1 | N/A | N/A |
| contact) | A, P | Driver | 90 | | | | 53.8 | | | | 62.1 | | | | 92.3 | | | | N/A |
| contact) | | Driver | 90 | | | | 56.3 | | | | 78.5 | | | | 93.2 | | | | N/A |
| (HAPI) | A, P | Driver | 5 | 1 | 0 | 2 | 3 | 3 | 1 | 0 | 4 | 1 | 2 | 1 | 1 | 1 | 2 | 4 | 7 |
| | | | | | | | | | | | | | | | | | | | |
| % of Nursing Policies Up to Date | A, M | Driver | 12.5 | | | | | | | | | 8 | 0 | 0 | 8 | 0 | 0 | 0 | 0 |
| % of patients that had pain reassessed post analgesic | Q, A | Driver | CB | | | | | | | | | | | | | | | | |
| **Patient Centered** | | | | | | | | | | | | | | | | | | | |
| % of inpatients that received AVS upon discharge | Q, S, P, A | Watch | 90% | 89% | 100% | 91% | 93% | 88% | 99% | 98% | 95% | 100% | 99% | 99% | 99% | 99% | 95 | 100% | 98% |
| % of response to post discharge follow up phone calls | Q, P | Driver | 50 | | | | | 58 | 48 | 67 | 58 | 51 | 56 | 51 | 53 | 55 | 65 | 47 | 56 |
| % of unresolved patient complaints | Q, M, S, P | Watch | 25 | | | | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Efficient** | | | | | | | | | | | | | | | | | | | |
| % of eligible employee's performance appraisals completed | Q, S, A | Driver | 80 | | | | | | | 78 | 78 | 87.5 | 95 | | 97 | | | | |
| Time to inpatient bed (90th Percentile) in hours | Q, P | Watch | 24hr | 29 | 43 | 22 | 31 | 17 | 50 | 89 | 52 | 49 | 47 | 28 | 41 | 31 | 39 | 29 | 33 |
| **Timely** | | | | | | | | | | | | | | | | | | | |
| % of patients with completed falls risk assessment within 24 hours of admission | Q, A, P | Driver | 100% | 70% | 68% | 72% | 70% | 66% | 58% | 35% | 53% | 64% | 55% | 73% | 64% | 68% | 81 | 86% | 78% |
| % of admits that had violence risk assessment completed within 24 hours of admission | Q, A, P | Watch | 80 | | | | | | | | | | | | | | | | |
| % of admits that had Braden scale risk assessment completed within 24 hours of admission | Q, A, P | Driver | 100 | 76% | 76% | 84% | 79% | 74% | 68% | 35% | 59% | 62% | 54% | 81% | 66% | 72% | 85 | 86% | 81% |
| **Equitable** | | | | | | | | | | | | | | | | | | | |
| Number of patients seen by Physiotherapy per day | Q, P | Watch | CB | | | | | | | | | | | | | | | | |
| Number of patients inovled in group Recreational sessions | Q | Watch | CB | | | | | | | | | | | | | | | | |
| Number of referrals to Behavioural Supports Ontario Nurse | Q, P | Watch | CB | | | | | | | | | | | | | | | | |
| **Integrated** | | | | | | | | | | | | | | | | | | | |
| Number of months that have Unit-Based Council Meetings | Q, S | Watch | 8 | Y | Y | N | 2 | N | N | Y | 1 | Y | Y | Y | 3 | Y | Y | Y | 3 |
| Number of referrals to Community Paramedic Programs | Q, P | Watch | CB | | | | | | | | | | | | | | | | |
| Number of Transfers to other institution (for admittance) | Q,P | Watch | CB | 14 | 11 | 11 | 36 | 17 | 11 | 17 | 45 | 4 | 16 | 8 | 28 | 14 | 11 | 16 | 41 |

[23] Campbellford Memorial Hospital Brief p. 5-6, June 5, 2023.

CAMPBELLFORD MEMORIAL HOSPITAL

# Inpatient Performance Dashboard April 2023 - March 2024

| Target/Benchmark Key | |
|---|---|
| | Target Met or Exceeded |
| | Close to Target |
| | Performance Standard not yet Met |

| Performance Indicators | Alignment to Standards | Driver or Watch | Target | Q1 | | | Q1 Total | Q2 | | | Q2 Total | Q3 | | | Q3 Total | Q4 | | | Q4 Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | Apr | May | June | | July | Aug | Sept | | Oct | Nov | Dec | | Jan | Feb | Mar | |
| **Safe** | | | | | | | | | | | | | | | | | | | |
| BCMA Compliance - Perentage Compliance | A, P | Watch | 85% | 84 | | | | | | | | | | | | | | | |
| Number of inpatient with a hospital acquired pressure injury (HAPI) | A, P | Driver | 5 | 0 | | | | | | | | | | | | | | | |
| **People Centered** | | | | | | | | | | | | | | | | | | | |
| % of inpatients that received AVS upon discharge | Q, S, P, A | Watch | 100% | 100 | | | | | | | | | | | | | | | |
| of patients that were satisfied with the information received at discharge | Q, P | Watch | 50 | N/A | | | | | | | | | | | | | | | |
| **Efficient** | | | | | | | | | | | | | | | | | | | |
| % of eligible employee's performance appraisals completed - quarterly not monthly | Q, S, A | Watch | 80 | | | | | | | | | | | | | | | | |
| Number of patient days in unconventional spaces (greater than 34 patients) | Q,P | Watch | CB | 0 | | | | | | | | | | | | | | | |
| Time to inpatient bed (90th Percentile) in hours | Q, P | Driver | 40.2hr | 23.4 | | | | | | | | | | | | | | | |
| **Timely** | | | | | | | | | | | | | | | | | | | |
| % of patients with completed falls risk assessment within 24 hours of admission | Q, A, P | Driver | 77% | 88 | | | | | | | | | | | | | | | |
| % of admits that had Braden scale risk assessment completed within 24 hours of admission | Q, A, P | Driver | 81% | 89 | | | | | | | | | | | | | | | |
| **Equitable** | | | | | | | | | | | | | | | | | | | |
| Average Number of patients seen by Physiotherapy per day | Q, P | Watch | CB | N/A | | | | | | | | | | | | | | | |
| Average Number of patients inovled in group Recreational sessions | Q | Watch | CB | 7.8 | | | | | | | | | | | | | | | |
| Number of referrals to Behavioural Supports Ontario Nurse | Q, P | Watch | CB | | | | | | | | | | | | | | | | |
| **Integrated** | | | | | | | | | | | | | | | | | | | |
| Number of months that have Unit-Based Council Meetings | Q, S | Watch | 8/yr | 1 | | | | | | | | | | | | | | | |
| Number of Nurse escorted transferss from Inpatient Unit | Q,P | Watch | CB | N/A | | | | | | | | | | | | | | | |

# SECTION III

# DISCUSSION AND ANALYSIS

## 3.1 Introduction

The IAC believes that the Panel (IAC Chairperson and both Nominees) has developed a comprehensive understanding of the professional responsibility concerns of the RNs working in the Campbellford Memorial Hospital Medical/Surgical Unit.

This understanding was achieved through the following:

- Review and analysis of the written submissions on June 5 2023, exhibits, oral presentations, and discussions at the IAC Hearing held on June 26th, June 29th, and June 30th,2023.
- Review of information provided by the Hospital and the Association during the IAC Hearing.
- Review of literature available in the public domain regarding models of nursing care and the practice of Medical/Surgical nurses.
- The IAC Panel's collective practice experience, knowledge, and expertise with similar issues.

## 3.2 Factors Impacting the Practice Environment

Discussion of professional responsibility within a Medical/Surgical IPU at the Campbellford Memorial Hospital must be considered within the context of the practice environment.

The IAC Panel's analysis and recommendations are based on assumptions regarding:

- Campbellford Memorial Hospital's overview,
- Campbellford Memorial Hospital Medical/Surgical Unit geographical configuration,
- Campbellford Memorial Hospital's Medical/Surgical Unit patient population, including patient acuity and complexity, occupancy.
- Campbellford Memorial Hospital Medical/Surgical nursing resources and support,
- Nursing standards of practice, and
- Healthy work environments.

### 3.2.1 Campbellford Memorial Hospital Overview [24]

Campbellford Memorial Hospital (CMH) is a 34-bed health care facility located in Trent Hills. It serves approximately 40,000 Northumberland, Peterborough, and Hastings County residents, as well as a large seasonal population of cottagers and tourists enjoying the beautiful Kawartha Lakes Region and the Trent River System.

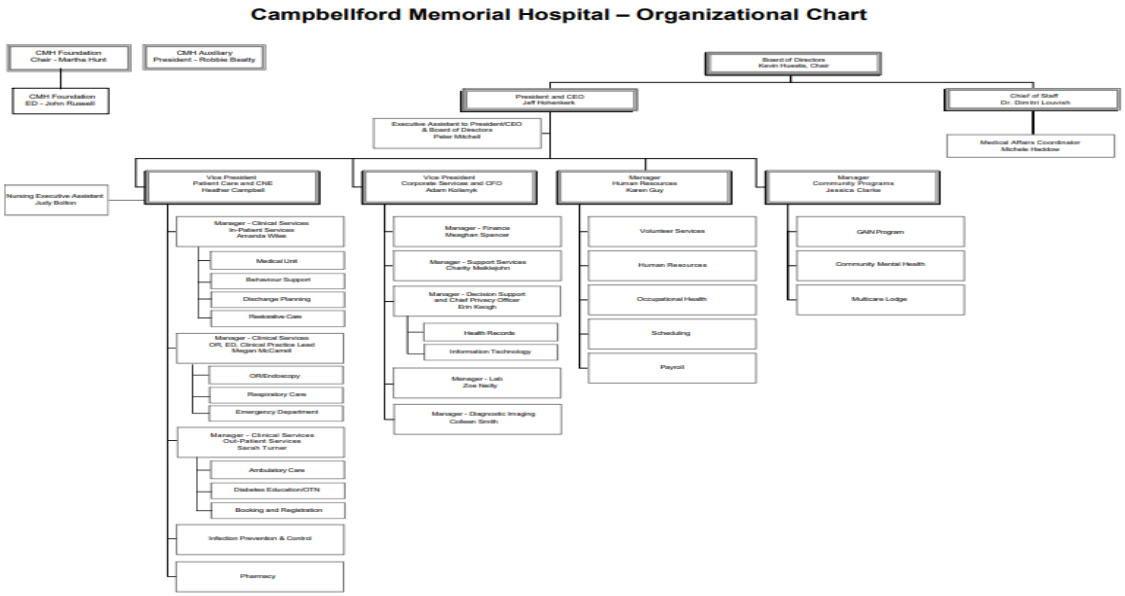
As the only hospital located between Belleville and Peterborough, Ontario, CMH provides a comprehensive array of acute care services including a Medical/Surgical Unit, a Special Care Unit, Endoscopy Surgical Suite,

[24] Campbellford Memorial Hospital Brief p. 3 June 5, 2023.

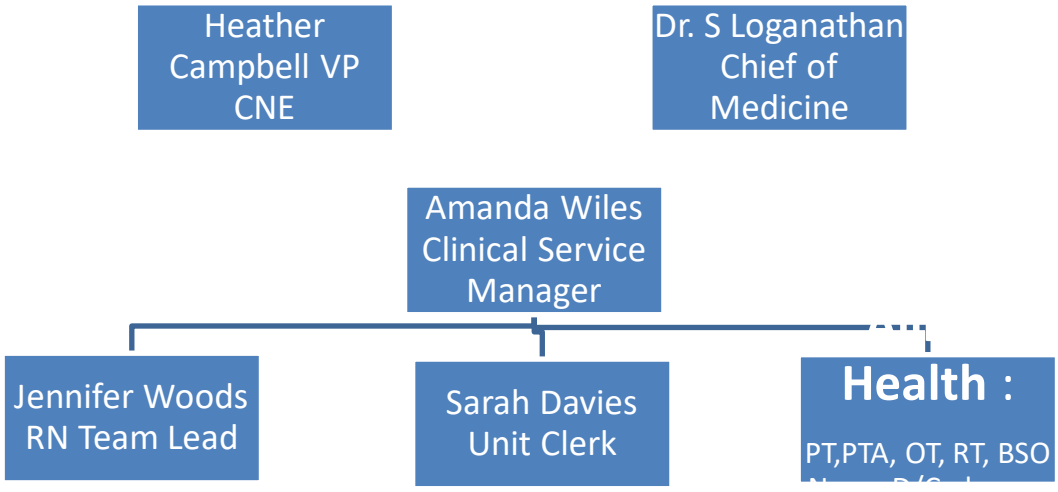
Diagnostic Imaging Department, Laboratory, numerous Out-Patient Clinics, 24/7 Emergency Department and numerous community programs including Mental Health, GAIN, and Supportive Housing.

To ensure comprehensive, coordinated, patient and family-centred care that meets local needs, the Campbellford Memorial Hospital's community health care campus partners include: Trent Hills Family Health Team; Campbellford Memorial Health Centre; Campbellford Memorial Multicare Lodge; as well as other area hospitals and community agencies. These partners ensure you receive the right care in the right place at the right time.

**Campbellford Memorial Hospital Leadership**[25]




**Campbellford Memorial Hospital Medical/Surgical Unit Leadership**



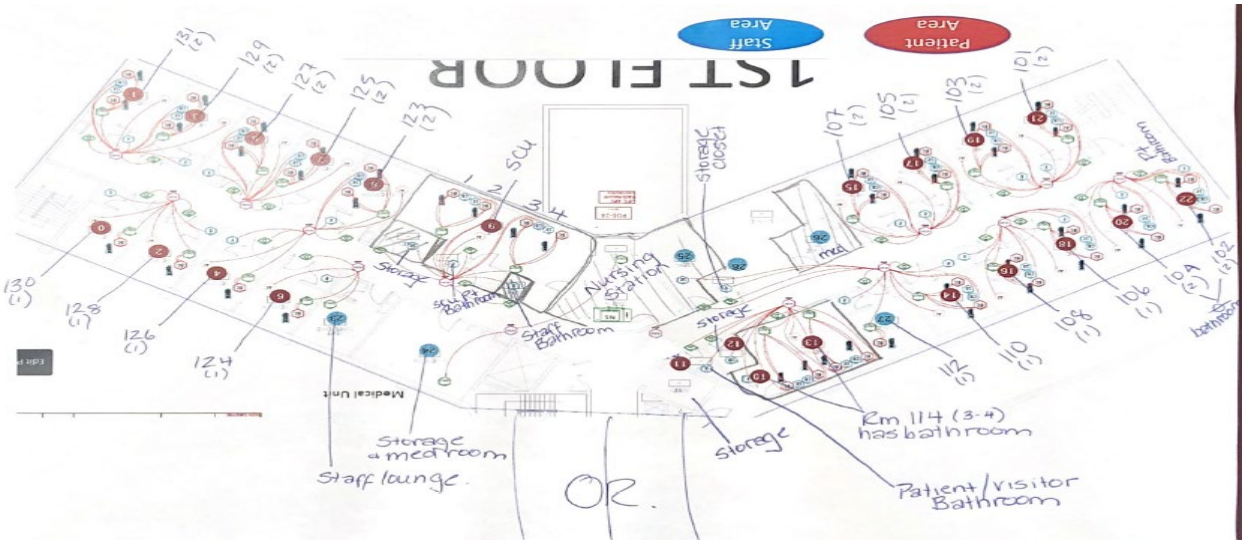

[25] Campbellford Memorial Hospital Presentation June 26th, 2023.

### 3.2.2 Campbellford Memorial Hospital's Medical/Surgical Unit Geographical Configuration[26]

The IPU is divided into two wings, Ranney Gorge and Ferris Lane with a large, centralized nursing station. The centralized nursing station provides easy access to each wing as well as a meeting point for multidisciplinary rounds that occur twice a week. Each wing is made up of private and semi-private rooms and has a designated medication and supply room. The Ranney Gorge wing has a patient and family lounge that is utilized for organized activities and family meetings. Ferris Lane includes a 4-bed wardroom that allows for close observation and telemetry monitoring and is directly accessible from the centralized nursing station. The Inpatient Unit staff lounge is also located on Ferris Lane which allows staff to have a private place to relax without leaving the unit or hospital. In addition to the patient and visitor lounge there is also a family quiet room that is down Trent River towards the Operating Rooms that allows for family to step away without leaving the unit for rest as well as to privately consult with members of the CMH interprofessional team. [27]

Each room including non-patient rooms such as the medication rooms and staff lounge have been fitted with a Nurse Call system. This allows for in-the-moment alerts and communication between patients and staff members as well as increases patient and staff safety as Code Blue and Staff Emergency switches are within reach. A central console is kept at the centralized nursing station as well to allow for easy access and close monitoring by the Inpatient Unit care team.

There is an additional third wing named Trent River where the Operating Room and Day Surgery space is located. The operating room consists of two rooms the first is used for outpatient endoscopies and the second operating room is the designated resuscitation room and allows for protected code blues. Day Surgery consists of 8 stretchered spots and a small nursing station. Space within Day Surgery is used when organizational surge plans are activated.




[26] Campbellford Memorial Hospital Presentation June 26th, 2023.
[27] Campbellford Memorial Hospital Brief p. 8-9, June 5th, 2023.

### Campbellford Memorial Hospital Medical/Surgical Unit Patient Population[28]

As the only hospital for an approximately 100-kilometer radius, Campbellford Memorial Hospital is the primary healthcare facility located between Belleville and Peterborough, Ontario. CMH provides acute care services including a 24/7 Emergency Department and the 34-bed inpatient and Special Care Unit. CMH also provides a variety of day and outpatient services in this moderate sized rural community hospital. The CMH community healthcare campus partners with Trent Hills Family Health Team; Campbellford Memorial Health Centre; Campbellford Memorial Multicare Lodge; as well as other area hospitals and community agencies. Patients may be transferred from any of these areas and facilities for care at CMH.

Campbellford is home to 3,372 residents (Statistics Canada, 2021). Almost 40 per cent, or 1,225 residents in this community are 65 years of age and older, and a predominantly English-speaking population. Additionally, another 40 per cent or more than 1,300 residents are gainfully employed in the community, in trades, sales, education, and healthcare industries. Seasonal population growth is common as Campbellford is a desirable location for visitors, easily accessible in Northumberland County and just an hour or so drive from the Greater Toronto Area (GTA). Campbellford is located on the Trent-Severn Waterway and offers local activities and desirable locals for visiting during peak vacation periods. Warkworth Institution, a medium-security correctional facility, is located 10 minutes south of Campbellford, and houses approximately 537 inmates. The hospital and Warkworth Institution are two predominant employers in the area.

Information reported by the employer in the Workload/Professional Responsibility Review Tool (Exhibit 2) indicates the hospital has an average 30 per cent ALC patient population. The medical surgical patient population also includes a wide and overarching range of acute medical patients with complex medical conditions such as acute kidney injury (AKI), conditions of altered mental status, sepsis, infectious disease conditions including Covid, pneumonia, respiratory syncytial virus (RSV), etc. Recovering surgical patients admitted to this unit include patients repatriated during their recovery from hip, femur, pelvis, and shoulder fractures and repair. Social admissions are also common in the patient population, including patients with behavioural/cognitive issues and/or those lacking housing options such as those from group homes and retirement homes, in need of relocation or repatriation to other assistive housing needs.

The four-bed SCU area is separate, an enclosed room on the Ferris Hall wing located behind the main nurse's station. The primary patients admitted into the SCU include patients with higher acuity conditions, including but not limited to, conditions such as cardiac conditions, angina, post Non-ST-Elevation-Myocardial Infarction (NSTEMI), Cerebrovascular Accident (CVA), Transient Ischemic Attack (TIA), Chronic Obstructive Pulmonary Disease (COPD) exacerbations, diabetic ketoacidosis (DKA) and hypoglycemia, atrial fibrillation (Afib)/Rapid Afib/Superventricular Tachycardia (SVT) and rhabdomyolysis. Patients that are admitted to SCU may be transferred to the medical surgical side once their condition stabilizes. The patient population often have multiple comorbidities based on their age group. The unit is an adult medical surgical unit, with no specific admission criteria; however, the RNs report the unit is not intended for admissions of patients under the age of 18 years.

## 3.3 Analysis and Discussion

### 3.3.1 Introduction

The IAC was requested to examine the resources within the Medical/Surgical Unit of including staffing that would support quality and safe patient care. The IAC has based its analysis on careful review of the extensive information provided by the Association and the Hospital prior to and during the Hearing.

[28] ONA Brief Volume I p. 8-9, June 5, 2023.

The IAC believes that the result of the IAC Panel's analysis will demonstrate the need for focused attention in the Medical/Surgical Unit at Campbellford Memorial Hospital related to leadership, best practices, policies and procedures, professional development, and quality nursing work life in a healthy work environment.

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

The Canadian Nurses Association (CNA) and the Canadian Federation of Nurses Unions (CFNU)[29] (2014) developed a joint statement outlining seven (7) key principles for practice environments that maximize outcomes for clients, nurses, and organizations. They are as follows:

1. **Communication and collaboration** —Communication [and collaboration are) at the foundation of nursing. Quality practice environments promote effective and transparent communication among nurses, between nurses and clients, between nurses and other health and non-health providers, between nurses and unregulated workers, and between nurses and employers. Quality practice environments are based on trust and respect among clients, staff, and employers.
2. **Responsibility and accountability** — A quality practice environment helps nurses fulfil their professional, legal, legislative, and collective agreement requirements and ensures they can participate in decision-making that affects their work, including developing policies, allocating resources, and providing client care.
3. **Safe and realistic workloads** - Quality practice environments support safe and realistic workloads for nurses. Workload is the top issue for Canadian nurses today and is often cited as a key factor in turnover. Sufficient numbers of nurses are required to provide safe, competent and ethical care.
4. **Leadership** — Effective leadership is important in all nursing roles and is an essential element of quality practice environments — for example, nurse managers who involve direct care nurses in decision making that affects the care they provide. At the same time, nurses (including direct care nurses) who act as collaborators, communicators, mentors, role models, visionaries and advocates for quality care also provide effective leadership. Therefore, all nurses have an important leadership role that affects their workplace environment and the care they provide.
5. **Support for information and knowledge management** — Quality practice environments include technologies that support critical thinking, enable the provision of safe and effective care, and provide optimal information and knowledge management (e.g., electronic health records and decision support tools). They also ensure that nurses have adequate time to access these technologies.
6. **Professional** development — Quality practice environments are adequately supported and funded to allow nurses to access professional development opportunities. These opportunities can include formal and continuing education, mentoring and online learning resources.
7. **Workplace culture** — A quality practice environment creates a workplace culture that values the wellbeing of clients and employees. This culture is continually assessed to ensure it embraces respect while developing practical knowledge [that] contributes to positive change, disseminating successful practices and strengthening health-care workplace cultures.

[29] https://cna-aiic.ca/~/media/cna/page-content/pdf-en/practice-environments-maximizing-outcomes-for-clients-nurses-and-organizations_joint-position-statement.pdf

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

1. Health Human Resources and Model of Care
2. Healthy Work Environments (HWE)
3. Leadership and Communication
4. Recruitment and Retention
5. Training and Orientation
6. Professional Development
7. Equipment
8. Professional Responsibility Workload Report Forms (PRWRF)
9. Hospital Association Committee (HAC)

If commitment and actions are implemented within each of these key areas, the IAC Panel believes that this will ultimately assist the Campbellford Memorial Hospital's Medical/Surgical Unit to become a quality practice environment reflecting the nine (9) key characteristics as outlined above.

# 1. Health Human Resources and Model of Care

### 1 Model of Care

Campbellford Memorial Hospital (CMH) is a 34-bed health care facility located in Trent Hills. It serves approximately 40,000 Northumberland, Peterborough, and Hastings County residents, as well as a large seasonal population of cottagers and tourists enjoying the beautiful Kawartha Lakes Region and the Trent River System. As the only hospital located between Belleville and Peterborough, Ontario, CMH provides a comprehensive array of acute care services including a Medical/Surgical Unit, a Special Care Unit, Endoscopy Surgical Suite, Diagnostic Imaging Department, Laboratory, numerous Out-Patient Clinics, 24/7 Emergency Department and numerous community programs including Mental Health, GAIN, and Supportive Housing. (CMH Brief)

The population demographic of Campbellford and surrounding areas demonstrates an aging population as well as many residents that are experiencing Socio-Economic Challenges. There is a lack of Long-Term Care Homes in Campbellford and surrounding areas as well as a need for Mental Health Services including Geri-Psychiatry. There are challenges in securing rehabilitation beds at surrounding hospitals and many residents do not have access to Primary Care Practitioners with approximately 4000 residents currently unattached. All of these external influences contribute to hospital admissions and increasing numbers of Alternate Level of Care (ALC) patients in acute care beds.

CMH's Medical/Surgical inpatient unit (IPU) nursing model of care includes Registered Nurses (RN) and Registered Practical Nurses (RPN). Collaboration is essential to improving healthcare delivery and a strengths-based approach leverages knowledge and skills of team members.

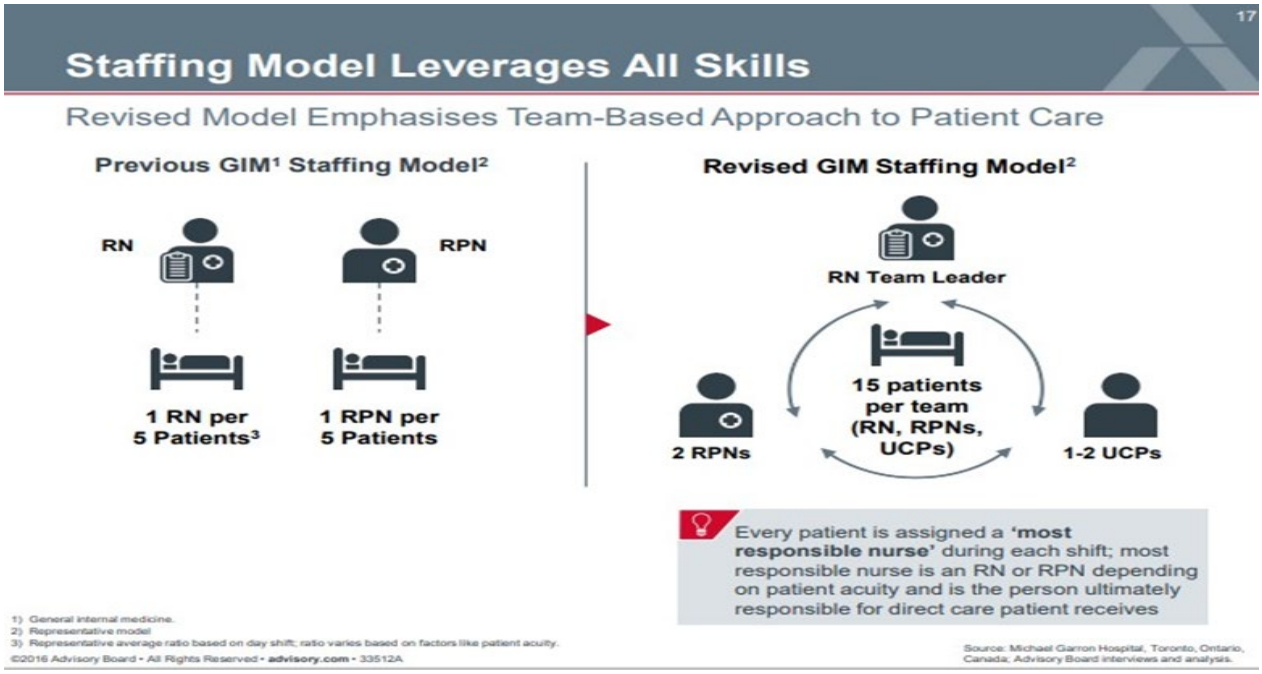
Throughout both CMH and ONA's presentations and staff testimonials, it was evident that challenges include an aging, outdated hospital contributing to new patient flow challenges, lack of primary care and discharge support for patients, use of agency nurses, and staff that are often working short staffed and experiencing burn out. It is a critical time in healthcare when we find that staffing is a much larger issue than the spread of COVID-19. There is currently a new body of healthcare and non healthcare resources focused on burn out and the health care crisis at the individual, organizational and global levels. This work focuses on positive psychology, resilience building models and lived experiences. In healthcare the health and joy of the workforce is directly correlated to recruitment, retention, positive patient experiences and outcomes. In

the table below from the Critical Care Services Ontario (CCSO)[30] Burnout survey in Critical Care 2022, it is evident that being fully staffed, the ability to deliver safe care and the opportunity to have time off is key when alleviating burnout. The strategies identified are key enablers in moving forward.

| Factors Leading to Burnout | Factors Alleviating Burnout | Strategies |
|---|---|---|
| Moral Distress/Emotional Exhaustion | Time off | Reduce physical toll/workload |
| Patient Safety | Support of colleagues | Introduction of support teams |
| Inability to get time off | Support of unit leadership | Access to wellness activities |

Hospital environments are rooted in traditional models of care, new models of care that are grounded in practice and research must be considered. There must be a proactive approach to the health human resource crisis spread outside of nursing, incorporating the whole health care team considering fairness, equity and focuses on a common purpose.

The primary nursing model emphasizes continuity of care by having one nurse provide complete care for a small group of inpatients within a nursing unit. A coordinated care team model focuses on an interprofessional collaborative approach. The team includes Registered Nurses (RNs), Registered Practical Nurses (RPNs), Allied Health professionals and unregulated care providers. In this model every patient is assigned a most responsible nurse during each shift, most responsible nurse is an RN or RPN depending on patient acuity and is the person ultimately responsible for the direct care the patient receives.




The Advisory Board Company published a document entitled Building the High-Value Care Team: Strategies for Delivering Cost-Effective, Coordinated Care identifying critical concepts in unlocking the value of a

[30] Critical Care Services Ontario (CCSO) Burn out survey 2022.

nursing care team.[31] The first is over reliance on RNs to complete the work that can be safely accomplished by support staff or other non RN members of the care team. The second is uncoordinated interprofessional care which can lead to duplication of efforts and waste and the third is the one size fits none care team regardless of patient needs.

As a new model of care is considered it is imperative to establish role clarity for each designation. This could include:

**Registered Nurses**

- Provide global perspective and coordination of care.
- Serves as team liaison with interdisciplinary groups.
- Acts as resource for RPNs and UCP's
- Provides direct care for high acuity patients within CNO 3-factor framework.

**Registered Practical Nurses**

- Provide direct patient care for most of team's patients.
- Partner with team lead to provide necessary patient education, care planning, and to develop discharge plans.
- Consults with other providers according to CNO 3-factor framework.

**Personal Support Workers (PSWs)**

- Responsible for daily living activities –toileting, bathing, feeding, ambulation
- May receive delegated tasks.

Collaboration is essential to improving health care delivery and a strengths-based approach leverages knowledge and skills of all team members. The key enablers to achieve this are role clarity regarding their own role as well as other team members, designated person to oversee the change management process and implementation, strong supportive communication process and allowing space for all disciplines to work in the same location. The below slide from Advisory Board Interviews and Analytics identifies barriers and opportunities.

[31] Advisory Board advisory.com 33512A Michael Garron Hospital Toronto, Ontario, Canada. Advisory Board interviews and Analytics.


It is important that all team members are on the same page which requires a clear common goal, supportive frameworks, and effective team coaching. A change in a model of care requires staff readiness, willingness and flexibility, authentic support by leadership as well as stabilization of leadership. The concept of Joy in Work leads to recruitment, retention, and productivity all of which contribute to a positive staff morale and safe quality patient outcomes.

**The IAC panel recommends:**

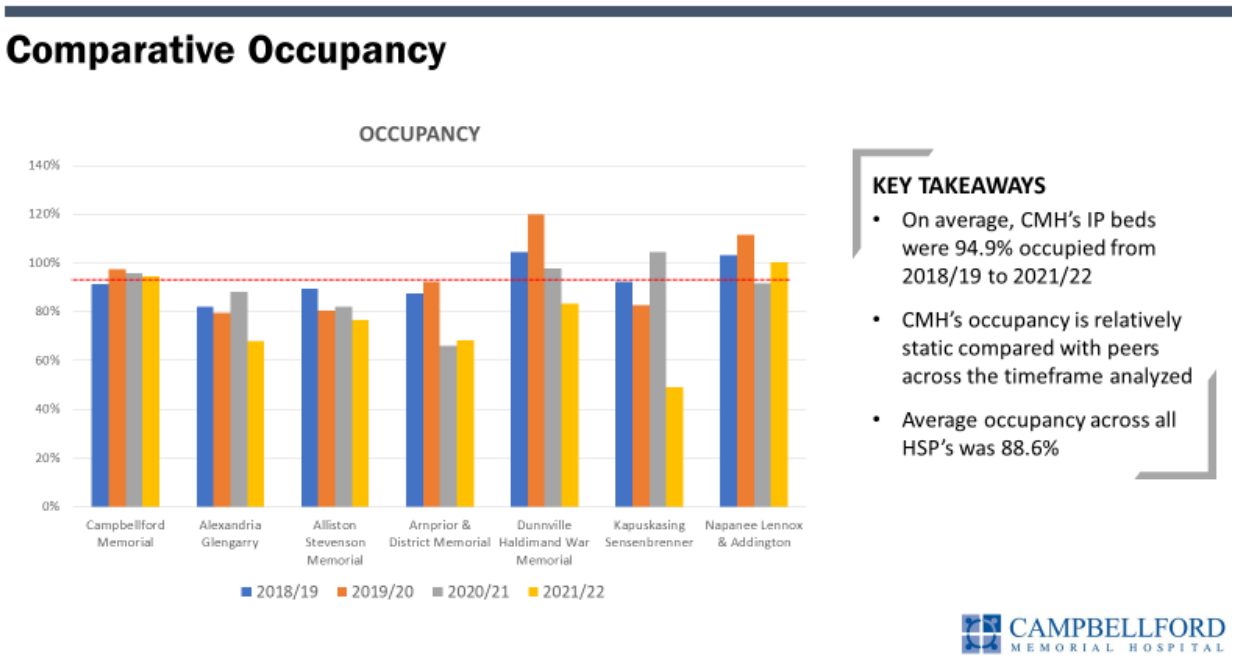
1. Support top of practice for all disciplines. The organization should ensure care teams contain sufficient support staff for RNs to delegate appropriate work and fully leverage the capabilities of RNs.
2. Revise role and job descriptions to reflect top of practice, ensuring all health care professionals are practicing to full scope of practice.
3. Complete a gap analysis to review scope of practice of each discipline incorporating competency assessments. Develop education programs based on the gap analysis and assessment.
4. Define role clarity for each discipline – This will ensure all members of the care team are well coordinated and do not duplicate work thereby eliminating waste. Team members frequently deliver patient care in silos, rather than as integrated teams. By defining role clarity teams are well-coordinated and equipped to deliver higher-quality and more efficient patient care.
5. Measurement for Improvement – Identify metrics prior to change that will demonstrate improvement. These could include:
    - Staff satisfaction
    - Patient satisfaction
    - Sick time/overtime
    - Increase in Professional Responsibility Workload Report Forms (PRWRF) being resolved at the unit level.
    - Decrease in PRWRFs going to HAC.
    - Decrease in patient and staff incident reports.

## 2. Medical/Surgical Inpatient Unit (IPU) Staffing

One of the most common issues raised in the Professional Responsibility Workload Form's (PRWFs)[32] is reduced baseline RN staffing to manage the volume and acuity of patients. The volume of PRWFs related to inadequate staffing to baseline are not disputed and it is Campbellford Memorial Hospital's (CMH) goal to achieve baseline staffing with recruiting and retention initiatives. CMH has outlined in detail the significant efforts it is making both: a) to retain and recruit RNs; and b) to provide non-RN support to RNs as a mitigation strategy.

Safe staffing requires an understanding of appropriate staffing levels, which can be attained only through ongoing monitoring of staffing and outcomes evidence at the organizational level (Patrician et al., 2011). Examples of evidence that leaders may use to support their staffing decisions are research studies, benchmarking from other similar organizations or units that reflects the highest quality of care, internal quality indicators, patient outcomes, and staff and/or patient satisfaction surveys[33].

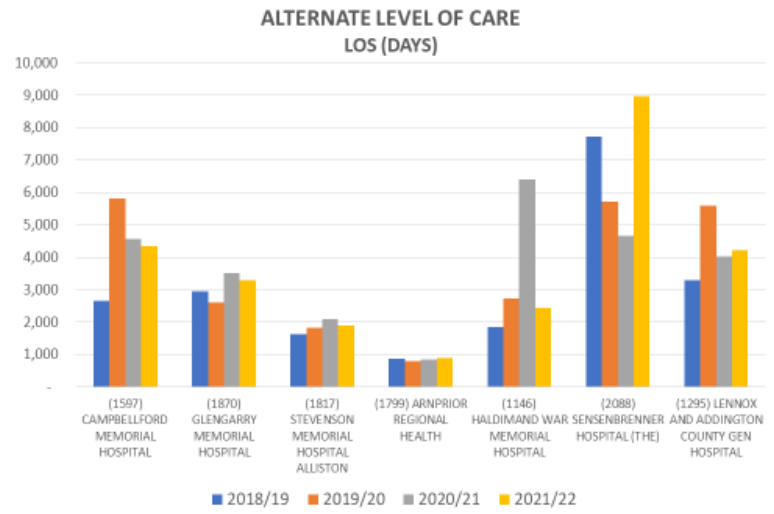
As part of CMH's submission, benchmarking data[34] with comparator hospitals was presented. This benchmarking included occupancy levels, Alternate Level of Care (ALC) patient's, acuity measured as Resource Intensity Weight (RIW), RN worked hours as well as RN full time equivalent's (FTE).




On average, CMH's IP beds were 94.9% occupied from 2018/19 to 2021/22. CMH's occupancy is relatively static compared with peers across the timeframe analyzed.

[32] CMH Disclosure Brief
[33] ONA Submission Brief Vol. 1
[34] CMH Disclosure Brief

## Comparative ALC Volumes




**KEY TAKEAWAYS**

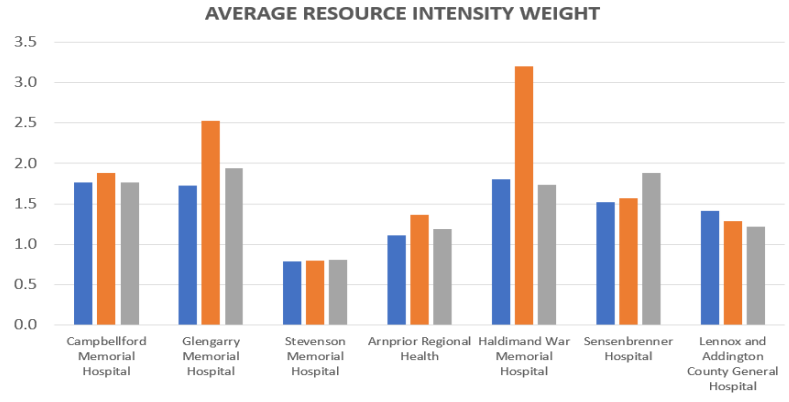
- On average, CMH's ALC % and LOS (days) was 57% and 4,347, respectively, from 2018/19 to 2021/22
- On average, CMH has 134% more ALC days/year than ASM, and 24% more than the average for all comparative HSP's

CAMPBELLFORD MEMORIAL HOSPITAL

As demonstrated in the chart above, on average, CMH's ALC % and LOS (days) was 57% and 4,347, respectively, from 2018/19 to 2021/22. CMH has 134% more ALC days/year than Alliston Stevenson Memorial Hospital, and 24% more than the average for all comparative hospitals. Many of these patients who are longer stay have had their acute care needs met, are waiting for their appropriate discharge destination[35].

2.5 Benchmarking

## Comparative Acuity




**KEY TAKEAWAYS**

- Resource Intensity Weight (RIW) is used to measure the intensity of resource use (relative cost) associated with different diagnostic, surgical procedures and demographic characteristics of an individual
- Essentially, the higher the RIW, the more complex the treatment & higher the cost
- CMH had a stable RIW across the prior three years

CAMPBELLFORD MEMORIAL HOSPITAL

Appropriate nurse staffing and workloads are fundamental to the efficient operation of health-care organizations and to the delivery of safe care to patients. They are also important for nurses' quality of life and for their leaders, who are under pressure by organizations to control costs. Safe, effective staffing and

[35] CMH Disclosure Brief

workload practices are critical components of a healthy work environment for nurses. Developing and sustaining such practices can improve nurses' well-being and retention, improve the quality of patient care, and yield financial benefits for organizations[36].

In October 2022, the employer announced their plan to change the nurse staffing model. The employer informed the union they would be eliminating two vacant RN positions they had been unable to fill. They added they would also be providing layoff notice to two full time RNs on the inpatient unit. The employer then reported they would be creating an RN float resource pool that would be composed of four full time RN positions. The resource pool RNs would float between the medical surgical unit and the emergency department as determined by staffing needs in the moment[37].

**Staffing Chart**

| Previous Staffing | | |
|---|---|---|
| **Day** | **Monday to Friday** | **Saturday to Sunday** |
| RN - D (0730-1930) | *3 | *3 |
| RN - TL (0730-1530) | 1 | 0 |
| RPN - D (0730-1930) | 5 | 5 |
| **Night** | | |
| RN - N (1930-0730)<br>*One of the three RNs is the CN and SCU RN assignment. | *3 | *3 |
| RPN - N (1930-0730) | 2 | 2 |

| Current Staffing | | |
|---|---|---|
| **Day** | **Monday to Friday** | **Saturday to Sunday** |
| RN - D (0730-1930) | *2 | *2 |
| RN - TL (0730-1530) | 1 | 0 |
| RPN - D (0730-1930) | 5 | 5 |
| **Night** | | |
| RN - N (1930-0730)<br>**One of the two RNs is the CN and SCU RN assignment. | *2 | *2 |
| RPN - N (1930-0730) | 4 | 4 |

The Employer realigned the laid off RN staff to create a resource team to, in their opinion, assist with staffing needs in both the medical surgical unit and the emergency department, by decreasing the baseline RN staffing per shift on the medical surgical unit. The employers' changes to the staffing model, in September 2022 resulted in one less RN being scheduled on both the day and night shift, and an additional RPN being scheduled per shift[38].

The recent IPU staffing model changes were based on a benchmarking exercise with the intent. to meet financial obligations of the hospital while keeping quality of care at the forefront with an interprofessional care team model. The changes did not impact the overall RN FTE count, as a float pool was created with 4 Full-Time RN positions to assist with floating between CMH's

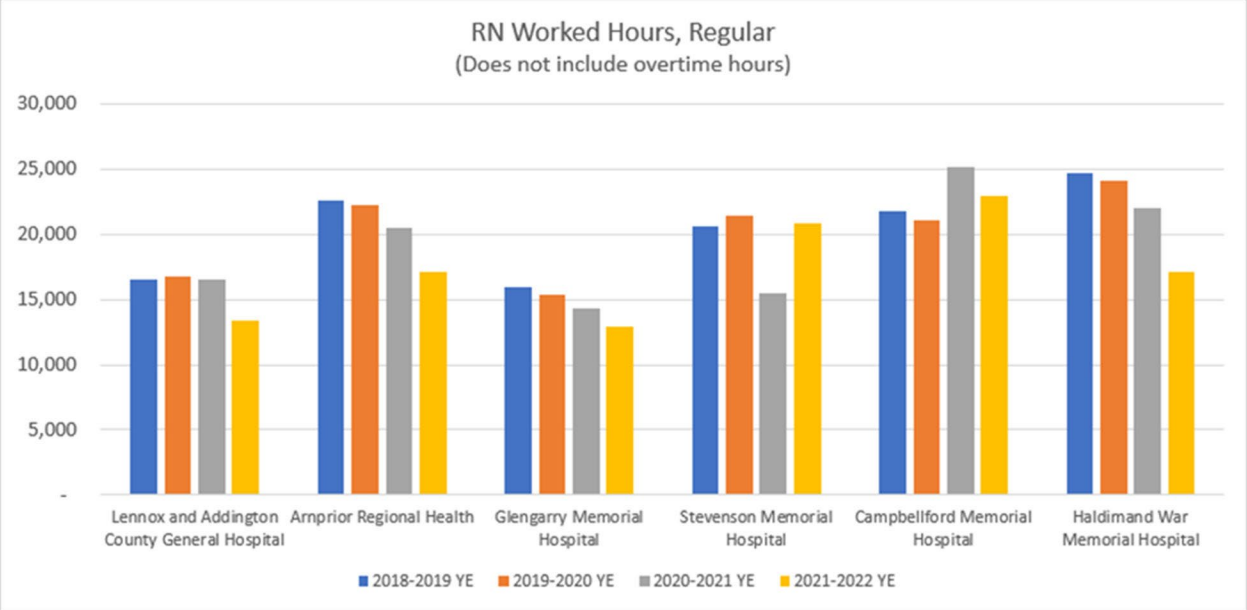
[36] RNAO Developing and Sustaining Safe, Effective Staffing and Workload Practices, 2010

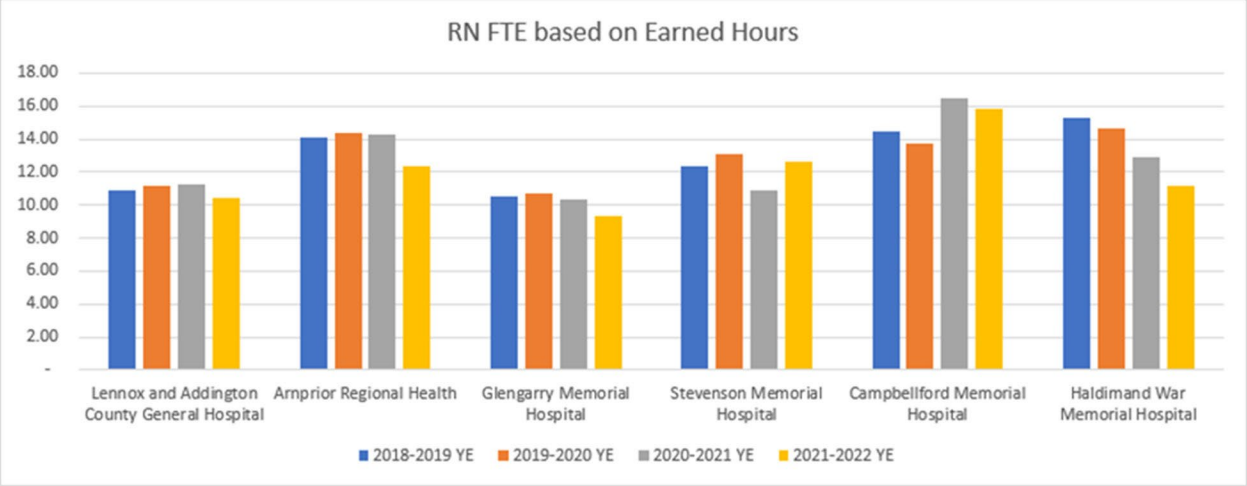
[37] ONA Brief Vol. 1

[38] CMH Disclosure Brief

clinical units[39]. Benchmarking is identified below:

RN regular hours worked grew by 5.3% between 2018/19 and 2021/22, while all other peer sites (except for Alliston Stevenson Memorial Hospital) experienced a decline in regular RN hours worked ranging from 18.5% to 30.8% over that period:




By converting the RN worked hours into FTEs, the above graph demonstrates that RN FTEs at CMH grew by 9.7% from 2018/19 to 2021/22, in contrast to an average 10.4% decrease across all other comparator sites over that timeframe.

The RN float resource pool of 4 Full time RN positions was developed as a strategy to assist with staffing across both the IPU as well as the Emergency Department. At the time of the hearing the resource float pool was staffed with 1 FT RN and the other 3 positions were vacant. In efforts to increase the opportunity to recruit RNs, CMH has recently posted 3 additional Full-Time RN positions for the IPU to offset the current Part-Time difficult-to-recruit positions.

[39] CMH Disclosure Brief

Throughout the hearing the IAC panel heard from RN staff that they were not involved in the discussions regarding the staffing model change and as such the RN's felt undervalued and felt they were unable to meet their professional practice standards as defined by the College of Nurses of Ontario (CNO). There is much literature to support that while staff may not be as familiar with alternative staffing models, frontline staff are experts in workflow challenges. As such, staff must actively participate in every step to redesign care within their workplace. CMH leadership has recently introduced both staff meetings and a nursing unit council which should serve as a place to encourage staff involvement with any existing and upcoming changes. The hospital based their decision making for the staffing changes on benchmarking data with comparator hospitals however the lack of staff involvement in the change is a contributing factor to the ongoing dissatisfaction.

Based on the review of both CMH and ONA's disclosure documents as well as staff testimonials.

**The IAC panel recommends:**

1. Dissolve the RN Float Resource Pool.
2. Reallocate the 4.0 FT RN positions (hours) to the IPU.
3. Utilizing the reallocation of the 4.0 FT RN add an additional RN to the 1900-0700 tour 7 days per week.
4. Extend the role of the Team Leader to 7 days per week 12 hours per day.
5. If reassignment of staff is required, this should be based on knowledge, skill, and judgement of the staff member.
6. If the unit is placed in overcapacity/surge additional RN staff must be called in first, if no RN staff are available then RPNs can be called in.
7. Collective agreement language must be adhered to for staff changes and scheduling.
8. Increase Ward Clerk coverage to sixteen (16) hours per day Monday through Friday.

**3. Special Care Unit (SCU)**

The IPU at CMH is funded for 34 beds and as a capacity strategy has the ability to open four (4) unfunded surge beds as required. There are 30 beds as part of the main unit and 4 beds which are identified as a Special Care Unit (SCU). It is important to note that the Special Care Unit is **not** designated by Critical Care Services of Ontario (CCSO) as a Level 2 Critical Care Unit. Patient level data from patients in the SCU beds is not inputted into the Critical Care Information system (CCIS).

The Critical Care Information System (CCIS) is a key component of Ontario's Critical Care Strategy which is overseen by Critical Care Services Ontario (CCSO). The CCIS provides near real time data on every patient admitted to level 3 and level 2 critical care units in Ontario's acute care hospitals. The system also provides information on bed availability, critical care service utilization and patient outcomes through the 'Reports' functionality. The system provides an important medium for monitoring and managing the province's critical care resources more effectively, and for highlighting opportunities to implement quality improvement initiatives at individual hospitals and across regions.

The CCIS Bed Availability Tool (BAT) automatically transfers critical care bed information to CritiCall Ontario's PHRS critical care resource screens. This information is used in real time by CritiCall Ontario agents and Provincial partners to help make informed decisions about placement of patients when hospitals experience a capacity issue (e.g., Moderate surge, Natural Disasters, Pandemic, major events, etc.), or patients need a higher level of care (e.g., 'Life or Limb'). The SCU beds are not monitored by CCIS, therefore Critical Care patients will not be transferred into these beds. The beds may be utilized if a CMH patient

condition deteriorates, and transfer is being arranged[40] As part of the hospital orientation package SCU is described as a 4-bed telemetry unit.

ONA in their Volume 1 submission states the nurses report that one RN is assigned to care for four patients in the Special Care Unit, while the second RN is assigned to the medical surgical unit. The SCU has capacity for four telemetry patients being monitored by one RN. Although the SCU is described as a step-up unit (CIHI, 2016), the acuity in the SCU is often higher and the patient population frequently has care needs that align with level two critical care criteria. There is no ICU at CMH, and the RN in SCU must manage higher acuity patient changes and for longer periods of time if a patient's condition deteriorates and they require transfer to a higher care facility. When a patient's condition declines, and the need for transfer is identified, it is the SCU RN who must coordinate and arrange the transfer while continuing to care for the patient, as well as the remaining patients in SCU.

The SCU should provide acute care to adults who may require a higher level of observation or an intervention that is not appropriate for the IPU. Patients may require frequent monitoring of vital signs or nursing interventions but do not require invasive monitoring. Patients that require a Level 2 or Level 3 critical care level of care should be transferred to a facility that provides this type of care. The treatment of these patients must be managed within the scope of practice of the admitting physician.

The unit lacks appropriate and reviewed admission criteria, often resulting in admission decisions that are unsuitable for the medical surgical unit. Higher acuity patients, with more acute and complex care needs should be transferred to other sites for admission, however, it is the comfort level of the physician or hospitalist that determines disposition of the patient. The unit staffing is not factored in the decision making and the lack of clear bed management and patient flow policies have resulted in inappropriate patients being admitted to the inpatient unit. These issues are exacerbated by the lack of adequate RN staffing and inadequate nursing skill mix[41].

The Campbellford Document Disclosure Tab F pg. 107-108[42], identifies a Special Care Unit admission policy. This policy does not identify in depth admission criteria or inclusion/exclusion criteria. The language in the policy is outdated and does not reflect equity, inclusion and consider the diversity of the population. Appropriate language is imperative to eliminate unconscious bias and increase inclusivity.

Admission criteria[43] for this type of unit may include:

- Patients over the age of 18 years requiring ECG monitoring, non invasive blood pressure monitoring, continuous oxygen saturation monitoring and/or bilevel ventilation.
- Patient must be assessed at minimum, daily by MRP/designate. Efficacy of treatment will be continuously monitored by MRP and nursing staff to determine the stability of the patient or the potential necessity for transfer to a higher level of care.
- Admitted patients will have working diagnosis, patient orders, progress notes, an estimated length of stay, and a plan of care.

The criteria for patient admission and discharge may include, but are not limited to, the following:

Inclusion Criteria: (Most Responsible Physician accountable to manage)

1. Hemodynamically stable Acute Coronary Syndrome (ACS)
2. Any hemodynamically stable dysrhythmia.

[40] CMH Disclosure Brief.
[41] ONA Submission Volume 1.
[42] Cambellford Document Disclosure Brief
[43] Groves Memorial Community Hospital Admission Discharge Criteria Special Care Unit

3. Congestive Heart Failure (CHF) without shock.
4. Hypertensive urgency without evidence of severe end-organ damage or hemodynamic instability.
5. Cardiac monitoring
6. Patients requiring short term (no longer than 2 hours without signs of improvement) non-invasive ventilation via BiPAP.
7. COPD exacerbation not requiring invasive ventilation.
8. Patients requiring closer observation post acute cerebral event. Note: Acute Stroke patients should be managed using the regional stroke pathway.
9. Any patient requiring frequent neurologic, pulmonary, or cardiac monitoring for a drug ingestion or overdose who is hemodynamically stable.
10. Diabetic Ketoacidosis (DKA) requiring frequent blood sampling and intravenous therapy, where DKA is responding to treatment in a timely manner (24-48 hours).
11. When a patient refuses a transfer to a higher level of care, they understand the limitations of the SCU and has made an informed decision for the refusal of transfer. This may include discussion with POA for Personal Care or Substitute Decision Maker for decisions when applicable.

Exclusion Criteria:

1. Hemodynamic instability requiring vasopressors/inotropes.
2. Respiratory instability not responsive to non-invasive ventilation (BiPAP, AirVo). Note: availability of Registered Respiratory Therapist role to support.
3. New acute diagnosis requiring services not offered at CMH.
4. New acute diagnosis not responding to treatment.

Special Considerations and Guidelines:

1. When deterioration in a patient's condition is predicted or is preventable only by more invasive interventions the MRP should consider a transfer of care to a higher level of care (Criteria to consider initiating transfer of care)
2. When a transfer to a higher level of care is likely to be required, the MRP will contact Criticall to assist with the transfer process; Criticall should be contacted early when clinical deterioration is anticipated.
3. Patient safety is always a priority. In the case of rapid or unanticipated deterioration, treatments for stabilization will be implemented prior to transfer to a higher level of care.

**Criteria to consider initiating transfer of care:**

Transfers to a higher level of care MUST be arranged through Criticall for all CMH patients:

- Patients requiring or who will require life sustaining interventions such as but not limited to; ventilation, inotropes, vasopressors
- Patients with a new and acute medical condition which is affecting more than one body system and cannot be safely managed within the guidelines of this policy.
- Patients with complex medical issue (s) that are not responding to intervention and/or treatment (ie: prolonged DKA >48 hours)
- Patients with medical issues that are outside the scope of the most responsible provider.
- Patients that may require multiple specialists consults not available at CMH.

The SCU is currently staffed with an RN that is ACLS certified. This RN should have the knowledge, skills, and judgement to work independently within SCU leveraging physician support. If a patient does not require the identified SCU level of care the patient should be transferred to the IPU to the appropriate bed for the appropriate level of care.

**The IAC panel recommends:**

1. Develop an SCU admission policy that identifies admission guidelines, inclusion/exclusion criteria and transfer considerations with support of the Professional Practice Lead. Stakeholder engagement should include but not limited to physicians, nursing, allied health.
2. The policy must be written in language that promotes equity, diversity and inclusivity.
3. Patient flow through SCU is a priority to ensure that there is capacity in SCU if required and to ensure the appropriate staff member is in place.
4. Ensure RN's working in SCU have ACLS certification.
5. Orientation for staff working in SCU is competency based that requires a self assessment by the employee and validation of competency is completed in collaboration with the Professional Practice Lead and/or the manager upon completion of orientation.
6. Length of orientation should be determined by the RN with support from the Professional Practice Lead and the manager based on a competency needs assessment.

**4. Clinical Support**

Research has identified four (4) types of non-nursing tasks; auxiliary, administrative, tasks belonging to allied health professionals and tasks from the medical profession.

Auxiliary and administrative are most frequent while expectations from allied health professionals and the medical profession are less frequent, however, are included in the conclusion that approximately one third of a nurse's shift is spent doing non-nursing functions. Working on a hospital medical unit that lacks resources coupled with patients who have predictable clinical outcomes may increase the occurrence of axillary tasks. [44]

The RNs on the IPU report and have documented on the PRWRF's a vast number of non-nursing tasks including but not limited to portering patients, answering the phone, collecting garbage and laundry, meal tray collection, cleaning floors, mobilizing patients when physiotherapy does not present on the unit etc. Nurses are expected to admit patients from ER in a timely fashion regardless of time of day/night, but unfilled housekeeping shifts can result in delays as nurses need to clean the bed and room for the new admission.[45]

HAC minutes dated January 12, 2021, provided evidence and the IAC heard from the RNs that housekeeping is not always replaced, and duties then fall to the nursing staff.

Bat removal should not be an expectation of registered nurses. Nursing responsibilities should include securing the area where the bat was seen and conduct patient assessments to ensure they have not been

[44] Prevalence and reasons for non-nursing tasks as perceived by nurses: Findings a large cross-sectional study Journal of Nursing Management 2021 / Volume 29, Issue 8/p.2658-2673.

[45] ONA Submission Volume III – PRWR forms June 2023.

exposed to the bat and offer reassurance. Security and maintenance staff must be notified immediately and assume the responsibility for bat and bat droppings removal.

Vacant positions in physiotherapy and clerical staff plus the difficulty covering night housekeeping shifts have all added to an increase in non–nursing tasks.

On an acute unit, Occupational Therapists (OT) play an important role in preparing patients to safely transition from hospital to home therefore decreasing the need of nurse's help with ADLs and decreasing the length of stay for some patients. With ALC patients there is even a greater need for OT to maintain strength, retraining and providing equipment that can help with ADLs.

The conclusion of one study involving nurses in sixty (60) medical and surgical units in both private and public hospitals found that professional nurses conduct many non-nursing tasks and leave several important nursing tasks left undone. The main nursing tasks left undone were comfort/talk with patients, educating patients and family and developing and updating nursing plans and pathways. Nursing tasks left undone cause the greatest degree of job dissatisfaction amongst professional nurses. [46]

The IAC panel identifies several opportunities for CMH to implement changes to reduce the performance of non- nursing tasks by RNs and thereby increase job satisfaction in the following proposed recommendations.

**The IAC Panel Recommends:**

1. All non-nursing duties require a review and appropriate resources for these non-nursing functions must be implemented within the next three (3) months.
2. Review clinical support staff positions, job responsibilities and accountabilities to ensure there is support for housekeeping, laundry pick-up, stocking of supplies and linen, and portering.
3. Training to be provided for all clinical support staff on safe patient transfers so they can assist with portering when required.
4. Replace allied health professions that are part of the IPU team (PT, Discharge Planners etc.) when off work for any reason.
5. Home and Community Care nursing/functional assessments should be completed by the Home and Community Care case manager who is on-site and can come to the IPU to complete the assessments.
6. Discharge planning assessments should be completed by the Discharge Planner who is on site and can come to the IPU to complete the assessments.
7. Consultation between nursing and pharmacy for ideas on how to improve the quality of medication rounds.
8. Pre-schedule Occupational Therapists twice weekly on IPU.
9. Provide additional training for staff on handling safe disposal of bodily fluids. Public Health Ontario: Best Practices Document Best Practices in IPAC | Public Health Ontario.
10. Replace clerical/administrative staff when off work for any reason.
11. All security staff and maintenance staff will be trained in bat/bat dropping removal, provided with proper PPE, and educated in the Bat Policy.
12. Delivery and pick up of meal trays should be completed by Food Services.

[46] Non-nursing tasks, nursing tasks left undone and job satisfaction among professional nurses Journal of Nursing Management 2015 Nov;23(8): 1115-1125.doi: 10.111/jonm12261. Epub 2014 Oct 27

**5. Glucometer Testing**

Glucose monitoring is a key factor in managing Diabetes. Advancements in glucose monitoring devices have made it easier to manage diabetes and in the prevention of hyper and hypoglycemia. Glycemic management incorporates the timing of testing, amount, and timing of medication administration, as well as the timing and amount of food intake. The usual cadence to test blood sugar is before meals, at bedtime and 2 hours after a meal if ordered. The current practice at CMH requires the lab to collect blood specimens at 0600. The results are reported to the IPU at approximately 0800. This is not ideal as nurses need to be aware of their patient's current glucose levels to administer the correct amount of insulin prior to breakfast. When a diabetic patient has been fasting overnight, a critical change in a patient's blood sugar can occur. Even with careful management, blood sugars can sometimes change unpredictably.

The Canadian Society for Medical Laboratory Science has a Point of Care Position Statement that endorses POCT and defines it as laboratory testing performed at or near the patient, outside a central laboratory environment. It is usually performed by non-laboratory health care professionals using a variety of methods which may include strips, kits, or instruments/devices. [47]

Medtek reports:[48]

**5 Important Benefits of Point-of-Care Testing (POCT)**

1. Point of care testing is faster than laboratory testing.
2. Point of care testing can be done anywhere and anytime.
3. Point of care testing can be performed by any healthcare practitioner.
4. Point of care testing is beneficial in emergency situations.
5. Point of care testing is cheaper than laboratory testing.

RNs have consistently asked for glucometer education, so they are able to provide the appropriate amount of medication such as insulin when required to their patients.

**The IAC panel recommends:**

1. Provide glucometer education to all nurses on the IPU.
2. Implement point of care glucometer testing at the bedside by nurses to provide a real time view of the blood glucose level.

**6.Patient Transfers**

CMH's submission describes the IPU as providing patient-centred care to acutely ill adult medical patients with an interdisciplinary care team. The interdisciplinary care team works with patients with acute illnesses that require admission to hospital. [49]

CMH is a small rural hospital resulting in a need for many acute services provided by specialists/clinics being performed in Peterborough or other larger centers. Transfers are either by air or land ambulance and often an RN escort must accompany the patient being transferred. These transfers can be prebooked or be required unexpectantly. Since the transfers must proceed, it is not uncommon for the Medicine Inpatient

[47] *https://csmls.org/About-Us/About-CSMLS/Position-Statements.aspx

[48] Medtek.com.ph/2022/06/03/5-important-benefits-of-point-of-care-testing-poct/

[49] CMH Submission

Unit staff to shift to accommodate the transfer. This shift means the nursing staff on the unit must take on additional patients thus leading to fragmented and interrupted patient care.

Research suggests fragmented and interrupted care can lead to increased errors and omissions. Although in some situations the transfer may not be prolonged, these transfers still exacerbate staffing shortages by requiring the removal of a nurse from the medical inpatient unit therefore reducing staffing flexibility.

A Canadian study identified that patient transfers, especially in rural areas are presenting additional staffing challenges. It was specifically found that "transfers to large tertiary centers for diagnostic testing and specialized care are often necessary because of the limited services available at the smaller hospitals."[50]

Literature regarding rural nursing has consistently described patient transfers as being especially problematic. Nurses are increasingly reluctant to go on patient transfers because these transfers are personally and professionally demanding.

Some reasons for the difficulty of patient transfers were leaving their colleagues to manage at their home hospitals with decreased levels of staffing and also the experience received when they go to the tertiary hospitals where the challenges of transporting unstable patients may not be fully appreciated by the receiving health care providers.[51]

Concerns identified on the IPU is the need to leave their patient assignment to attend on patient transfers. CMH attempts to call in additional RNs to either attend on transfer or cover for the transfer RN but often due to the last-minute call-in system, no additional RN is available. There are other incidents where the need to transfer a patient was identified at least one day prior to transfer and no additional RN support was provided by CMH. Patient transfers for consultations, testing etc. usually take place during the week on day shifts.

**The IAC panel recommends:**

1. Expand access to and utilization of the Ontario /telemedicine Network (OTN) for consultations and follow up appointments for patients to minimize the transportation of patients.
2. In the event of a patient transfer, it is imperative planning and scheduling occurs in advance to ensure nursing resources are readily available if required.

## 2. Recruitment and Retention

**1 Recruitment and Retention**

In March 2022, the Ontario Hospital Association reported vacancy rates of the 115 responding hospitals to be 8.84%. Specialty RN and RPN vacancy rates of responding provincial hospitals were even higher at 12.63%. These strains have been amplified and exacerbated by more recent shifts in the healthcare sector and labor market more broadly. Some of these trends include new opportunities for health care professionals and changing expectations for work-life balance. These trends influence the interest in bed-side nursing and shift work. Even in the best of times, the Hospital can be challenged with recruitment as it has the added difficulty of trying to entice nurses to relocate to the Campbellford area for front line roles.[52]

[50] Montour, A., Blythe, J., Hunsberger, M. The changing nature of nursing work in rural and small community hospitals. Rural and Remote Health. (2009) at 8

[51] Hunsberger, M., Baumann A., Blythe, J., Crea, M., Sustaining the Rural Workforce: Nursing Perspectives on Worklife Challenges. The Journal of Rural Health. (Winter, 2009) at 21.

[52] CMH Briefing Note June 2023 p. 25-28

When turnover occurs, the challenge for the Hospital is that departing staff typically provide only two weeks' notice, but to post, recruit and provide orientation of at least thirteen shifts to replace this vacancy can take months. Timelines to fill vacancies have been exacerbated by the current labor market conditions. In addition to the length of time it takes to replace transfers or resignations out of the unit, the temporary vacancies (e.g., maternity/pregnancy/parental leaves) and unplanned incidental absences (e.g., illness and other emergencies) contribute to the staffing challenges. During the height of the pandemic (fiscal 2020-21 and 2021- 22), sick usage and overtime rates were much higher than normal. [53]

With the current health human resource crisis, it has been difficult to recruit into the float pool as intended and only 1 position has been filled to date. Ongoing recruitment is occurring and there is some potential to hire NGGI's into the float pool lines. In efforts to increase the opportunity to recruit RNs, CMH has recently posted 3 additional Full-Time RN positions for the IPU to offset the current Part-Time difficult-to-recruit positions.[54]

The RN turnover on the medical surgical unit has been significant, as has the turnover of other regulated and unregulated staff. Since 2017, there has been an almost 400 per cent turnover of part time RNs, 200 per cent turnover of full-time staff and more than 50 per cent turnover of casual RN staff. According to the RNs, 16 part time RNs have left PT status, three assuming a casual position, the remainder leaving the organization, 23 full time RNs have left FT status (17 left the organization and 6 of them changed status to casual). The vacancy report data provided by human resources has often been inconsistent and inaccurate. Since October 2022 there have been unfilled vacancies related to maternity and other leaves of absence, as well as resignations from the organization (Exhibit 44).[55]

Information shared with ONA through the hospital's draft Talent Management Plan (Exhibit 48) revealed several gaps related to actions or lack thereof, for recruitment and retention. Specifically, some gaps highlighted inaccurate job postings, incomplete validation of qualifications, unmet new hire check-ins, inadequate mentorship opportunities and a lack of psychological health and safety program. Discussions at the February 21, 2023, HAC meeting attended by the LRO and the Bargaining Unit President, addressed issues of recruitment and retention, the new staffing model and utilization of the Nursing Graduate Guarantee Program (NGG) however the employer reported they were unable to recruit into the NGG program (Exhibit 27). [56]

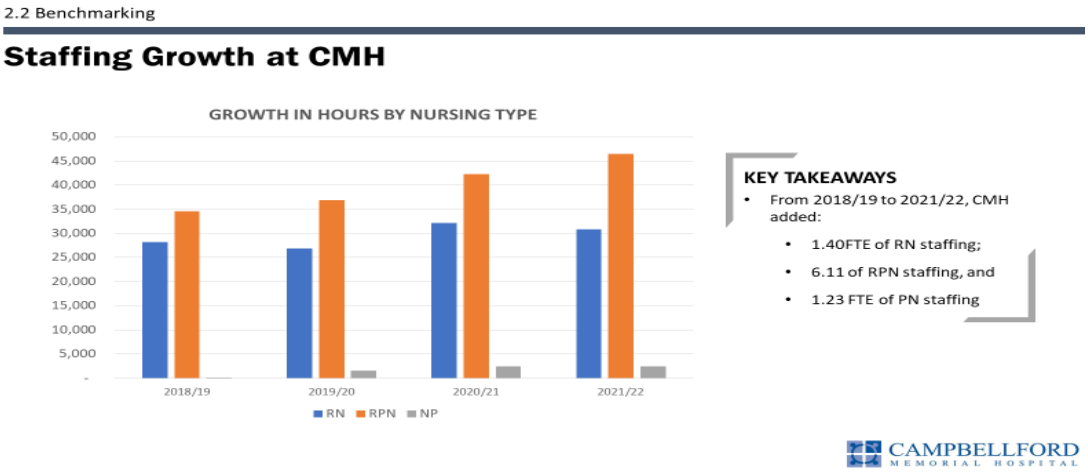
During the Covid–19 Pandemic it became clear that all healthcare workers were experiencing tremendous levels of physical and emotional stress. The nurses who were struggling and feeling overwhelmed needed their employers to provide as safe an environment as possible and psychological safety support. The IAC heard several testimonials from RNs that did not feel safe nor supported by management at CMH and have resigned or decreased to casual employment. York Regional Public Health had great success with supporting and retaining staff after implementing a Trauma –informed Organizational Capability Approach.

CMH has employed a skill mix as a strategy to support the IPU staffing model given the challenges in recruiting RNs. This has not been as a replacement strategy for RN positions, but to support the RNs in their work and to ensure all team members are working to full scope of practice.

CMH increased RPNs to the clinical care model to support inpatients in a collaborative care model when acuity dictates. As a result of these changes, over the last several years the Hospital has seen RPN hours

[53] CMH Briefing Note June 2023 p. 25-28
[54] CMH Briefing Note June 2023 p.25-28
[55] ONA Brief Volume I June 2023 p. 46
[56] ONA Brief Volume I June 2023 p. 47

increasing at a faster rate than RNs. These additional hours have been added to support the RNs to offload certain tasks. This is demonstrated in the below chart: [57]




CMH has been struggling with the same Health Human Resource (HHR) challenges as all healthcare organizations, and this is demonstrated in the increasing overtime use since the start of the pandemic. The overtime usage at CMH is higher than the usage at peer hospitals which the Hospital attributes to use of sick leave and pregnancy/parental leaves. CMH is isolated and the cost of living in the area has risen sharply over the course of the pandemic making recruiting challenging. CMH currently supports nurses with both courses (tuition) and clinical hours (salary) to achieve the base preparation for the IPU department as a successful recruiting initiative. [58]

**Recruitment and Retention Strategies[59]**

In response to both the ongoing shortage of HHR and the increase in capacity in the Healthcare System to respond to pressures created by demographic shifts and the pandemic, CMH has invested into advertising and marketing to help position itself as a preferred choice for healthcare workers. In addition to attempting to attract active healthcare workers CMH has focused its engagement with the next generation of healthcare with presence at job fairs and increasing student placements, all with a view to identifying, developing, and hiring students as the next generation of CMH team members. CMH has made the following investments:

- Recruitment bonus of $7500 offered.
- Reimbursement of up to $1500 in relocation and moving expenses.
- Referral bonus program offering up to $3000 for hard to recruit positions.
- Participant in the Community Commitment Program for Nurses (CCPN), which provides up to $25,000 in grant funding to eligible Nurses in return for a two-year commitment of service.
- Designated community and participant in the Canada Student Loan Forgiveness for Nurses of up to $4,000 per year to a maximum of $20,000 over five years.
- Strategic over hiring and adjustment of nursing staffing ratios to 80/20 FT to PT positions.
- Participant in the Enhanced Extern Program
- Participant in Supervised Practice Experience Partnership (SPEP) with the College of Nurses of Ontario

As of August 2022, there are several initiatives that have been put in place to support existing staff. These include:

[57] CMH Briefing Note June 2023 p.25-28
[58] CMH Briefing Note June 2023 p.25-28
[59] CMH Briefing Note June 2023 p.25-28

- Engaging and supporting staff that would like Mentoring Opportunities
- Developing an enhanced Onboarding and Orientation program for New Staff
- Informal daily check-ins
- Regular and formal check in meetings with new staff beginning at 14 days.
- Review, Revision and Education of Required Operational Practices
- Ongoing promotion and tracking of Incident Reports
- Ongoing 90 Day Engagement Plans (implemented prior to August 2022)
- Performance Appraisals
- Attendance Support Program
- Thank You/ Recognition Cards
- Weekly huddles and huddle highlights
- Quarterly Staff Meetings
- Department Scorecards
- Manager Engagement in Unit Council
- Promotion and support to attend education opportunities, for example: Wound Care, Stroke Education Conference, ACLS RNAO Webinar and Online Courses, Ontario Shores, Ontario Tech Micro Credentialing
- Promoting in-house education
- Let's Talk About… Series.
- Trivia Tuesdays/Thursdays
- CMH "Guest" Speakers - Josh Landry – Ethicist, Dr. Parks – Palliative Care Primer

**The IAC panel recommends:**

1. Update CMH's recruitment section on their existing website to reflect all of the initiatives that are currently being implemented to recruit nurses.
2. Exit interviews for all nurses who leave the department/hospital as well as those who change their working status. These interviews to be conducted by the Human Resources Department.
3. Ensure Recruitment and Retention is an ongoing agenda item at all Hospital Association Committee meetings.
4. Continue to encourage ongoing professional development through financial support and paid time (where possible) as a recruitment and retention strategy.
5. Create collaborative opportunities with staff input to help make the department a success in retaining staff.
6. The manager ensures an adequate number of skilled staff are scheduled on each shift including Agency nurses. The manager to meet with the Team Lead each morning to review the anticipated staffing and associated patient assignment implications for the next 24 hours and make a joint decision. Friday morning discussions would include a review of the weekend.
7. Explore the *Learn and Stay* grant being offered in Ontario[60] to determine if there are other recruitment and retention strategies that could be employed at Campbellford Memorial Hospital.
8. Manager or Educator to send an e-mail to casual RNs for the education sessions that are happening at CMH on a weekly basis.
9. Manager to meet with casual RNs individually on an annual basis to investigate any opportunities to increase their availability and to make sure they are aware of the options that are in the Collective Agreement i.e. weekend worker.
10. Request RNAO to provide CMH with the educational webinar: Supporting workforce mental health in the face of adversity: A trauma – informed organizational capability approach.

[60] Innovating health care — transforming the role of nurses (canadian-nurse.com)

11. Establish a Registered Nurses Recruitment and Retention Committee made of local residents, local business professionals, and RNs that is a source of community information to potential recruits and a welcoming committee for new hires. This committee would establish community partnerships to support travel, accommodations and other supports required to become established within Campbellford i.e.: childcare, schools etc. The goal is to ensure the RNs feel like a valued member of this community and to make their family's move as smooth as possible.

**2.Clinical Externs**

**Clinical Externs**

The Enhanced Extern Program (EEP)[61] sponsored by the Ministry of Health in 2021, is another excellent recruitment and retention strategy CMH continues to support. Externs are clinical learners who are employed as unregulated care providers to work under the supervision of regulated care providers. Types of eligible clinical learners includes those in nursing, respiratory therapy, medicine, physiotherapy, occupational therapy, and paramedic programs. Each organization is required to determine how Externs can be incorporated appropriately to best support workflow and patient management. Wage and salary expenses for Externs and Extern Mentor/Coordinators will be eligible for reimbursement through the COVID-19 incremental expenses process.

To date CMH has had one (1) RN student expression of interest and for 1 additional extern.[62]Clinical Externs at Campbellford Memorial Hospital are students within a health studies program nearing the end of their education who are supported by a supervising regulated professional and work as unregulated health care providers to assist in providing patient care. [63]

ONA indicated in their brief that CMH did not have a job description for the Clinical Extern. CMH has a draft job description for the Clinical Extern position. [64]

**The IAC panel recommends:**

1. Continue to advertise for the role of the Clinical Extern including promoting this role at community colleges and universities.
2. Continue to seek ongoing funding support from the Ministry of Health for the Enhanced Extern Program as a means for recruitment and retention of nurses at CMH.
3. Finalize the draft job description of the Clinical Extern immediately.
4. Ensure there is an orientation program for the Clinical Extern and mentor within three (3) months.
5. Develop an evaluation process for the Clinical Extern in collaboration with the Nurse Manager, Nurse Educator, and mentor.
6. Ensure an exit interview is performed with the Clinical Extern upon completion of their assigned time with CMH.
7. Develop a posted schedule that works for the Clinical Extern and the IPU.

[61] https://www.oha.com/Bulletins/Enhanced%20Extern%20Program%20Guide%204.0%20October%202021.pdf
[62] CMH Brief June 2023.
[63] CMH Brief June 2023 p. 24.
[64] CMH Document Brief June 2023 p.68

### 3. Agency Nurses

**Agency Nursing Staff Recommendations**

Given today's health human resource demands, many health care facilities have had to rely on numerous strategies to provide patient care. One such strategy is the utilization of agency nurses. Based on current research, it has been well documented agency nurses are not effective substitutes for permanent, experienced registered nurses in terms od patient safety. [65] This study concluded agency RNs have no significant impact and therefore should not, at the margin, be treated as effective substitutes for experienced permanent RNs.[66]

Agency RNs have been utilized on the medical/surgical unit at Campbellford Memorial Hospital under a full-time contract since Fall 2022 and will expire September 2023. Agency nurses continue to be employed. When RN staff vacancies are unable to be filled or when their contract with the agency dictates the employer utilizes agency staffing. The RNs report, the employer's contract with a staffing agency commits them to providing full time hours for agency staff. The CMH RNs report this has resulted in agency RNs being the only RN staffing on a shift, being placed in the Charge RN role and in the SCU. It has also resulted in CMH RN staff not being scheduled. [67]

CMH's contract with their current agency has developed a process for how they book agency staff. Once the schedule is posted, all the vacant shifts for that posted schedule gets added to Vocantas. CMH staff can bid on all the shifts available including casuals, part-time, full-time at straight and overtime. After 48-72 hours, agency staff are then booked to fill in the vacancies two (2) weeks at a time. If there are still vacancies after booking agency staff, these vacant shifts get sent out to CMH staff and they are offered double time. If there are any sick calls or unexpected call-ins, then the shift is offered at straight or double time even if there are extra agency staff on. The agency agreement is to hire for full time hours in three-month increments and CMH is responsible and accountable to train, supervise and protect health and safety of agency staff. [68]

On April 15, 2023, the PRWRF submission identified the unit to be short staffed by three RN staff, and a ward clerk. No ward clerk replacement was provided; however, the three RN vacancies were replaced with three agency RNs. None of the agency RNs were familiar with CMH, the unit, or their policies and procedures, however they were required to support the unit, fulfill the charge RN role, and assume care for patients in the SCU. The RNs also reported following the April 15, 2023, night shift, that the RN staffing for two consecutive shifts had been only agency RN staff. There were no regular CMH RN staff scheduled on either shift. On the night shift, one agency RN was assigned the CN role and the second agency RN was completing their first shift on the unit. There was no ward clerk scheduled to assist on the unit on either shift. The RN from the previous shift wrote she felt unsafe giving report to only agency RN staff, with junior RPN staff working and no other supports available. The new agency RN was also a new graduate RN and was assigned to the SCU. The new RN reported a lack of knowledge and training, a lack of experience using the documentation system (EPIC), the medication system Automatic Dispensing Unit (ADU), and being unable to interpret telemetry monitoring. The RNs reported to management the issues, and the agency RNs were advised to reach out to ED for support if needed. The agency RN staff reported they were unaware how, in the event it was required, to transfer a patient to a regional hospital. The CMH RN relayed to ONA, the moral distress experienced by having to assign and instruct an RN without the required knowledge, skill, and

[65] Nurse staffing and inpatient mortality in the English National Health Service: a retrospective longitudinal study. BMJ Qual Saf 2023:32:254-263. https://qualitysafety.bmj.com/content/qhc/32/5/254.full.pdf[65]
[66] Nurse staffing and inpatient mortality in the English National Health Service: a retrospective longitudinal study. BMJ Qual Saf 2023:32:254-263. https://qualitysafety.bmj.com/content/qhc/32/5/254.full.pdf[66]
[67] ONA Brief Volume I p. 44-47. June 5, 2023.
[68] CMH Presentation Submission. June 29, 2023.

judgment to care for the patient. The RNs on the medical surgical unit reported to ONA the agency RNs were unfamiliar with hospital policies and many junior RPNs were working on the shift, further exacerbating the available patient supports and resources.

A PRWRF was submitted on April 16, 2023, by the CMH RNs following the two shifts reported above. The documentation in their PRWRF identified vital patient information and documentation was missed during transfer of accountability by the outgoing agency staff, including patient care plan data, admissions and discharges pending. CNO (2022) highlights the significance and importance of information transfer during "report" or "handover" as a crucial component of the care transition process and key to maintaining patient safety. The risk for miscommunicating client information during transfer of care is high, and increased when care providers are unfamiliar or have not received adequate orientation or training. Agency usage data provided by the employer in January 2023, indicated that CMH had utilized 19,695 hours of agency RN staffing between July and October 2022, the equivalent of 10 FT RNs per year (Exhibit 48).[69]

In a recent article published by CBC news, that earlier this year, the provincial government passed a bill that will limit the use of health-care staffing agencies, with a goal of banning hospitals from using them by the end of 2025.[70]Research into the use of contracted nursing workers, assessed agency use in 605 medical and surgical nursing units at 166 hospitals in the United States and found that the utilization of contract nurses was strongly associated with higher hospital-acquired pressure ulcers (Ferguson et al., 2020). Poor work environments, such as those with lower nurse to patient ratios, and/or high rates of part time and casual nursing workforce contribute to increased overtime, sick time, and agency use, all of which contribute to increased health care costs. [71]

Agency nurses are paid higher salaries than hospital employed nurses, and yet are seen as less efficient and require more support in their practice (Jeffs et al., 2015). In addition, RN staff working alongside agency staff are discouraged and demoralized when their organization would rather utilize more expensive but less effective resources. Their employer has failed to stabilize their own staffing model by providing appropriate support and resources that are in the best interest of patients and staff.

Errors are often the result of multiple ''system'' factors within an organization and temporary staff may be especially vulnerable to these system errors. Temporary staff are often not familiar with permanent staff, care management systems, protocols, or procedures. Thus, they may be at risk for ineffective communication and teamwork, difficulty retrieving medical information, and being unaware of what procedures to follow (Pham et al., 2011). A knowledge deficit or not following a protocol was a reported cause in nearly half of all medication errors made by temporary staff (Pham et al., 2011). Additionally, temporary staff may have gaps in knowledge related to the most current information, as they typically self-manage their own continuing education and are usually not included in hospital continuing education services (Pham et al, 2011). [72]

CMH regularly assigns agency RNs to the charge role on the medical surgical unit. A PRWRF submitted on March 19, 2023, reported the agency RN assumed the charge role, as the scheduled CMH RN was not orientated to the charge role. Management has since oriented all CMH PT and FT RN staff to the CN role. Agency staff are also listed on the posted schedule however they are not oriented to charge. In the above

[69] ONA Brief Volume I p. 44-47. June 5, 2023.

[70] CBC News May 12m 2023. https://www.cbc.ca/news/health/cost-nursing-agencies-1.6839273

[71] ONA Brief Volume I p. 44-47. June 5, 2023.

[72] ONA Brief Volume I p. 44-47. June 5, 2023.

situation, the agency RN accepted the charge report as it was the best solution, of two poor choices (Exhibit 49). [73]

In addition to this, an RN anonymously wrote in ONA's survey (Exhibit 26) that *"Because of the staffing issues there is sometimes only one RN working or only one RN that is SCU qualified. Because of this I rarely get more than one break a day, which does not allow me to properly rest, affecting the quality of care I provide to my patients. With some shifts only have Agency staff on, it affects the safety of patients, as they do not know hospital policies, procedures, who to contact in case of an emergency, or how to transfer out an acutely ill patient."* [74]

**The IAC panel recommends:**

1. Continue to actively recruit RN positions to fill vacancies and over hire RN positions to decrease the utilization and/or eliminate the use of agency nurses.
2. Explore other staffing strategies like weekend workers, and job-sharing positions to recruit and retain staff.
3. Review the agency staffing contract utilizing ONA's Collective Agreement Article 10:12 (b) & (c) prior to the September 2023 contract renewal to ensure requirements are met. Upon this contract renewal it is recommended to propose a decrease in the amount of incremental time that is required to post in advance for fill full-time hours for agency nurses.
4. Create an orientation program with nursing input for the agency nurses to ensure all aspects of the Medical/Surgical Unit is covered for quality and safe patient care.

## 3 Healthy Work Environment

### 1 Health and Safety

Health and Safety issues and concerns were a dominant theme throughout the ONA submission and the IAC hearing. These included concerns reported on the unit tour, the Joint Health and Safety Committee (JHSC) minutes, ONA's Health & Safety Specialist report titled "Urgent Concerns at Campbellford" (ONA exhibits, Tab 90) and vocalized on the third day of the hearing by the Registered Nurse's testimonies.

Under an Internal Responsibility System (IRS), all employees, supervisors and employers are legally responsible for health and safety in the workplace. The JHSC audits the activities of the IRS by analyzing all data collected from accident and incident reports/reviews and workplace inspections, to assess if the IRS is functioning well. Unfortunately, at CMH the IRS is not functioning well and the JHSC cannot function as it should by auditing and providing recommendations since often the data they require is deferred and JHSC meetings cancelled.

The Occupational Health and Safety Act requires employers in Ontario to assess the risks of workplace violence and harassment and develop a policy and prevention program. The Public Services Health & Safety Association (PSHSA) is assigned as the lead in Ontario, in establishing the Workplace Violence Prevention in Health Care Leadership Table, to better protect health care professionals. The PSHSA has developed a five (5) step process to Building Your Workplace Violence Prevention Program that follows the Occupational Health & Safety Act (OHSA). An important first step is securing senior management commitment and employee involvement.

[73] ONA Brief Volume I p. 44-47. June 5, 2023.
[74] ONA Brief Volume I p. 44-47. June 5, 2023.

Health and Safety throughout CMH should be analyzed and reviewed by the JHSC. The JHSC committee should be reviewed including terms of reference, membership, education for members as well as defined roles, responsibilities, and accountabilities. The IAC committee recommends that the CMH JHSC utilizes standards from external agencies such as PSHSA's directives, toolkits, and webinars as a Resource.

**The IAC panel recommends:**

1. The IAC panel recommends that the CMH JHSC utilizes standards from external agencies such as PSHSA's directives, toolkits, and webinars as a resource for rebuilding the committee.
2. The JHSC meets every two months and as necessary for critical incident debriefs etc. Accident data & analysis and the workplace violence report should be a priority at every meeting and not deferred.
3. Workplace Violence Prevention Program should be reviewed with feedback from the JHSC prior to finalization. This should be completed by November 30, 2023.
4. CMH should complete a security coverage gap analysis to identify areas of opportunity. These results to be shared with the JHSC for forward planning.
5. CMH to increase to Level 3 for security guards and implement the healthcare security guard training checklist found in the Security Toolkit by PSHSA.
6. A Level 3 security guard is recommended for one-to –one observation of violent patients as determined by the JHSC.
7. Paid mandatory non-violent crisis intervention education to be provided to all nurses annually.
8. CMH must adhere to the OHS Act, including a worker representative must be in attendance to investigate cases in which a worker is critically injured.
9. JHSC to review to provide the PSHSA Formal Personal Safety Response System toolkit and provide suggestions on the need to incorporate the personal alarm as part of a system and not merely a device.
10. JHSC to review the PSHSA Formal Emergency Response to Workplace Violence (Code White) tool kit. The toolkit will provide guidance on the evaluation of current code white responses to violence in the workplace but also provides resources and information that can be incorporated into CMH's existing policies.
11. Personal alarms must work in all areas of CMH and until this can happen a security guard must accompany any nurse or nurses to the basement and back to the unit.
12. The tub in bathroom at end of Ranney Gorge hall to be removed.
13. The bathroom doors that open out will have the door handles replaced with knobs to prevent the two doors from locking together.
14. A key to the patient bathrooms will be provided and kept in a secure location at the nursing station.
15. The JHSC add an RN from the Medical Surgical Inpatient unit to its worker membership and add the CNE also.
16. CMH should integrate health, safety, and wellness into the organization's core business through PSHSA's Health and Safety Management System (HSMS). When successfully implemented, it leads to a positive culture of health, safety, and wellness.
17. Ensure all CMH leadership including Team Leads/Charge Nurses complete supervisor training as determined in the Occupational Health and Safety Act.
18. CMH has a general duty to co-operate with and help the JHSC to carry out its functions under the OHS Act [clause 25(2)(e)]. The employer is also required to:
    - provide any information that the JHSC has the power to obtain from the employer.
    - respond to JHSC recommendations in writing (subsection 9(20))
    - give the JHSC copies of all written orders and reports issued by the Ministry of Labour, Immigration, Training and Skills Development inspector.

- report any workplace deaths, injuries, and illnesses to the JHSC (subsection 52(1))

19. CMH must also advise the JHSC of the results of an assessment of risks of workplace violence [section 32.0.3]and provide the results of any report on occupational health and safety that is in the employer's possession [clause25(2)(1)]

**2 Critical Incident Debriefing**

The RN staff have reported during hearing testimonies as well as through PRWRFs feeling burnt out, overwhelmed, unsupported by their leadership team, feeling unsafe and unable to meet CNO standards. The reality of being a rural and remote hospital, the escalating provincial wide nursing shortage, along with multiple nursing and HR leadership changes at CMH have created a significant degree of instability for nursing staff. These issues in place long before the pandemic was made worse with the impact of the COVID 19 pandemic.

Heavy workloads and low morale go hand in hand in the nursing profession. Research shows that heavy workloads contribute to job strain, with short term increases in productivity leading to long term health costs. Nurse stress may lead to poor judgement that can hurt patients and contribute to negative outcomes. As cited in the 2001 report Commitment and Care: The Benefits of a Healthy Workplace for Nurses, "Nurses in most clinical units in Ontario, particularly nurses in emergency and medical surgical units work at intensities that could harm their health. The study noted an almost perfect correlation between the hours of overtime worked and sick time (Baumann et al., 2021)."[75]

The same 2001 report Commitment and Care discussed nurses quitting their jobs because they were physically and mentally exhausted. The 2005 National Survey of the Work and Health of Nurses (Shields and Wilkins 2006) found that among 19,000, 9% experienced clinical depression during the previous year – higher than the general population. Close to 20% reported that their mental health had made their workload difficult to handle, and just over 10% had taken time off for their mental health. Fast forward to 2019 to the survey conducted by the Canadian Federation of Nurses Unions (Stelnicki et al.2020). As reported the results are startling, with high numbers of nurses screening positive for a mental disorder, high rates of suicidal behaviours and burnout (Stelnicki and Carleton 2021). All of this was before COVID-19 even arrived in Canada. [76]

Nurse leaders have the potential to dramatically impact nurse well- being by shaping the day-to-day work life of nurses, setting the culture and tone of the workplace, developing and enforcing policies, and serving as excemplars of well-being (Ross et al., 2017). Nurse leaders have a responsibility to create a safe work environment with a culture of inclusivity and respect, and to implement and enforce strong policies to protect nurses. In particular, nurse leaders must be skilled in recognizing signals of toxicity and strategically responding to them (Rutherford et al.,2019). [77]

There is a need for a culture change to foster effective communication and collaboration towards joint and mutually agreed resolutions. An important part of the process is a clearly identified nursing authority within the organization. This individual plays a crucial role in ensuring that the nursing team can effectively carry out its duties and provide the best possible care to patients. Ultimately, responsibility for timely resolution

[75]Commitment and Care: The Benefits of a Healthy Workplace for Nurses, Their Patients and the System

[76]Longwoods com., Acknowledging the Hidden Tsunami; Nursing Leadership 34(2) June2021

[77] National Academy of Medicine; Committee on The Future of Nursing 2020-2030; Flaubert JL, Le Menestrel S, Williams DR, et al., editors. Supporting the Health and Professional Well Being of Nurses -The Future of Nursing 2020-2030: Charting a Path to Achieve Health Equity. National Academies Press (US) May 2021.

to the practice and workload concerns raised by nurses lies with the nurse who holds the highest level of authority within the organization, which is the CNE.

At CMH the CNE has changed frequently from person to person over the past few years. The inconsistent leadership at CMH has resulted in a continuing erosion of staff resources, staff morale and staff commitment to the organization. The revolving leadership also contributes to negativity and a toxic workplace environment.

An area of concern articulated by RNs in the IPU during Day Three (3) of the IAC Hearing was the lack of proper follow up on critical incident debriefing by leadership related to critical incidents staff experienced within the Medical IPU.

A Critical Incident (CI) is defined as "any situation or event faced by emergency or public safety personnel (responders) or individuals that cause distressing, dramatic or profound change in their physical appearance or psychological functioning. CIs also may initiate the crisis response within those who are involved. Examples of Cis include sudden death, work-related injuries, suicide of a colleague, a mass causality incident, events involving children, or events in which the victim is known to the personnel. Cis may be different for everyone. What is a CI to one person may not be a CI to another person involved in the same situation. Stress can be defined as any nervousness, tension, conflict or anxiety".[78]

It is fundamentally important for the IPU staff to be provided a forum for critical incident debriefing coupled with the professional resources and support required for staff to have the opportunity to share their stories and the impact this has had on them in a timely manner.

The positive impact of creating and sustaining a healthy work environment (HWE) is well documented. To be a HWE, the following six (6) components must be in place:

- skilled communication,
- true collaboration,
- effective decision making,
- appropriate staffing,
- meaningful recognition, and
- authentic leadership

Meaningful recognition is a low-cost, high-impact strategy associated with job embeddedness and engagement in the workplace. It is an important component of a HWE and a good starting point for organizations to create environments of practice that attract and retain nurses. To effectively use this strategy, congruently in what is valued as meaningful recognition should exist between nurses and the organizations that employ them. Identifying what meaningful recognition is to nurses can optimize its impact on our nursing workforce, the patients they critical care for, and the nursing profession.[79]

The IPU RNs report overall feelings of being unsafe at work, fatigue, and burnout, coupled with feelings of helplessness and professional distress when denied the ability attend and be heard at CI debriefs, when they do happen on the unit.

[78] November2016 VOLUME 42: ISSUE 6 WWW.JENONLINE.ORG

[79] C.D. Sweeney, & R. Wiseman (2023) Retaining the Best Recognizing What Meaningful Recognition Is to Nurses as a Strategy for Nurse Leaders JONA Volume 53, Number 2, pp81-87.

The RN members on the Joint Health and Safety Committee (JHSC) also have difficulty getting access to critical incident debriefings as well as employee accident information and investigations. The JHSC met three (3) times in 2022 and again in January of 2023; the Accident Data & Analysis was deferred at all four (4) meetings and the Workplace Violence Report was deferred at two (2) out of (3) meeting in 2022. The JHSC minutes from June 22, 2022, records the Workplace Violence Report as deferred but under New Business the staff reps brought up that a debrief that happened on the IPU, had not included any staff members of the JHSC and did not involve the staff from the lab, who was also witness to the event. This concern was to be taken back to the Senior Team. There is nothing noted in the later JHSC minutes of a reply from Senior Team. The January 2023 JHSC minutes notes two (2) incidents of patient to worker violence dating back to August 2022 and December 2022 and neither had an investigation attached.[80]

The IAC believes a cultural change is essential to foster a collaborative workplace environment is essential to improve staff morale, job satisfaction, patient and staff safety and the overall workplace environment.

**The IAC panel recommends:**

1. Within the next 3-6 months CMH develops in collaboration with the CNE and JHSC a Critical Incident Debriefing Process with the appropriate resources and tools to support IPU staff following a critical incident.
2. Establish a Peer Support Network for Critical Incident Debriefing for staff.
3. Within the next 3-6 months CMH to provide education to the Unit Manager and Team Leads to initiate a Critical Incident Debriefing process with staff immediately following a critical incident.
4. CMH to abide by the Occupational Health and Safety Act and the Collective Agreement and ensure union members of the JHSC are present to investigate staff critical incidents and report on them.
5. When a critical incident involves ONA members in any way (witness, victim etc.) then an ONA JHSC member should be present for the debriefing session.
6. Implement psychological health and safety standards to promote the employees' psychological safety within CMH.

# 4 Training and Orientation

**Training and Orientation**

As the nursing shortage continues to grow and the experience complexity gap is widening, it is even more imperative today to create a healthy work environment where nurses feel supported with an engaging orientation program to the organization and program with which they have been hired. A highly effective and well-defined orientation program can inspire a positive attitude and help new nursing staff demonstrate competence in nursing care. As nurses learn, nursing competence will lead to improved quality of patient care and satisfaction of both patients and nurses.

During the IAC hearing, staff testimonials and shared lived experiences described the lack of continuity and consistency of training and orientation, lack of a Nurse Educator, lack of a structured and competency-based program, and how this has impacted their ability to be well prepared to work safely and competently in the IPU.

A well-developed orientation program provides newly hired nurses with concise and accurate information to bring more comfort in the new role, encourage employee confidence, improves communication, help new employees adapt faster to the job, contribute to a more effective, productive workforce which improve

[80] ONA Supplemental Evidence; Tabs 67-70

employee retention (Kothari, 2018).[81] A comprehensive orientation program also supports nurses knowledge, knowledge application, competency, experience, therapeutic relationships, clinical judgement and critical thinking skills.

The College of Nurses of Ontario emphasizes the importance of a "nurse's ability to use her/his knowledge, skill, judgment, attitudes, values and beliefs to perform in a given role, situation and practice setting" (2018a, p. 5). All nurses are responsible to enhance their practice by expanding beyond the foundational knowledge they acquire during formal education. In the medical surgical unit at CMH, the RNs have reported on 24 PRWRFs significant concerns related to the lack of educator support, inadequate orientation and training, and their inability to provide quality and effective mentorship to novice RN staff. The RNs have recommended in their PRWRFs the importance of developing a fulsome and well-rounded education and training program to enhance their skills and support them to deliver safe, quality patient care. During the current nursing shortage crisis, it is imperative for all health care organizations to invest in effective and quality professional development opportunities to attract and retain new nurses. "Healthy work environments are ones that recognize the importance of a nurses' professional development to career satisfaction" (Price, 2017, p. 10). [82]

Although the employer has established a general orientation program with training for some core skills such as blood transfusions, wound care, stroke protocol, emergency preparedness and NVCI (Exhibit 53), the RNs report that the curriculum is inconsistent for every new hire. The RNs report that only one day is given for EPIC training and the remaining education is provided by their mentor during buddy shifts with the RN. The recent model of care change has led to substantial RN turnover, dramatically impacting the balance of RN skill mix of novice to expert. A PRWRF from March 22, 2023, the RN reported her inability to adequately support the orientation of a newly hired RN due to short staffing. The significant impact of the loss of highly skilled RNs on this unit is evident in the RNs inability to support and safely oversee and coach new and novice staff on the unit. The impact of insufficient orientation and mentorship is resulting in new RNs being delayed in completing patient assessments, medication administration and documentation. Novice RNs report feeling under prepared to practice on the unit due to lack of proper education and feel unsupported by management. They report feeling frustrated in their inability to advocate, facilitate and provide timely care to their patients. [83]

The Canadian Nurses Association has developed and maintained "The Medical-Surgical Nursing Exam List of Competencies" which includes an array of skills required to perform the work of a medical surgical nurse (2015). CMH has developed a similar list titled "Acute Care Practice Assessment" (Exhibit 14), which integrates concepts of Benner's Theory of Novice to Expert, with an adaptation of CNA's List of Competencies, however, there is a lack of consistency with the application of this tool. RNs have reported they have not been given the opportunity for self-assessment to determine their proficiency according to Benner's Theory. RNs reported that they have never seen this document before. The union has recommended the employer take deliberate steps and make a concerted effort to implement the CNA's Medical Surgical Nursing Competencies into their clinical orientation for RNs. [84]

The Clinical Educator position has been vacant since the end of 2020 at CMH however, this role has been filled to support training and orientation.[85] The IPU has an extensive and comprehensive orientation program for newly hired nurses that provides 22.5 hours of general orientation that includes 7.5 hours of corporate

[81] https://implementationscience.biomedcentral.com/articles/10.1186/s13012-017-0700-y

[82] ONA Brief Volume 1 June 2023.
[83] ONA Brief Volume 1, June 2023.
[84] ONA Brief Volume 1, June 2023.
[85] CMH Presentation June 26, 2023.

orientation, core education and EPIC orientation inclusive. Nurses then receive an additional 96-120 hours of IPU specific orientation. Of note, this can be extended upon request based on the needs of the individual nurse.[86]

**The IAC panel recommends:**

1. Develop a competency-based Medical/Surgical orientation program with the Nurse Educator, Nurse Manager, and staff input within three (3) months.
2. Develop a competency-based orientation for the Special Care Unit (SCU) with the Nurse Educator, Nurse Manager, and staff input within three (3) months.
3. Orientation will be for a period of three (3) to six (6) weeks in length dependent on the level of competency the nurse has effective immediately.
4. If the nurse hired has previous nursing experience, the above time frame may be reduced. This would be a decision of the nurse, mentor, Nurse Educator, and the Clinical Manager effective immediately.
5. The nurse on orientation will not be taken off orientation and will be considered extra staff.
6. CMH will ensure all new hires are supported financially and with time to complete ACLS and Coronary Care Level one (CC1) after at least six months on the unit.
7. Upon completion of the above ACLS and Coronary Care Level I is completed the new RNs will complete the competency based SCU orientation including three days of theoretical content and eight (8) buddy shifts with an expert RN in the Special Care Unit (SCU) before being assigned to work independently.
8. The nurse on orientation will be scheduled with one mentor and follow her/his rotation and assignment. There may be times when the mentor is off for various reasons, the nurse will then be mentored by another senior nurse on duty for that shift or shifts.
9. Ongoing support for EPIC training will be provided to support nurses as required through on-site and/or Regional Network support.
10. Evaluation of the nurse will be done by the nurse, manager, mentor, and the Nurse Educator every two (2) months during this period.
11. The nurse on orientation will be provided with the required education to feel competent and comfortable working within the Medical/Surgical/SCU Unit.
12. The Nurse Educator will provide hands-on education with the nurse within the department as requested/required by either the nurse, mentor, or manager. The Nurse educator will be readily available while she is working to assist the orientee.
13. The Team Leader/Charge Nurse role will be introduced once the nurse has at least six (6) months experience. There will also be orientation for a minimum of five (5) shifts to the Team Leader/Charge Nurse role.

# 5 Leadership and Communication

### 1 The Role of the Chief Nursing Executive

The RNs on the IPU at CMH have experienced increasing and significant instability in their workplace environment, related to numerous and ongoing leadership changes within the organization. Several leadership changes have transpired since 2017. The Chief Executive Officer (CEO) role has been replaced four times in five years. The CEO, who most recently left the position, had been in the role for only 18 months. The current candidate in the CEO role began on March 20, 2023 (Exhibit 1). The Chief Nursing Officer (CNO) position has turned over four times since 2017. When ONA began meeting with the employer in May 2022, the CNO at that meeting then resigned in June 2022. The following CNO held the role for eleven months, from June 2022 to April 2023. She only began her tenure at CMH in February of 2022 as the

[86] CMH Presentation June 26, 2023.

manager of medical surgical and moved into the CNO role shortly thereafter (Exhibit 56). The current Chief Nursing Executive (CNE) began the position in April of 2023.[87]

The Chief Nursing Executive (CNE) is an integral role within the organization. Based on current legislation specifically the *Excellent Care for all Act, 2010,* this role is a designated member of the Quality Committee of the Board as well as an active Senior Team/Board of Directors member.

The CNE role has governance, leadership, and practice accountabilities. The role establishes a nursing vision for the organization and champions safe, quality care as well as evidence-based nursing practice. The CNE must ensure that nurses are meeting the standard of nursing practice that are consistent with the College of Nurses Standards and evidence-based Practice guidelines (RNAO, 2011).

**The IAC panel recommends:**

1. Establish a vision for nursing practice linked to the Quintuple Aim. https://www.ihi.org/communities/blogs/on-the-quintuple-aim-why-expand-beyond-the-triple-aim
2. Ensures that nurses are meeting the standard of nursing practice which are consistent with the College of Nurses Standards and evidence-based Practice guidelines.
3. Establishes a Professional Practice Framework
4. Establishes a Nursing Professional Practice Council within three to six (3-6) months of the IAC submission.
5. Champions Nursing Leadership Development
6. Develops an Interprofessional Model of Care to support positive patient outcomes.
7. Focuses on quality indicators that measure value and evidence-based outcomes.
8. Builds caring resilient teams with a focus on wellness and well being.
9. Champions Recruitment and Retention with a focus on mentorship
10. Builds trusting relationships with labour partners.
11. Measures patient experience and patient engagement
12. Creates a culture of inclusivity.

**Unit Councils/Huddles/Staff Meetings/Staff Rounding**

To optimize communication, teams should plan to meet regularly. Regularly scheduled unit council meetings, huddles and staff meetings are an effective way to engage frontline staff in problem identification and build a culture of collaboration and quality, thereby enhancing the ability to deliver safe patient care.

Regularly scheduled meetings will strengthen work culture and improve staff morale.

**Unit Councils**

Unit based councils are unit level shared governance councils and committees designed to discuss ways to improve individual units and address ongoing issues. Nurses work collaboratively to make decisions that affect nursing practice, quality, and safe patient care. Nurses are accountable for their practice that includes meeting their professional standards, role descriptions, policies, and procedures. Unit councils provide a forum for nurses to share evidence and best practices to ensure quality and safe patient care.

CMH has implemented Unit Councils which are being led by nurses. Minutes of Unit Councils were share with the IAC panel.

[87] ONA Brief Volume I p. 76 June 2023.

**Huddles**

A huddle, in the context of healthcare delivery, is a short meeting involving interdisciplinary healthcare team members– no more than 10-15 minutes in duration – that proactively enables teams to focus on patient safety, thereby facilitating team communication. The purpose of the huddle is to share information and highlight concerns to be followed up – not solve issues. Ideally, concerns raised during huddles are then directed to the appropriate person or groups for resolution, such as supervisors or patient safety committees. (Shaikh, 2020). It occurs at a consistent time daily, generally at the beginning of a shift. There is a standard work document (status exchange) that is used to ensure that all critical information is collected. The purpose of the status exchange is to proactively address issues, plan and provide support for staff. Please see the sample tool attached.[88]

It is evident that huddles occur frequently as noted in CMH's exhibit submission[89] and notes are posted for all staff to review. This is an excellent process, and the IAC panel encourages huddles to continue with the Manager.

**Staff Meetings**

A staff meeting is a forum for shared communication. These occur less frequently than a huddle and are often of longer duration. This is an opportunity to provide staff with organizational and departmental updates, discuss the potential impact of any upcoming changes as well as recognition of staff. Staff can also provide feedback regarding changes that have occurred, opportunities for improvement as well as recognition of colleagues. There should be an established meeting time, so it becomes familiar with options for in person or virtual attendance. The agenda should be circulated one week prior to the meeting to all staff in the department with a call for agenda items to be discussed. An updated agenda should be circulated 5 days prior to the meeting to ensure informed participation. Minutes will be distributed to all staff.

**Staff Rounding**

Rounding for outcomes is a consistent practice of asking questions of key stakeholders – leaders, staff, physicians, and patients to obtain actionable information. Studer's evidence-based practices to improve performance, patient satisfaction and engagement through staff rounding is an excellent approach to ensure staff engagement with the intent to enhance quality patient care and outcomes.

The focus for questions during staff rounding is to:

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

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

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

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

---

[88] Shaikh, Ulfat (2020). Improving Patient Safety and Team Communication through Daily huddles. https://psnet.ahrq.gov/primer/improving-patient-safety-and-team-communication-through-daily-huddles.

[89] CMH Exhibit Submission June 2023 p. 1119-1266.

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

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

Because many health care employees tend to notice what is wrong or not working—instead of what is right and working—it's particularly important to ask questions that look for the positive. While diagnosing what's wrong is critical to ensuring quality clinical outcomes in patients, it serves as an obstacle in an organization's effort to create a positive work culture, so we must build in opportunities to notice what's right.

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

Given the discussions throughout the IAC hearing related to staff not seeing their manager, lack of trust and poor communication, rounding for outcomes with staff is a meaningful way to develop trust, engage in meaningful dialogue with staff and to understand issues relevant to them. Simultaneously, holding huddles and regularly scheduled staff meetings is of equal importance for staff and leadership to stay engaged and feel empowered to bring forward issues.

**The IAC panel recommends**:

1. The CNE participates in staff rounding once per week to foster collaboration and trust with the Medical/Surgical IPU staff effective immediately.
2. Continue the huddles with the Manager daily and consider utilizing a status exchange tool[90] as another method of reviewing potential issues of the day, appropriate escalation as well as planning and accountability assigned for follow up effective immediately. Continue with the current practice of posting notes of the huddle exchanges.
3. Manager to round at a minimum of twice daily checking with Team Leader or delegate to understand patient flow, staffing or other concerns effective immediately.
4. Implement monthly staff meetings led by the Manager. This meeting should occur at the same time each month to establish a familiar cadence. Options for virtual attendance should be offered. The agenda should be circulated one week prior to the meeting to all staff in the department with a call for agenda items to be discussed. An updated agenda should be circulated 5 days prior to the meeting to ensure informed participation. Minutes will be distributed to all staff.
5. ONA and CMH will meet annually in accordance with the local CA Letter of Understanding RE: OPTIMAL COMPLEMENT OF REGISTERED NURSES (RNs).

[90] Cambridge Memorial Hospital ED Daily Status Exchange Tool

ED Daily Status Sheet Exchange

| | | Mon | Tues | Wed | Thurs | Fri | Actions/Close the Loop |
|---|---|---|---|---|---|---|---|
| Date: | | | | | | | |
| Safety | Are there any patient or staff safety concerns? | | | | | | |
| | Have there been any safety incidents? Falls, med errors, violence etc. | | | | | | |
| Quality | Patient concerns | | | | | | |
| | Any supply / equipment issues? | | | | | | |
| Patient and Family Centered Care | Number of patients? How many admits to no bed? Discharges? | | | | | | |
| | Are there any special care needs? 1:1 / | | | | | | |
| | Any Flagged patients? | | | | | | |
| People | Staffing issues today? | | | | | | |
| | What challenges came up yesterday that we didn't plan for? | | | | | | |
| | Any staff issues/concerns? | | | | | | |
| | Any other issues? | | | | | | |
| | Are there any outstanding | | | | | | |

## 2 Nursing Practice Council

### Implementation of a Nursing Professional Practice Council (NPPC) – Recommendation

ONA identified the need to follow collective agreement requirements regarding a Nursing Advisory, or Professional Development Committee. The absence of a professional development committee to support nurses and promote collaboration and processes to address strategies for effective positive change, patient safety initiatives and growth in nursing practice. [91]

The purpose of the Nursing Professional Practice Council is to provide a forum for Registered Nurses to discuss and address nursing professional practice issues throughout the organization. The NPPC will promote and support the professional practice and leadership development of all members. Members of NPPC are responsible for providing nursing leadership across all programs and services. NPPC promotes evidence-based practice and fosters a culture of inter-professional practice that is aligned with the strategic plan of the organization.

**The IAC panel recommends:**

1**.** The establishment of a Nursing Professional Practice Council by November 2023. While the IAC's focus was on the Medical/Surgical IPU at CMH, the establishment of the NPPC with representation across the organization will provide an opportunity to develop leadership qualities in nursing staff and will work to improve the quality of work life of nurse's organization wide.

The panel provides a template below for consideration in the development of the Nursing Professional Practice Council (NPPC):

**Objectives:**

1. Recommend strategic directions using evidence informed nursing practice and data driven decision-making informed by a nursing scorecard
Ensure nursing is adhering to practice standards, completes appropriate quality assurance/renewals, and remains in good standing with their regulatory body.
3. Promote interprofessional collaboration to optimize scope of practice and enhance patient outcomes

[91] ONA Brief Volume I p. 110

4. Act in an advisory capacity for decisions related to legislative and/or regulatory requirements regarding nursing practice
5. Ensure linkages are developed and maintained with other professions and corporate bodies.
6. Support professional development, orientation, and mentorship to foster a culture of continuous learning
7. Support learners by fostering positive student placement experiences and engaging with academic partners
8. Promote nursing research, including participation in and knowledge transfer of research and evidence-based nursing practice
9. Advance nursing leadership everywhere in mindful and sustainable ways
10. Recognize nursing innovation and achievements
11. Review, consult, endorse, and provide feedback on corporate policies and medical directives
12. Establish communication pathways and opportunities for dissemination with all nurses in the organization
13. Promote and contribute to the advancement of the nursing profession at CMH.

**Membership:**
Members of the Nursing Advisory Council include:

1. Chief Nursing Executive
2. Director (Clinical)
3. Clinical Manager(s) (Co-chair)
4. Co-chair – to be selected from the membership.
5. Clinical Managers (All; rotation)
6. Clinical Education Facilitators (All)
7. Staff nurses – 1-2 per patient area, RNs and RPNs
8. IPAC, HSW
9. ONA President (or designate) + 1 member.
10. SEIU President (or designate) + 1 member.

**Responsibility of the Co-chair(s):**

1. Provide leadership in guiding the activities of the Council towards the objectives.
2. Ensure agendas, minutes, and supporting materials are available in advance.
3. Maintain a central record of council activities.
4. Seek out additional resources needed to facilitate the work of the Council.

**Responsibility of the Council Members:**

1. Actively participate in the initiatives of the council
2. Liaise with their respective unit/departments and obtain perspective on issues. related to professional nursing practice.
3. Disseminate information related to NPPC activities and initiatives to unit nursing staff.
4. Disseminate information from the unit/departments to the NPPC.
5. Meeting attendance is essential to ensure all nursing units are represented fairly during discussions. Council members may send a delegate when unable to attend meetings.
6. Represent the goals and objectives of their program.

**Meeting Frequency:**

Minimum 6 times per year. Additional meetings may be called at the discretion of the Co-chair(s) as required.

**Agenda Preparation:**
Call for agenda items will go out a week prior to the agenda. The agenda will be developed by the Co-chairs in advance of the scheduled meeting.

**Minutes:**
Formal meeting minutes will be documented by the Co-chair(s) or designate highlighting the general discussion undertaken and actions where required.
Circulation of minutes will include all Council members and others as required and noted within the meeting minutes. Distributed to members of NPC and VP/CNE.

### 3 Medical/Surgical Unit Policies and Procedures

Policies, procedures, and competencies are the foundation of quality and safe patient care and drive nursing practice.

On April 16, 2023, it was reported in a PRWRF that both the previous and following shift were staffed only with agency RNs and no core CMH RN staff. Of greatest concern was patient safety as the agency staff lacked organizational knowledge of CMH policies and procedures. [92]

**The IAC panel recommends:**

1. CMH policies and procedures are reviewed during orientation with all agency staff to ensure best practices, policies and procedures are always followed.
2. CMH language in policies is outdated and does not reflect equity, inclusion and consider the diversity of the population. It is imperative appropriate language be used to eliminate unconscious bias and increase inclusivity.
3. RNs provide input and feedback to all policies and procedures.

## 6 Professional Development

### 1 Professional Practice Lead/Diabetes Education

The role of the Professional Lead and Diabetes Educator is a critical role within the Campbellford Memorial Hospital (CMH) team. This role had been vacant for a prolonged period however it has recently been filled with an internal candidate. The vacancy in this role has contributed to a lack of support in onboarding new staff as well as supporting patients with Diabetes. In ONA's Volume 1 submission[93] the impact of this vacancy is described as the lack of educator support has resulted in a lack of core and advanced RN skill development opportunities. The education provided during a skills week in September 2022 consisted of nurses reading educational boards and being tested after each one. There was no didactic or theoretical in person instruction or opportunity for questions and critical thinking development. Although reassignment occurs between both the medical surgical unit and the Emergency Department (ED), the RNs have not been properly oriented to the other unit or department.

The World Health Organization (WHO)[94] states the appropriate preparation of nurse educators is critical to the development of knowledge, skills, and attitudes, of nurses. WHO has developed Nurse Educator Core Competencies to enable educators to effectively contribute to the attainment of high-quality education, and

[92] ONA Submission Brief Volume I June 2023.
[93] ONA submission Volume 1
[94] Retrieved : Nurse educator core competencies (who.int)

the production of effective, efficient, and skilled nurses who are able to respond to the health needs of the populations they serve.

In small, rural hospitals support roles within an organization often have a dual purpose. These dual roles are developed to sustain specific programs while maximizing support. In the CMH submission[95] it states the Diabetes Nurse Educator and Professional Practice Lead is responsible for working within a primary health care framework and a self-management model of service delivery. The role provides clinical nursing-based care, education, and consultation to diabetes clients and their families/caregivers within the Diabetes Educator Program and for supporting virtual patient consultations via Ontario Telemedicine Network (OTN). Additionally, it supports development of clinical nursing skills amongst nursing staff within the Emergency Department and Medical/Surgical unit. They assist in the onboarding of new nurses to develop the knowledge and skills required for practice within the clinical environment and provide ongoing coaching and support to enhance the learning experience.

While the importance to support both the Diabetes Education program as well as onboarding new staff, the numbers of both patients and new staff that are supported are small. This low volume needs to be considered in the division of time spent within the dual role. Strong communication, planning and visibility are key components that will contribute to the success of this role and in the support of both patients and staff.

**The IAC panel recommends:**

1. There is a posted schedule each week identifying planned Diabetes clinic and education sessions. This will provide visibility into the role.
2. The role will work proactively with Human Resources and the IPU manager to identify onboarding requirements each month.
3. If additional education support is required, the IPU manager will engage the Professional Practice lead as soon as possible to support the staff member.
4. This role will develop an education program to support nursing when providing patients with Diabetes education when the role is not available such as weekends and holidays.

**2 The Role of the Acute Medicine Nurse Practitioner**

Nurse Practitioner's (NP) are Registered Nurses who have met additional nursing education, experience and exam requirements set by the College of Nurses of Ontario. Only those registered with the College in the Extended Class can call themselves "Nurse Practitioner" or "NP". NPs are authorized to diagnose, order, and interpret diagnostic tests, and prescribe medications and other treatments for clients. NP practice includes health promotion with the aim of optimizing the health of people, families, communities, and populations. This enables NPs to practice with diverse client populations in a variety of contexts and practice settings such as acute care, primary care, rehabilitative care, curative and supportive care, and palliative/end-of-life care[96].

The role of the NP within a hospital setting is a valuable one. NPs are not physician substitutes; they work in collaboration and consultation with physicians, nurses, and other health professionals.

While it is true that both NPs and physicians are qualified to diagnose illnesses and prescribe medications, it is a misconception to assume that these are antagonizing roles. When NPs and physicians are viewed as collaborators instead of competitors, the benefits of this cooperation become clear. With their extensive

[95] CMH Submission

[96] Nurse Practitioner Practice Standard. Retrieved www.cno.org/standards.

training and experience as nurses, NPs have exceptional patient communication skills and can participate in both the care and cure of the patient[97]

The CMH disclosure brief describes the role of the Acute Medicine Nurse Practitioner as one that is a member of the Acute Medicine Multidisciplinary Health Care Team and has a unique role in providing medical care to our acute medical population. She/he provides patient centred care within the scope of the College of Nurses Practice Standards for Nurse Practitioners[98]. In 2022, the medical surgical unit was supported by a nurse practitioner, who conducted ALC patient assessments as part of their role. The NP position has been vacant for more than six months, and the employer has been unsuccessful in recruiting to fill this role in 2023[99].

Throughout the IAC hearing both CMH and ONA agreed the role of the NP was viewed as supportive and a valuable role. The hospital has identified they have secured an agency NP for a period of three months to support the IPU however are continuing to recruit to secure their own resource.

**The IAC panel recommends:**

1. Continue to actively recruit for the Acute Medicine Nurse Practitioner in a permanent role.
2. Leverage all Ministry initiatives to enhance NP recruitment such as Health Force Ontario, Community Commitment Program for Nurses.
3. Establish a mentor for the role both nursing and a physician to ensure all stakeholders understand role clarity as well as defined responsibilities. This mentorship is essential in building trust and establishing secure relationships, which is necessary to build a strong foundation for the role, optimizing safe, quality patient outcomes as well as increased staff satisfaction.

# 7 Equipment

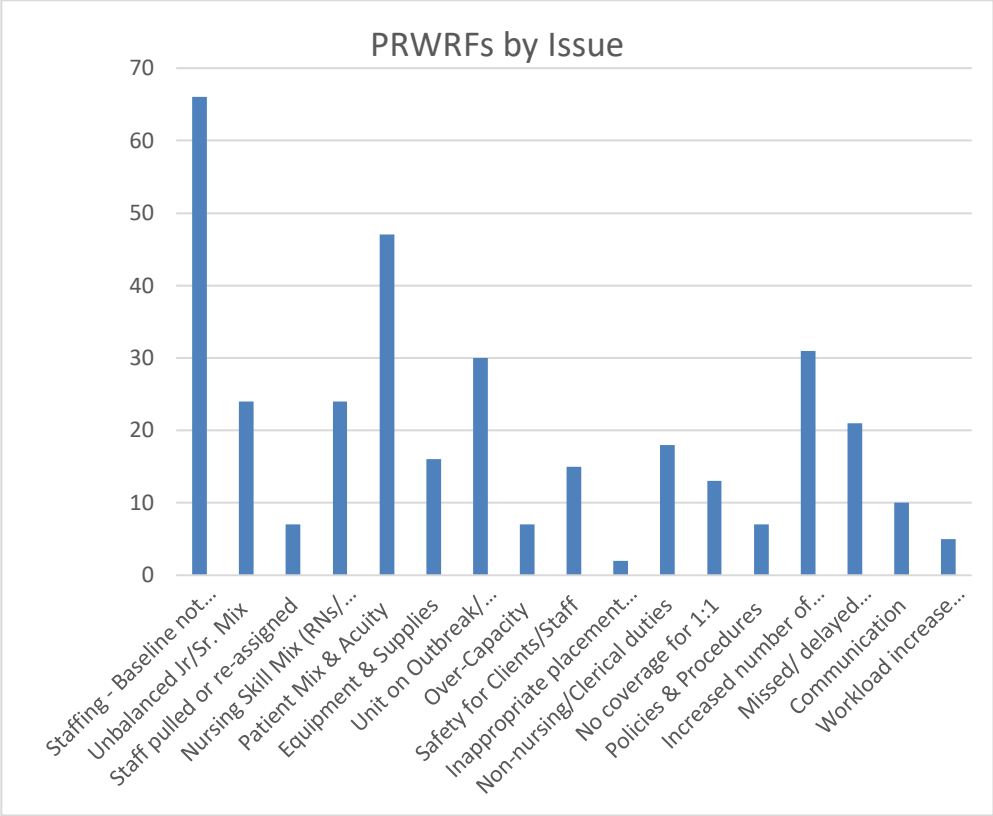
### 1 Medical Equipment

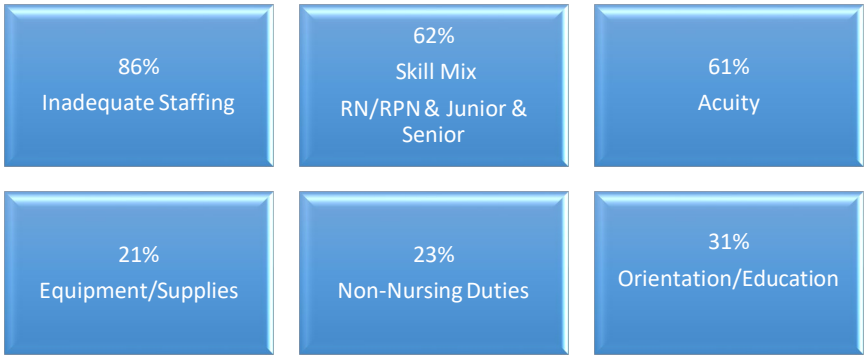
Medical equipment is an important component of a health system and is a tool used by nurses to prevent, diagnose, monitor, and treat diseases as well as during rehabilitation after disease or injury. It can be in the form of a machine, instrument, appliance, software, or material intended by the manufacturer to be used alone or in combination with other devices. Medical equipment has a lifecycle requiring calibration, maintenance, repair, user training and finally retirement. A responsive health system guarantees communities equitable access to essential medical equipment of assured quality, safety, and cost effectiveness[100]. Shortage of medical equipment, either due to unavailability or non-functioning, is a barrier to the ability of the health system to deliver quality health services.

ONA's Volume 1 submission identifies several concerns regarding availability of equipment as well as equipment that is non-functioning as a concern for staff working in the IPU. The six semi-private rooms on Ranney Gorge have no suction equipment, and two of these rooms (102 and 104) have no bathrooms. The RNs on the medical surgical unit at CMH have reported numerous incidents regarding inadequate and

[97] Nurse Practitioner's: An Underutilized Resource. Retrieved: NURSE PRACTITIONERS – AN UNDERUTILIZED RESOURCE - UBC Medical Journal
[98] CMH Disclosure Brief
[99] ONA Submission Vol.1
[100] Experiences of nurses on the critical shortage of medical equipment at a rural district hospital in South Africa: a qualitative study. Retrieved: Experiences of nurses on the critical shortage of medical equipment at a rural district hospital in South Africa: a qualitative study - PMC (nih.gov)

dysfunctional equipment, including an insufficient supply of IV pumps, vital signs equipment, oxygen saturation monitor probes, and Pinel restraints[101]. See chart(s) below:




In ONA's IAC submission Volume 2, pages 380-411, minutes from both the May and June 2022 action plan involving both the association and the hospital note that the hospital has completed a survey involving the RNs to determine equipment and supplies needed for the provision of safe and timely patient care as well as conducted an analysis of existing equipment and to immediately replace outdated or broken items[102]. The IAC panel notes this analysis has occurred however an ongoing schedule for review must be established to ensure safety and availability of all equipment on the unit.

[101] ONA IAC Submission Vol. 1
[102] ONA IAC Submission Vol. 2

The College of Nurses of Ontario *Practice Guideline: RN and RPN practice: The Client, the Nurse and the Environment*[103] identifies the physical environment and access to equipment can support and increase the efficiency and effectiveness of client care, services, and programs. Indicators of a supportive physical environment include availability of equipment and supplies that meet client needs, reliability of equipment and regular maintenance of equipment.

Possible strategies include:

- having sufficient access to equipment to support professional practice.
- involving nurses in facility improvement planning
- involving nurses in equipment selection.

The IAC panel acknowledges the concerns that staff have verbalized and documented on the PRWLF's regarding equipment concerns and acknowledge the inventory of equipment that the hospital has completed to address these concerns. This is a supported strategy moving forward.

**The IAC panel recommends:**

1. Equipment needs, replacements and concerns are a standing agenda item at both staff and unit council meetings.
2. The hospital schedules an annual equipment inventory review with staff input to identify opportunities.
3. The hospital devises a visual management system, such as tagging, to identify broken or malfunctioning equipment in collaboration with facilities and/or Biomedical for timely repair.
4. The hospital work with the Biomedical team to develop a proactive Biomedical equipment process to perform preventative maintenance and to ensure that all equipment is in working order or is replaced in a timely manner.
5. A replacement strategy for capital items including replacement and addition of beds including speciality beds such as Bariatric, IV pumps and patient lifts are part of the annual capitol planning and purchase strategy with input from staff.

**2 Location of Crash Cart**

The ONA brief alerted the IAC that at the present time there is no crash cart within the IPU due to it being relocated during the COVID-19 pandemic to the operating room wing OR #2 as per Public Health recommendations.

The current practice is for the nursing team to transfer the patient during a code blue to OR #2 as there is more space to provide care as well as to ensure a protected code blue procedure and its protocols are maintained. The challenge is that the current process could negatively impact patient care due to time required to transfer the patient. This practice increases the risk of negative outcomes to the patient and also increases the risk of injuries to staff. Mobile crash carts allow quick and easy access to lifesaving medical equipment and medicines when seconds count.

Medical emergencies have the tendency to create an uneasiness and a sense of chaos during the event. These feelings may be magnified if the emergency equipment used to rescue the patient is not readily available. The intent of a crash cart is to ensure that the correct emergency equipment, medications and supplies are readily available to manage the emergency.[104]

[103] College of Nurses of Ontario *Practice Guideline: RN and RPN practice: The Client, the Nurse and the Environment*
[104] Pennsylvania Patient Safety Authority: Clinical Emergency: Are You Ready in Any Setting? June 2010; 7 (2) 52-60

The IAC understands that space for equipment is at a premium on the Medical In-Patient Unit but re-locating a crash cart back onto the unit should be a priority.

**The IAC panel recommends:**

1. Review the current Code Blue procedure with Infection Prevention and Control, Professional Practice Lead, Nursing Staff, and engagement from other key stakeholders including Physicians.
2. The crash cart needs to be easily accessible to all areas of the Medical Surgical Inpatient Unit.
3. Given the most at-risk patients are in the SCU, the location of the crash cart must be in proximity.
4. The required PPE should be in the same location as the crash cart.
5. RNs will be responsible for restocking the crash cart on the Medical/Surgical In-Patient Unit.
6. Collect and monitor data related to unsafe incidents concerning the crash cart or emergency equipment. Evaluate and analyze to determine the best solution for the issue and mitigate the risk.

# 8 Professional Responsibility Workload Report Forms (PRWRF)

The Professional Responsibility and Workload (PRW) process was developed to assist Registered Nurses (RNs) through the difficult and often stressful process of raising and resolving issues related to professional practice, patient acuity, fluctuating workloads, and fluctuating staffing; and resolving these concerns in a timely and effective manner.

The PRW process was designed not only to promote the safety and best possible care of patients, but also for the protection of the Ontario Nurses' Association (ONA) members who may identify that patients and staff are at risk because of improper staffing, skill mix, practice, and workload issues. The collective agreement specifies the process for documenting these issues in writing on the Professional Responsibility Workload Report Form (PRWRF), and thus initiating a process that facilitates employers to work with ONA and its members in order to mutually resolve issues in the best interest of safe, ethical and proper patient care.

The College of Nurses of Ontario (CNO) has Standards of Practice that registrants are expected to meet to provide safe, ethical, and quality patient care within their scope of practice. RNs have a professional obligation to ensure nursing practices are carried out according to the CNO Standards of Practice. If nurses cannot meet these standards, it is up to individual nurses to report these concerns to the employer and attempt to resolve the issues. The employer, on the other hand, has an obligation to respond to the reported concerns, and to provide a quality practice environment that facilitates and permits nurses to meet CNO standards. The Professional Responsibility Clause is designed to assist both frontline and administrative RNs in meeting their professional obligation to the CNO and to enhance and promote safe, quality patient care.[105]

The RNs on the medical surgical unit at CMH have been reporting on their PRWRFs, their workload and practice issues since April 25, 2017. The data reported on 77 PRWRFs submitted to date relate to inadequate baseline staffing, worsened by sick calls and vacancies, an unstable RN and RPN skill mix, gaps in staffing when an RN must take a patient on transfer to another facility, and the impact on staffing and patient care when already insufficient staffing resources are further depleted, as well as when an RN is required to respond to all hospital-wide codes. Other issues reported include high patient acuity, a lack of or malfunctioning equipment and supply issues, a lack of adequate and or effective orientation and education, especially pertaining to the lack of training for SCU. Staff and patient safety concerns such as the lack of

[105] ONA Submission Brief Volume 1 June 2023.

panic alarms, and nonexistent negative pressure rooms and non-nursing duties were also noted as ongoing issues.[106]

Further, the members report that the manager has not met the requirements of the collective agreement to discuss the PRWRF issues at the unit level. Often the management response provided merely acknowledges an issue exists. Furthermore, the manager has stated at a HAC meeting that she uses the unit council (Exhibit 27a) to discuss the PRWRFs, which is not the appropriate forum as per the collective agreement and fails to provide the required efforts and communication necessary to understand the issues (Exhibit 27).

A letter forwarding the unresolved issues to the IAC was submitted by the Union to the IAC Chairperson on January 23, 2023 (Exhibit 28). As indicated in the Union's Letter of Referral, ONA respectfully requests that the IAC assess the nursing practice and workload concerns put before them from the perspective of being able to provide safe, ethical, competent, and professional quality patient care in a quality practice setting, according to relevant professional and specialty standards, and supporting research and literature, including the following CNO Practice Standards and Guidelines:

14. Code of Conduct (Exhibit 29)
15. Professional Standards Revised 2002, 2018 (Exhibit 8)
16. RN and RPN Practice – The Client, the Nurse and the Environment, 2018 (Exhibit 30)
17. Therapeutic Nurse-Client Relationship Revised 2006, 2019 (Exhibit 31)
18. Authorizing Mechanisms, 2020 (Exhibit 32)
19. Decisions about Procedures and Authority Revised, 2020 (Exhibit 33)
20. Confidentiality and Privacy – Personal Health Information, 2019 (Exhibit 34)
21. Ethics, 2019 (Exhibit 35)
22. Documentation Revised 2008, 2019 (Exhibit 36)
23. Medication Revised 2008, 2019 (Exhibit 37)
24. Conflict Prevention and Management, 2018 (Exhibit 38)
25. Consent, 2017 (Exhibit 39)
26. Directives, 2020 (Exhibit 40).

**The IAC panel recommends:**

1. RNs in the Medical/Surgical Unit continue to document their concerns on the Professional Responsibility Workload Report Form, in alignment with the Collective Agreement.
2. The Hospital and the local Association work together to improve the Professional Responsibility Workload (PRW) process with the goal of implementing a collaborative approach to resolving workload concerns. This will include commitment on both sides to follow the steps in the collective agreement including timelines established in this process.
3. RNs in the IPU initially communicate their patient care concerns to the Clinical Manager to give management the opportunity to resolve the matter and facilitate decisions that will support safe, quality patient care.
4. Management review and respond to the PRWRF in writing as per the Collective Agreement and engage in dialogue with the nurse(s) about the complaint with the goal to resolve the immediate issue and move toward a long-term resolution, if required.
    a. The manager is to respond within 10 days as per the Collective Agreement utilizing the OHA/ONA PRWRF tool.
    b. The manager is to use the 10-day window to discuss the workload complaint with the nurse(s) involved, with an ONA representative present, if desired, to understand the concerns and to seek resolution.

[106] ONA Submission Brief Volume 1 June 2023.

c. Unresolved complaints will be presented at the Hospital Association Meeting as per the Collective Agreement with the intent to identify themes and work together on resolutions.
d. The Clinical Manager provides the Chief Nursing Executive (CNE) with a Workload Complaint Summary Report, every two weeks for the next six months, to include the number of PRWRFs completed, the workload issue documented, and any developing themes of concern.
e. The CNE to support the Clinical Manager to develop corrective action plans and to support the Clinical Manager and the nurses to resolve issues in a timely and effective manner.

## 9 Hospital Association Committee (HAC)

The intent of the Hospital Association (HAC) meetings is to provide a forum for both the Association and the Hospital to engage in meaningful dialogue about issues including workload and to seek common resolutions.

The Hospital-Association Committee (HAC) at Campbellford Memorial Hospital is scheduled to meet bimonthly and at times more often, as necessary, in accordance with Articles 6.03 and 8.01. The key professional responsibility issues reported by the RNs working on the medical surgical unit include staffing and serious and significant health and safety concerns. CMH and ONA Labour Relations Officer (LRO) and PPS staff met at HAC meetings to discuss unresolved PRWRFs every two months, in 2022. Meetings occurred bimonthly, in January, March, May, September and November. The parties were unable to achieve any meaningful resolution at these meetings. In addition, discussions regarding the HAC terms of reference identified that the hospital does not have in effect any current terms of reference. The only terms of reference document are dated 2009, however, it does not contain a specific date or authorizing signatures enacting them (Exhibit 10). The current employer parties, working with ONA were unaware of any past or current terms of reference document for the HAC (Exhibit 11). [107]

Professional Practice issues for the medical surgical unit were first discussed at HAC on May 6, 2022, and a subsequent email was sent on May 11, 2022 (Exhibit 12). A Professional Practice Specialist supported the bargaining at the employer meeting. Unsuccessful discussions deemed ongoing support from PPS would be required, and a Professional Practice Specialist was assigned to the file. The employer was notified by letter sent via email on May 9, 2022 (Exhibit 13). A request for information disclosure was exchanged between ONA and the Employer, with a request for receipt of information dated May 30, 2022. The employer failed to comply with the collective agreement, and on May 30, 2022, were notified of their violation of the process in Article 8 (Exhibit 14). Subsequent email correspondences were shared on June 6, 2022 (Exhibit 15) to obtain the required information requests. The Professional Practice Specialist provided the employer on June 14, 2022, with an updated version with embedded notes for the meeting on June 6, 2022 (Exhibit 16). The Employer followed up with pieces of disclosure information via email on June 30, (Exhibit 14) July 4 and July 6, 2022, however, not all requested disclosure was provided (Exhibit 14a, 17).

ONA's efforts to resolve the issues involved four meetings of the sub-HAC, with the employer. Meetings occurred on May 6, 2022, June 6, 2022, July 19, 2022, and August 16, 2022. The discussion during these meetings as captured in the action plans/meeting notes (Exhibits 12, 16, 18, 19, 20, 21, 22) outline the multiple PRWRFs reporting the employer's failure to maintain baseline staffing or replace vacant shifts created as a result of sick calls, unfilled vacancies, and other leaves of absence. Additional issues reported and discussed included negative patient outcomes due to insufficient staffing and resulting in delayed care, delayed treatments, missed or delayed ability to aid with activities of daily living, delayed medication administration, patient assessments, postponed transfer for tests, and unsafe nurse-to-patient ratios. The

[107] ONA Submission Brief Volume 1 June 2023.

inability of RNs to take appropriate rest periods or breaks was also reported as an issue. The sub-HAC meeting scheduled for September 26, 2022, was cancelled due to illness of an ONA team member. Communication with the employer failed to reach an alternative date or time to reschedule the meeting. ONA proposed to meet for a fourth meeting on November 18, 2022, (Exhibit 23) and proposed to utilize a mediation process to attempt mutually agreeable resolutions. The employer did not reply with follow up.

Action plan documents were presented at the sub-HAC meetings with the employer and updates were shared with the employer after each meeting. The employer failed to provide any responses to the action plan; or provide any additional information or report any actions or strategies being taken to achieve resolution. While the ONA team documented meeting minutes (Exhibit 20, 21, 22), no joint meeting minutes were shared. ONA recommended and provided an acuity and workload tool to the Employer, as requested; however, the employer refused to consider or implement the tool or investigate other appropriate acuity measurement tools (Exhibit 12). ONA proposed a validated acuity tool as a strategy to support improved staffing and safer nurse to patient ratios, however, the employer was not agreeable, nor did they propose or suggest alternative solutions to resolve the issues.

Following the breakdown of effective meetings and communication with CMH, ONA proposed mediation as an alternate dispute resolution strategy, on August 16, 2022, and again on November 18, 2022. The employer did not engage or respond to ONAs verbal recommendation, or subsequent written request, and additional proposal for mediation on December 14, 2022 (Exhibit 24). ONA's efforts to engage the employer in a process of mediation was futile, as the employer simply did not respond. Simultaneous to proposing mediation, ONA forwarded an Items of Agreement document proposing some items could be resolved and signed by the parties (Exhibit 24). The employer also failed to respond to these proposals. As such, ONA was obligated to proceed, as per the collective agreement and advance the workload issues to the Independent Assessment Committee, in a letter sent on January 19, 2023 (Exhibit 25).

The Employer realigned the laid off RN staff to create a resource team to, in their opinion, assist with staffing needs in both the medical surgical unit and the emergency department, by decreasing the baseline RN staffing per shift on the medical surgical unit. The employers' changes to the staffing model, in September 2022 resulted in one less RN being scheduled on both the day and night shift, and an additional RPN being scheduled per shift. The new baseline staffing model resulted in a significant change in the balance of nursing skill mix on the unit, with 75 per cent of the staffing on both shifts being RPNs. As such, the RNs report they struggle to meet their professional standards of practice and the care needs of their highly acute patients and provide the necessary supports and expert resource needed to the remaining nursing staff (Exhibit 26).

The RNs on the IPU at CMH have been reporting on their PRWRFs, their workload and practice issues since April 25, 2017. The data reported on 77 PRWRFs submitted to date relate to inadequate baseline staffing, worsened by sick calls and vacancies, an unstable RN and RPN skill mix, gaps in staffing when an RN must take a patient on transfer to another facility, and the impact on staffing and patient care when already insufficient staffing resources are further depleted, as well as when an RN is required to respond to all hospital-wide codes. Other issues reported include high patient acuity, a lack of or malfunctioning equipment and supply issues, a lack of adequate and or effective orientation and education, especially pertaining to the lack of training for SCU. Staff and patient safety concerns such as the lack of panic alarms, and nonexistent negative pressure rooms and non-nursing duties were also noted as ongoing issues.

Further, the members report that the manager has not met the requirements of the collective agreement to discuss the PRWRF issues at the unit level. Often the management response provided merely acknowledges an issue exists. Furthermore, the manager has stated at a HAC meeting that she uses the unit council (Exhibit 27a) to discuss the PRWRFs, which is not the appropriate forum as per the collective agreement and fails to provide the required efforts and communication necessary to understand the issues (Exhibit 27).

6.03 Hospital-Association Committee [108]

(a) There shall be a Hospital-Association Committee comprised of representatives of the Hospital, one of whom shall be the Chief Nursing Executive or nursing designate and of the Union, one of whom shall be the Bargaining Unit President or designate. The number of representatives is set out in the Appendix of Local Provisions and the membership of the Committee may be expanded by mutual agreement.

(b) The Committee shall meet every two (2) months unless otherwise agreed and as required under Article 8.01 (a) (iv). The duties of chair and secretary shall alternate between the parties. Where possible, agenda items will be exchanged in writing at least five (5) calendar days prior to the meeting. A record shall be maintained of matters referred to the Committee and the recommended disposition, if any, unless agreed to the contrary. Copies of the record shall be provided to Committee members.

(c) The purpose of the Committee includes:

i) Promoting and providing effective and meaningful communication of information and ideas, including but not limited to workload measurement tools and the promotion of best practices. Such communication may include discussion of nursing workload measurement and patient acuity systems. The Hospital will provide, upon request, information on workload measurement systems applicable to nursing currently used by the Hospital, and evaluations completed by the Hospital of such systems.

ii) Reviewing professional responsibility complaints with a view to identifying trends and sharing organizational successes and solutions, making joint recommendations on matters of concern including the quality and quantity of nursing care and discussing the development and implementation of quality initiatives.

iii) Making joint recommendations to the Chief Nursing Executive; on matters of concern regarding recurring workload issues including the development of staffing guidelines, the use of agency nurses and use of overtime.

iv) Dealing with complaints referred to it in accordance with the provisions of Article 8, Professional Responsibility.

v) Discussing and reviewing matters relating to orientation and in-service programs.

vi) Promote the creation of full-time positions for nurses and discuss the effect of such changes on the employment status of the nurses.

This may include the impact, if any, on part-time and full-time, job sharing and retention and recruitment.

[108] 20230331_HospCentralAgreementF [37429] p. 7 Expires March 2023

(d) The Hospital agrees to pay for time spent during regular working hours for representatives of the Union attending at such meetings.

(a) Where a committee representative designated by the Union attends Committee meetings outside of their regularly scheduled hours, they will be paid for all time spent in attendance at such meetings at their regular straight time hourly rate of pay. Such payment shall be limited to two (2) Committee representatives per meeting.

**The IAC panel recommends:**

1. The HAC meetings be re-established on a renewed basis with the intent to follow the process and intent outlined in Article 6.03 of the Collective Agreement.
2. All parties in attendance at the HAC, treat one another in a professional, respectful manner and through dialogue seek to find common solutions to identified concerns.
3. The following format for HAC be adopted.
    a. Meetings to be Chaired on an alternating basis by ONA and the Hospital.
    b. Minutes continue to be taken by ONA and the Hospital, alternating monthly and circulated within one week to all members of the Committee.
    c. The agenda be circulated 5 days prior to the meeting to give all parties ample opportunity to add any issues/items required by either party.
    d. The CNE/Clinical Managers to attend all HAC meetings.
    e. When agreement on an issue(s) is achieved, the agreement be put in writing, reviewed, and signed by all parties to ensure that all agree and sign off on joint decisions.
    f. That a separate meeting be called to deal with workload concerns that are escalating in a particular unit so that trends can be identified, and corrective action put in place in a timely and effective manner.
    g. The Professional Practice Lead and ONA Professional Practice Specialist conduct joint education on the PRWRF process and responsibilities.
    h. The Professional Practice Lead and ONA Professional Practice Specialist conduct education on the College of Nurses Code of Conduct and Scope of Practice standards.

# SECTION IV

# CONCLUSION AND SUMMARY OF RECOMMENDATIONS

## 4.1 Conclusion

Article 8.01 of the Collective Agreement between the Ontario Nurses' Association and CMH Medical/Surgical IPU Independent Assessment Committee to specifically address the issue of whether RNs are being requested to perform more work than is consistent with proper patient care.

The IAC Panel completed a thorough analysis, which included an in-depth review of information received prior to and during the IAC Hearings held June 26th, June 29th, and June 30th, 2023, in relation to the literature relating to emergency nursing and care, consideration of factors impacting the CMH Medical/Surgical IPU practice environment, and integration of the Panel's cumulative practice, knowledge, experience and expertise.

## 4.2 Summary of Recommendations

## 1 Health Human Resources and Model of Care

**1 Model of Care**

**The IAC panel recommends:**

1 Support top-of- practice for all disciplines. The organization should ensure care teams contain sufficient support staff for RNs to delegate appropriate work and fully leverage the capabilities of RNs.

2 Revise role and job descriptions to reflect top of practice, ensuring all health care professionals are practicing to full scope of practice.

3 Complete a gap analysis to review scope of practice of each discipline incorporating competency assessments. Develop education programs based on the gap analysis and assessment.

4 Define role clarity for each discipline – This will ensure all members of the care team are well coordinated and do not duplicate work thereby eliminating waste. Team members frequently deliver patient care in silos, rather than as integrated teams. By defining role clarity teams are well-coordinated and equipped to deliver higher-quality and more efficient patient care.

5 Measurement for Improvement – Identify metrics prior to change that will demonstrate improvement. These could include:

- Staff satisfaction
- Patient satisfaction
- Sick time/overtime
- Increase in Professional Responsibility Workload Report Forms (PRWRF) being resolved at the unit level.
- Decrease in PRWRFs going to HAC.
- Decrease in patient and staff incident reports.

**2 Medical/Surgical Unit Staffing**

**The IAC panel recommends:**

1. Dissolve the RN Float Resource Pool.
2. Reallocate the 4.0 FT RN positions to the IPU.
3. Utilizing the reallocation of the 4.0 FT RN add an additional RN to the 1900-0700 tour 7 days per week.
4. Extend the role of the Team Leader to 7 days per week 12 hours per day.
5. If reassignment of staff is required, this should be based on knowledge, skill, and judgement of the staff member.
6. If the unit is placed in overcapacity/surge additional RN staff must be called in first, if no RN staff are available then RPNs can be called in.
7. Collective agreement language must be adhered to for staff changes and scheduling.
8. Increase Ward Clerk coverage to sixteen (16) hours per day Monday through Friday.

**3 Special Care Unit**

**The IAC panel recommends:**

1 Develop an SCU admission policy that identifies admission guidelines, inclusion/exclusion criteria and transfer considerations with support of the Professional Practice Lead. Stakeholder engagement should include but not limited to physicians, nursing, allied health.
2 The policy must be written in language that promotes equity, diversity and inclusivity.
3 Patient flow through SCU is a priority to ensure that there is capacity in SCU if required and to ensure the appropriate staff member is in place.
4 Ensure RN's working in SCU have ACLS certification.
5 Orientation for staff working in SCU is competency based that requires a self assessment by the employee and validation of competency is completed in collaboration with the Professional Practice Lead and/or the manager upon completion of orientation.
6 Length of orientation should be determined by the RN with support from the Professional Practice Lead and the manager based on a competency needs assessment.

**4 Clinical Support**

**The IAC Panel Recommends:**

1 All non-nursing duties require a review and appropriate resources for these non-nursing functions must be implemented within the next three (3) months.
2 Review clinical support staff positions, job responsibilities and accountabilities to ensure there is support for housekeeping, laundry pick-up, stocking of supplies and linen, and portering.
3 Training to be provided for all clinical support staff on safe patient transfers so they can assist with portering when required.
4 Replace allied health professions that are part of the IPU team (PT, Discharge Planners etc.) when off work for any reason.
5 Home and Community Care nursing/functional assessments should be completed by the Home and Community Care case manager who is on-site and can come to the IPU to complete the assessments.
6 Discharge planning assessments should be completed by the Discharge Planner who is on site and can come to the IPU to complete the assessments.

7 Consultation between nursing and pharmacy for ideas on how to improve the quality of medication rounds.
8 Pre-schedule Occupational Therapists twice weekly on IPU.
9 Provide additional training for staff on handling safe disposal of bodily fluids. Public Health Ontario: Best Practices Document Best Practices in IPAC | Public Health Ontario.
10 Replace clerical/administrative staff when off work for any reason.
11 All security staff and maintenance staff will be trained in bat/bat dropping removal, provided with proper PPE, and educated in the Bat Policy.
12 Delivery and pick up of meal trays should be completed by Food Services.

**5 Glucometer Testing**

**The IAC panel recommends:**

1 Provide glucometer education to all nurses on the IPU.
2 Implement point of care glucometer testing at the bedside by nurses to provide a real time view of the blood glucose level.

**6 Patient Transfers**

**The IAC panel recommends:**

1. Expand access to and utilization of the Ontario /telemedicine Network (OTN) for consultations and follow up appointments for patients to minimize the transportation of patients.
2. In the event of a patient transfer, it is imperative planning and scheduling occurs in advance to ensure nursing resources are readily available if required.

## 2 Recruitment and Retention

**1 Recruitment and Retention**

**The IAC panel recommends:**

1 Update CMH's recruitment section on their existing website to reflect all of the initiatives that are currently being implemented to recruit nurses.
2 Exit interviews for all nurses who leave the department/hospital as well as those who change their working status. These interviews to be conducted by the Human Resources Department.
3 Ensure Recruitment and Retention is an ongoing agenda item at all Hospital Association Committee meetings.
4 Continue to encourage ongoing professional development through financial support and paid time (where possible) as a recruitment and retention strategy.
5 Create collaborative opportunities with staff input to help make the department a success in retaining staff.
6 The manager ensures an adequate number of skilled staff are scheduled on each shift including Agency nurses. The manager to meet with the Team Lead each morning to review the anticipated staffing and associated patient assignment implications for the next 24 hours and make a joint decision. Friday morning discussions would include a review of the weekend.
7 Explore the *Learn and Stay* grant being offered in Ontario[109] to determine if there are other recruitment and retention strategies that could be employed at Campbellford Memorial Hospital.

[109] Innovating health care — transforming the role of nurses (canadian-nurse.com)

8 Manager or Educator to send an e-mail to casual RNs for the education sessions that are happening at CMH on a weekly basis.
9 Manager to meet with casual RNs individually on an annual basis to investigate any opportunities to increase their availability and to make sure they are aware of the options that are in the Collective Agreement i.e., weekend worker.
10 Request RNAO to provide CMH with the educational webinar: Supporting workforce mental health in the face of adversity: A trauma – informed organizational capability approach.
11 Establish a Registered Nurses Recruitment and Retention Committee made of local residents, local business professionals, and RNs that is a source of community information to potential recruits and a welcoming committee for new hires. This committee would establish community partnerships to support travel, accommodations and other supports required to become established within Campbellford i.e. childcare, schools etc. The goal is to ensure the RNs feel like a valued member of this community and to make their family's move as smooth as possible.

**2 Clinical Externs**

**The IAC Panel recommends:**

1 Continue to advertise for the role of the Clinical Extern including promoting this role at community colleges and universities.
2 Continue to seek ongoing funding support from the Ministry of Health for the Enhanced Extern Program as a means for recruitment and retention of nurses at CMH.
3 Finalize the draft job description of the Clinical Extern immediately.
4 Ensure there is an orientation program for the Clinical Extern and mentor within three (3) months.
5 Develop an evaluation process for the Clinical Extern in collaboration with the Nurse Manager, Nurse Educator, and mentor.
6 Ensure an exit interview is performed with the Clinical Extern upon completion of their assigned time with CMH.
7 Develop a posted schedule that works for the Clinical Extern and the IPU.

**3 Agency Nurses**

**The IAC panel recommends:**

1 Continue to actively recruit RN positions to fill vacancies and over hire RN positions to decrease the utilization and/or eliminate the use of agency nurses.
2 Explore other staffing strategies like weekend workers, and job-sharing positions to recruit and retain staff.
3 Review the agency staffing contract utilizing ONA's Collective Agreement Article 10:12 (b) & (c) prior to the September 2023 contract renewal to ensure requirements are met. Upon this contract renewal it is recommended to propose a decrease in the amount of incremental time that is required to post in advance for fill full-time hours for agency nurses.
4 Create an orientation program with nursing input for the agency nurses to ensure all aspects of the Medical/Surgical Unit is covered for quality and safe patient care.

# 3 Health and Safety

### 1 Health and Safety

**The IAC panel recommends:**

1 The IAC panel recommends that the CMH JHSC utilizes standards from external agencies such as PSHSA's directives, toolkits, and webinars as a resource for rebuilding the committee.

2 The JHSC meets every two months and as necessary for critical incident debriefs etc. Accident data & analysis and the workplace violence report should be a priority at every meeting and not deferred.

3 Workplace Violence Prevention Program should be reviewed with feedback from the JHSC prior to finalization. This should be completed by November 30, 2023.

4 CMH should complete a security coverage gap analysis to identify areas of opportunity. These results to be shared with the JHSC for forward planning.

5 CMH to increase to Level 3 for security guards and implement the healthcare security guard training checklist found in the Security Toolkit by PSHSA.

6 A Level 3 security guard is recommended for one-to –one observation of violent patients as determined by the JHSC.

7 Paid mandatory non-violent crisis intervention education to be provided to all nurses annually.

8 CMH must adhere to the OHS Act, including a worker representative must be in attendance to investigate cases in which a worker is critically injured.

9 JHSC to review to provide the PSHSA Formal Personal Safety Response System toolkit and provide suggestions on the need to incorporate the personal alarm as part of a system and not merely a device.

10 JHSC to review the PSHSA Formal Emergency Response to Workplace Violence (Code White) tool kit. The toolkit will provide guidance on the evaluation of current code white responses to violence in the workplace but also provides resources and information that can be incorporated into CMH's existing policies.

11 Personal alarms must work in all areas of CMH and until this can happen a security guard must accompany any nurse or nurses to the basement and back to the unit.

12 The tub in bathroom at end of Ranney Gorge hall to be removed.

13 The bathroom doors that open out will have the handlebars replaced with knobs to prevent the two doors from locking together.

14 A key to the patient bathrooms will be provided and kept in a secure location at the nursing station.

15 The JHSC add an RN from the Medical Surgical Inpatient unit to its worker membership and add the CNE also.

16 CMH should integrate health, safety, and wellness into the organization's core business through PSHSA's Health and Safety Management System (HSMS). When successfully implemented, it leads to a positive culture of health, safety, and wellness.

17 Ensure all CMH leadership including Team Leads/Charge Nurses complete supervisor training as determined in the Occupational Health and Safety Act.

18 CMH has a general duty to co-operate with and help the JHSC to carry out its functions under the OHS Act [clause 25(2)(e)]. The employer is also required to:

- provide any information that the JHSC has the power to obtain from the employer.
- respond to JHSC recommendations in writing (subsection 9(20))
- give the JHSC copies of all written orders and reports issued by the Ministry of Labour, Immigration, Training and Skills Development inspector.

- report any workplace deaths, injuries, and illnesses to the JHSC (subsection 52(1))

19 CMH must also advise the JHSC of the results of an assessment of risks of workplace violence [section 32.0.3]and provide the results of any report on occupational health and safety that is in the employer's possession [clause25(2)(1)]

**2 Critical Incident Debriefing**

**The IAC panel recommends:**

1 Within the next 3-6 months CMH develops in collaboration with the CNE and JHSC a Critical Incident Debriefing Process with the appropriate resources and tools to support IPU staff following a critical incident.
2 Establish a Peer Support Network for Critical Incident Debriefing for staff.
3 Within the next 3-6 months CMH to provide education to the Unit Manager and Team Leads to initiate a Critical Incident Debriefing process with staff immediately following a critical incident.
4 CMH to abide by the Occupational Health and Safety Act and the Collective Agreement and ensure union members of the JHSC are present to investigate staff critical incidents and report on them.
5 When a critical incident involves ONA members in any way (witness, victim etc.) then an ONA JHSC member should be present for the debriefing session.
6 Implement psychological health and safety standards to promote the employees' psychological safety within CMH.

# 4 Training and Orientation

**1 Training and Orientation**

**The IAC panel recommends:**

1 Develop a competency-based Medical/Surgical orientation program with the Nurse Educator, Nurse Manager, and staff input within three (3) months.
2 Develop a competency-based orientation for the Special Care Unit (SCU) with the Nurse Educator, Nurse Manager, and staff input within three (3) months.
3 Orientation will be for a period of three (3) to six (6) weeks in length dependent on the level of competency the nurse has effective immediately.
4 If the nurse hired has previous nursing experience, the above time frame may be reduced. This would be a decision of the nurse, mentor, Nurse Educator, and the Clinical Manager effective immediately.
5 The nurse on orientation will not be taken off orientation and will be considered extra staff.
6 CMH will ensure all new hires are supported financially and with time to complete ACLS and Coronary Care Level one (CC1) after at least six months on the unit.
7 Upon completion of the above ACLS and Coronary Care Level I is completed the new RNs will complete the competency based SCU orientation including three days of theoretical content and eight (8) buddy shifts with an expert RN in the Special Care Unit (SCU) before being assigned to work independently.
8 The nurse on orientation will be scheduled with one mentor and follow her/his rotation and assignment. There may be times when the mentor is off for various reasons, the nurse will then be mentored by another senior nurse on duty for that shift or shifts.
9 Ongoing support for EPIC training will be provided to support nurses as required through on-site and/or Regional Network support.
10 Evaluation of the nurse will be done by the nurse, manager, mentor, and the Nurse Educator every two (2) months during this period.
11 The nurse on orientation will be provided with the required education to feel competent and comfortable working within the Medical/Surgical/SCU Unit.

12 The Nurse Educator will provide hands-on education with the nurse within the department as requested/required by either the nurse, mentor, or manager. The Nurse educator will be readily available while she is working to assist the orientee.
13 The Team Leader/Charge Nurse role will be introduced once the nurse has at least six (6) months experience. There will also be orientation for a minimum of five (5) shifts to the Team Leader/Charge Nurse role.

# 5 Leadership and Communication

### 1 Role of the Chief Nurse Executive (CNE)

**The IAC panel recommends:**

1 Establish a vision for nursing practice linked to the Quintuple Aim. https://www.ihi.org/communities/blogs/on-the-quintuple-aim-why-expand-beyond-the-triple-aim
2 Ensures that nurses are meeting the standard of nursing practice which are consistent with the College of Nurses Standards and evidence-based Practice guidelines.
3 Establishes a Professional Practice Framework
4 Establishes a Nursing Professional Practice Council within three to six (3-6) months of the IAC submission.
5 Champions Nursing Leadership Development
6 Develops an Interprofessional Model of Care to support positive patient outcomes.
7 Focuses on quality indicators that measure value and evidence-based outcomes.
8 Builds caring resilient teams with a focus on wellness and well being.
9 Champions Recruitment and Retention with a focus on mentorship
10 Builds trusting relationships with labour partners.
11 Measures patient experience and patient engagement
12 Creates a culture of inclusivity.

**Staff Rounding**

**The IAC panel recommends**:

1 The CNE participates in staff rounding once per week to foster collaboration and trust with the Medical/Surgical IPU staff effective immediately.
2 Continue the huddles with the Manager daily and consider utilizing a status exchange tool[110] as another method of reviewing potential issues of the day, appropriate escalation as well as planning and accountability assigned for follow up effective immediately. Continue with the current practice of posting notes of the huddle exchanges.
3 Manager to round at a minimum of twice daily checking with Team Leader or delegate to understand patient flow, staffing or other concerns effective immediately.
4 Implement monthly staff meetings led by the Manager. This meeting should occur at the same time each month to establish a familiar cadence. Options for virtual attendance should be offered. The agenda should be circulated one week prior to the meeting to all staff in the department with a call for agenda items to be discussed. An updated agenda should be circulated 5 days prior to the meeting to ensure informed participation. Minutes will be distributed to all staff.
5 ONA and CMH will meet annually in accordance with the local CA Letter of Understanding RE: OPTIMAL COMPLEMENT OF REGISTERED NURSES (RNs).

[110] Cambridge Memorial Hospital ED Daily Status Exchange Tool

**2 Nursing Practice Council**

**The IAC panel recommends:**

1. The establishment of a Nursing Professional Practice Council by November 2023. While the IAC's focus was on the Medical/Surgical Unit at CMH, the establishment of the NPPC with representation across the organization will provide an opportunity to develop leadership qualities in nursing staff and will work to improve the quality of work life of nurse's organization wide.

**3 Policies and Procedures**

**The IAC panel recommends:**

1 CMH policies and procedures are reviewed during orientation with all agency staff to ensure best practices, policies and procedures are always followed.
2 CMH language in policies is outdated and does not reflect equity, inclusion and consider the diversity of the population. It is imperative appropriate language be used to eliminate unconscious bias and increase inclusivity.
3 RNs provide input and feedback to all policies and procedures.

## 6 Professional Development

**1 Professional Practice Lead/Diabetes Education**

**The IAC panel recommends:**

1 There is a posted schedule each week identifying planned Diabetes clinic and Education sessions. This will provide visibility into the role.
2 The role will work proactively with Human Resources and the IPU manager to identify onboarding requirements each month.
3 If additional education support is required, the IPU manager will engage the Professional Practice lead as soon as possible to support the staff member.
4 This role will develop an education program to support nursing when providing patients with Diabetes education when the role is not available such as weekends and holidays.

**2 Role of the Acute Care Nurse Practitioner**

**The IAC panel recommends:**

1 Continue to actively recruit for the Acute Medicine Nurse Practitioner in a permanent role.
2 Leverage all Ministry initiatives to enhance NP recruitment such as Health Force Ontario, Community Commitment Program for Nurses.
3 Establish a mentor for the role both nursing and a physician to ensure all stakeholders understand role clarity as well as defined responsibilities. This mentorship is essential in building trust and establishing secure relationships, which is necessary to build a strong foundation for the role, optimizing safe, quality patient outcomes as well as increased staff satisfaction.

# 7 Equipment

1 Medical Equipment

**The IAC panel recommends:**

1 Equipment needs, replacements and concerns are a standing agenda item at both staff and unit council meetings.
2 The hospital schedules an annual equipment inventory review with staff input to identify opportunities.
3 The hospital devises a visual management system, such as tagging, to identify broken or malfunctioning equipment in collaboration with facilities and/or Biomedical for timely repair.
4 The hospital work with the Biomedical team to develop a proactive Biomedical equipment process to perform preventative maintenance and to ensure that all equipment is in working order or is replaced in a timely manner.
5 A replacement strategy for capital items including replacement and addition of beds including speciality beds such as Bariatric, IV pumps and patient lifts are part of the annual capitol planning and purchase strategy with input from staff.

**2 Location of the Crash Cart**

**The IAC panel recommends:**

1. Review the current Code Blue procedure with Infection Prevention and Control, Professional Practice Lead, Nursing Staff, and engagement from other key stakeholders including Physicians.
2. The crash cart needs to be easily accessible to all areas of the Medical Surgical Inpatient Unit.
3. Given the most at-risk patients are in the SCU, the location of the crash cart must be in proximity.
4. The required PPE should be in the same location as the crash cart.
5. RNs will be responsible for restocking the crash cart on the Medical/Surgical In-Patient Unit.
6. Collect and monitor data related to unsafe incidents concerning the crash cart or emergency equipment. Evaluate and analyze to determine the best solution for the issue and mitigate the risk.

# 8 Professional Responsibility Workload Report Forms

**1 PRWRF**

**The IAC panel recommends:**

1 RNs in the IPU continue to document their concerns on the Professional Responsibility Workload Report Form, in alignment with the Collective Agreement.
2 The Hospital and the local Association work together to improve the Professional Responsibility Workload (PRW) process with the goal of implementing a collaborative approach to resolving workload concerns. This will include commitment on both sides to follow the steps in the collective agreement including timelines established in this process.
3 RNs in the Medical/Surgical Unit initially communicate their patient care concerns to the Clinical Manager to give management the opportunity to resolve the matter and facilitate decisions that will support safe, quality patient care.

4 Management review and respond to the PRWRF in writing as per the Collective Agreement and engage in dialogue with the nurse(s) about the complaint with the goal to resolve the immediate issue and move toward a long-term resolution, if required.

a. The manager is to respond within 10 days as per the Collective Agreement.
b. The manager is to use the 10-day window to discuss the workload complaint with the nurse(s) involved, with an ONA representative present, if desired, to understand the concerns and to seek resolution.
c. Unresolved complaints will be presented at the Hospital Association Meeting as per the Collective Agreement with the intent to identify themes and work together on resolutions.
d. The Clinical Manager provides the Chief Nursing Executive (CNE) with a Workload Grievance Summary Report, every two weeks for the next six months, to include the number of PRWRFs completed, the workload issue documented, and any developing themes of concern.
e. The CNE to support the Clinical Manager to develop corrective action plans and to support the Clinical Manager and the nurses to resolve issues in a timely and effective manner.

**8.Hospital Association Committee (HAC)**

**1 HAC**

**The IAC panel recommends:**

1 The HAC meetings be re-established on a renewed basis with the intent to follow the process and intent outlined in Article 6.03 of the Collective Agreement.

2 All parties in attendance at the HAC, treat one another in a professional, respectful manner and through dialogue seek to find common solutions to identified concerns.

3 The following format for HAC be adopted.

i. Meetings to be Chaired on an alternating basis by ONA and the Hospital.
j. Minutes continue to be taken by ONA and the Hospital, alternating monthly and circulated within one week to all members of the Committee.
k. The agenda be circulated 5 days prior to the meeting to give all parties ample opportunity to add any issues/items required by either party.
l. The CNE/Clinical Managers to attend all HAC meetings.
m. When agreement on an issue(s) is achieved, the agreement be put in writing, reviewed, and signed by all parties to ensure that all agree and sign off on joint decisions.
n. That a separate meeting be called to deal with workload concerns that are escalating in a particular unit so that trends can be identified, and corrective action put in place in a timely and effective manner.
o. The Professional Practice Lead and ONA Professional Practice Specialist conduct joint education on the PRWRF process and responsibilities.
p. The Professional Practice Lead and ONA Professional Practice Specialist conduct education on the College of Nurses Code of Conduct and Scope of Practice standards.

The IAC Panel identified one hundred and forty-one (141) commendations.

# SECTION V

# Appendices (Updated as of March 24, 2023)

**Appendix 1: Article 8.01: Professional Responsibility**

20201210_IAC Guidelines and Chair

**Appendix 2: Campbellford Memorial Hospital Nominee**

Hicks Morley Hamilton Stewart Storie LLP
366 King St. E., Suite 310
Kingston, ON K7K 6Y3
Tel: 613.549.6353 Fax: 613.549.4068

SOPHIA DUGUAY
sophia-duguay@hicksmorley.com
Direct: 613.541.4004
Cell: 613.329.0703

Toronto
Waterloo
London
Kingston
Ottawa

File No. 12736-10
February 27, 2023

**DELIVERED BY EMAIL**
**STRICTLY PRIVILEGED & CONFIDENTIAL**

Donna Rothwell, RN BScN MN
Stantec Consultants, Principal
56 Carriage Road
St. Catharines, ON L2P 1T1

(drothwell9@gmail.com)

Rozanna Haynes
1483 Harmony Road
Corbyville, ON K0K 1V0

(haynesrozanna75@gmail.com)

Dear Ms. Rothwell and Ms. Haynes:

**Re: Campbellford Memorial Hospital and Ontario Nurses' Association Professional Responsibility Complaint – Medical Surgical Program: Independent Assessment Committee – ONA #201908394**

As you are aware, we are counsel for the Campbellford Memorial Hospital in the above-noted matter.

The Hospital has invited Stephanie Pearsall to be its Nominee. Ms. Pearsall's contact information is set out below:

Stephanie Pearsall
Vice President Clinical Services/CNE
Cambridge Memorial Hospital
Guelph, Ontario

Email: stephaniepearsall3@gmail.com

We are agreeable to July 26, 27, 29 and 30, 2023 for the Hearing of this matter.

Yours very truly,

Sophia Duguay

SD/ak
c: Client
Stephanie Pearsall (stephaniepearsall3@gmail.com)

**Appendix 3: ONA Nominee**

www.ona.org

Ontario Nurses' Association
85 Grenville Street, Suite 400, Toronto, Ontario M5S 3A2
TEL: (416) 964-8833 FAX: (416) 964-8864

January 23, 2023

Donna Rothwell, RN BScN MN
Stantec Consultants, Principal
56 Carriage Road
St. Catharines, ON L2P 1T1
Home: 905-687-3980
Cell: 647-801-1589
Email: drothwell9@gmail.com

Dear Ms. Rothwell,

**RE: Campbellford Memorial Hospital and Ontario Nurses' Association: Professional Responsibility Complaint – Medical Surgical Program: – Independent Assessment Committee – ONA GEL #201908394**

---

Thank you for accepting the nomination to chair an Independent Assessment Committee (IAC) investigating a complaint at Campbellford Memorial Hospital. The Association has spoken with Mr. David McCoy, Director, Labour Relations at Ontario Hospital Association and both parties have agreed to you chairing this IAC.

I have attached to this email the Guidelines for the Chairperson of the IAC, which I believe has previously been provided to you, as well as a copy of the current Central Hospital Collective Agreement. If you require any other documents, please do not hesitate to let me know and I will forward them to you.

The Association's nominee name and contact information is attached below. The Employer will provide their nominee. Please set up dates with the nominees, who will confirm with their respective parties.

The Association's nominee is:

Rozanna Haynes
Home: (613) 477-2352 Cell: (613) 847-2352
1483 Harmony Road,
Corbyville, ON K0K 1V0
haynesrozanna75@gmail.com

Yours truly,

**ONTARIO NURSES' ASSOCIATION**

Andrea Cashman RN, BScN, M.Ed.
Counselling Professional Practice Specialist

C: Kelly Robert, ONA Local Coordinator
Lisa Barrett-Cagliostro, ONA Bargaining Unit
President Kim Chisholm, ONA Servicing LRO
Rozanna Haynes, ONA Nominee
Lorrie Daniels, ONA Manager Professional Services Learning and Development Jackie Kehoe-Donaldson, ONA Manager Professional Practice
Karen Guy, Director of Human Resources Nicole Wood, Chief Nursing Officer Amanda Wiles, Unit Manager
David McCoy, Director, Ontario Hospital Association

Hospital Collective Ageement, expires M

IAC Guidelines

20201210_IAC Guidelines and Chair

IAC Procedural Guidelines

APPENDIX 8 - Procedural Guideline

**Appendix 4 Additional Questions for Campbellford Hospital**

**Additional Questions for Campbellford Hospital**

## Appendix One:

## Independent Assessment Committee for Campbellford Memorial Hospital

**Data Request on March 13, 2023, with request for information no later than Monday June 5th, 2023.**

1) **Patient Information for the Medical Surgical Unit for the past three fiscal years April 1, 2020, to March 31, 2021; April 1, 2021, to March 31, 2022; and April 1, 2022, to March 31, 2023**

   Patient demographics including ALC patients.
   Total number of inpatient beds including surge beds
   Patient assignment guidelines
   Number of transfers out

2) **Unit Organization/Functioning**
   a) Structural drawing of the Med/Surg Unit
   b) Description of how the Med/Surg unit is organized.
   c) Organizational Chart for Nursing in the Med/Surg Unit.
   d) Job Descriptions for Team Leader/Charge Nurse, Registered Nurse, Registered Practical Nurse, Nurse Practitioner, Advanced Practice Nurse, Nurses Educators, Professional Practice Leaders any other registered staff including all allied health professionals; Does Team Leader/Charge Nurse have a patient assignment?
   e) Admission Guidelines
   f) Criteria for admission to SCU/ICU
   g) Staff assignment sheets
   h) Number of times staff pulled to work in another department.
   i) Number of times ER closed.
   j) Orientation Program for RNs, including number of weeks with a preceptor/buddy.
   k) Description of how RNs are prepared to work in the SCU/ICU
   l) Support roles, such as, but not limited to Personal Support Worker, Ward Clerk/Clerical Assistant
   m) Copy of a typical chart format/template
   n) Charting guidelines and/or policies
   o) Changes or initiatives that have impacted Med/Surg in the last three years.
      I. External issues that impact patient flow
      II. Major process changes, model of care changes, technology implementations, special projects in the unit

3) **Staffing Data for fiscal 2020-2021, 2021-2022, 2022-2023 (April 1st to March 31st)**
   a) Budgeted Full-time Equivalents (FTEs) for all staff categories in Med/Surg
   b) Total paid hours in FTEs for full-time (FT), part-time (PT), casual, agency RNs YTD

c) Number of FT, PT, and casual RNs (i.e., headcount)
d) Number of RN and RPN positions in the current fiscal year 2022-2023
e) Sick-time, overtime in FTEs for RN's and comparison over last three fiscal years
f) Copy of ads for past and current RN positions
g) Current RN vacancy rate
h) Turnover rate for RNs
i) Experience Profile – number of RNs with ED experience (under 1 year, 2 years, 3 to 5 years, 5 to 10 years, 10 t0 15 years, 15 to 20 years, greater than 20 years
j) Number of nursing staff on modified work or have permanent accommodations.
k) Copy of local collective agreement
l) Master schedule: copy of the posted schedules for RNs for the past year and a copy of daily assignment sheets for the past year.
m) Number of Nurse Practitioners, Advanced Practice Nurses, Educators, other non-bedside leadership nursing positions
n) Allocation of Allied Health Professionals (Physiotherapist, Occupational Therapist, Social Workers, Dietitians, Pharmacists, Physician Assistants, other
o) Allocation of support staff such as, but not limited to, Personal Support Workers, Ward Clerk/Clerical Assistants,
p) If utilized by the Med/Surg: the size and utilization of a department or organizational float pool.
q) Number of short, staffed shifts for RN/RPN/ward clerk/PSW/housekeeping.

**4) Budget and Performance Indicators for the past three fiscal years 2020-2021, 2021-2022, 2022-2023 (April 1st to March 31st)**

a) Total planned and expended budgeted for Med/Surg: Staffing and Equipment and Supplies

**5) Quality of Care Performance Indicators**

a) Patient Satisfaction Results in Med/Surg for the past three years
b) Staff and Physician Satisfaction Results for the past two time periods collected.
c) Number and type of critical incidence in the Med/Surg for the past three years
d) Number and type of staff injury in Med/Surg for the past three years
e) Number of Medication incidents in the past three years
f) Campbellford's violence prevention program and the number of violent incidents in the last two years
g) Number of patients falls in the past three years.
h) Program Quality Committee Minutes and/or Department or Program Meetings related to staffing and change processes for the past three years.
i) Reports on any other indicators being utilized to monitor and evaluate efficiency, effectiveness, and quality care during the past three years.

**6) Hospital Association Committee (HAC) Agendas and Minutes from 2020, 2021 and 2022 and any other Agendas and Minutes of meetings regarding workload complaints in Med/Surg**

**7) Med/Surg Staff Meeting Minutes for 2020, 2021 and 2022**

**8) Media Articles**

a) All media articles since 2020

**Appendix 5 Revised Agenda March 17, 2023**

# Independent Assessment Committee Hearing

## Ontario Nurses' Association (ONA) and Campbellford Hospital

## Draft Agenda

## Monday June 26th, 2023

| | |
|---|---|
| 08:00 – 08:30 | *Independent Assessment Committee Meeting (Committee Members only)* |
| 08:30 – 08:45 | Welcome and Introductions |
| 08:45 – 10:00 | Tour of the Campbellford Hospital Med/Surg Unit via Zoom<br>Follow-up Questions<br>**Note: The tour needs to involve representatives from ONA and the Hospital** |
| 10:00 – 10:15 | Break |
| **10:15** | **Commencement of Hearing** |
| 10:15 – 10:30 | ●Introduction and Review of Proceedings by Chairperson |
| 10:30 – 12:30 | ●Ontario Nurses' Association Submission Presentation **(1.5 hrs)**<br>◆Response to questions of clarification by: **(0.5 hrs)**<br>·Independent Assessment Committee<br>·Campbellford Hospital |
| 12:30 -13:30 | Lunch |
| 13:30 – 15:30 | ● Campbellford Hospital Submission Presentation **(1.5 hrs)**<br>◆Response to questions of clarification by: **(0.5 hrs)**<br>·Independent Assessment Committee<br>·Ontario Nurses' Association |
| 15:30 – 15:45 | ●Review of Process for Wednesday, June 28th, 2023, Thursday June 29th, 2023 |

by IAC Chairperson

15:45 Adjournment of Hearing

Initial Draft: March 13, 2023

# Independent Assessment Committee Hearing

## Ontario Nurses' Association / Campbellford Hospital

## Draft Agenda

## Tuesday June 27th, 2023

08:00 – 16:00 ***Both parties work on developing their responses to the presentations held On Monday June 26th, 2023, in preparation for Thursday June 29th, 2023***

# Independent Assessment Committee Hearing

## Ontario Nurses' Association / Campbellford Hospital

## Draft Agenda

## Thursday June 29th, 2023

07:30 – 08:30 *Independent Assessment Committee Meeting (Committee members only)*

08:30 Continuation of Hearing

08:30 – 11:30
- Campbellford Hospital Response to Ontario Nurses' Association Submission **(2 hours maximum to present)**
  - Response to questions from **(1 hour for questions)**
    - Independent Assessment Committee

·Ontario Nurses Association
- Discussion

11:30 – 12:30 Lunch Break

12:30 – 15:30 ●Ontario Nurses' Association Response to Hospital Submission
- Response to questions from Campbellford Hospital

**(2 hours maximum to present)**

·Independent Assessment Committee **(1 hour for questions)**
· Campbellford Hospital
- Discussion

15:30 – 15:45 ●Review of Process for Friday June 30th, 2023, by Chairperson

15:45 Adjournment of Hearing

16:00 – 20:30 *Independent Assessment Committee Meeting (Committee members only)*

***Note: The timing of the agenda is 'fluid'. If the Campbellford Hospital Response submission/discussion is concluded before lunch, we will proceed with the ONA Response submission/discussion before the lunch break. If the ONA Response submission/discussion concludes before 15:30, the Hearing will adjourn. The Hearing will adjourn at 16:00 at the latest.***

# Independent Assessment Committee Hearing

## Ontario Nurses' Association / Campbellford Hospital

## Draft Agenda

## Friday, June 30th, 2023

| | |
|---|---|
| 08:30 | Continuation of Hearing |
| 08:30 – 12:30 | ●Questions to both ONA and Campbellford Hospital by IAC<br>• **Med/Surg nurses have opportunity to present their issues/stories. This will be time limited.** |
| 12:30 – 13:00 | ●Closing Remarks and Discussion of Next Steps by Chairperson |
| **13:00** | **Closure of Hearing** |
| 13:00 – 15:00 | *Independent Assessment Committee Meeting (Committee members only)* |

Appendix 6 Attendee List

**IAC Panel**

Rozanna Haynes – ONA Nominee

Stephanie Pearsall – Campbellford Hospital Nominee

Donna Rothwell – IAC Chair

**ONA & Campbellford Hospital**

IAC Panel:

| Name | Email | Phone |
|---|---|---|
| Donna Rothwell(IAC CHAIR) | Donna.Rothwell@stantec.com | 647 801-1589 or 905 385-3234 |
| Rozanna Haynes (ONA) | cgabrielli@cogeco.ca | |
| Stephanie Pearsall (CMH) | spearsall@cmh.org | |

ONA:

| Name | Email | Phone |
|---|---|---|
| Andrea Cashman - Lead - Professional Practice Specialist (PPS) | | 1-800-387-5580, ext 4141 |
| Kat Armenta (PPS) | kathrinea@ona.org | |
| Tanya Beattie (PPS) | tanyab@ona.org | |
| Kim Chisolm | kimc@ona.org | |
| Jackie Kehoe-Donaldson | jackieK@ona.org | 613-929-5130 |
| Lorrie Daniels | lorried@ona.org | |
| DJ Sanderson | djs@ona.org | |
| Meghan Dunk (ONA litigator) | meghand@ona.org | |
| Angela Preocanin, ONA VP | AgenlaP@ona.org | 905 512 7413 |
| Bernadette Robinson - ONA Regional VP | bernier@ona.org | |

| | | |
|---|---|---|
| Erin Ariss - ONA President | ErinA@ona.org | |
| Katie Maynard | katiemaynard@hotmail.com | |
| Jenn Woods | jen_8728@hotmail.com | |
| Leanne Rose | leannerose7@hotmail.com | |
| Leslie Cockins | lesliecockins@gmail.com | |

| | | |
|---|---|---|
| Jen Petherick | jennpetherick@hotmail.com | |
| Lisa Barrett-Cagliostro (Bargaining Unit Prez) | local003tr@ona.org | |
| Ashley Coady | Ashleybuck_11@hotmail.com | |

Campbellford Memorial Hospital (CMH):

| **Name** | **Email** | **Phone** |
|---|---|---|
| Sophia Duguay (Counsel) | Sophia-Duguay@Hicksmorley.com | |
| Karen Guy (HR Manager) | kguy@cmh.ca | |
| Heather Campbell (Vice President of Patient Care and Chief Nursing Executive) | hcampbell@cmh.ca | |
| Amanda Wiles (Inpatient Clinical Service Manager) | Inpatient Clinical Service Manager | |
| | | |