Independent Assessment Committee Report

Constituted under Article 8.01 of the

Collective Agreement

between

Collingwood General and Marine Hospital

and

Ontario Nurses' Association

March 21st, 23rd and 24th, 2023

Independent Assessment Committee

Collingwood General and Marine Hospital
and
The Ontario Nurses' Association

Tracey Fletcher
Interim VP Patient Experience and Chief Nurse Executive
Collingwood General and Marine Hospital

Sandy Paproski
Professional Practice Specialist
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 Emergency Department at the Collingwood General and Marine Hospital.

The Professional Responsibility Complaint was presented to the Independent Assessment Committee, in accordance with Article 8.01 of the Collective Agreement between the Collingwood General and Marine Hospital and the Ontario Nurses' Association, at a Hearing held March 21st, 23rd and 24th, 2023.

The Independent Assessment Committee Panel recognizes and appreciates especially during this unprecedented time with the COVID-19 Pandemic, the time, energy, and thoughtfulness provided by representatives of the Collingwood General and Marine Hospital, the Ontario Nurses' Association and the Registered Nurses working in the Emergency Department 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 Emergency Department.

Respectfully submitted on May 8, 2023.

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

Stephanie Pearsall, BScN, MHS
Guelph General Hospital Nominee

Cindy Gabrielli, RNEC, BScN, MSN
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 Collingwood General and Marine 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

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

ONA/Hospital Professional Responsibility Workload Report Form to the nurse(s) within ten (10) calendar days of receipt of the form with a copy to the Bargaining Unit President, Chief Nursing Executive, and the Senior Clinical Leader (if applicable).
When meeting with the manager, the nurse(s) may request the assistance of a Union representative to support/assist 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 Emergency Department at the Collingwood General and Marine Hospital have consistently identified ongoing nursing practice and workload issues as evidenced by the information and data submitted from the 224 Professional Workload Report Forms (PRWRF) since January 2021 as evidenced by ONA's submission dated February 27, 2023, and received by the IAC Chairperson and Committee February 27, 2023. [2] **(See Section 2.1.2 Events Following Referral of the Professional Responsibility Complaint for further details) The number of 224 PRWRF's is inclusive of the supplemental submission received from ONA on March 15,2023**

ONA followed up with emails to the OHA (August 22, 2022) and a letter (August 24, 2022) confirming the IAC Chair and naming ONA's nominee to the IAC Panel. The Employer responded in writing to confirm their nominee, on September 16, 2022[3]

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 August 24, 2022. ONA forwarded this correspondence to the Chair, naming ONA's nominee, Cindy Gabrielli RN (EC), BScN, MSN. [4]Collingwood General and Marine Hospital named their nominee for the IAC, Stephanie Pearsall, BScN, MHS on September 16, 2022.[5]

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, Cindy Gabrielli, RN (EC), BScN, MSN on August 24, 2022 (*Appendix 2*) and the Hospital's Nominee, Stephanie Pearsall, BScN, MHS on September 16, 2022. (*Appendix 3*).[6]

1.4.1.2 IAC Introductory Teleconference

The IAC Chairperson contacted the Nominees January 2023 and provided copies of correspondence related to IAC Guidelines and Nominee Role. ONA's correspondence related to Collingwood General and Marine Hospital's overview of the issues and a list of items for Collingwood General and Marine Hospital to submit as requested for the upcoming IAC for the Nominees to review.

[2] ONA Submission to IAC Volume 1: ONA Brief and PRWRF Tracking Report Feb 27, 2023
[3] ONA Submission to IAC Volume 1: ONA Brief and PRWRF Tracking Report Feb 27, 2023
[4] Appendix 2
[5] Appendix 3
[6] As noted above

On December 12, 2022, both the Association and Collingwood General and Marine Hospital received a draft agenda for the IAC hearing scheduled for March 21, 23 and 24th, 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 March 9, 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 Thursday March 9, 2023, following receipt of the Association's and Collingwood General and Marine Hospital submissions to discuss any issues or concerns. The meeting occurred with the IAC Chairperson and the Nominees. It was decided following our March 9, 2023, meeting the IAC Committee Chair and Nominees would meet again on Sunday March 12, 2023.

1.4.1.3 Hearing Confirmation and Hearing Brief Distribution

The date for the Hearing was confirmed on November 28, 2022. 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 CMGH, the IAC scheduled for March 21st, 23rd and 24th, 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 CMGH.

The IAC Chairperson wrote to the Hospital and the Association on November 28, 2022, 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 February 27, 2023.

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

- Association Brief and Hospital Brief received on February 27, 2023, and distributed to the IAC Panel, ONA and the Hospital on February 27, 2023.
- IAC Panel held an initial call to review materials and respond to any questions in preparation for the IAC hearing Thursday March 9, 2023.
- IAC Panel met again to review the responses and review data on Sunday March 12 and 19th, 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 CMGH 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 was revised to ensure there was adequate time on day one for the entire panel and those in attendance to preview the virtual video. The Hospital developed an initial video and shared it with the Association and IAC Panel on March 7, 2023, however, there was no union representation. The video was redone to include both parties on Monday March 20, 2023, in preparation for the IAC Hearing.

1.4.1.6 CMGH ED Tour: Tuesday March 21st, 2023

On the morning of Tuesday March 21st, 2023, the IAC Panel and those in attendance observed a Site Tour of CMGH ED developed in collaboration with ONA representation. The following individuals attended the Site Tour: ONA, Staff and Hospital representation.

The Tour provided an opportunity to understand the complexity of the diverse patient population being cared for in the Emergency Department at the Collingwood General and Marine Hospital, the practice environment, care provision, supplies, equipment inter and intraprofessional 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.

Tuesday March 21st, 2023: 08:30 – 13:50 hours

Thursday March 23rd, 2023: 08:30 – 13:15 hours

Friday March 24th, 2023: 08:30 – 11:02 hours

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

1.4.2.2 Hearing Day 1: Tuesday March 21, 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 Collingwood Marine General Hospital and ONA.
- Both parties have provided excellent submissions and briefs to inform our hospital nominee Stephanie Pearsall, our ONA nominee Cindy Gabrielli, myself as your Chair of the IAC Panel, and both parties of the issues at the Collingwood Marine General Hospital's Emergency Department.

- I want to recognize and thank all of you for your extraordinary efforts and care you provided throughout the COVID-19 Pandemic to so many patients and families. It was evident that there were numerous challenges during this unprecedented time.
- 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 Sandy Paproski, 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 CGMH ED program 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 1230 hours and was presented by Tracey Fletcher, Interim VP and CNE, Collingwood General and Marine Hospital. An overview of the CMGH ED department, 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 March 23, 2023

The IAC Chairperson opened the Hearing at 0830 hours.
Tracey Fletcher, supported by members of the Hospital IAC Hearing team, provided the Hospital's response to the ONA Hearing Submission. Following a break, Sandy Paproski, 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 1315 hours.

1.4.2.4 IAC Panel Intra-Hearing Meeting

The IAC Chair began with additions to the ground rules for all parties present. The IAC Hearing is to be confidential and private and is not to be discussed outside of the hearing. Secondly, the IACIAC Chair

wanted to ensure those staff attending should feel safe sharing their stories without any negative repercussions following the hearing.
The IAC Panel met March 21st, 2023, prior to and after the meeting. The IAC Panel met during the morning and afternoon on March 23rd, 2023, and March 24th, 2023. 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 March 24, 2023

The IAC Chairperson opened the Hearing at 08:30 hours.

The IAC Chairperson once again reviewed with all those in attendance the ground rules for meaningful and professional discussions. The IAC Panel asked a series of questions.

All Hearing participants in attendance were provided the opportunity to address the IAC Panel and actively participate in the discussions. Staff shared their lived experiences, personal stories in person, through correspondence and video.

Tracey Fletcher, Interim VP and CNE on behalf of the Hospital, and Sandy Paproski, Professional Practice Specialist on behalf of the Association, provided closing remarks following the break.

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 Emergency Department especially during the unprecedented time with COVID-19 Pandemic.
- 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 – Cindy 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

The initial draft of the IAC report was circulated on April 1, 2023, to the Nominees to provide more detail of the proposed recommendations in preparation for an IAC Panel teleconference to be held on Monday April 10, 2023.The purpose of this call was to discuss the overall framework of the IAC report and recommendations.

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 March, April, and May 2023 to review the second, third, fourth, fifth, sixth draft and final 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 May 8, 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

The Collingwood General & Marine Hospital (CGMH) is an 84-bed facility serving more than 74,000 permanent residents and 3.5 million annual visitors to the communities of Wasaga Beach, Collingwood, Clearview, and the Blue Mountains. CGMH is an acute care hospital providing emergency care, diagnostic services including lab, imaging, and cardiorespiratory therapy, as well as two inpatient units (medicine and surgery). [7]

The facility provides 24/7 emergency services, diagnostic services including laboratory, medical imaging, and cardiorespiratory therapy, as well as in-patient care on medical, surgical, and obstetrical units; however, there are no paediatric inpatient services. In addition, CGMH also includes intensive care services for critical patients in a five-bed Level 2 Basic Intensive Care Unit (ICU). The hospital also provides outpatient services for dialysis and a wide range of clinics, including mental health, asthma, surgical, obstetrical, and paediatric clinics as well as surgical and pulmonary rehabilitation services. [8]

The closest larger acute care center is Royal Victoria Hospital in Barrie, 55 kilometers (kms) east and Owen Sound Hospital 63 km west. Any Level 2 Advanced intensive care needs such as traumas from the CGMH ED, must be transported to the Greater Toronto Area, to St. Michael's Hospital for Adults or The Hospital for Sick Children for paediatrics, both more than 150 kms away and two or more hours by land. CGMH does not have in-patient paediatric services and must also transfer any paediatric patient admissions to Orillia Soldiers Memorial Hospital, 75 km to the east of Collingwood.[9]

The hospital is also an integral part of the South Georgian Bay Ontario Health Team. By working cooperatively with other health care providers, CGMH can maximize its efficiencies, reduce costs and ensure that the people of the area are educated about their own health and always have access, within the region, to the health services they require.

Across the entire hospital, CGMH employs 681 staff and 75 volunteers who are committed to partnering with patients and families to provide high quality, compassionate care. In early 2022, the Hospital launched its refreshed Strategic Plan which will guide the Hospital's direction until the end of 2024.[10]

[7] Collingwood General and Marine Hospital Brief Feb 27, 2023, p. 2

[8] ONA Submission to IAC Volume 1: ONA Brief and PRWRF Tracking Report Feb 27, 2023, p, 4

[9] ONA Submission to IAC Volume 1: ONA Brief and PRWRF Tracking Report Feb 27, 2023, p, 4

[10] Collingwood General and Marine Hospital Brief Feb 27, 2023, p. 2

CMGH Emergency Department Overview

CGMH's Emergency Department (ED) provides a full range of services, 24 hours per day, seven days a week. CGMH is a community hospital. Therefore, critically ill patients who are beyond the scope of the care team are stabilized in the ED and then transferred to other health care facilities depending on their care needs. The ED volume is approximately 36,000 visits per year (projected 2022/23 volume), The department has 15 surfaces, 5 zones including 2 seclusion rooms. The highest volume days are typically Monday with the greatest number of patients presenting between 0900-2100 hours. [11]

CGMH is a community hospital with a full-service ED. The ED operates 24/7 and manages over 34,500 visits annually, averaging approximately 95 patients per day. The CGMH vision statement describes a goal to provide *Outstanding Care - For Life*, by advancing community health through compassionate, innovative, and collaborative care. The emergency department has outgrown its physical space, and the plan for a new facility is in development. The plan has existed since before 2014, when the expansion plans were first approved by the Board. The hospital acknowledges their current facilities are substandard in the ED and this is contributing to several of the challenges for staff and in the delivery of safe proper patient care. [12]

The Hospital presented to staff in 2015, the *"Building our Future Hospital"* document, which reported the hospital was and continued to function at greater than 100% capacity since 2013. As predicted in the employer's data, capacity issues have only increased further compromising patient care and exacerbating the unsafe workplace and working conditions for staff. At that time, CGMH also predicted at minimum a 30% growth of inpatient care needs to be seen by 2023, anticipating most patients to be those 65 years or older. While the ED care spaces have increased since 2015, the staffing in this same period has had minimal improvements, with two Registered Practical Nurses (RPN) added to the staffing complement in 2019 to manage the See and Treat area, and one RN 1900 to 0700 hours, in 2020 to provide overnight triage coverage. [13]

All 224 of the PRWRFs submitted by ED RNs since 2021 indicate that the current RN staffing is not sufficient. Often, the emergency department contains more patients than can be physically and safely housed and cared for, due to the lack of staff. These conditions are creating a significant negative impact on patient safety and correspondingly on nursing practice. [14]

There is no designated area for ambulance offload in the department, nor is there an assigned staff member. Ambulances are offloaded into stretcher spaces and hallways and patients are added to any existing RN patient assignments. In the Minutes of Settlement (MOS) signed in December 2020 (Exhibit 2) for this unit, the hospital agreed to increase staffing by one RN from 1000 to 2200 hours, as a Covid 19 Pandemic Response. Additional temporary funding, monies from Pay for Results (P4R) initiatives to

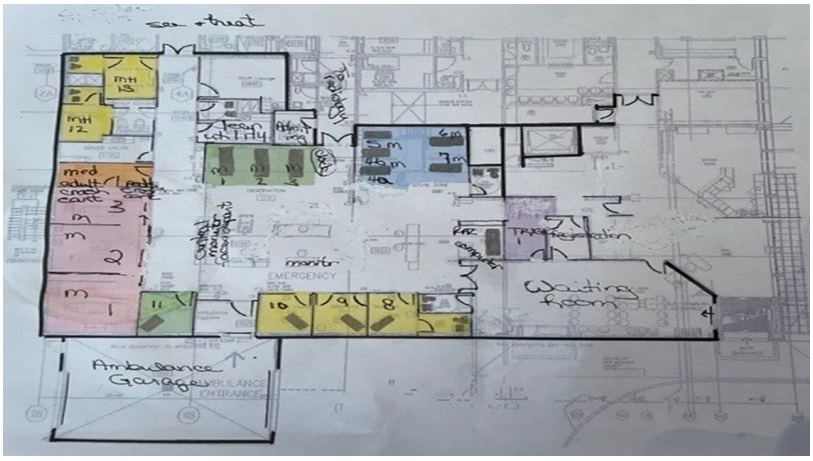
[11] Collingwood General and Marine Hospital Brief Feb 27, 2023, p. 2
[12] ONA Submission to IAC Volume 1: ONA Brief and PRWRF Tracking Report Feb 27, 2023, p, 6
[13] ONA Submission to IAC Volume 1: ONA Brief and PRWRF Tracking Report Feb 27, 2023, p, 6.
[14] ONA Submission to IAC Volume 1: ONA Brief and PRWRF Tracking Report Feb 27, 2023, p, 7.

support ED strategies, also included an RPN from 1000 to 2200 hours daily. The assignment sheets in 2021 indicate that both positions have since been eliminated. [15]

The ED has 17 acute care stretcher spaces, three trauma rooms, nine cardiac monitored bed spaces and two secure rooms for Mental Health patients in crisis. The Rapid Assessment Zone (RAZ), located just inside the department is an unstaffed area with one stretcher, utilized by the triage RN or Resource/CN for quick assessments of patients from the waiting room needing ECGs or blood work. The department also includes a See and Treat area which is located outside the main emergency department space. The See and Treat area has eight dedicated rooms with a fluctuating number of stretchers and chairs. A physician and two RPNs are staffed in this area, seven days per week from 0900 hours to 2300 hours daily. This space often has patients awaiting treatment, care and discharge instructions, after the hours of operation conclude. The total capacity for this emergency department is twenty-five care spaces.[16]

Unit Map CMGH Emergency Department

Below is a map of the CGMH ED. [17]



The ED is a single large open care space, divided into designated assignment areas. ED 2, or what is known as the See and Treat area is located outside the main department, through double doors and down the hallway.

There are 17 stretcher spaces, for individual patients, in the main ED care area. Designated care spaces are noted in pink, blue, yellow, green, orange and purple on the map. The pink area or trauma/resus area consists of three stretchers and is the cardiac monitored, critical care assignment. This assignment has recently been divided into three separate rooms. Staff report these rooms are designated as isolation rooms and are equipped with air exchanger ventilation or ventilation outside. None of these

[15] ONA Submission to IAC Volume 1: ONA Brief and PRWRF Tracking Report Feb 27, 2023, p, 7
[16] ONA Submission to IAC Volume 1: ONA Brief and PRWRF Tracking Report Feb 27, 2023, p, 7
[17] ONA Submission to IAC Volume 1: ONA Brief and PRWRF Tracking Report Feb 27, 2023, p, 8

rooms have an anti-room, resulting in donning and doffing of infectious Personal Protective Equipment (PPE) to be done in the hallway.

The medication room, noted in orange, is beside the trauma/resus area, and entrance into the medication room is either from the hallway or the trauma/resus area. The adult and paediatric crash carts are placed just outside of the door of the medication room in trauma/resus room three.

The yellow zone (rooms 8, 9, 10, 12, 13) are another nursing assignment. These five rooms are not equipped with cardiac monitoring capabilities although portable monitors are often utilized for patients placed in these rooms who require this intervention. Rooms 12 and 13 are seclusion rooms, for patients experiencing mental health crisis issues. The desk space between 12 and 13 is where a security officer is assigned. Room 8 is a true isolation care space, fitted with negative and positive pressure capability. According to the hospital, room 9 is to be utilized as the anteroom for isolation room 8 however, staff report they are rarely able to use room 9 in this capacity as it is frequently required as a patient care space.

The same circumstances are reported for isolation patients placed in the trauma/resus rooms, where donning and doffing of PPE must be done in the hallway. The clean and dirty utility rooms are located in the hallway across from rooms 12 and 13.

The green area has four care spaces (rooms 1, 2, 3 and 11) and is another nursing assignment. Rooms 1, 2, and 3 have cardiac monitoring capabilities. The patient care spaces in these rooms are divided by curtains. Room 11 is a private patient room, and is often required, in addition to rooms 12 and 13, for patients experiencing a mental health crisis. Bedside rooms 1, 2, and 3 there is a space the RNs identify as “under the clock”. This unconventional space frequently has an acute patient on a stretcher that is added to the nurse’s assignment, and as such creates a five-patient assignment.

The blue area includes patient spaces 4a, 4b, 5, 6 and 7, also a five patient nursing assignment. Four of the care spaces are equipped with central cardiac monitors. This area is also divided by curtains and frequently staffed by RPNs when the ED is short of RNs, and due to staffing challenges. The acuity and appropriateness of this assignment is not always prioritized.

The area central to the entire department is the main nursing station, which has two central monitor displays, one for the trauma/resus area and one for the rest of the monitors in the department. The Resource/CN and the ED unit clerk are stationed in this area, which is also used by the RNs assigned patients in the yellow, green and blue areas.

The purple area is triage and is staffed with one RN 24/7. The registration clerk is stationed beside the triage nurse however, due to increased patient volumes, is frequently displaced to allow a second triage RN to assess patients in a separate care space. Beside triage is a space with one stretcher, utilized by the Resource/CN or triage RN to obtain blood samples or ECGs to expedite care for patients from the waiting room. The RAZ area is not a specific assignment within the ED, and frequently falls to the Resource/CN or triage nurse to care for and monitor patients placed in this area, as an additional assignment.

As noted earlier, the See and Treat area is located outside of the main footprint of the ED, through double doors and down the hall. This care area has five stretchers, and a flexible number of patient chairs, adjusted as the needs arise. The See and Treat care area is staffed by two RPNs and one physician and is only meant to be open from 0900 hours to 2300 hours; however, as previously noted, patients are often held here awaiting treatment, care and/or discharge instructions as there are no other spaces available. When this holding space is used outside of the planned hours, it creates competing workload priorities for the RNs, complicated by the geographic location and lack of resources to cover the assignment between 2300 hours and 0900 hours nightly.[18]

CMGH Emergency Nursing Model of Care

CGMH's ED nursing model of care includes RNs and RPNs, with a large majority of the workload assigned to the RNs. Collaboration is essential to improving healthcare delivery and a strengths-based approach leverages knowledge and skills of team members. [19]

The RN and RPN baseline staffing is six RNs on the dayshift and six RNs on the night shift, with one RPN temporarily scheduled 24/7 and two RPNs scheduled on swing shifts, one RPN is scheduled 0900 to 2100 hours and one RPN is scheduled 1100 to 2300 hours). The role of the temporary RPN scheduled 24/7 in the main ED, is to support the care of admitted patients being held in the department due to the lack of available inpatient beds, within the organization. Both RPNs on the swing shifts are assigned to the See and Treat area.[20]

The goal of the ED staffing model is a primary care model however nurses are assigned based on geographical area. Often this results in high acuity patients being in care spaces assigned to new or novice RNs or an RPN. Either circumstance can create a situation where the care needs of the patient exceed the scope, knowledge, skill, and competence of the assigned care provider; however, no other option is available.[21]

The ED adheres to the College of Nurses of Ontario (CNO) three-factor framework professional practice model of care that has the following guiding principles:[22]

(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.

[18] ONA Submission to IAC Volume 1: ONA Brief and PRWRF Tracking Report Feb 27, 2023, p, 8-11.
[19] Collingwood General and Marine Hospital Brief Feb 27, 2023, p.10.
[20] ONA Submission to IAC Volume 1: ONA Brief and PRWRF Tracking Report Feb 27, 2023, p, 11.
[21] ONA Submission to IAC Volume 1: ONA Brief and PRWRF Tracking Report Feb 27, 2023, p, 12
[22] Collingwood General and Marine Hospital Brief Feb 27, 2023, p.10.

(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.[23]

The ED Resource Nurse role is responsible for facilitating patient flow based on acuity as well as supporting all members of the interdisciplinary team. In the past, the ED only had a resource nurse on day shift but in 2022, the Hospital hired two additional resource nurses so the ED could introduce 24/7 coverage. Resource nurses follow the same DDNN rotation as other staff which provides consistent leadership within the department. There are currently 4 RNs in the permanent Resource Nurse role.

The RN assigned as the triage nurse does not have a patient assignment. Recognizing that the demands of an ED are dynamic, the Hospital encourages staff to adjust assignments as required in response to patient acuity. They are also encouraged to reallocate staff within the department to adapt to the circumstances at the time. A team approach is essential to an efficient ED so that staff can leverage skill sets, experience, and expertise in response to changes, which are typical and expected in any emergency department environment.[24]

Professional Responsibility and Workload Process[25]

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.

[23] Collingwood General and Marine Hospital Brief Feb 27, 2023, p. 10
[24] Collingwood General and Marine Hospital Brief Feb 27, 2023, p. 10
[25] ONA Submission to IAC Volume 1: ONA Brief and PRWRF Tracking Report Feb 27, 2023, p.13-15

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 Professional Responsibility and Workload Issue(s), it is the administrative nurses' accountability to their own CNO Standards to advocate for and pursue resolution.[26]

2.1.2 Events Following Referral of the Professional Responsibility Complaint

Of note prior to the current issues being advanced to the IAC, the parties resolved some issues in the ED through the PRW process in 2020 and signed Minutes of Settlement (MOS) were achieved in December 2020. Many issues, including RN staffing, equipment and repair processes, housekeeping support, laboratory support, security support, violence policies and safety education for staff, as well as a policy to support safe care for patients placed on a Form 1, were agreed upon. However, since January 2021, the RNs have submitted an additional 224 PRWRFs reporting their concerns related to increased patient volumes, patient acuity, and the provisions of safe quality patient care. The RNs have advanced their concerns to their nursing leadership; their manager, director and interim CNE.

Early in the PRW process in 2020, it was revealed that the CNE, Lauren Tindall, was not registered as an RN with the College of Nurses of Ontario. ONA notified the organizational leadership, and they responded on August 10, 2020 (Exhibit 7), that neither the hospital nor Ms. Tindall were aware of her lack of registration with CNO. As a result, of ONA's inquiry, the Hospital assigned the CNE title on an interim basis to Ms. Aimee Stinson, the Manager of Inpatient Surgery and Maternal Newborn, as a solution until Ms. Tindall could obtain her registration to practice as a registered nurse in Ontario (Exhibit 8). Since first being informed of Ms. Tindall's lack of CNO registration, the Employer has assigned the title of CNE to a second candidate, Ms. Marianne Beardsall. However, to date Ms. Tindall remains unregistered with CNO, and continues to use the protected title of RN. CGMH continues to identify Ms. Tindall on their public website as the CNE. The role of CNE is one deemed by legislation, within the Public Hospitals Act, 1990, that must be filled with a Registered Nurse.[27]

The Hospital-Association Committee (HAC) at Collingwood General and Marine Hospital is scheduled to meet bi-monthly, in accordance with Articles 6.03 and 8.01 however both parties agreed to meet monthly for discussions to achieve joint resolutions for multiple PRWRFs on multiple units. The HAC is the forum for discussing issues related to workload and practice raised by ONA members and to allow both parties to propose solutions or ideas for resolution; however, over the last two years very little resolution or progress has been achieved.

There have been multiple concerns and issues raised related to RN staffing and an inadequate RN baseline, in addition to the extreme wait times and excessive delays to conducting the initial patient

[26] ONA Submission to IAC Volume 1: ONA Brief and PRWRF Tracking Report Feb 27, 2023, p, 13-15.
[27] ONA Submission to IAC Volume 1: ONA Brief and PRWRF Tracking Report Feb 27, 2023, p, 16.

triage. The PRWRFs report multiple incidents that highlight the lack of supportive leadership and poor communication between leadership and frontline staff.

On February 17, 2022, ONA shared the working Action Plan document via email with the Employer, in advance of the February 22, 2022, meeting[28]. The first meeting with ONA PPS on February 22, 2022, ONA presented the Action Plan and supporting recommendations. The employer responded to ONA's Action Plan on March 21, 2022, providing information regarding the ED layout, unit processes and the educator role secondment. The employer identified they were posting a subsequent point five educator to support orientation for new temporary positions for unregulated staff and the initiation of safety huddle.

A subsequent meeting took place on April 4, 2022, where discussions between ONA and the employer, driven by the Action Plan document, failed to resolve the issues (Exhibit 13). The employer also shared the completed Appendix 9 document at this meeting (Exhibit 14) and noted that based on their benchmarking, they felt they were staffed adequately. Prior to the meeting on May 16, 2022, the employer provided ONA with some aspects of disclosure as previously requested by email on May 11, 2022 (Exhibit 15). The action plan was again presented to the employer at meetings on May 16, 2022 (Exhibit 16), and June 20, 2022 (Exhibits 17a & 17b). At the June 20, 2022, meeting, due to the employer's lack of action and failure to provide tangible resolutions to the RNs reported concerns, the Union informed the Employer they would be advancing the file to the IAC, in a letter submitted on June 30, 2022 (Exhibit 18).[29]

A total of six meetings with CGMH leadership and the ED took place over nine months. Minimal actions to achieve resolutions of the RNs workload concerns have been agreed to or implemented. While the employer agreed to the Resource Nurse/CN role, without an assignment 24/7, the RNs report the role is not reliably filled with a consistent RN and the RN filling CN or Resource RN frequently have a patient assignment in addition to their Resource/CN responsibilities, on the day and night shift. All resolutions to the practice and workload issues remain unresolved and the action plan updates provided by the Employer including the December 19, 2022, received January 19, 2023, include no actions or resolutions. (Exhibit 26)[30]

Of the 208 PRWRFs submitted, management has failed to respond to more than 40% of the PRWRFs submitted by the ED RNs. Most of the management responses, reiterate the shift details and patient census, or describe why management were unable to fill a vacancy, sick leave, or long-term absence. Responsibility for resolution falls on management, that has responsibility for operational decision-making, quality of care and patient and staff safety. RNs in the ED report situations of insufficient baseline staffing, high and unsafe patient to nurse ratios, inappropriate skill mix, lack of orientation/training, high patient volumes, escalating patient acuity, lack of space, high volumes of admitted patients in the department and significantly long delays at triage, especially in relation to an

[28] ONA Submission to IAC Volume 1: ONA Brief and PRWRF Tracking Report Feb 27, 2023
[29] ONA Submission to IAC Volume 1: ONA Brief and PRWRF Tracking Report Feb 27, 2023
[30] ONA Submission to IAC Volume 1: ONA Brief and PRWRF Tracking Report Feb 27, 2023

initial triage assessment from the time of arrival in the department. These conditions have resulted in missed, gaps in, or rationed care, an inability to maintain Canadian Triage and Acuity Scale (CTAS) guidelines for patient initial assessment, negative patient outcomes, and delays in assessing and intervening for patients experiencing chest pain and any other acute conditions, and increased errors.[31]

The ongoing strain and burden of managing very high workloads, has decreased job satisfaction, increased stress, and burnout among staff, which has resulted in an ongoing loss of qualified and established RNs and contributed to an unstable workforce in the ED. The outstanding practice and workload issues of insufficient staffing, high patient acuity, high patient volumes and increased workload, poor orientation, concerns about risks to patient and staff safety, along with the lack of effective nursing leadership and effective communication, have all resulted in staff burnout and poor morale creating a toxic workplace environment. No effective resolutions to any of the issues raised by the RNs in the ED have been achieved since the onset of the submission of their PRWRFs. [32]

A Letter of Complaint was submitted to the Employer to forward the issues for Collingwood General and Marine Hospital Emergency Department to the Independent Assessment Committee by the Union on June 30, 2022 (Exhibit 18). As indicated in the Union's Letter of Complaint, 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 College of Nurses of Ontario (CNO) Practice Standards and Guidelines:

- Code of Conduct (Exhibit 27)
- Professional Standards Revised 2002, 2022 (Exhibit 5)
- RN and RPN Practice – The Client, the Nurse and the Environment, 2018 (Exhibit 28)
- Therapeutic Nurse-Client Relationship Revised 2006, (Exhibit 29)
- Authorizing Mechanisms, 2020 (Exhibit 30)
- Decisions about Procedures and Authority Revised, 2020 (Exhibit 31)
- Confidentiality and Privacy – Personal Health Information, 2019 (Exhibit 32)
- Ethics, 2019 (Exhibit 33)
- Documentation Revised 2008, 2019 (Exhibit 34)
- Medication Revised 2008, 2019 (Exhibit 35)
- Conflict Prevention and Management, 2018 (Exhibit 36)
- Consent, 2017 (Exhibit 37)
- Directives, 2020 (Exhibit 38)
- Working with Unregulated Care Providers (Exhibit 39)
- Accountability of Nurses during Covid-19 Pandemic (Exhibit 40)[33]

[31] ONA Submission to IAC Volume 1: ONA Brief and PRWRF Tracking Report Feb 27, 2023, p. 19-20
[32] ONA Submission to IAC Volume 1: ONA Brief and PRWRF Tracking Report Feb 27, 2023, p. 20
[33] ONA Submission to IAC Volume 1: ONA Brief and PRWRF Tracking Report Feb 27, 2023, p. 20-21.

2.2 Ontario Nurses' Association and Collingwood General and Marine Hospital (CMGH) Perspectives

The Hearing was structured such that:

- On March 21st, 2023, the Association, and the Hospital each provided an oral Submission presentation highlighting the key elements of their previously submitted written Brief.
- On March 23rd, 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 March 24th, 2023, the IAC Panel posed several questions to both parties to obtain a more comprehensive understanding of the issues. All staff in attendance was given the opportunity to share their concerns, make statements and provide us with their own testimonials related to CGMH ED.

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 fifty-nine (59) recommendations based on two hundred and twenty-four (224) 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.[34]
The following are ONA's recommendations:

Professional Practice – Staffing

1. Immediately increase the daily Registered Nurse baseline staffing to 17 RNs in a 24-hour period, such that there are eight RNs scheduled on both the day shift and the night shift and at a minimum, one RN included in the baseline staffing scheduled as a mid-shift, 1100 to 2300 hours, to support and back-up, as second triage RN during this 12-hour period. This staffing model will support seven RNs in the main ED, one RN 24/7 in See and Treat, and one RN swing shift, to support triage. This staffing model will support each RN to achieve the highest level of care as required by the College of Nurses of Ontario Standards.
2. Increase RN staff resources by one RN when more than five admitted patients are present in the ED and add one additional nurse RN for every additional five admitted patients. Utilize CNO's Practice Guideline, RN and RPN Practice - The Client, the Nurse, and the Environment to guide patient assignment and decision making regarding the most appropriate care provider.
3. Increase the daily organizational resources to include one RN 24/7 available to support patient transfers to other healthcare facilities. This role must be filled by RNs who possess the required knowledge, skills and ability to manage the highly acute, critically ill patients that require transfer to a higher-level facility.

[34] ONA Submission to IAC Volume 1: ONA Brief and PRWRF Tracking Report Feb 27, 2023, p. 96-105

4. The above recommended staffing model would provide for one RN Resource/CN daily, without an assignment, one Triage RN, and a second Triage RN from 1100 to 2300 hours, two RNs assigned to trauma/resus, three RNs assigned to the patient care area in the main emergency room, assigned by patient acuity and needs of patients according to the CNO Practice Guideline, RN and RPN Practice, The Client, the Nurse and the Environment.
5. Staff the See and Treat area, with one RN and one RPN and maintain this area 24/7. Realizing the emergency department is rarely a stable environment allowing RNs to provide consultation and support to RPNs.
6. Increase unit clerical support, to provide 24/7 coverage, by adding an additional unit clerk to be scheduled from 2300 to 0700 hours, daily. This will provide essential support to meet the increased demands of the ED and allow RNs to focus on providing required nursing care. This would achieve one unit clerk 24/7, and a second unit clerk, as currently scheduled, between 1000 and 1900 hours daily.

Missed or Delayed Care

7. Immediately increase the daily RN baseline staffing to 17 RNs in a 24-hour period, such that there are eight RNs scheduled on both the day shift and the night shift, and at a minimum one RN included in the baseline staffing as a mid-shift, 1100 to 2300 hours to support a back-up second triage RN during this 12-hour period. This staffing model will allow the triage RN to complete safe and timely assessments and reassessments, including observation of the triage line and patients in the waiting room, as per CTAS guidelines. This staffing model will also support each RN to achieve the highest level of care as required by CNO Standards.
8. In addition to the above noted RN resources, immediately increase RN staff resources by one RN when more than five admitted patients are present in the ED and add one additional nurse for every additional five admitted patients. Utilize the CNO Practice Guideline - RN and RPN Practice: The Client, the Nurse and the Environment to guide patient assignment and decision making regarding the most appropriate care provider.
9. Ensure all staff assigned to work in the ED are fully skilled and trained to provide care to the diverse patient population presenting to the CGMH ED, and to deliver the specialized nursing care and interventions that are essential in the ED due to the high acuity and complexity of this population.
10. Implement a Unit Aide position, assigned specifically to the ED, with 24/7 coverage. The unit aide will be responsible for a wide range of patient support activities, including but not limited to:
    a. Sort, straighten, standardize, and sustain the supply room and exterior room carts in all care spaces.
    b. Monitoring and re-ordering of special supplies, as required.
    c. Accessing urgently required supplies and equipment from other departments, as necessary.
11. Ensure all staff receive regular and ongoing training, to remain current in their skills and competencies, along with regular refreshers, annual skills days and required certifications.
12. Immediately conduct a review of staff skill mix and establish a balance of novice to expert RNs and RPNs per shift. Ensure the master schedule is balanced with sufficient expert RNs on each shift to support the learning and growth needs of all staff especially the novice RN and RPN staff. Benner's Model of Novice to Expert is a recognized tool for this purpose.
13. Review the RN and RPN staff's skills and competence annually and ensure the master schedule has a balance of appropriate skill mix to meet the scheduling needs as outlined above.

Patient Acuity - Acuity and Capacity

14. Immediately increase the daily RN baseline staffing, as previously noted, by two RNs 24/7, and one mid-shift RN 1100 hours to 2300 hours, to support RN staff to achieve the highest level of care as required by the College of Nurses of Ontario Standards.
15. Increase RN staff resources by one RN when more than five admitted patients are present in the ED and add one additional nurse for every other five admitted patients. Utilize CNO Practice Guideline, RN and RPN Practice: The Client, the Nurse and the Environment to guide patient assignment and decision making regarding the most appropriate care provider.
16. When more than 5 admitted patients are present in the ED without an in-patient bed assignment, CGMH will relocate them to a care space outside the emergency department, staffed with RNs or RPNs not associated with the emergency staffing pool and not reporting to emergency department leadership.
17. Increase daily organizational resources to include one RN 24/7 available to support transfers of patients to other care facilities. This role must be filled by RNs who possess the required knowledge, skills, and ability to manage the highly acute, critically ill patients that require transfer to a higher-level facility.

Fluctuating Workload - Skill Mix, Novice Staffing, Education

18. Immediately increase the daily RN baseline staffing by two RNs 24/7, such that there are eight RNs scheduled on the day shift and the night shift, to ensure that each RN can achieve the highest level of care as required by CNO Standards.
19. Immediately increase the daily RN baseline staffing, by one RN 12 hours per day, to include a mid-shift 1100 to 2300 hours to ensure adequate support for triage, allowing the triage nurse to complete safe timely assessments and reassessments, including observation of the triage line and patients in the waiting room, as per CTAS guidelines.
20. Ensure all staff assigned to work in the ED are fully trained and skilled to provide the required elements of patient care for the diverse patient population presenting to the CGMH ED, and to deliver the specialized nursing care and interventions that are critically required due to the acuity and complexity of the patient population.
21. Ensure RPNs are supported with adequate Practice is in accordance with College of Nurses of Ontario, RN/RPN Practice: The Client, the Nurse, and the Environment.
22. Ensure RPNs are supported with adequate RN resources to provide access to timely consultation and collaboration and to prevent RPN practice from being compromised and RPNs working beyond their scope of practice.
23. Ensure the Emergency/Critical Care educator is available to provide just in time education in the ED, at minimum 75 % of their worked time. Providing flexible hours to support staff in the ED outside of daytime hours, supporting shift workers is necessary.
24. The employer will establish and maintain an updated thorough Orientation program with a minimum one week in class theory education, provided by the clinical educator with didactic lecture and discussion, in person interaction and hands on skills training, in addition to the corporate orientation. This education will be followed by at minimum 36 buddied shifts with a consistent assigned mentor. Needs of the new staff member will be assessed at mid-point and determine if further buddied shifts may be required. This orientation and mentorship program will provide a comprehensive orientation

and mentorship for all new staff and support a safe, quality transition for new nurses and nurses new to the role, while also promoting retention and job satisfaction.

25. The employer must ensure all new RNs have a minimum of one year's experience in the ED prior to training to the Resuscitation area per NENA Standards (2018).
26. The employer must ensure all RNs have a minimum of two years experience in ED and minimum one year experience in CGMH ED before being assessed for readiness to train to the Triage role, per NENA Standards (2018).
27. The employer will support ongoing paid education opportunities, education leaves as able to accommodate, with priority for emergency nursing programs: Emergency or Critical Care Nursing Certificate, ACLS/BCLS initial training and recertification, ENPC/PALS initial training and recertification, TNCC initially training and recertification, offer opportunity for paid NRP certification, initial CTAS training and biannual recertification.
28. The employer will arrange for and facilitate all RN staff to attend an annual in-house, educational skills/competency day, combined with annual training on Delegated Controlled Acts for all staff, on mandatory paid time, provided by the employer.
29. Immediately conduct a review of staff skill mix, and balance of novice to expert RNs and RPNs per shift. Ensure the master schedule is balanced with sufficient expert RNs on shift to support the learning and growth needs of all staffing but especially the novice RN and RPN staff. Benner's model of Novice to Expert is a recognized tool for this purpose.
30. Review the RN and RPN staff's skills and competence annually and ensure the master schedule has a balance of appropriate skill mix to meet the scheduling needs as outlined above.

Fluctuating Staffing - Non-Nursing

31. Increase unit clerical support to provide 24/7 coverage by adding a unit clerk daily, to be scheduled 2300 to 0700 hours, to provide support for increased demands of the ED and allowing RNs to focus on providing required nursing care.
32. A unit attendant will be scheduled, daily, 24/7 to support stocking, appropriate patient transport within the organization and other non-nursing tasks such as: monitoring and obtaining IV pumps and poles, wheelchairs, pillows, and other essential equipment and supplies necessary for the smooth flow of the department and improved timely patient care.

Leadership and Communication

33. Immediately increase the daily RN baseline staffing, as previously noted to 17 RNs, in a 24-hour period, such that there are eight RNs scheduled on both the day shift and the night shift, and at minimum one RN included in the baseline staffing as a mid-shift, RN 1100 hours to 2300 hours, to support a backup second triage RN during this 12-hour period. This staffing model will allow the triage RN to complete safe timely assessments and reassessments, including observation of the triage line and patients in the waiting room, as per the CTAS guidelines. This staffing will also support each RN staff to achieve the highest level of care as required by CNO Standards.
34. Increase RN staff resources by one RN when more than five admitted patients are admitted in the ED and add an additional nurse for every additional five admitted patients. Utilize the CNO Practice Guideline, RN and RPN Practice: The Client, the Nurse and the Environment to guide patient assignment and decision making regarding the most appropriate care provider.
35. Increase daily organizational resources to include one RN 24/7 available to support transfers of patients to other care facilities. This role must be filled by RNs who possess the required knowledge,

skills, and ability to manage the highly acute, critically ill patients that require transfer to a higher-level facility.

36. The Program Manager to round daily, and as needed, to support the team, to consult with the Resource Nurse to assess the patient care requirements and to support short term staffing needs for the next 24 hours. On Fridays, the consultation includes assessing any known staffing gaps throughout the weekend.
37. The Program Manager will assess the key areas of nurse dissatisfaction within the ED and develop a corrective action plan, which is to be informed through staff input, to address the identified issues within six months.
38. Manager to connect twice daily with a resource nurse to review assignments.
39. Hospital Coordinators to consistently round through the department, each shift and review patient activity, volumes, and acuity, and facilitate patient/bed flow and staffing needs.
40. Implement daily safety connects with staff to review the following key areas: staff safety issues, staffing pressures, Infection Control issues, corporate and department policy updates and changes, equipment/tool/supply issues, and provide positive feedback such as staff recognition and patient feedback.
41. Hospital Coordinators will contribute to managerial written responses to PRWRFs when the issues raised by the RNs occur on their shift, in accordance with the collective agreement timelines.
42. 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 are to be printed and posted on the unit bulletin board and shared electronically.
43. The employer will ensure leadership, as well as staff adhere to organizational policies.
44. The organizational Interprofessional Practice Council should welcome engaged ONA representatives as members on the committee.
45. Implement an organizational leadership training and development program. Include all program managers, directors, VPs and CNE, once all vacancies are filled.
46. Initiate and budget for regular management and leadership training for all nursing leadership, annually.
47. Examine, observe, and ensure all nursing leadership maintains professionalism and integrity, in all practices and communications.
48. Nursing Leadership will engage positively in the Professional Responsibility Process to create a dynamic and positive culture, to establish collaboration, problem-solving and open and effective communication at all times, with a solution focus and problem-solving perspective to achieve mutually agreeable resolutions.
49. Manager communication should be clear, effective, and transparent at all times.
50. 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.
51. Supervisor Competency Training will be required and completed by all nursing leadership.

Morale and Work Environment

52. Immediately increase the daily RN baseline staffing to 17 RNs in a 24-hour period, such that there are eight RNs scheduled on both the day shift and the night shift, and at minimum one RN included in the baseline staffing as a mid-shift, 1100 to 2300 hours, to support a backup second triage RN during this 12-hour period. This staffing model will allow the triage RN to complete safe timely assessments and reassessments, including observation of the triage line and patients in the waiting room, as per the CTAS guidelines. This staffing will also support each RN can achieve the highest level of care as required by the College of Nurses of Ontario Standards.
53. Improve staffing and the quality practice environment; to improve nurse to patient ratios and foster improved morale, improved job satisfaction and reduce burnout and intention to leave.
54. Ensure every RN on every shift can deliver nursing care at a level of 10/10 on a bad day and much greater on a good day, as is expected of all registered nurses by their regulatory body the College of Nurses of Ontario.
55. Improving the quality practice environment requires several elements:
    a. Effective and Professional Communication
    b. Authentic and Transformational Leadership
    c. Shared Decision Making
    d. Patient-centred culture focused on quality care
    e. Appropriate Staffing
    f. Autonomous Practice
    g. Professional Development
    h. Teamwork
    i. Intra- and Inter-professional Collaboration
56. Initiate an independent external third-party intervention to address issues of excessive RN staff turnover, poor morale.
57. The employer will engage in an authentic and effective external Team Building Program, that includes intentional actions, employer receptiveness and responsiveness, and is outcomes and action-based, to be implemented in a collaborative spirit.
58. Conduct an ED specific staff satisfaction survey regarding the work environment, leadership, safe nursing practice, safety of the practice environment and safe patient care, to be utilized as data for an external Team Building Program intervention.
59. The employer will conduct exit interviews on all staff who leave the ED.

2.2.2 Collingwood General and Marine Hospital

Context of Discussion at the IAC

About the Hospital

The Collingwood General & Marine Hospital (CGMH) is an 84-bed facility serving more than 74,000 permanent residents and 3.5 million annual visitors to the communities of Wasaga Beach, Collingwood, Clearview, and the Blue Mountains. CGMH is an acute care hospital providing emergency care, diagnostic services including lab, imaging, and cardiorespiratory therapy, as well as two inpatient units (medicine and surgery).

In addition, CGMH also provides care in specialty areas including obstetrics, orthopaedics, intensive care, and surgery. The Hospital also provides outpatient care including dialysis and a wide range of clinics including mental health and rehabilitation services. CGMH continues to provide care close to home for our community and plays a key role as an integrated orthopaedic centre for our region.

The hospital is also an integral part of the South Georgian Bay Ontario Health Team. By working cooperatively with other health care providers, CGMH can maximize its efficiencies, reduce costs and ensure that the people of the area are educated about their own health and always have access, within the region, to the health services they require.

Across the entire hospital, CGMH employs 681 staff and 75 volunteers who are committed to partnering with patients and families to provide high quality, compassionate care. In early 2022, the Hospital launched its refreshed Strategic Plan which will guide the Hospital's direction until the end of 2024. The Hospital identified its Vision, Mission and Values (attached at **Tab 1**):

The Strategic Plan also confirmed the Hospital's four strategic pillars, providing new goals for each. The Strategic Plan is attached [35]

PATIENT EXPERIENCE

We focus on the ongoing evolving needs of our patients and families.

We will provide compassionate patient and family-centered care of the highest standard to deliver an exceptional experience. Within a best practice environment, key drivers will include the patient/family voice, and a culture of innovation and safety.

WE WILL:

- improve access to care closer to home.
- enhance capacity and coordination of services for frail seniors, and individuals with complex mental health needs.

OUR PEOPLE

We deeply value our skilled and dedicated staff, physicians and volunteers.

We will ensure a healthy, safe and inclusive workplace which embraces our organizational values. Building upon a culture of engagement in an interprofessional setting, our people will be empowered and encouraged to contribute their input and expertise to enrich the patient experience today and introduce new ideas tomorrow. We are committed to safety, diversity, open dialogue, continuous learning/development and the education of the next generation of our people.

WE WILL:

- retain, develop and recruit highly skilled people.
- continue to build a CGMH team that reflects equity, inclusion and the diversity of our community.
- listen, focus and act to support the health and wellness of our people.

PARTNERSHIPS

We focus on the ongoing evolving needs of our patients and families.

We will contribute to the development of a care delivery system that builds upon and significantly advances the health of our community. We will continue to work with our many partners so that patients receive care in the most appropriate setting and find it easier to navigate the health "system". We align with provincial and community priorities to transform and integrate the healthcare system.

WE WILL:

- improve health outcomes of our local population as a member of the South Georgian Bay Ontario Health Team.
- collaborate with patients, families, caregivers and community partners to co-design the right care in the most appropriate setting.

INNOVATION

We deeply value our skilled and dedicated staff, physicians and volunteers.

We will seek innovative solutions to enhance the patient experience, health outcomes for our community, and hospital sustainability while strengthening existing and building new partnerships.

WE WILL:

- seek and share innovative ideas to improve service, environmental sustainability and value across the health system.
- use technology to advance safety, quality of care and efficiency.
- plan a state-of-the-art hospital with our people, community and partners.

[35] Collingwood General and Marine Hospital Brief Feb 27, 2023, p. 4-5

Emergency Department Overview

CGMH's Emergency Department (ED) provides a full range of services, 24 hours per day, seven days a week. CGMH is a community hospital. Therefore, critically ill patients who are beyond the scope of the care team are stabilized in the ED and then transferred to other health care facilities depending on their care needs. The ED volume is approximately 36,000 visits per year (projected 2022/23 volume), The department has 15 surfaces, 5 zones including 2 seclusion rooms. The highest volume days are typically Monday with the greatest number of patients presenting between 0900-2100 hours.

Quality and Performance

CGMH is proud of its consistently high quality and performance rankings.

From September 26 to 29, 2022, CGMH maintained its Accredited with Exemplary Standing status following a 4-day process achieving 100% of the required organizational practices (ROPs) and met 97.9% of the more than 2,300 accreditation standards. In the Emergency Department specifically, CGMH met 71 of 72 high priority criteria (98.6%) and 105 other criteria (98.1%) which are in addition to the ROPs noted and were achieved despite the challenges imposed by the pandemic.

Accreditation Canada is an independent, not for profit, Canadian organization which for over 50 years has set national standards and shared leading practices from around the globe in the pursuit of raising the bar for health quality. Accreditation Canada accredits more than 1,100 healthcare and social service organizations in Canada and around the world.

CGMH also consistently ranks highly on Ontario Health's P4R rankings (previously prepared by Cancer Care Ontario). Out of 74 Hospitals, CGMH has placed:

(a) 2019/20: 16th

(b) 2020/21: 26th

(c) 2021/22: 21st

This consistently puts CGMH in the top third for performance across the province.

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 Collingwood General and Marine Emergency Department.

This understanding was achieved through the following:

- Review and analysis of the written submissions, exhibits, oral presentations, and discussions at the IAC Hearing held on March 21st, March 23rd and March 24th, 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 Emergency Nursing, and.
- 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 an Emergency Department within the Collingwood General and Marine Hospital must be considered within the context of the practice environment.

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

- Collingwood General and Marine Hospital's overview,
- CMGH ED geographical configuration,
- CMGH ED patient population, including patient acuity and complexity, occupancy.
- CMGH nursing resources and support,
- Nursing standards of practice, and
- Healthy work environments.

3.2.1 Collingwood General and Marine Hospital Overview

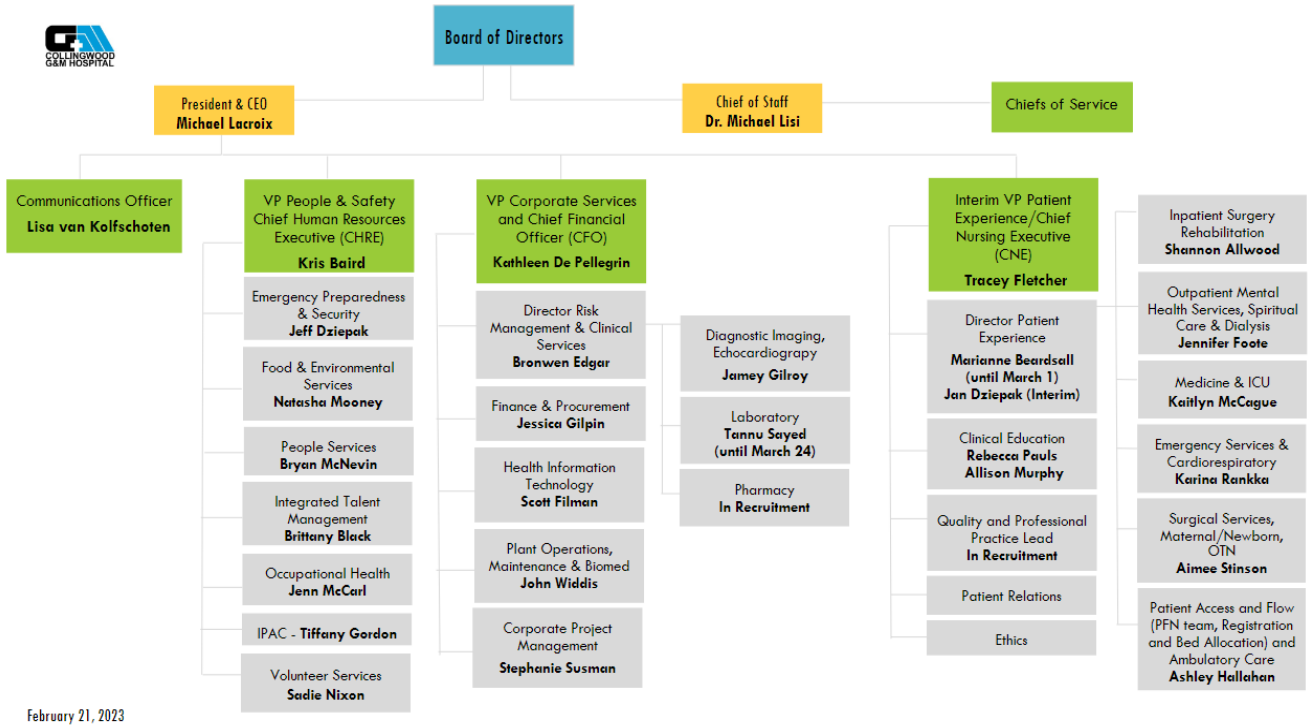
The Collingwood General & Marine Hospital (CGMH) is an 84-bed facility serving more than 74,000 permanent residents and 3.5 million annual visitors to the communities of Wasaga Beach, Collingwood, Clearview, and the Blue Mountains. CGMH is an acute care hospital providing emergency care, diagnostic services including lab, imaging, and cardiorespiratory therapy, as well as two inpatient units (medicine and surgery).

In addition, CGMH also provides care in specialty areas including obstetrics, orthopedics, intensive care and surgery. The Hospital also provides outpatient care including dialysis and a wide range of clinics including mental health and rehabilitation services. CGMH continues to provide care close to home for our community and plays a key role as an integrated orthopedic center for our region.

CGMH's Emergency Department (ED) provides a full range of services, 24 hours per day, seven days a week. CGMH is a community hospital. Therefore, critically ill patients who are beyond the scope of the care team are stabilized in the ED and then transferred to other health care facilities depending on their care needs. The ED volume is approximately 36,000 visits per year (projected 2022/23 volume), The department has 15 surfaces, 5 zones including 2 seclusion rooms. The highest volume days are typically Monday with the greatest number of patients presenting between 0900-2100 hours. [36]

Leadership

The Emergency Department is supported by an Interim VP Patient Experience and Chief Nursing Executive that reports directly to the President and CEO. [37]

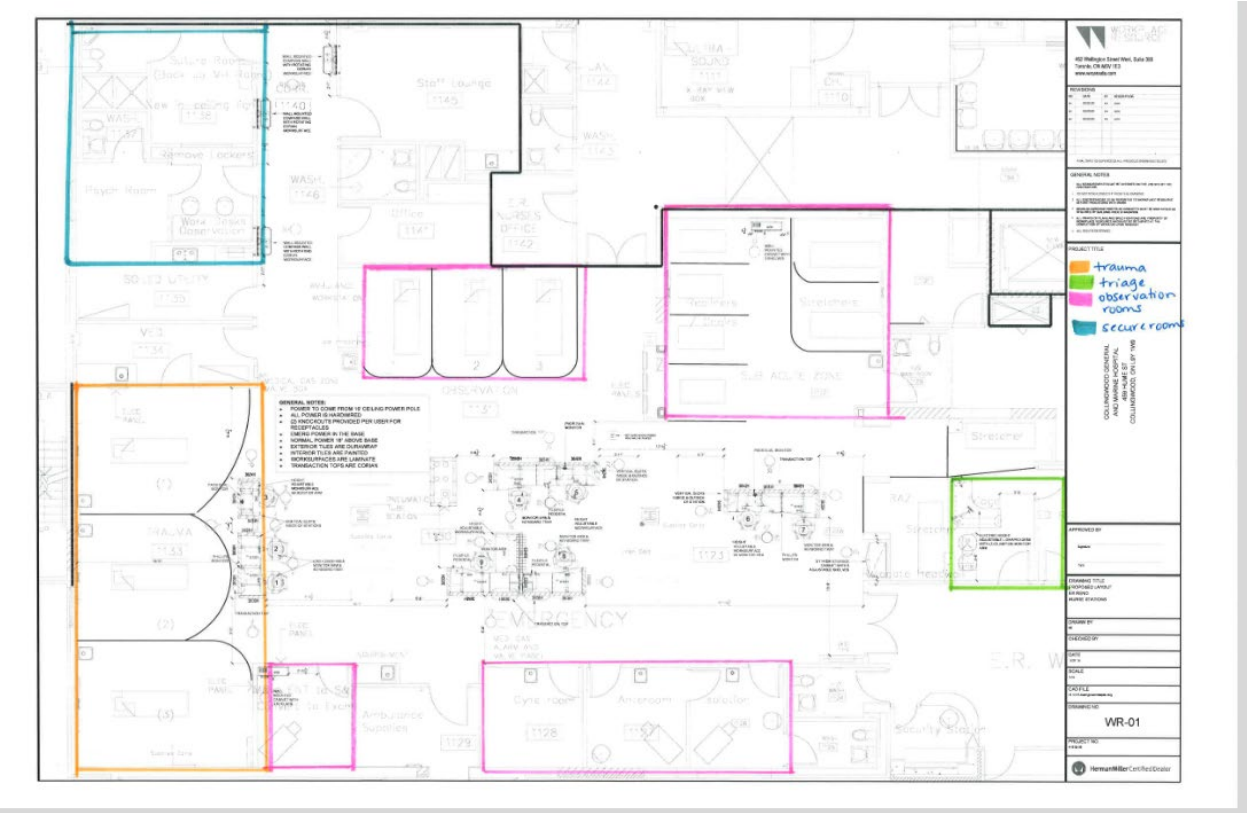


[36] Collingwood General and Marine Hospital Brief Feb 27, 2023, p.2-4

[37] Collingwood General and Marine Hospital Brief Feb 27, 2023, Hicks Morley (sharefile.com)

3.2.2 CMGH ED Geographical Configuration

Below is a map outlining the geographical layout of the Emergency Department.[38]



Patient Population

CGMH's Emergency Department (ED) provides a full range of services, 24 hours per day, seven days a week. CGMH is a community hospital. Therefore, critically ill patients who are beyond the scope of the care team are stabilized in the ED and then transferred to other health care facilities depending on their care needs. The ED volume is approximately 36,000 visits per year (projected 2022/23 volume), The department has 15 surfaces, 5 zones including 2 seclusion rooms. The highest volume days are typically Monday with the greatest number of patients presenting between 0900-2100 hours. [39]

The CGMH patient demographic is changing, with the South Georgian Bay(SGB) area data showing that almost 50% of the population are persons between the ages of 50-80, versus the provincial levels for the same demographic in Ontario, which are approximately 33%. Health risk, chronic conditions and risk for injury increases as people age. With a growing aging population there are rising healthcare concerns,

[38] Collingwood General and Marine Hospital Brief Feb 27, 2023, Hicks Morley (sharefile.com)
[39] CGMH Brief p. 4

and an increased need for regular access to primary care providers. Within the SGB area, the need for family physicians is great, at more than 90% in some areas, and this has greatly impacted the demand for emergency services. [40]

The risk for cardiovascular disease begins in the second decade of life, and the aging process has a continuous linear effect on cardiovascular health. CGMH is a medium size urban hospital that offers limited, Level 2 Basic intensive care, with a five bed ICU. Patients requiring advanced cardiac care and interventions including medications such as Tenecteplase (TNK) or Alteplase (TPA) for acute stroke or cardiac events, often require transfer outside the SGB region to meet these care needs. These care interventions are also time sensitive, meaning these patients presenting in the emergency department, require immediate and timely care, and are very RN resource demanding. Critically ill patients who are beyond the scope of the care services in the Level 2 Basic ICU at CGMH are stabilized in the ED and transferred to other healthcare facilities. Patient transfers from CGMH happen almost daily, and at times more than once per day. Despite ONA's recommendation, no additional staffing resources have been allocated for transfers which would ensure appropriate and timely patient care is provided.

The paediatric population in the SGB area is estimated to be approximately 20% of the population. Given that CGMH does not provide inpatient paediatric services, there are no inhouse or local paediatric experts, therefore all paediatric patients are transferred to another healthcare facility.

The SGB area is a popular tourist destination, attracting approximately 3.5 million visitors per year. The activities and attractions offered in the region appeal to visitors of all ages, and generally visitors come to enjoy the high adrenaline sports and activities, such as downhill skiing, mountain biking and a multitude of water activities. However, traumatic injuries that result from such extreme sports, frequently require significant nursing and healthcare resources, and often transfer to a tertiary healthcare facility outside of the area.

[40] ONA Brief Volume 1 p. 5-6

3.3 Analysis and Discussion

3.3.1 Introduction

The IAC was requested to examine the resources within the ED 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.

The IAC believes that the result of the IAC Panel's analysis will demonstrate the need for focused attention in the Emergency Department at CGMH including its allocated resources, configuration, and patient demographics.

Secondly the IAC deems there must also be a focus on clinical 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 CGMH 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)[41] (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

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

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.

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

1. Model of Care in the CGMH Emergency Department and Health Human Resources
2. Leadership and Communication
3. Healthy Work Environments (HWE)
4. Recruitment and Retention
5. Admit No Beds
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 CGMH ED to become a quality practice environment reflecting the seven (7) sentinel characteristics as outlined above.

1 Model of Care – Health Human Resources

1. Resource Nurse

Role of the Emergency Department Resource Nurse

As outlined in the CGMH job description of the Resource Nurse it states, "The primary purpose of this position is to support the Nurse Manager in the coordination and daily operation of the Emergency Department. Reporting to the Clinical Manager, the Resource Nurse is a Registered Nurse who assumes a leadership role for the Patient Care Team. This position coordinates all patient care activities and is a liaison for the ED to ensure that care can be delivered in an efficient and safe manner. The Resource Nurse appropriately delegates the workload and is a role model for teamwork, leadership, and professionalism in the ED." (2D Job Description)[42]

The Resource Nurse supports patient flow and communication through coordinating the daily care activities of the staff and ensures compliance with the hospital and ED standards, policies, and procedures, sets priorities for patient placement in consultation with the triage nurse (be conscious of unload times for ambulance patients), and promotes positive working relationships with inpatient units through negotiated timing of transfers to highlight a few of the practice expectations.

"The Resource Nurse acts as a clinical resource person and assists with patient care activities when clinical support is needed (does not normally have a patient assignment, but this may change from time to time due to the department demands). Works with staff to ensure standards of care are met through role modeling and consultation. Ensures accurate and complete communication regarding patient related issues from shift to shift. Possesses the abilities, skills, competencies, and knowledge to assume care at any level in the ED. Be prepared to provide assistance to staff where needed during crisis times." [43]

It was evident on numerous PRWRFs and Resource Nurses testimonials during the IAC Hearing, the Resource Nurse takes on the responsibility of a patient assignment frequently. Although it indicates in the job description up *above (does not normally have a patient assignment, but this may change from time to time due to the department demands)* this seems to be quite common. Not only is the Resource Nurse pulled to take patient assignments, but may need to be the off-load nurse, trauma nurse and triage nurse. This significantly impacts the roles and responsibilities as espoused in the Resource Nurse job description resulting in the inability to coordinate and operate the Emergency Department in an efficient and effective manner nor the ability to support nursing colleagues and other members of the interprofessional team.

[42] CGMH Brief Feb 27, 2023, Exhibits
[43] CGMH Brief Feb 27, 2023, Exhibits

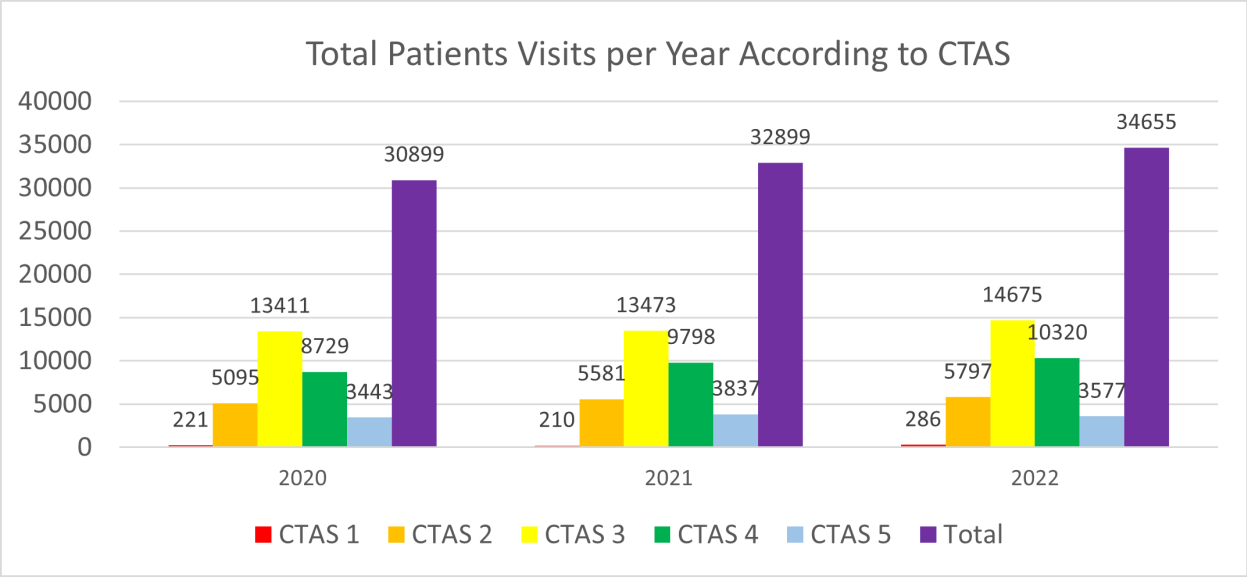
The IAC Recommends:

1. The Resource Nurse must be supported in their leadership role by the Clinical Manager daily. (See recommendations for Huddles/Staff Meetings/Staff Rounding).
2. The Chief Nurse Executive must also provide support and leadership for the Resource Nurse role through leadership rounding as well as ongoing professional development opportunities.
3. The Resource Nurse should be encouraged to be an active member of the CGMH Nursing Practice Council.
4. The Resource Nurse does not assume the responsibility and accountability of a patient assignment.
5. The Resource Nurse will provide coordination and daily ED operations as their primary responsibility and accountability by assigning appropriate resources ie., for break relief by ensuring safe, quality patient care, supporting staff, and managing patient flow.
6. The Resource Nurse, Clinical Manager and Nurse Educator will develop a competency skills checklist for the Resource Nurse role collaboratively.
7. Review the Resource Nurse manual to ensure all the required resources to support the Resource Nurse role is current and reflects best practices.
8. The Resource Nurse will have a formal education program to their roles and responsibilities with a focus on teamwork, critical incident debriefing, communication and leadership and core competencies for success in this leadership role.
9. Resource Nurse will be buddied for five (5) tours of duty as part of their orientation.
10. The Resource Nurse will have the opportunity for ongoing leadership development education annually to support their professional growth and development.

2. Triage RN

All hospitals in Canada must assign priority levels to all patients based on the five level Canadian Triage and Acuity Scale (CTAS) (Health Quality Ontario), who arrive in the emergency department. To ensure patients who are more urgent get the care first, a nurse who is specially trained in emergency care/triage examines and assesses how serious a patient's condition is upon arrival. A standard scale is used across the country, to ensure all patients are triaged fairly and in the same way (www.ontario.ca. Dec 18, 2017). Timely and accurate triage in the ED is critical to ensure the patients with the most urgent, life-threatening condition is seen and treated as quickly as possible. There are 5 categories related to the triage system, level 1 being the most acute/urgent up to level 5 least acute/less urgent.

Total visits to the ED are increasing toward pre-pandemic volumes of over 36,000 visits per year at CGMH. (ONA brief. Vol 1 p.6 and 30). The percentage of visits by triage hour are relatively the same since 2019. The highest peak hours being between 1000-2200 hrs.



[44]

The triage desk at CGMH is in the main waiting room at the main entrance to the emergency department. Ambulances do not enter through this doorway. The nurse has a view of the waiting room, although they may have to physically leave their room, depending on where the patient is sitting. Across from the triage area are red chairs in which patients wait for their initial assessment by the nurse. Following triage, the patients will sit in the grey chairs and will be registered by the registration clerk, located beside the triage area. If the triage nurse must implement any medical directives, ie, ECG, labs, the patient will be placed in the RAZ area, located behind the triage desk, resulting in the RN having to leave the waiting room without any nurse visualizing the patients. Implementing these directives can be difficult when there are patients waiting to be assessed or reassessed. With the increasing numbers of patients arriving to the ED, there are times which were both verbalized at the hearing as well as in many PRWRF's, ECGs, lab work may not get done in a timely manner, as well as triage category 2's are waiting to be seen by the triage nurse. Also, staff have reported on the PRWRF's as well during the hearing, wait times to be assessed by the triage nurse could be anywhere from 15 mins to 3 hours, and sometimes longer. The triage standard, patients are to have an initial assessment within 10 minutes of arrival. The hospital states they are unable to track this wait time. The time to triage by the hospital is 5.98-6.89 mins, this is pulled from data of arrival time (health card info system), triage time and registration time. The IAC believes this does not accurately assess triage wait times. The one nurse at triage is not always able to meet the triage standards of seeing patients in 10 mins upon arrival or the reassessments based on acuity.

The nurses' state, as well have documented on a regular basis, the difficulties maintaining their reassessment times which are outlined in CTAS guidelines, which includes CTAS 1 continuous care, CTAS2 every 15 mins, CTAS 3 every 30 mins, CTAS 4 every 60 mins, and CTAS 5 every 120 mins. (44).

[44] ONA Brief Volume 1 2023

Patients may go for minutes to hours without a reassessment because of the one triage nurse doing initial assessment, medical directives, and monitoring the waiting room of any changes.

The hospital has provided a phlebotomist from 0930-1630, 7 days per week and are available for stat blood draws after hours. Beginning April 2023, the phlebotomists will also be able to do ECG's. (Hospital presentation, March 21, 2023). This will help relieve the triage nurse of the duties, as well as the nurses in the main ED.

Collingwood General and Marine Hospital have a triage nurse 24 hours per day, 7 days per week. This position is relieved by either another nurse or the resource nurse, taking them away from their other nursing duties/patients. The IAC supports a second triage nurse at peak hours to allow for nurses to meet their standards, CTAS guidelines and implement the required medical directives in a timely manner while monitoring the waiting room for any changes in a patients' condition.

The IAC Recommends:

1. The Hospital will explore options for screening/time of patient arrival to the ED for triage within 3 months, with the intent of collecting consistent data to support the time to triage.
2. The Hospital will benchmark with other emergency departments to explore solutions to develop more accurate time to triage.
3. The Hospital must ensure 24-hour coverage 7 days per week, at the triage area in the emergency department.
4. A second triage nurse will be assigned from the hours of 1100-2300, 7 days per week to cover a second triage nurse (this is over and above baseline as an added 1 RN effective immediately)
5. The second triage nurse priority will help the triage nurse with initial assessments, medical directives and to complete secondary assessments, as well monitor the waiting room.
6. If triage has no patients /all assessments/reassessments are complete, the second triage will help within the main ED without a patient assignment.
7. The second triage will continually collaborate with the primary triage nurse, to ensure there is no backlog at triage or with any reassessments etc.
8. Once the secondary triage nurse arrives, both nurses will be able to relieve each other for breaks etc.
9. Nurses in the ED will not be assigned to triage until they have completed the CTAS education as well been in the ED for a minimum of 2 years [45]
10. The hospital will provide a minimum of five (5) shifts for orientation to triage with an experienced triage nurse.
11. Develop competency skills list for triage, involving staff who work at triage, the resource nurse, and the educator.

[45] (Emergency Nursing, Scope and Standards of Practice, Sixth Edition. Revised 2011, Copyright 2018).

3. See and Treat

See and Treat Model

The increasing demands on the emergency department (ED) can result in lengthy waits for non-urgent presenting patients. See and Treat models of care demonstrate a positive trend towards reduced length of stay in the ED as well as improved patient satisfaction without any significant complications.

CGMH, within their IAC submission, describes the See and Treat area within the ED. This area provides care to patients with minor injuries. There are eight (8) treatment rooms and an internal waiting room dedicated to See and Treat. Once a patient is assessed in triage and their CTAS score and complaint is appropriate for an RPN scope of practice, the patient is directed to the internal See and Treat waiting room. Patients will then be assessed by an RPN based on his/her scope of practice and physician or physician's assistant. The physician's assistant started in June 2022.

CGMH's ED nursing model of care described in their brief includes RNs and RPNs, with a large majority of the workload assigned to the RNs. Collaboration is essential to improving healthcare delivery and a strengths-based approach leverages knowledge and skills of team members.

The ED 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.

Through the ONA IAC submission's concerns were raised with the See and Treat staffing model. These concerns included: during times of high volume RPN's were being pulled to assist with staffing in the main department, patients were being placed in See and Treat who may potentially require a higher level of care and the potential of patients remaining in the area once See and Treat has closed. Between 2020 – 2022 a 12 hr RPN was added to See and Treat in July 2021 to support ED flow of low acuity patients (CTAS 4-5) and maintain flow in the main ED department as well as an extension of hours until 2300 to support patient flow.

ONA identified concerns of the inability of the RPN to escalate to a dedicated RN if required.

The IAC Recommends:

1. RPN'S is See and Treat are practicing to full scope.
2. Development of Inclusion/Exclusion criteria for See and Treat. This could include but not limited to (to ensure appropriateness of care)
    - ✓ Appropriate CTAS level for RPN care
    - ✓ Return for Diagnostics
    - ✓ IV medication – Administration
    - ✓ Wound Care – Dressing Change
    - ✓ Nose i.e., Nasal packing removal, epistaxis
    - ✓ Lacerations
    - ✓ Extremity follow-up
3. All roles and responsibilities of providers in See and Treat are well defined so staff ensure accountabilities.
4. Transport Nurse, when not on Transport, will be available to support staff in the See and Treat area if needed. **See Recommendation for Transport Nurse**.
5. Data collection, including volume, patient type, escalation of care that has occurred in See and Treat to be evaluated at a minimum quarterly and shared with staff. This information will inform improvement strategies.

4. Transport Nurse

The Role of the Transport Nurse

Throughout both CGMH and ONA's brief (s) the geographical location of CGMH has been described.

The Collingwood General & Marine Hospital (CGMH) is an 84-bed facility serving more than 74,000 permanent residents and 3.5 million annual visitors to the communities of Wasaga Beach, Collingwood, Clearview, and the Blue Mountains. CGMH is an acute care hospital providing emergency care, diagnostic services including lab, imaging, and cardiorespiratory therapy, as well as two inpatient units (medicine and surgery). In addition, CGMH also provides care in specialty areas including obstetrics, orthopaedics, intensive care, and surgery. The Hospital also provides outpatient care including dialysis and a wide range of clinics including mental health and rehabilitation services. CGMH continues to provide care close to home for our community and plays a key role as an integrated orthopaedic centre for our region. (CGMH Brief)

The closest larger acute care center is Royal Victoria Hospital in Barrie, 55 kilometers (kms) east and Owen Sound Hospital 63 km west. Any Level 2 Advanced intensive care needs such as traumas from the CGMH ED, must be transported to the Greater Toronto Area, to St. Michael's Hospital for Adults or The Hospital for Sick Children for paediatrics, both more than 150 kms away and two or more hours by land. CGMH does not have in-patient paediatric services and must also transfer any paediatric patient admissions to Orillia Soldiers Memorial Hospital, 75 km to the east of Collingwood. (ONA IAC Vol 1)

In the ONA IAC Volume 1 submission, members describe the number of patient transfers. It states RNs reported on 96 PRWRFs citing transfers of patients to other healthcare facilities as well as on 19 PRWRFs

citing paediatric patients transferred out. A total of 115 of 208 PRWRFs reported that the RNs workload was increased, unsafe and put ED patients at risk when an RN has to leave the department on transfer with a critical or paediatric patient. Many times, often more than once per shift, an RN leaving on patient transfer leaves the department struggling with even less RN resources. RNs report that on average, at least one transfer is required per day, many times one or more per shift.

CGMH in their Day 2 IAC presentation provided data regarding ED patients transferred to another acute center. This was provided for fiscal year 2014/15 to 2022/23 (April – February).

Fiscal Year	ED Patients Transferred to Another Acute Care	Daily Average
2014/15	309	0.85
2015/2016	305	0.84
2016/2017	318	0.87
2017/2018	334	0.92
2018/2019	302	0.83
2019/2020	315	0.86
2020/2021	302	0.83
2021/2022	305	0.84
2022/2023 (Apr-Feb)	327	0.98

This table provides an average of approximately one patient per day. The IAC panel recognizes that this is an average number and is aware of fluctuations day to day.

In CMGH's Day 2 IAC presentation the roles and responsibilities of a Transfer Nurse were identified. This role(s) is in active recruitment. The position is budgeted for 11.25 hours per day 7 days per week. The role and responsibilities were identified as:

- Current RN Registration with the College of Nurses of Ontario
- Knowledge of principles of intensive care, cardiac care, emergency care, medical-surgical, and palliative care
- ACLS certified.
- Administers patient care within the scope of practice based on the established care plan.
- Monitors the patient's response and outcomes.
- Modifies the plan of care to reflect the patient's changing needs.
- Coordinates and facilitates communication among the care providers to best meet the health care needs of the assigned patients.

- Provides care and transfer to Intensive care, ED, medical, surgical, chronic, rehabilitative and/palliative patients transferring to other hospitals.

Based on the defined roles and responsibilities this is a highly skilled nurse whose requested skill set aligns with the transfer of acutely ill patients and can support high acuity areas.

The IAC Recommends:

1. The transport nurse will report into the ED functional Center (base budget).
2. The transport nurse will transfer acutely ill patients that require a higher level of care. Patients that do not require this support should be transferred with a staff member that are appropriate to the acuity of the patient.
3. When not on transfer, the Transport RN will act as a resource/support if required for the See and Treat area.
4. This role will not have a patient assignment.

5. Off Load Nurse

Offloading ambulances is a challenge in any emergency department across the province, CGMH is not unique to this challenge. Emergency volumes are increasing toward pre-pandemic numbers. These volumes include ambulance arrival. Ambulances arrive at the main ED and are triaged within this area. If there are no rooms available, the ambulances typically wait outside the secure rooms and may also be under the clock.

Peak hours for ambulances per the Hospital brief appear to be between the hours of 1100-2300. It was noted in the PRWRF's and was viewed on the video, ambulances will wait in the hallway or under the clock as previously mentioned. There is no nurse specifically assigned to triage ambulances at this time, so patients arriving by ambulance wait on the stretcher to be assessed.

Presently it is the accountability of the resource nurse, trauma nurse or the triage nurse, to assess patients arriving by EMS ultimately increasing their workload. Priority patients by ambulance will automatically go into a trauma room. The provincial government recently announced they would be investing money over the next three years to fund the offload nurse program.

The IAC Recommends:

1. The hospital collaborates with the local EMS within the next 3 months to discuss a possible partnership strategy to cover an offload nurse.
2. The hospital is proactive in moving forward to explore the recently announced funding available for an offload nurse.

6. Hospital Coordinator

The Role of the Hospital Coordinator

A hospital coordinator provides administrative and clinical leadership, with special attention to issues of high risk across the hospital in the off shift, weekends, and statutory holidays. As key stakeholders in the

organization the role is essential in ensuring the provision of high-quality patient care. Their primary accountabilities often include but are not limited to managing staffing, including managing sick calls, ensuring the appropriate staff coverage for patients, crisis management, as well as patient flow. Similarly, patient satisfaction and responding to patient concerns are important and challenging responsibilities.

Besides leadership and clinical expertise, recent research (reference below) identified the following key skills necessary for this leadership role.[46]

- ***Effective communication*** is essential when discussing an issue with patients, nursing staff, physicians, or other departments, as well as when listening to their concerns and working together for a solution. It also fosters teamwork, as administrative supervisors keep staff updated on admissions and what is going on in the rest of the hospital, enlist the cooperation of other departments, and support other units with additional nursing staff during busier times.[1]
- ***Conflict management*** involves fielding any complaints and concerns that escalate during a shift. Conflict resolution approaches help administrative supervisors to handle a multitude of issues that may arise between staff, physicians, patients, and families. Sometimes, patients and families respond differently to someone in a supervisory position; other times, the supervisor may have to deescalate a situation before discovering what the patient really needs. Occasionally, the assistance of the on-call administrator is needed to help resolve an issue.
- ***Time management*** is critical because administrative supervisors often need to respond to multiple situations happening at the same time. With less staff on the evening and night shifts, delegation is not typically a possibility for these leaders. Supervisors must learn how to complete their time-sensitive responsibilities while responding to emergencies and weaving in their other responsibilities throughout the shift.

The CGMH presentation Day 2 identifies the role and duty requirements of a hospital coordinator to include:

- Must be a clinician with 3-5 years of acute care experience with 2 years of experience in a management or supervisory role.
- Must be registered in good standing with a health college in the province of Ontario.
- Is on-site from 1500-2300 on weeknights and then on call thereafter.
- Is on-site from 0900-2100 on weekends and statutory holidays and then on call thereafter.
- Supports Unit/Department staffing, and replacement calls on evenings and weekends.
- Implements and manages surge protocols.
- Collaborates with all Hospital departments to facilitate patient flow.
- Promotes problem solving, collaboration, and dialogue amongst Hospital Units/Departments

[46] Weaver S. *Exploring the Administrative Supervisor Role and its Perceived Impact on Nurse and Patient Safety*. Ann Arbor, MI: ProQuest Dissertations Publishing; 2016

- Liaises with the Senior Leader on Call regarding critical incidents or situations posing risk to patients, staff, volunteers, and physicians.

The Hospital Coordinator is a key leader that provides support across the organization. This role as indicated provides both clinical and administrative leadership and has a more fulsome understanding of the resource requirements across the organization.[47]

The IAC Recommends

1. Hospital Coordinator to consistently round through ED, each shift and review patient activity, volumes, and acuity, and facilitate patient/bed flow and staffing needs.
2. Hospital Coordinator should huddle within ED utilizing a status exchange tool to review potential issues, appropriate escalation as well as planning and accountability assigned for follow up. This should be completed during times of high volume, high acuity to ensure that staff are supported.
3. Hospital Coordinator, upon review of the organization's staffing and acuity needs will have the authorization to call in staff as needed. This will proactively address ED and hospital staffing issues.
4. Hospital Coordinator will contribute to managerial written responses to PRWRFs when the issues raised by the RNs occur on their shift, in accordance with the collective agreement timelines.

7. Ward Clerk/Bed Allocator/Registration Clerk Support

The Bed Allocator/Registration Clerk and Ward clerk roles are an invaluable resource to support patient care and patient flow within the ED. These roles have critical functions as part of hospital operations.

Currently the Bed/Allocator is scheduled 24 hours per day/ 7 days per week. The CGMH job description describes responsibilities to include- reception duties, registration of patients & confirmation of demographic data, patient admission and bed allocation, data quality, facilitation of payment, wayfinding, and non-clinical patient assistance (responding to general inquiries, directing patients and visitors to the most appropriate clinical team member, aiding patients to obtain services). After hours' registration is adjacent to the ED.

The Clerical (Ward Clerk) provides coverage in ED from 0700-2300 hours. There are two clerks scheduled during peak patient hours from 1100-1900 to offload clerical tasks from nursing. This schedule is in place 7 days per week. The CGMH job description describes responsibilities to include assists in maintaining orderly flow of daily activities associated with admissions, discharges, and transfers of patients. Provides reception and clerical duties including requisitioning of clerical supplies, equipment, and services from

[47] Weaver S, Cadmus E, Lindgren T. Profile of the administrative supervisor: what do we know. *Nurse Leader*. 2018;16(2):134–141.

other departments. Also assists in arranging transportation to other facilities. Assists during trauma situations by entering stat orders and paging services (i.e., Respiratory Therapist, Diagnostic Imaging).

There is an identified gap in ward clerk coverage from 2300-0700 each day. ONA's brief Vol 1 identifies a need for coverage from 2300-0700 to provide essential support to meet the increased demands of the ED and allow RNs to focus on providing required nursing care.

Coded data provided by the hospital demonstrates like all EDs across the province, the volume of patient visits is not evenly distributed across each hour of the day. Despite only accounting for one-half of the hours of the day, the period from 0900-2100 accounts for around 75% of ED visits. Please see attached table for reference.

Table 1: Percentage of ED Visits by Triage Hour & Fiscal Year

Percentage of ED Visits by Triage Hour & Fiscal Year				
Triage Hour	**2019-20**	**2020-21**	**2021-22**	**2022-23 (Apr-Oct)**
0	1.73%	1.78%	1.85%	1.98%
1	1.41%	1.37%	1.42%	1.61%
2	1.28%	1.25%	1.13%	1.29%
3	1.15%	0.94%	1.02%	1.21%
4	1.14%	0.92%	1.05%	1.10%
5	1.08%	1.00%	1.05%	1.18%
6	1.31%	1.39%	1.55%	1.72%
7	2.61%	2.35%	2.54%	2.79%
8	4.02%	3.60%	3.99%	4.52%
9	6.07%	5.98%	5.95%	5.95%
10	7.11%	6.99%	6.97%	7.06%
11	7.49%	7.70%	7.26%	7.19%
12	6.84%	7.50%	7.28%	6.79%
13	6.58%	6.83%	6.67%	6.63%
14	6.50%	6.77%	6.54%	6.06%
15	6.28%	6.81%	6.33%	5.71%
16	6.04%	6.29%	6.08%	5.71%
17	5.54%	5.82%	5.69%	5.49%
18	5.50%	5.58%	5.49%	5.23%
19	5.47%	5.20%	5.53%	5.16%
20	5.05%	4.63%	4.89%	5.17%
21	4.05%	3.96%	4.14%	4.28%
22	3.21%	3.09%	3.25%	3.52%
23	2.55%	2.25%	2.31%	2.66%

As can be seen by the chart above, the visits by triage hour are quite consistent year-over-year with 1000-1300 being the busiest hours for arrivals.

Table 2: 2022-23 YTD ED Visits by CTAS & Triage Hour

FY 2022-23 YTD ED Visits by CTAS & Triage Hour					
Triage Hour	**CTAS 1**	**CTAS 2**	**CTAS 3**	**CTAS 4**	**CTAS 5**
0	8.1%	2.5%	2.1%	1.6%	1.5%
1	4.7%	2.8%	1.7%	1.0%	1.1%
2	3.4%	2.1%	1.6%	0.7%	0.5%
3	1.4%	2.0%	1.4%	0.8%	0.5%
4	2.0%	1.6%	1.2%	0.8%	1.0%
5	0.7%	1.4%	1.4%	0.8%	0.9%
6	2.0%	2.0%	1.9%	1.4%	1.6%
7	4.1%	2.7%	2.8%	2.9%	2.7%
8	4.7%	3.9%	3.8%	5.8%	4.4%
9	2.0%	4.2%	5.1%	7.6%	7.4%
10	6.8%	5.3%	6.2%	8.5%	8.8%
11	7.4%	6.5%	6.7%	7.7%	8.7%
12	4.1%	5.8%	7.0%	6.7%	7.7%
13	2.7%	6.0%	6.0%	7.4%	7.9%
14	6.8%	6.1%	5.9%	6.1%	6.2%
15	4.1%	5.9%	5.9%	5.5%	5.3%
16	4.1%	5.7%	6.0%	5.5%	5.4%
17	6.1%	5.5%	5.7%	5.4%	4.9%
18	6.1%	5.1%	5.1%	5.6%	4.8%
19	10.1%	5.0%	5.3%	4.8%	5.6%
20	2.0%	5.6%	5.3%	4.8%	5.3%
21	3.4%	4.9%	4.6%	3.7%	4.0%
22	2.7%	4.1%	4.1%	3.0%	2.1%
23	0.7%	3.4%	3.1%	2.1%	1.6%

ED volumes are just now approaching pre-pandemic levels and CTAS acuity has held stable.

The IAC panel upon review of both submissions as well as review of data agrees that there should be support for these tasks to allow the RNs to provide nursing care from 2300-0700. The panel recognizes that patients will remain in ED for treatment and appropriate disposition after 2300 hours, but volume does decrease significantly.

The IAC Recommends:

1. The Bed Allocator/Registration clerk that is adjacent to ED provides clerical support to ED from 2300-0700 hours effective immediately.
2. Education and Training if required should be provided immediately as well as incorporated into the Bed Allocator/Registration clerk orientation/onboarding.
3. Review the adjacency to ED location that currently hosts the Bed Allocator/Registration clerk to ensure it will meet the requirements for coverage. If not, ensure there are technology enablers available to support.

8. Patient Navigator Role

The Patient flow navigator at CGMH is funded through P4R to support the Emergency Department. The funding is for 2.6 FTE [48]

The role is dedicated to the ED from 0800-1600 unless required to help elsewhere in the hospital. Rounds each morning and available by request for the remainder of the day. Their purpose both in the ED and inpatient units is to initiate a safe discharge plan on admission to help reduce the length of stay. In the ED, the Patient Navigator provides consultation to identify barriers to return patients back to their home. This individual works with allied health professionals and community agencies to provide safe and timely transition of patients.

Although the posting does not require an RN, the hospital maintains 80-90% of the time a RN has been the successful applicant to support discharge planning, including determining what kind of care a patient needs after leaving the hospital and should try to avoid hospital readmissions.

The IAC Recommends:

1. The navigator to make rounds in the ED at minimum twice daily and increase as required during high volumes and acuity times.
2. Collaborate with the resource nurse /physician re potential discharge and services which may be required.
3. The IAC would support the continuous use of a RN for this important position.

9. PSW Role

A Personal Support Worker is a trained worker and works as part of the health care team at CGMH. They provide care to any person who requires personal assistance with activities of daily living (ADL). They may also provide care delegated by a Regulated Health Professional as needed and when it can be performed safely within the provincial regulations (Ontario PSW Association.com).

Part of the PSW tasks within the department include ADL's. Delegated tasks which have been delegated by a registered health professional. Continually observe person(s) and their environments, and report and document unsafe conditions and behavioural, physical, and cognitive changes to an appropriate health care provider (Extracted from job description PSW CGMH). May also be involved with discussion of inventory and stocking of supplies.

[48] Hospital Presentation Day One of the Hearing March 21, 2023

PSW was introduced in the ED summer of 2022 as a temporary measure. The ED staff as mentioned above found the increased hours and expanded scope of practice, compared to a unit aide, to be valuable. The PSW role became permanent in November 2022, 24 hours per day, 7 days per week.

The IAC Recommends:

1. The PSW will monitor, and stock unit supplies twice per shift, once being at the beginning of the shift i.e. 0700 and 1900hrs.
2. Stocking of supplies will also involve the stocking of exam rooms.
3. The PSW will assist with ADL's as required/requested by registered staff.
4. The PSW will provide observation when requested by a RN in the emergency department for those patients who may require observation.
5. The RN will ensure the observation is appropriate and within the PSW scope.

10. Upstaffing

CGMH Up Staffing for Special Events and Holidays

The Collingwood General & Marine Hospital (CGMH) is an 84-bed facility serving more than 74,000 permanent residents and 3.5 million annual visitors to the communities of Wasaga Beach, Collingwood, Clearview, and the Blue Mountains. [49]

The SGB area is a popular tourist destination, attracting approximately 3.5 million visitors per year. The activities and attractions offered in the region appeal to visitors of all ages, and generally visitors come to enjoy the high adrenaline sports and activities, such as downhill skiing, mountain biking and a multitude of water activities. However, traumatic injuries that result from such extreme sports, frequently require significant nursing and healthcare resources, and often transfer to a tertiary healthcare facility outside of the area. [50]

We heard through staff testimonials, that during peak times like long weekends, March Break and other events have significant impacts on the CGMH ED.

IAC Recommendation

1. CGMH increase its staffing model by one (1) RN 24/7 during holidays, holiday weekends and other special events in anticipation of increased care requirements for the volume of visitors in Collingwood. This is to begin the next holiday weekend May 19-22, 2023.

Note: The Educator Role will be discussed in the Professional Development Recommendations

[49] CGMH IAC Brief p. 1 Feb 27, 2023
[50] ONA Brief Vol I p. 6

2. Leadership and Communication

1 The Role of the Chief Nursing Executive

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 Recommends:

Collingwood General and Marine Hospital (CGMH) has had several interim candidates filling this role. Understanding that active recruitment is underway, the IAC panel recommends the successful candidate will:

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 (3) months of the hiring of the CNE.
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.

2. **Nursing Practice Council**

Implementation of a Nursing Professional Practice Council (NPPC) - Recommendation

The purpose of the Nursing Professional Practice Council is to provide a forum 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 Recommends:

1**.** The establishment of a Nursing Professional Practice Council by September 2023. While the IAC's focus was the Emergency Department, 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:

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

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 CGMH

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.

Huddles/Staff Meetings/Staff Rounding

To optimize communication, teams should plan to meet regularly. Regularly scheduled 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.

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.[51]

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?")

[51] 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.

► 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?")

► 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 Recommends:

1. The CNE participates in staff rounding once per week to foster collaboration and trust with the ED staff effective immediately.
2. Implement huddles with the Manager/Hospital Coordinator daily utilizing a status exchange tool to review potential issues of the day, appropriate escalation as well as planning and accountability assigned for follow up effective immediately.
3. Manager to round at a minimum of twice daily checking with Resource Nurse or delegate to understand patient flow, staffing or other concerns effective immediately.
4. Manager is encouraged to share a daily schedule with the Resource nurse or delegate to facilitate communication and accessibility if needed effective immediately.
5. 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.[52]

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						

Critical Incident Debriefing

The RN staff have verbally reported as well as through PRWRFs feeling intimidated, burnt out, overwhelmed and unsupported by their leadership team. The impact of the COVID 19 pandemic and the escalating nursing shortage, along with multiple leadership changes at CGMH, long before the pandemic, have created a significant degree of instability for nursing staff. Staff report feeling demeaned and undermined by leadership, often experiencing distress regarding their lack of ability to deliver safe, quality patient care and ensure patient safety, while managing an overwhelming number of interventions. Staff report a feeling of moral distress and struggles with ethical dilemmas. Staff have identified issues of inadequate resources and insufficient RNs to fill the schedule on a regular basis.[53]

Heavy workloads and low morale go hand in hand in the nursing profession. As discussed, and highlighted, in the missed care section of this document, nurses must often juggle multiple patients, tasks, and responsibilities, which can lead to high levels of stress and burnout. In Ontario, the nursing workforce is facing several challenges that can contribute to high and unmanageable workloads,

[52] Cambridge Memorial Hospital ED Daily Status Exchange Tool

[53] ONA Brief Volume 1 p.81

including but not limited to, an aging population, a growing demand for healthcare services, and a shortage of nurses.[54]

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 judgment that can hurt patients and contribute to negative outcomes. As cited in the report, Commitment and Care, "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., 2001).[55]

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

Outlined in the RNAOs Chief Nursing Executive / Chief Nursing Officer Role and Responsibilities Framework, the CNE's responsibility is to: "Ensure a practice environment that enables the implementation of evidence-based nursing best practices that are consistent throughout the organization and aligned with the organization's broader quality improvement plan". [56]

At CGMH, the CNE role has vacillated between the person performing the functions, who was not registered to practice as a nurse in the province of Ontario and the person holding the title, as an interim CNE; however, without the decision-making capacity of the CNE. The ineffective leadership at CGMH has resulted in a continuing erosion of staff resources, staff morale and staff commitment to the organization. The lack of leadership also contributes to negativity and a toxic workplace environment.[57]

An area of concern articulated by staff nurses in ED during Day Three (3) of the IAC Hearing was the lack of follow up or critical incident debriefing by leadership related to critical incidents staff experienced within the ED.

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 casualty incident, events involving children, or events in which the victim is known to the personnel. CI's

[54] ONA Brief Volume 1 p.83
[55] ONA Brief Volume 1 p. 84
[56] ONA Brief Volume 1 p. 84
[57] ONA Brief Volume 1

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, and anxiety". [58]

It is fundamentally important for ED 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 an 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 an HWE and a good starting point for organizations to create environments of practice that attract and retain nurses. To effectively use this strategy, congruency 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 care for, and the nursing profession.[59]

CGMH ED staff report an overall feeling of fatigue and burnout, and morale has been reported at an all-time low. The inability to meet Professional and Specialty Standards results in moral distress, decreased morale, and burnout for nurses, related to their need to make significant decisions about the allocation of limited time and resources that impact patients. A culture change to foster a collaborative workplace environment is essential to improve staff morale, job satisfaction and the overall workplace environment. [60]

The IAC Recommends:

1. Within the next 3-6 months CGMH develops in collaboration with the CNE and Human Resources a Critical Incident Debriefing process with the appropriate resources and tools to support ED staff following a critical incident.
2. Establish a Peer Support Network for Critical Incident Debriefing for staff.
3. Provide education to the Resource Nurse to initiate a Critical Incident Debriefing process with staff immediately following a critical incident within six (6) months.

[58] November 2016 VOLUME 42 • ISSUE 6 WWW.JENONLINE.ORG 475

[59] 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, pp 81-87

[60] ONA Brief Volume 1

CGMH ED Policies and Procedures

Policies, procedures, and competencies are the foundation of emergency patient care and drive nursing practice. Numerous policies and procedures were shared with the IAC panel ie., Overcapacity Policy[61]

Of note, the owner's name is identified on the policy.

The IAC Recommends:

1. CGMH Policies and Procedures change the owner from an individual's name to a role or position immediately.

3. Healthy Work Environments (HWE)

1 Security

Emergency departments have a heightened organizational risk due to the uncertainty of the patients who enter the department via front door or by ambulance. CGMH have security 24/7 who are stationed in the ED, however, are responsible to perform multiple jobs, vs applying focus to the ED for safety prevention. Therefore, security is not always present to respond quickly to potentially violent/threatening behaviours of patients. This puts the nurses in the ED at risk for workplace injuries and/or trauma from violent behavior.

Effects of workplace violence can impair job performance, decrease productivity, and cause them to make errors. Not all violent incidents or outburst result in devastating consequences, many may cause injury and damage worker morale and their sense of safety. [62] Before the pandemic, health care providers were four times more likely than other workers to experience violence in the workplace, with half of these occurring in emergency departments.[63] Starting to see patients we would normally not think would be aggressive both verbally and physically. Chronic understaffing, poor access to other health and social services, and the dual crisis of Covid-19, mental illness and addictions have added to the congestion, noise, and confusion in emergency departments. This increases the level of anxiety and stress for staff, patients and
family.

CGMH has an extensive risk of harm bundle to be used based on the Violent Assessment tool on patients potentially at risk. This policy outlines potential risks of patients and to help staff decide on the type of observation required for the patient. The Hospital also provides personal alarm systems for all staff, as well panic buttons are situated throughout the department on the walls, as well under the desk

[61]Hospital Brief Submissions on Behalf of Collingwood General and Marine Hospital Feb 27, 2023
[62]Canadian Centre for Occupational Health and Safety, volume13, issue 9, Government of Canada 2015/09

[63] CMAJ, We are desensitized": Violence escalating in struggling emergency departments. Diana Duong, and Laren Vogel Sept 12, 2022 194(35)E1216-E1217:).

at triage. Many staff have been trained in de-escalation as noted in the PRWRFs and this training has been utilized several times.

The security guard office is situated between the two secure rooms with a window to view the patients in those rooms. Also, within the security office are the controls for the lights in the secure rooms as well as monitors from the CCTV cameras. The guards lock the office if not in the department, this is a lock and key device. The staff in ED, however, do not have a key for this office. If the nurse requires entry to the secure rooms for patient care, the lights must be turned on in the security office. If security is not in the department, the lights can not be turned on.

It became evident in the PRWF's and at the hearing, the security officers are not always in the department. Both guards attend Code White's, hospital rounds, as well as other duties throughout the hospital. At the beginning of each shift, they are meeting staff to check the panic badges. It is understandable the guards must leave to attend a Code White as per hospital policy. The hospital did advise security can be called in when needed however it is important to note when they leave the ED it does put staff and patients at risk.

The IAC Recommends:

1. Ensure all staff are trained in de-escalation.
2. Provide paid education re de-escalation annually.
3. Security presence in the emergency department 24/7, effective immediately, in that there is always one security guard in the department.
4. Security will do rounding of the ED q1hour, including the waiting room.

Security involvement of all Form 1 in collaboration with the Resource Nurse as per Form 1 policy/ Risk of harm policy. If based on the risk score of the patient, the resource nurse will assess for additional resources to maintain close observation of the patient on Form 1/restrained patient. Staffing resources will also be based on observation level per Risk of Harm - Enhanced level of observation policy and if deemed to be required, the Resource nurse will call in staff and will notify the Clinical Manager or Hospital Coordinator.

The IAC Recommends:

1. If a patient requires observation and does not require one to one nursing will utilize security/PSW if appropriate.
2. If there is a code white in the hospital, security must ensure the resource nurse is aware that they must leave the department and arrange for another staff to provide observation of a patient if required. Use of the PSW for observation only, of a risked patient if deemed appropriate based on nursing assessments.
3. Based on RN assessment if there are patients requiring constant observation to provide quality and pt safe care, the nurse will have authority to call in additional registered staff

It was noted during the video of the Emergency Department; the secure rooms are key locked, as well as the security office. The keys are left in the door for staff. The IAC does recognize there is a spare key at

the nurse's station. Only security services have a key to their office. As with anything which requires a key, there is always the potential for loss. This could occur by a staff person or even an upset patient family who may take the key while walking by.

The IAC Recommends:

1. The secure rooms which have lock and key will be changed to card access within the next three months.
2. The security services office will also be changed to card swipe, this will allow access for nurses to turn on the light in the secure room to provide nursing care to their patients. This will occur within the next month.
3. The hospital review staffing of the security services to ensure there will always be a security guard in the ED 24/7

2 Team Building

Team Building

The IAC Panel read evidence and heard issues during the IAC Hearing related to the lack of teamwork, workplace incivility, the need for change management and the importance of better support from their leadership team, in particular the Clinical Director and Senior Director.

Nursing leadership during trying times like the COVID-19 Pandemic [64] has never been more important. The IAC Panel believes that these three key themes are essential given the evidence presented during the IAC Hearing and for leadership to consider. Moore (2020) suggests three key themes when leading in crisis leadership:

1. Communication.
2. Clear vision and values.
3. Caring relationships.

Nursing is a profession that is based on collaborative and professional relationships with clients and colleagues. When two or more people view issues or situations from different perspectives, these relationships can be compromised by conflict.

Conflict is commonly perceived as being a negative issue. However, the experience of dealing with conflict can lead to positive outcomes for nurses, their colleagues, and clients. Conflict that is managed effectively by nurses can lead to personal and organizational growth.

If conflict is not managed effectively, it can hinder a nurse's ability to provide quality client care and escalate into violence and abuse. Because of this, nurses need to be aware of the ways in which conflict can escalate and be prepared to prevent or manage it in the workplace.

While conflict is an inherent part of nursing, the provision of professional services to clients does not include accepting abuse. In addition, conflict among colleagues can lead to antagonistic and passive-aggressive behaviors (such as bullying or horizontal violence) that compromise the therapeutic nurse-client relationship.

[64] https://www.nursingtimes.net/clinical-archive/leadership/nurse-leadership-during-a-crisis-ideas-to-support-you-and-your-team-16-11-2020/ **Citation: Moore C** (2020) Nurse leadership during a crisis: ideas to support you and your team. *Nursing Times* [online]; 116: 12, 34-37.

Nurses who effectively deal with conflict demonstrate respect for their clients, their colleagues, and the profession. Conflict that remains unresolved can have far reaching effects that ultimately influence every aspect of client care.[65]

Healthy work environments are practice settings that:

(a) maximize the health and well-being of nurses and other health workers and

(b) improve organizational performance and patient, client, resident, and societal outcomes.[66]

The IAC believes that team-building support from a source externally to the unit with team building skills and expertise is required.

The IAC Recommends:

1. The Hospital engages an external expert to facilitate team building sessions to enhance a unit culture that is founded on the principles that underpins CMGH's code of conduct, mission, vision, and values. This should include change management, teambuilding, conflict resolution and communication activities that engage staff participation within six to nine (6-9) months of the VP CNE position starting.
2. Complete an evaluation within three (3) months of the team building session to identify any areas of improvement.
3. Develop an evaluation framework that garners feedback from staff to identify areas of opportunity for improvement annually.

3 Orientation

A comprehensive orientation program is imperative to the success of any nurse to a department, but especially to any novice nurse. A good orientation program also will aid in the retention of nurses. The hospital has a comprehensive orientation program which includes 8 hrs Corporate Orientation, 12 hours General Nursing Orientation, 8 hours Non-violent Crisis Intervention, 8 hours Meditech and in the ED there are 12-14, 11.25-hour shifts.[67] These shifts can be extended to meet individual need requirements. As part of the orientation program, the individual nurse does a learning needs assessment on criteria specific to the ED followed by a learning plan to ensure gaps and learning goals are achieved. This has been developed by the Educator based on feedback from the ED staff. The IAC supports continuation of this tool.

Although the IAC supports the orientation program, the amount of time spent in the department with the mentor is limited. The ED is a specialized unit which changes from day to day and with 12-14 shifts, one would be limited to learning even the basics of emergency nursing. The IAC supports and believes there should be an extended period for the nurse to orientate to the unit. The learning in any ED is expansive, and the IAC does understand there are aspects of experiences which may not happen for several months or years. Through the PRWRFS s and during the hearing it was clear there are a number

[65] CNO https://www.cno.org/globalassets/docs/prac/47004_conflict_prev.pdf

[66] https://rnao.ca/sites/rnao-ca/files/bpg/Preventing_violence_harrassment_and_bullying_against_health_workers_final.pdf

[67] CGMH Hospital Brief p.16

of novice nurses in the ED at CGMH. To support their success, an extended amount of time will be spent on orientation.

All orientee's have a mentor, but due to illnesses, vacation, or the activity within the department this may not be consistent. Although a dedicated mentor may be challenging, the IAC believes a consistent mentor will support the orientee in developing the skills they will require to be a competent, knowledgeable emergency nurse. In reviewing the assignment sheets, it is also clear there are times the nurse on orientation is pulled off orientation to meet the requirement for basic staffing. The IAC does not feel this is beneficial to either the nurse being orientated, the mentor or the hospital. This makes for a negative experience for the nurse and the possibility of leaving the department.

The ED has several areas within the department. The main ED involves several positions for nurses to become competent. These include the resource nurse position. The PRWRF's as well as nurses' experiences at the hearing, indicated there have been times, little to no orientation was given. Triage is another area of expertise within the department, this position also requires orientation, and the nurse would not be assigned this position until there has been 2 years experience in the ED. These positions are addressed elsewhere in this report. The other aspect of the ED are the trauma rooms as well as the number of Form 1, mental health patients which arrive at the ED. In depth orientation should be provided to these areas.

The IAC Recommends:

1. Orientation will be extended to 6 months in length for all new employees to the department effective immediately.
2. The nurse on orientation will not be taken off orientation and will be considered extra staff.
3. If the nurse hired has emergency nursing experience, the 6 months may be reduced, this would be a decision of the nurse, mentor, and ED educator as well as the manager effective immediately.
4. 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.
5. Evaluation of the nurse will be done by the nurse, manager, mentor, and the ED educator, every one to two months during this period.
6. If the nurse or mentor agree the nurses' orientation can be shortened, a discussion with all involved will take place.
7. The nurse on orientation will be provided with the needed education required to feel competent and comfortable working within the ED.
8. The educator will provide hands-on education with the nurse within the department as requested/required by either the nurse, mentor, or manager.
9. There will also be orientation for a minimum of five (5) shifts to the resource nurse role.
10. There will be specific orientation to the trauma area as identified by the nurses' needs.
11. The nurse will be at triage with her mentor due to her assignment but will not be assigned until there has been 2 years ED experience (either internal or external experience) and will be provided orientation for a minimum of five (5) shifts.
12. The ED educator will be readily available while she is working to assist the orientee.

4. Recruitment and Retention

Vacancy rates across the province as of March 2022 from 115 hospitals stand at 8.84%. Specialty RN positions were even higher at 12.63% (hospital presentation March 21/ 2023).[68] The hospital claims the vacancy rate for permanent positions is approximately 14%.

The Hospital has been working on numerous strategies to recruit nurses. These include supporting tuition costs and clinical hours to take their emergency certificate course, in addition to regular orientation. The hospital is presently supporting 4 nurses with 2 more in June. Another strategy is being present at job fairs, increasing student placements, developing a more fulsome preceptor program, reimbursement of up to $1500.00 in relocation and moving expenses, reimbursement up to $3000.00 in temporary accommodation expenses and a referral bonus program offering up to $5000.00 for hard to recruit positions.[69]

The vacancies at the present time as per the Hospital 3 Fulltime and 4 Regular Part Time. The Hospital states 1 FT went to the OR, FT went to casual part-time on the medical unit and 1CPT resigned. ONA in their brief states 'loss and replacement of 19 FT over two plus years, almost 100% turnover of FT positions. Exit interviews are done on those who leave the employment of the hospital but not on those who leave to work elsewhere in the building.

The IAC believes turnover of staff whether to leave employment or to change units should be given an exit interview. Some nurses have left the department or have switched categories such as full time, part time or casual for various reasons, however some have left due to consistent short staffing, which affects workload, feeling unappreciated and the concern of being unable to provide safe and good quality care to their patients. Regardless of the reason any nurse is leaving, there is an impact on the Hospital and ultimately the unit involved. Interviewing the exiting nurse can provide information to the Hospital regarding potential changes.

The Hospital has/is doing some recruiting strategies and has had some success in doing so. The Hospital changed the master schedule to DDNN as per the ED nurse's request. Also, the Manager works with the PT staff to schedule them based on their personal preference while meeting the organizational needs. The hospital provides recognition initiatives; however, these may be difficult for the ED nurses to attend. Recruitment without retention will not solve the gaps in resources. With being short staffed, the nurses in the ED must choose between the good quality of care they want to give, and patients expect and the bare minimum to keep the patient safe.

The IAC Recommends:

1. Exit interviews on 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
2. Encourage professional development.
3. Create collaborative opportunities with staff input to help make the department a success in retaining staff.
4. The manager ensures an adequate number of skilled staff are scheduled on each shift.
5. The manager will address concerns of the ED staff in a timely manner with a written response.
6. Develop an ED specific staff survey (anonymous) by August 2023
7. Evaluation of this survey and an action plan, involving staff input to address the issues by September 2023

[68] CGMH Presentation March 21, 2023

[69] CGMH Presentation March 21, 2023

5. Admit No Beds in the Emergency Department

Admissions in any Emergency Department is a regular occurrence. The CGMH is not unique. ONA in their submission and frequently documented on the PRWRF's upward of 13 admissions in a day. Any admission in the emergency department causes a backlog of the entire department.

It is not clear to the IAC whether the resource nurse attends bed meetings for her/him to be informed of the situation hospital wide. These meetings would provide the resource nurse information of what is happening in the hospital as well as the remainder of the hospital would be aware of the situation in the ED.

The Hospital does have an overcapacity plan for management of hospital surge[70] The policy outlines how to determine whether to utilize the Overcapacity Guidelines. The Guidelines themselves explain when and who are involved. The overcapacity guidelines have three (3) categories, Conventional, Contingency and Crisis. It has been documented and questioned by the nurses in the PRWRF's of why the plan was not called when there are more than the seven (7) admits (required under the Conventional Guideline).

The RPN within the ED was hired to help with these admissions. But due to the number of patients and staffing shortages, this is not always the case. The RPN has a patient assignment which could be outside her scope which adds to the workload of the nurses either due to transfer of care or assistance of the RN. The admission may be out of the scope of practice of the RPN.

The IAC believes any admission in the ED should be the responsibility of the service in which the patient is admitted. The majority of the admission to the ED are medical patients, if there are no ICU beds or ICU has been closed due to staffing, the majority of the patients are transported thru criticall. The IAC does appreciate staffing within the hospital can be a challenge, however it is the strong belief of the hospital that these patients should be cared for by a medical nurse.

The IAC Recommends:

1. The resource nurse will attend bed meetings which occur daily and report at this meeting the number of admits with no bed and any potential admissions.
2. The RPN to be assigned stable admitted patients within her/his scope of practice based on the College of Nurses the RN and RPN Practice: The Client, the Nurse, and the Environment
3. The Hospital develop a policy within the next 3 months which would assign a medical nurse to care for the admitted patient when there are 5 admits in the ED who have no beds and no anticipated beds in the next 8 hours.
4. This policy gives the authority of the Resource Nurse to call in ED RN, without consultation of the Hospital Coordinator as follows:
    a. When a medical nurse is not available
    b. If an RN is not available, an RPN will be called if within the scope of practice.
    c. If no ED nurse is available, call the Hospital Coordinator to facilitate a staff reassignment from within the Hospital.

[70] CGMH Hospital Brief 2

5. Evaluate this policy within 6 months with involvement of the Association, Resource Nurse and the Management.

6 Professional Development

1. Nurse Educator Role

Education is a vital component in nursing as it maintains and enhances knowledge. Every year nurses advance their knowledge in an ever-changing healthcare system. New standards of care, new procedures, interventions are developed along with new technologies. Therefore, it is essential that all nurses be current on the most up to date evidence-based practices to implement them in their everyday practice.

The Nursing Educator is responsible for ensuring that nurses receive the appropriate education, support and supervision when acquiring new knowledge and skills. Developing, implementing, and facilitating learning activities that help nurses enhance their practice and supporting nurses in engaging in ongoing learning. The Educator must also identify and evaluate information sources that are useful for professional practice and promote an environment that facilitates questioning and learning.[71]

The Hospital added a clinical educator who is responsible for ED, ICU and Mental Health. The Hospital in their brief states at this time the majority of the educator's time is spent in the ED to provide in person education as well as facilitating knowledge translation.[72] The Hospital also outlined training provided by the Educator which included : interdisciplinary huddles with health and safety for mental health patients in the ED, eCTAS/triage training, deteriorating patient (nurses assist)SIM, Opti flow and Airvo review with RT team and massive hemorrhage protocol. However, it was not clear how much time the educator spends in the ED. It is important for the role to focus on real time education as well as in services. As the ED is an unpredictable busy environment, it is very important that all nurses are given the opportunity to succeed by giving them the skills and training required to provide the best quality of care for their patients.

The hospital does provide orientation for corporate, general nursing, nonviolent assessment, Meditech, followed by 12-14 shifts (11.25hrs) in the ED itself. This can be extended if required. We heard throughout the IAC as well as documentation in the PRWRF's, the ED at CGMH, employs a number of novice nurses. With the hospital actively recruiting, the number of novice nurses could potentially increase. The IAC also heard, the orientation program is short and often these novice nurses are left on their own due to staffing. Also, what was heard, the educator does not provide enough time hands on to help while things may be happening.

The IAC Recommends:

1. Orientation will be extended to 6 months in the ED at CGMH effective immediately.
2. This extension would include those nurses currently in orientation, if the additional time is identified to be required.

[71] CNO (College of Nurses of Ontario: Practice Standard: professional standards, revised 2002).

[72] CGMH Hospital Brief March 23, 2023, slide 6

3. The Nurse Educator will spend 80% of her time with the ED and the remainder for preparation and other hospital duties per the job description for the next 6-9 months.
4. There are overlapping education/orientation competencies for ED/ICU nurses, and it is encouraged that these are completed simultaneously to promote knowledge translation and relationship building between programs. The Nurse Educator will provide both theory and hands-on education.
5. The Nurse Educator will be visible throughout her shift to answer and help with any questions or procedures requested by any staff.
6. The Nurse Educator will provide thoughtful attention to new/novice nurses to ensure they will strive for success in their journey in the ED.
7. The Nurse Educator will request from all staff what they feel they require to keep themselves updated.
8. The Nurse Educator will continue to provide SIMS education throughout the year ensuring an adequate number of time slots are allotted.
9. The Hospital will provide an opportunity for staff who are working to attend education sessions that may be offered,
10. The hospital will provide replacement for staff who will be attending the education sessions, so patient care is not compromised.
11. Staff coming in for education will be paid for their time.

2. Professional Development

The IAC Panel read and heard issues related to the lack and support of Professional Development for the Emergency nurses at CGMH. The staff are asking for education, training, and support to maintain the standards of care in the ED.

For professional nurses continuing education is essential for safe and effective nursing care for the diverse patient population they care for in the Emergency Department. The amount of knowledge required to take care of critically ill patients cannot be obtained simply through experience on the unit or at bedside.

ENA states the following.
"*According to the Emergency Nurses Association position statement, (ENA, 2019) "Emergency nursing is an independent, collaborative, and specialized area of practice. Providing safe, quality emergency nursing care requires expertise in triage and prioritization, resuscitation, intervention and stabilization, discharge training, crisis intervention, and emergency preparedness. Unique to emergency nursing practice is the extensive knowledge and broad scope of practice required to care for diverse patients across the lifespan with a wide variety of complex illnesses and injuries within a limited time period. Operating from the presenting chief complaint rather than an admitting diagnosis is a unique approach to emergency and ambulatory nursing practice. Emergency nurses work in stressful, fast-paced environments where they integrate evidence-based knowledge, make rapid assessments, critical decisions, and life-saving interventions while prioritizing and multitasking. Emergency nurses therefore require a skill set well beyond that necessary for nursing licensure one that is specific to their practice environment and the care of a wide variety of patients"*[73]

[73] ENA https://www.enao.ca/wp-content/uploads/2021/09/ENAO_Core_Competencies_Final_-_April_2019.pdf

There is continued increasing emphasis on the need to demonstrate ongoing education and competency. Nurses have a professional and legal responsibility to update their knowledge and apply their knowledge to the bedside.

Despite the abundance of continuing education that is offered, many nurses do not participate in them. Several barriers have been cited in the literature, including financial considerations and the lack of institution support, time constraints and family commitments.[74] [75] [76] These barriers are real and must be addressed by individuals and institutions.

Research illustrate institutions must make a much more stronger commitment of lifelong continuing education of nurses and other healthcare providers.[3] Support for education is too susceptible to random budget cuts in the time of economic evaluation, and many institutions do not provide time or money for nurses or other professionals to attend conferences or other continuing education events.

The following education programs may be mandatory for health care providers so health care facilities can meet regulatory requirements for evidence of education programs that support competency-based practice of Emergency Nursing:

- Emergency Certification
- ACLS
- Basic Life Support (BLS) Health Care Provider Course
- ENPC – Emergency Nursing Pediatric Course and Pediatric Advanced Life Support (PALS)
- Trauma Nursing Core Course (TNCC) initial training and recertification
- Initial CTAS training and biannual recertification
- Neonatal Resuscitation Program (NRP)

The IAC believes that funded mandatory annual education programs will provide the Emergency nurses with current and up to date knowledge and skills that would meet and or exceed the standards for best practice guidelines.

The IAC Recommends:

1. The hospital provides funded mandatory educational programs, in house or external, that will demonstrate ongoing current education, and support competency-based practice for Emergency Nurses
   The funded educational programs should include:

[74] Fawaz, M. A., Hamdan-Mansour, A. M., & Tassi, A. (2018). Challenges facing nursing education in the advanced healthcare environment. *International journal of Africa nursing sciences*, *9*, 105-110.
[75] Sarver, W., Cichra, N., & Kline, M. (2015). Perceived benefits, motivators, and barriers to advancing nurse education: Removing barriers to improve success. *Nursing Education Perspectives*, *36*(3), 153-156.
[76] Saifan, A., AbuRuz, M. E., & Masa'deh, R. (2015). Theory practice gaps in nursing education: A qualitative perspective. *Journal of Social Sciences/Sosyal Bilimler Dergisi*, *11*(1).

a. CTAS

b. ACLS

c. ATLS

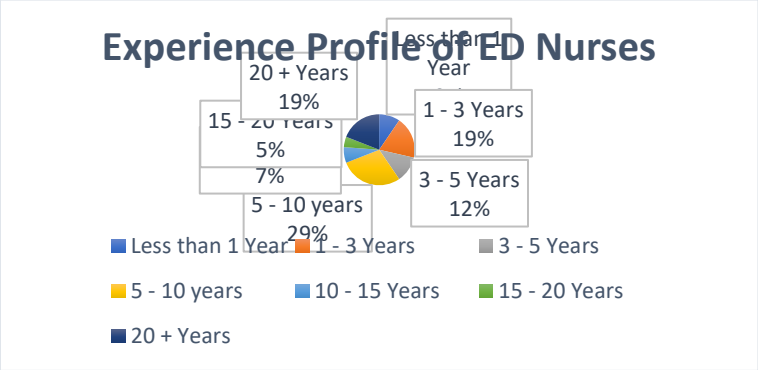
3. Mentoring Novice Nurses Within the CGMH Emergency Department

One outstanding issue identified in the 224 PRWRF's and through the staff's testimonials on Day Three, was their inability to provide much needed support and mentoring to novice nurses within the Emergency Department.

Of concern overall is the CGMH's turnover data shared by both the Hospital and the Association in their briefs. The turnover rate is high enough to raise concern. While there are many reasons that nurses may leave their jobs such as retirement, to pursue education or another career, or choosing to work in another organization, it is commonly accepted that a high turnover rate can occur when nurses feel unappreciated, dealing with short staffing which leads to heavy workload, and concern about the inability to provide safe, quality care. Whatever the reasons that a RN leaves their position there is an impact on the Hospital both from a quality of care and financial perspective. Losing an experienced nurse from the ED who is replaced by a novice nurse means that it could be a minimum of two years before that nurse is competent to replace the lost skills, knowledge, and experience of the exiting nurse. This will negatively impact the quality of care, especially if this novice nurse is one of many to be orientated into a complex under-staffed Department. From a financial position it is very costly to recruit and train a new nurse, especially in a specialty area such as the Emergency Department. The ED requires a stable workforce to consistently deliver safe, quality care and a high turnover compromises the Department's ability to maintain a stable workforce.[77]

Outlined below is CGMH's Experience Profile of ED Nurses graph that includes casual part time staff.

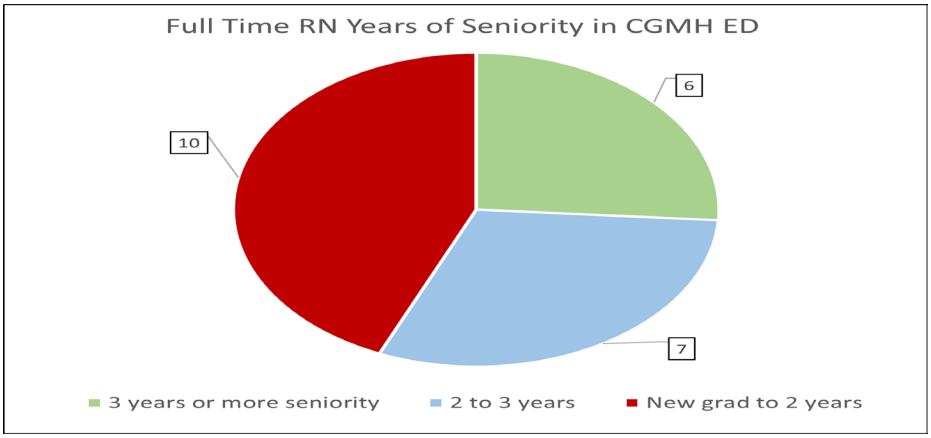
CGMH [78]



[77] Independent Assessment Committee Report July 16, 2021, Emergency Department, St. Mary's General Hospital and Ontario Nurses' Association

[78] CMGH Hospital Brief p. 14

Outlined below is the Association's graph.
ONA [79]



Benner's Novice to Expert Model[80]

TABLE
Benner's Five Stages of Proficiency

Novice	Beginning nurse with little or no experience who relies extensively on memorized rules and principles to guide practice.
Advanced Beginner	Nurse with limited experience who has a beginning perception of meaningful patterns that reoccur in practice situations.
Competent	Nurse whose confidence has increased, but whose work stresses consistency rather than routinely tailoring care to encompass individual differences.
Proficient	Nurse who has an increased ability to perceive patient situations as a whole based on past experiences, focusing in on the relevant aspects of the situation; not guided primarily by recalling memorized rules.
Expert	Nurse with extensive experience and a broad knowledge base who is able to quickly grasp a patient situation and initiate appropriate action; a sense of salience grounded in practice guides actions and priorities.

Adapted from Benner, 1984.

Using Benner's Novice to Expert Model; a novice nurse has limited performance as they perform their practice under guidance (Benner et al, 2009, Brykcznski, 2017), an advanced beginner does not have

[79] ONA Brief Vol 1 p. 47
[80] Benner 1984

enough experience, typically 6 months or less, to expand their vision to patients past experiences and future expectations. They are unable to decide the order of nursing diagnoses and practices according to what's important to the individual (Benner).
Nurses progress through several stages to become an expert. The Competent Stage would include those nurses with 1-2 years experience.

If we use the hospital percentage there is 9% of all nurses less than 1 yr. (novice stage), and 19% less than 3 years, competent stage accounts for 28% of all nurses working in the ED including casual.

When reviewing ONA's without the casual results in 30% of nurses less than 2 years in the ED. This would increase the more senior nurse's workload. This is, based on the PRWRFS and staff testimonials causing not only an increase in their workload but to moral distress as they are not able to provide the required support and mentoring of novice ED nurses.

The experienced nurses may not always be available to support and teach, at the same time as they are carrying a heavy patient assignment, leading to frustration and morale distress. Orientation, education and mentoring of new hires and ongoing professional development is essential for developing a high functioning team of ED nurses.

The IAC Recommends:

1. The Hospital develop an updated novice to expert list of RNs and RPNs
2. The Clinical Manager and Director review this list monthly to ensure appropriate support and mentoring is being provided to the novice nurses.
3. The Clinical Manager, Director and Nurse Educator ensure that all novice nurses have an assigned mentor and the mentor's assignment allows him/her to provide the required support and mentoring.

7 Equipment

For all healthcare facilities to function, they require appropriate equipment. In an ED, it is imperative there is the right equipment at the right time to be working. During the tour and presentation at the IAC hearing, it was noted there were not cardiac monitors in each of the main ED rooms. Without this, the nurses would be required to move patients around the department to allow for another patient being brought into the department who require a monitor. There are 3 rooms within the ED which do not have cardiac monitors, this is exclusive of the seclusion rooms.

The IAC also noted during the tour, one crash cart located in trauma 3 for the whole department. This again increases the nurse's workload as depending on where it is needed, they would have to go and get it or have someone else do this. The equipment is not at their fingertips especially in the trauma rooms.

The hospital has purchased or has been donated some equipment to improve patient care. This includes stretchers in the trauma room which have the capacity to have x rays done so patients do not have to be moved. This also allows the nurse to remain in the department and not to go to diagnostic imaging.

There are presently 3 vital sign machines located within the ED. Vital signs are an important part of an assessment and reassessment of any patient within the department. They also help the nurse to determine any change in condition from the patient's norm. Increasing the number available to staff would ensure immediate hands-on equipment when required versus the potential for waiting for a machine. Having an increase will ensure infection control protocols.

There is a gynecological stretcher in the RAZ room which is used for gynecological procedures. The stretcher is moved from the RAZ room when required for its purpose to another room within the ED. The IAC feels this is a task which could be prevented by keeping the stretcher in another room.

There was documentation in the PRWF's relating to some equipment not working and having to find replacement and contacting biomedical. The issues were resolved. Equipment throughout the hospital but especially in an Emergency Room should always be up to date and in good working order. The nurses are the best people to discuss equipment needs/issues as they work regularly with the equipment.

The IAC Recommends:

1. Ensure all beds in the main ED have a cardiac monitor, other than the seclusion rooms for safety reasons.
2. There will be a minimum of three Crash carts, purchased immediately and completely stocked, including a defibrillator, to be placed in the See and Treat area of the emergency department as well as in Trauma 1 and 2.
3. The hospital will minimally purchase a mobile vital signs machine for every nurse working. The vital signs machine will include thermometer, blood pressure monitors and oxygen saturation. This would include one at triage, second triage room and two in See and Treat.
4. The gynecology stretcher will be moved inside the department, to prevent any moving back and forth of stretchers if needed. A non gyn stretcher will be placed in the RAZ area.
5. Biomedical will round weekly and more frequently if required to ensure all equipment under their service is in working order. Biomed will work with the Clinical Manager to ensure the timing of the end-of-life equipment so there will be replacement prior to expiration.
6. Staff need to be involved in the discussion surrounding capital equipment.

8. Professional Responsibility Workload Report Forms (PRWRF)

The 224 PRWRFs submitted in total for the CGMH ED (in the initial submission Feb 27, 2023) and then an additional sixteen (16) PRWRFs were submitted [81] for a total of two hundred and twenty-four (224) PRWRFs over the past two years.

The Hospital-Association Committee (HAC) at Collingwood General and Marine Hospital is scheduled to meet bi-monthly, in accordance with Articles 6.03 and 8.01 however both parties agree to meet monthly for discussions to achieve joint resolutions for multiple PRWRFs on multiple units. The HAC is the forum for discussing issues related to workload and practice raised by ONA members and to allow both parties to propose solutions or ideas for resolution; however, over the last two years very little resolution or

[81] ONA Brief IV March 15, 2023

progress has been achieved. The Union presents scenarios, identifies root causes, such as a lack of staff, and the Employer's response has been that staffing is a non-starter issue, referencing the shortage of RNs is a provincial issue. They have taken the position and informed ONA that there is no possibility of improving staffing or adding more RN positions. The meetings, from the Union's perspective and the process for the HAC at CGMH is non-productive, thus the Bargaining Unit members have requested further involvement of ONA's Professional Practice Specialist (PPS) in several units.

Early in the PRW process in 2020, it was revealed that the CNE, Lauren Tindall, was not registered as an RN with the College of Nurses of Ontario. ONA notified the organizational leadership, and they responded on August 10, 2020,[82] that neither the hospital nor Ms. Tindall were aware of her lack of registration with CNO. As a result, of ONA's inquiry, the Hospital assigned the CNE title on an interim basis to Ms. Aimee Stinson, the Manager of Inpatient Surgery and Maternal Newborn, as a solution until Ms. Tindall could obtain her registration to practice as a registered nurse in Ontario (Exhibit 8). Since first being informed of Ms. Tindall's lack of CNO registration, the Employer has assigned the title of CNE to a second candidate, Ms. Marianne Beardsall. However, to date Ms. Tindall remains unregistered with CNO, and continues to use the protected title of RN. CGMH continues to identify Ms. Tindall on their public website as the CNE. The role of CNE is one deemed by legislation, within the Public Hospitals Act, 1990, that must be filled with a Registered Nurse.

Prior to the current issues being advanced to the IAC, the parties resolved some issues in the ED through the PRW process in 2020 and signed Minutes of Settlement (MOS) were achieved in December 2020. Many issues, including RN staffing, equipment and repair processes, housekeeping support, laboratory support, security support, violence policies and safety education for staff, as well as a policy to support safe care for patients placed on a Form 1, were agreed upon. However, since January 2021, the RNs have submitted an additional 208 PRWRFs reporting their concerns related to increased patient volumes and patient acuity, and the provisions of safe quality patient care. The RNs have advanced their concerns to their nursing leadership; their manager, director and interim CNE. Often, responses from the manager have been delayed, or simply a reiteration of the day's events, and many include a copy and paste response of the Employer's attempts to hire, or no response is provided at all. The manager is accountable and responsible for the operational functions of the unit, and makes decisions related to recruitment, retention, and increasing resource capacity, as well as ensuring the required resources are provided to allow staff to provide quality care and ensure patient safety.

The ED manager is well informed of the issues through the 208 PRWRFs submitted. The current manager of the ED assumed the role in 2020. There have been multiple concerns and issues raised related to RN staffing and an inadequate RN baseline, in addition to the extreme wait times and excessive delays to conducting the initial patient triage. The PRWRFs report multiple incidents that highlight the lack of supportive leadership and poor communication between leadership and frontline staff.

The ED at CGMH receives Pay for Results (ED P4R) funding annually since 2011. In late 2020, the P4R funding supported a temporary increase in baseline RN staffing for one RN float position, scheduled 1000 to 2200 hours and one RPN scheduled 1000 to 2200 hours. These positions were maintained throughout early 2020 but at some point, mid-year disappeared from the schedule. Workload issues have been escalating throughout 2020 to present, even with an additional temporary RPN assigned to the main ED, although this staffing is achieved very sporadically. The loss of the RN and RPN hours in mid-2021, has exacerbated the burden of workload significantly.

[82] ONA Brief Volume 1 Feb 27, 2023

The Bargaining Unit President and Labor Relations Officer (LRO) attended multiple Hospital Association Committee (HAC) meetings, monthly in 2021, to discuss the workload and practice issues being raised by the RNs in the ED. Failing resolution of the identified issues at these meetings, the ONA PPS became involved in January 2022.

On February 17, 2022, ONA shared the working Action Plan document via email with the Employer, in advance of the February 22, 2022, meeting. The first meeting with ONA PPS on February 22, 2022, ONA presented the Action Plan and supporting recommendations. The employer responded to ONA's Action Plan on March 21, 2022, providing information regarding the ED layout, unit processes and the educator role secondment. The employer identified they were posting a subsequent point five educator to support orientation for new temporary positions for unregulated staff and the initiation of safety huddle.

A subsequent meeting took place on April 4, 2022, where discussions between ONA and the employer, driven by the Action Plan document, failed to resolve the issues. The employer also shared the completed Appendix 9 document at this meeting and noted that based on their benchmarking, they felt they were staffed adequately. Prior to the meeting on May 16, 2022, the employer provided ONA with some aspects of disclosure as previously requested by email on May 11, 2022. The action plan was again presented to the employer at meetings on May 16, 2022, and June 20, 2022. At the June 20, 2022, meeting, due to the employer's lack of action and failure to provide tangible resolutions to the RNs reported concerns, the Union informed the Employer they would be advancing the file to the IAC, in a letter submitted on June 30, 2022 (Exhibit 18). ONA followed up with emails to the OHA (August 22, 2022) and a letter (August 24, 2022) confirming the IAC Chair and naming ONA's nominee to the IAC Panel. The Employer responded in writing to confirm their nominee, on September 16, 2022 (Exhibit 20).

ONA and the Employer continued to meet throughout the Fall. The Employer shared an updated action plan on September 9, 2022, for the meeting on September 12, 2022. The final meeting occurred on November 21, 2022. ONA outlined the list of required resolutions and recommendations necessary to be implemented to resolve the PRWRFs submitted by the ONA RNs. Up to and including this final meeting, the Employer failed to provide any meaningful responses or take any actions to resolve the issues. The employer also failed to provide data requested by ONA, or to provide solutions to move the issues forward. The employer reported at the September 12, 2022, meeting, they had received approval for an additional Clinical Nurse Educator, and noted the position had been posted; however, they were unable to specifically comment on the job description or explain how the educator would be utilized to support the ED RNs.

At the November 21, 2022, meeting, ONA presented the employer with the suggested resolutions from the action plan in an attempt to heighten the needs identified by the RNs; however, the Employer was not receptive to addressing the issues in this manner. The Hospital followed up with a letter to ONA to "raise their concern with ONA's approach and conduct, and new or additional proposed recommendations for resolution". The Hospital stated ONA was not timely in providing information, although they are the holders of the information. The Hospital felt they had engaged in and agreed to some of the noted actions. To date, the employer has agreed to act on a few of the resolutions; however, follow up and implementation have not occurred. ONA provided a follow up response to the employer on December 10, 2022, proposing the employer identify actions they are willing to take, to reach mutually agreeable solutions, so that Minutes of Settlement could be developed, and the IAC could be averted. No such action has been taken or communicated.

A total of six meetings with CGMH leadership and the ED took place over nine months. Minimal actions to achieve resolutions of the RNs workload concerns have been agreed to or implemented. While the employer agreed to the Resource Nurse/CN role, without an assignment 24/7, the RNs report the role is not reliably filled with a consistent RN and the RN filling CN or Resource RN frequently have a patient assignment in addition to their Resource/CN responsibilities, on the day and night shift. All resolutions to the practice and workload issues remain unresolved and the action plan updates provided by the Employer including the December 19, 2022, received January 19, 2023, include no actions or resolutions. (Exhibit 26)

Of the 208 PRWRFs submitted, management has failed to respond to more than 40% of the PRWRFs submitted by the ED RNs. Most of the management responses, reiterate the shift details and patient census, or describe why management were unable to fill a vacancy, sick leave, or long-term absence. Responsibility for resolution falls on management, that has responsibility for operational decision-making, quality of care and patient and staff safety. RNs in the ED report situations of insufficient baseline staffing, high and unsafe patient to nurse ratios, inappropriate skill mix, lack of orientation/training, high patient volumes, escalating patient acuity, lack of space, high volumes of admitted patients in the department and significantly long delays at triage, especially in relation to an initial triage assessment from the time of arrival in the department. These conditions have resulted in missed, gaps in, or rationed care, an inability to maintain Canadian Triage and Acuity Scale (CTAS) guidelines for patient initial assessment, negative patient outcomes, and delays in assessing and intervening for patients experiencing chest pain and any other acute conditions, and increased errors.

The ongoing strain and burden of managing very high workloads, has decreased job satisfaction, increased stress, and burnout among staff, which has resulted in an ongoing loss of qualified and established RNs and contributed to an unstable workforce in the ED. The outstanding practice and workload issues of insufficient staffing, high patient acuity, high patient volumes and increased workload, poor orientation, concerns about risks to patient and staff safety, along with the lack of effective nursing leadership and effective communication, have all resulted in staff burnout and poor morale creating a toxic workplace environment. No effective resolutions to any of the issues raised by the RNs in the ED have been achieved since the onset of the submission of their PRWRFs.

A Letter of Complaint was submitted to the Employer to forward the issues for Collingwood General and Marine Hospital Emergency Department to the Independent Assessment Committee by the Union on June 30, 2022 (Exhibit 18). As indicated in the Union's Letter of Complaint, 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 College of Nurses of Ontario (CNO) Practice Standards and Guidelines:

- Code of Conduct (Exhibit 27)
- Professional Standards Revised 2002, 2022 (Exhibit 5)
- RN and RPN Practice – The Client, the Nurse, and the Environment, 2018 (Exhibit 28)
- Therapeutic Nurse-Client Relationship Revised 2006, (Exhibit 29)
- Authorizing Mechanisms, 2020 (Exhibit 30)
- Decisions about Procedures and Authority Revised, 2020 (Exhibit 31)
- Confidentiality and Privacy – Personal Health Information, 2019 (Exhibit 32)
- Ethics, 2019 (Exhibit 33)
- Documentation Revised 2008, 2019 (Exhibit 34)
- Medication Revised 2008, 2019 (Exhibit 35)

- Conflict Prevention and Management, 2018 (Exhibit 36)
- Consent, 2017 (Exhibit 37)
- Directives, 2020 (Exhibit 38)
- Working with Unregulated Care Providers (Exhibit 39)
- Accountability of Nurses during Covid-19 Pandemic (Exhibit 40)[83]

The IAC Recommends:

1. RN's in the ED 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 ED initially communicate their patient care concerns to the Clinical Manager or Hospital Coordinator 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.

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 Collingwood General and Marine Hospital is scheduled to meet bi-monthly, in accordance with Articles 6.03 and 8.01 however both parties agree to meet monthly

[83] ONA Brief Volume 1 Feb 27, 2023

for discussions to achieve joint resolutions for multiple PRWRFs on multiple units. CMGH and the Association met four (4) times in 2020, seven (7) meetings in 2021 and one (1) meeting in 2022.

The HAC is the forum for discussing issues related to workload and practice raised by ONA members and to allow both parties to propose solutions or ideas for resolution; however, over the last two years very little resolution or progress has been achieved.

The Union presents scenarios, identifies root causes, such as a lack of staff, and the Employer's response has been that staffing is a non-starter issue, referencing the shortage of RNs is a provincial issue. They have taken the position and informed ONA that there is no possibility of improving staffing or adding more RN positions. The meetings, from the Union's perspective and the process for the HAC at CGMH is non-productive, thus the Bargaining Unit members have requested further involvement of ONA's Professional Practice Specialist (PPS) in several units.

6.03 Hospital-Association Committee [84]

(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

[84] 20230331_HospCentralAgreementF [37429] p. 7 Expires March 2023

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.

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

(d) 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 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/Directors/Clinical Managers continue to attend meetings when related to workload.
    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.

SECTION IV

CONCLUSION AND SUMMARY OF RECOMMENDATIONS

4.1 Conclusion

Article 8.01 of the Collective Agreement between the Ontario Nurses' Association and CGMH ED the 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 March 21, 23 and 24th, 2023 in relation to the literature relating to emergency nursing and care, consideration of factors impacting the CGMH Emergency Department practice environment, and integration of the Panel's cumulative practice, knowledge, experience and expertise.

4.2 Summary of Recommendations

The IAC Panel identified 136 recommendations.

Resource Nurse

The IAC Recommends:

1. The Resource Nurse must be supported in their leadership role by the Clinical Manager daily. (See recommendations for Huddles/Staff Meetings/Staff Rounding).
2. The Chief Nurse Executive must also provide support and leadership for the Resource Nurse role through leadership rounding as well as ongoing professional development opportunities.
3. The Resource Nurse should be encouraged to be an active member of the CGMH Nursing Practice Council.
4. The Resource Nurse does not assume the responsibility and accountability of a patient assignment.
5. The Resource Nurse will provide coordination and daily ED operations as their primary responsibility and accountability by assigning appropriate resources ie., for break relief by ensuring safe, quality patient care, supporting staff, and managing patient flow.
6. The Resource Nurse, Clinical Manager and Nurse Educator will develop a competency skills checklist for the Resource Nurse role collaboratively.
7. Review the Resource Nurse manual to ensure all the required resources to support the Resource Nurse role is current and reflects best practices.

8. The Resource Nurse will have a formal education program to their roles and responsibilities with a focus on teamwork, critical incident debriefing, communication and leadership and core competencies for success in this leadership role.
9. Resource Nurse will be buddied for five (5) tours of duty as part of their orientation.
10. The Resource Nurse will have the opportunity for ongoing leadership development education annually to support their professional growth and development.

Triage RN

The IAC Recommends:

1. The Hospital will explore options for screening/time of patient arrival to the ED for triage within 3 months, with the intent of collecting consistent data to support the time to triage.
2. The Hospital will benchmark with other emergency departments to explore solutions to develop more accurate time to triage.
3. The Hospital must ensure 24-hour coverage 7 days per week, at the triage area in the emergency department.
4. A second triage nurse will be assigned from the hours of 1100-2300, 7 days per week to cover a second triage nurse (this is over and above baseline as an added 1 RN) effective immediately.
5. The second triage nurse priority will help the triage nurse with initial assessments, medical directives and to complete secondary assessments, as well monitor the waiting room.
6. If triage has no patients /all assessments/reassessments are complete, the second triage will help within the main ED without a patient assignment.
7. The second triage will continually collaborate with the primary triage nurse, to ensure there is no backlog at triage or with any reassessments etc.
8. Once the secondary triage nurse arrives, both nurses will be able to relieve each other for breaks etc.
9. Nurses in the ED will not be assigned to triage until they have completed the CTAS education as well been in the ED for a minimum of 2 years [85]
10. The hospital will provide a minimum of five (5) shifts for orientation to triage with an experienced triage nurse.
11. Develop competency skills list for triage, involving staff who work at triage, the resource nurse, and the educator.

See and Treat

The IAC Recommends:

1 RPN'S is See and Treat are practicing to full scope.

2 Development of Inclusion/Exclusion criteria for See and Treat. This could include but not limited to (to ensure appropriateness of care)

- ✓ Appropriate CTAS level for RPN care
- ✓ Return for Diagnostics

[85] (Emergency Nursing, Scope and Standards of Practice, Sixth Edition. Revised 2011, Copyright 2018).

- ✓ IV medication – Administration
- ✓ Wound Care – Dressing Change
- ✓ Nose i.e., Nasal packing removal, epistaxis
- ✓ Lacerations
- ✓ Extremity follow-up

3 All roles and responsibilities of providers in See and Treat are well defined so staff ensure accountabilities.

4 Transport Nurse, when not on Transport, will be available to support staff in the See and Treat area if needed. **See Recommendation for Transport Nurse**.

5 Data collection, including volume, patient type, escalation of care that has occurred in See and Treat to be evaluated at a minimum quarterly and shared with staff. This information will inform improvement strategies.

Transport Nurse

The IAC Recommends:

1. The transport nurse will report into the ED functional Center (base budget).
2. The transport nurse will transfer acutely ill patients that require a higher level of care. Patients that do not require this support should be transferred with a staff member that are appropriate to the acuity of the patient.
3. When not on transfer, the Transport RN will act as a resource/support if required for the See and Treat area.
4. This role will not have a patient assignment.

Offload Nurse

The IAC Recommends:

1. The hospital collaborates with the local EMS within the next 3 months to discuss a possible partnership strategy to cover an offload nurse.
2. The hospital is proactive in moving forward to explore the recently announced funding available for an offload nurse.

Hospital Coordinator

The IAC Recommends

1. Hospital Coordinator to consistently round through ED, each shift and review patient activity, volumes, and acuity, and facilitate patient/bed flow and staffing needs.
2. Hospital Coordinator should huddle within ED utilizing a status exchange tool to review potential issues, appropriate escalation as well as planning and accountability assigned for follow up. This should be completed during times of high volume, high acuity to ensure that staff are supported.

3. Hospital Coordinator, upon review of the organization's staffing and acuity needs will have the authorization to call in staff as needed. This will proactively address ED and hospital staffing issues.
4. Hospital Coordinator will contribute to managerial written responses to PRWRFs when the issues raised by the RNs occur on their shift, in accordance with the collective agreement timelines.

Ward Clerk/Bed Allocator/Registration Clerk

The IAC Recommends:

1. The Bed Allocator/Registration clerk that is adjacent to ED provides clerical support to ED from 2300-0700 hours effective immediately.
2. Education and Training if required should be provided immediately as well as incorporated into the Bed Allocator/Registration clerk orientation/onboarding.
3. Review the adjacency to ED location that currently hosts the Bed Allocator/Registration clerk to ensure it will meet the requirements for coverage. If not, ensure there are technology enablers available to support.

Patient Navigator Role

The IAC Recommends:

1. The navigator to make rounds in the ED at minimum twice daily and increase as required during high volumes and acuity times.
2. Collaborate with the resource nurse /physician re potential discharge and services which may be required.
3. The IAC would support the continuous use of a RN for this important position.

PSW Role

The IAC Recommends:

1. The PSW will monitor, and stock unit supplies twice per shift, once being at the beginning of the shift i.e., 0700 and 1900hrs.
2. Stocking of supplies will also include the stocking of exam rooms.
3. The PSW will assist with ADL's as required/requested by registered staff.
4. The PSW will provide observation when requested by an RN in the Emergency Department for those that may require observation.
5. The RN will ensure the observation is appropriate and within the PSW scope.

Upstaffing

IAC Recommendation

1. CGMH increase its staffing model by one (1) RN 24/7 during holidays, holiday weekends and other special events in anticipation of increased care requirements for the volume of visitors in Collingwood. This is to begin the next holiday weekend May 19-22, 2023.

Chief Nurse Executive

The IAC Recommends:

Collingwood General and Marine Hospital (CGMH) has had several interim candidates filling this role. Understanding that active recruitment is underway, the IAC panel recommends the successful candidate will:

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 (3) months of the hiring of the CNE.
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.

Nursing Practice Council

The IAC Recommends:

1**.** The establishment of a Nursing Professional Practice Council by September 2023. While the IAC's focus was the Emergency Department, 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.

Huddles/Staff Meetings/Staff Rounding

The IAC Recommends:

1. The CNE participates in staff rounding once per week to foster collaboration and trust with the ED staff effective immediately.
2. Implement huddles with the Manager/Hospital Coordinator daily utilizing a status exchange tool to review potential issues of the day, appropriate escalation as well as planning and accountability assigned for follow up effective immediately.

3. Manager to round at a minimum of twice daily checking with Resource Nurse or delegate to understand patient flow, staffing or other concerns effective immediately.
4. Manager is encouraged to share a daily schedule with the Resource nurse or delegate to facilitate communication and accessibility if needed effective immediately.
5. 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.[86]

Critical Incident Debriefing

The IAC Recommends:

1. Within the next 3-6 months CGMH develops in collaboration with the CNE and Human Resources a Critical Incident Debriefing process with the appropriate resources and tools to support ED staff following a critical incident.
2. Establish a Peer Support Network for Critical Incident Debriefing for staff.
3. Provide education to the Resource Nurse to initiate a Critical Incident Debriefing process with staff immediately following a critical incident within six (6) months.

Policies and Procedures

The IAC Recommends:

1. CGMH Policies and Procedures change the owner from an individual's name to a role or position immediately.

Security

The IAC Recommends:

1. Ensure all staff are trained in de-escalation.
2. Provide paid education re de-escalation annually.
3. Security presence in the emergency department 24/7, effective immediately, in that there is always one security guard in the department.
4. Security will do rounding of the ED q1hour, including the waiting room.
5. If a patient requires observation and does not require one to one nursing will utilize security/PSW if appropriate.
6. If there is a code white in the hospital, security must ensure the resource nurse is aware that they must leave the department and arrange for another staff to provide observation of a patient if required. Use of the PSW for observation only, of a risked patient if deemed appropriate based on nursing assessments.
7. Based on RN assessment if there are patients requiring constant observation to provide quality and pt safe care, the nurse will have authority to call in additional registered staff

[86] Cambridge Memorial Hospital ED Daily Status Exchange Tool

8. The secure rooms which have lock and key will be changed to card access within the next three months.
9. The security services office will also be changed to card swipe, this will allow access for nurses to turn on the light in the secure room to provide nursing care to their patients. This will occur within the next month.
10. The hospital review staffing of the security services to ensure there will always be a security guard in the ED 24/7

Team Building

The IAC Recommends

1. The Hospital engages an external expert to facilitate team building sessions to enhance a unit culture that is founded on the principles that underpins CMGH's code of conduct, mission, vision, and values. This should include change management, teambuilding, conflict resolution and communication activities that engage staff participation within six to nine (6-9) months of the VP CNE position starting.
2. Complete an evaluation within three (3) months of the team building session to identify any areas of improvement.
3. Develop an evaluation framework that garners feedback from staff to identify areas of opportunity for improvement annually.

Orientation

The IAC Recommends:

1. Orientation will be extended to 6 months in length for all new employees to the department effective immediately.
2. The nurse on orientation will not be taken off orientation and will be considered extra staff.
3. If the nurse hired has emergency nursing experience, the 6 months may be reduced, this would be a decision of the nurse, mentor, and ED educator as well as the manager effective immediately.
4. 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.
5. Evaluation of the nurse will be done by the nurse, manager, mentor, and the ED educator, every one to two months during this period.
6. If the nurse or mentor agree the nurses' orientation can be shortened, a discussion with all involved will take place.
7. The nurse on orientation will be provided with the needed education required to feel competent and comfortable working within the ED.
8. The educator will provide hands-on education with the nurse within the department as requested/required by either the nurse, mentor, or manager.
9. There will also be orientation for a minimum of five (5) shifts to the resource nurse role.
10. There will be specific orientation to the trauma area as identified by the nurses' needs.
11. The nurse will be at triage with her mentor due to her assignment but will not be assigned until there has been 2 years ED experience (either internal or external experience) and will be provided orientation for a minimum of five (5) shifts.

12. The ED educator will be readily available while she is working to assist the orientee.

Recruitment and Retention

The IAC Recommends:

1. Exit interviews on 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
2. Encourage professional development.
3. Create collaborative opportunities with staff input to help make the department a success in retaining staff.
4. The manager ensures an adequate number of skilled staff are scheduled on each shift.
5. The manager will address concerns of the ED staff in a timely manner with a written response.
6. Develop an ED specific staff survey (anonymous) by August 2023
7. Evaluation of this survey and an action plan, involving staff input to address the issues by September 2023

Admit No Beds

The IAC Recommends:

1. The resource nurse will attend bed meetings which occur daily and report at this meeting the number of admits with no bed and any potential admissions.
2. The RPN to be assigned stable admitted patients within her/his scope of practice based on the College of Nurses the RN and RPN Practice: The Client, the Nurse, and the Environment
3. The Hospital develop a policy within the next 3 months which would assign a medical nurse to care for the admitted patient when there are 5 admits in the ED who have no beds and no anticipated beds in the next 8 hours.
4. This policy gives the authority of the Resource Nurse to call in ED RN, without consultation of the Hospital Coordinator as follows:
5. When a medical nurse is not available
6. If an RN is not available, an RPN will be called if within the scope of practice.

Nurse Educator Role

The IAC Recommends:

1. Orientation will be extended to 6 months in the ED at CGMH effective immediately.
2. This extension would include those nurses currently in orientation, if the additional time is identified to be required.
3. The Nurse Educator will spend 80% of her time with the ED and the remainder for preparation and other hospital duties per the job description for the next 6-9 months.
4. There are overlapping education/orientation competencies for ED/ICU nurses, and it is encouraged that these are completed simultaneously to promote knowledge translation and relationship building between programs. The Nurse Educator will provide both theory and hands-on education.
5. The Nurse Educator will be visible throughout her shift to answer and help with any questions or procedures requested by any staff.

6. The Nurse Educator will provide thoughtful attention to new/novice nurses to ensure they will strive for success in their journey in the ED.
7. The Nurse Educator will request from all staff what they feel they require to keep themselves updated.
8. The Nurse Educator will continue to provide SIMS education throughout the year ensuring an adequate number of time slots are allotted.
9. The Hospital will provide an opportunity for staff who are working to attend education sessions that may be offered,
10. The hospital will provide replacement for staff who will be attending the education sessions, so patient care is not compromised.
11. Staff coming in for education will be paid for their time.

Professional Development

The IAC Recommends:

1. The hospital provides funded mandatory educational programs, in house or external, that will demonstrate ongoing current education, and support competency-based practice for Emergency Nurses. The funded educational programs should include:
    a) CTAS

    b) ACLS

    c) ATLS

Mentoring Novice Nurses

The IAC Recommends:

1. The Hospital develop an updated novice to expert list of RNs and RPNs
2. The Clinical Manager and Director review this list monthly to ensure appropriate support and mentoring is being provided to the novice nurses.
3. The Clinical Manager, Director and Nurse Educator ensure that all novice nurses have an assigned mentor and the mentor's assignment allows him/her to provide the required support and mentoring.

Equipment

The IAC Recommends:

1. Ensure all beds in the main ED have a cardiac monitor, other than the seclusion rooms for safety reasons.
2. There will be a minimum of three Crash carts, purchased immediately and completely stocked, including a defibrillator, to be placed in the See and Treat area of the emergency department as well as in Trauma 1 and 2.
3. The hospital will minimally purchase a mobile vital signs machine for every nurse working. The vital signs machine will include thermometer, blood pressure monitors and oxygen saturation. This would include one at triage, second triage room and two in See and Treat.

4. The gynecology stretcher will be moved inside the department, to prevent any moving back and forth of stretchers if needed. A non gyn stretcher will be placed in the RAZ area.
5. Biomedical will round weekly and more frequently if required to ensure all equipment under their service is in working order. Biomed will work with the Clinical Manager to ensure the timing of the end-of-life equipment so there will be replacement prior to expiration.
6. Staff need to be involved in the discussion surrounding capital equipment.

Professional Responsibility Workload Report Forms

The IAC Recommends:

1. RN's in the ED 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. RN's in the ED initially communicate their patient care concerns to the Clinical Manager or Hospital Coordinator 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.

Hospital Association Committee

The IAC 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/Directors/Clinical Managers continue to attend meetings when related to workload.
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.

SECTION V

Appendices (Updated as of March 24, 2023)

Appendix 1: Article 8.01: Professional Responsibility

20201210_IAC Guidelines and Chair

Appendix 2: Collingwood General and Marine Hospital Nominee

COLLINGWOOD G&M HOSPITAL

Friday September 16, 2022

Donna Rothwell
56 Carriage Road
St. Catharines, ON L2P 1T1

Delivered Electronically

Re: Independent Assessment Committee, Collingwood General and Marine Hospital Emergency Department

Dear Donna,

I am writing today pursuant to my email to Sandy Paproski of August 25, 2022, to provide you with the name and contact information of Collingwood General and Marine Hospital's nominee to the IAC Committee.

The Hospital's nominee to the IAC is Stephanie Pearsall. Stephanie's contact information is:

Stephanie Pearsall RN MHS
Cellular Phone: 519-546-8581.
Email: stephaniepearsall3@gmail.com

I trust that this will be satisfactory however, please do not hesitate to contact me regarding any other information that you require.

Yours Truly,

Bryan McNevin
Manager, People Services
Collingwood General and Marine Hospital

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

August 24, 2022

SENT BY EMAIL

Donna Rothwell

56 Carriage Road

St. Catharines, ON L2P 1T1

Dear Donna,

RE: Independent Assessment Committee, Collingwood General and Marine Hospital Emergency Department, ONA File # 202108186

Thank you for accepting the nomination to Chair the Independent Assessment Committee (IAC) investigating a complaint in the Emergency Department (ED) at Collingwood General and Marine Hospital (CGMH). I have contacted the Director, Labour Relations at the Ontario Hospital Association, Mr. David McCoy, and the parties have agreed to you Chairing this IAC.

I am attaching a copy of the Guidelines for the Chairperson of the IAC and a copy of the current Central Hospital Collective Agreement. Should you require any further documentation, please do not hesitate to let me know and I will forward that to you.

The attached letter provides you with the name and contact information of the Ontario Nurses' Association's nominee to the IAC Committee – and requests that the employer provide you with that information for their nominee within the timeframes set out in the

Collective Agreement. The Employer should provide the name and contact information of their Nominee as soon as possible as per Article 8.01 a) xii).

The Ontario Nurses' Association's nominee to the IAC is Cindy Gabrielli. Cindy's contact information is:

Cindy Gabrielli RN (EC)

6285 McMicking St

Niagara Falls, ON

L2J 1W7

C: 905-329-3597

Email: cgabrielli@cogeco.ca

Please set dates to meet with the nominees, based on their availability.

Yours truly,

ONTARIO NURSES ASSOCIATION

Sandy Paproski

Professional Practice Specialist

Phone: **1-800-387-5580, ext. 2323**

Email: SandyP@ona.org

C: Marianne Beardsall, Interim Chief Nursing Executive, CMGH
Catherine Hoy, ONA President, and Interim CEO

David Vijanmaa, Human Resources Strategist & Director, Labour Relations, CMGH
Karina Rankka, Manager, Emergency Department

Erica Miller, ONA Local Coordinator & Bargaining Unit President, Local 092

Cindy Gabrielli, ONA Nominee

Lorrie Daniels, ONA Manager, Professional Services Learning and Development

Todd Davis, ONA Manager, Region 4

Josh Henley, ONA Servicing Labour Relations Officer

Hospital Collective Ageement, expires M

IAC Guidelines

20201210_IAC Guidelines and Chair

IAC Procedural Guidelines

APPENDIX 8 - Procedural Guideline

Email confirmation to Nominee

Nominee For Collingwood Genera

Appendix 4 Additional Questions for Collingwood General and Marine Hospital December 12, 2022

Additional Questions for Collingwood and General Marine Hospital

Appendix One:

Independent Assessment Committee for Collingwood General and Marine Hospital

Data Request on November 25, 2023, with request for information no later than Friday February 17, 2023

1) **Patient Information for the Emergency Department (ED) for the past three fiscal years April 1, 2019 to March 31, 2020; and April 1, 2020 to March 31, 2021, April 1, 2022 to date**

   Volumes by year, day of the week and by hour of the day
   Distribution by CTAS level; by year, day of the week, and hour of the day
   Ambulance volumes and offload times by year, day of the week, date, and hour of day
   Time to triage
   Time to initial assessment by nurse and by doctor
   Admission by CTAS level including admission rate
   Number of admits with no beds by hour of the day
   Time to admission after decision to admit
   ED length of stay by day of the week

2) **Unit Organization/Functioning**
   a) Structural drawing of the ED layout
   b) Description of how the ED is organized; zones and functions (triage, minor, major, other)
   c) Organizational Chart for Nursing in the ED
   d) Job Descriptions for Team Leader/Charge Nurse, Triage Nurse, Registered Nurse, Registered Practical Nurse, Nurse Practitioner, Advanced Practice Nurse, Nurses Educators, any other registered staff including all allied health professionals; Does Triage Nurse and/or the Team Leader/Charge Nurse have a patient assignment?
   e) Triage Assignment Guidelines
   f) Orientation Program for RNs, including number of weeks with a preceptor/buddy
   g) Support roles, such as, but not limited to Personal Support Worker, Ward Clerk/Clerical Assistant
   h) Charting guidelines and/or policies for ED
   i) Policies regarding gridlock/overcapacity in the ED and actions to be taken if volumes/admissions exceed capacity; including any procedures/policies regarding calling in additional staff to manage high volumes/admissions
   j) Changes or initiatives that have impacted ED in the last three years
      I. External issues that impact patient flow/emergency volumes
      II. Major process changes, model of care changes, technology implementations, special projects in the ED

3) **Staffing Data for fiscal 2019-2020, 2020-2021, 2021-to date (April 1st to March 31st)**
   a) Budgeted Full-time Equivalents (FTEs) for all staff categories in the ED

b) Total paid hours in FTE's 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
e) Number of nurses on MLOAs, sick leaves etc
f) Next schedule (6 weeks out)
g) Sick-time, overtime in FTE's for RN's and comparison over last three fiscal years
h) Current RN vacancy rate
i) Turnover rate for RNs
j) 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
k) Number of nursing staff on modified work or have permanent accommodations
l) Copy of local collective agreement
m) Master schedule: copy of the posted schedules for RNs for the past year and a copy of daily assignment sheets for the past year
n) Number of Nurse Practitioners, Advanced Practice Nurses, Educators, other non-bedside leadership nursing positions
o) Allocation of Allied Health Professionals (Physiotherapist, Occupational Therapist, Social Workers, Dietitians, Pharmacists, Physician Assistants, other
p) Allocation of support staff such as, but not limited to, Personal Support Workers, Ward Clerk/Clerical Assistants, other
q) If utilized by the ED: the size and utilization of a department or organizational float pool

4) Budget and Performance Indicators for the past three fiscal years

a) Total planned and expended budgeted for the ED: Staffing and Equipment and Supplies
b) P4P indicators, targets and results

5) Quality of Care Performance Indicators

a) Patient Satisfaction Results in ED 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 ED for the past three years
d) Number and type of staff injury in ED for the past three years
e) Number of Medication incidents in the past three years
f) Number of patient falls in the past three years
g) Results of triage audits for 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 in the ED during the past three year

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 the ED

7) ED Staff Meeting Minutes for 2020, 2021 and 2022

Appendix 5 Revised Agenda December 12, 2022

Independent Assessment Committee Hearing

Ontario Nurses' Association (ONA) and Collingwood General and Marine Hospital

Draft Agenda

Tuesday March 21, 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 Collingwood General and Marine Hospital ED via Zoom Follow-up Questions
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) 🔔Response to questions of clarification by: (0.5 hrs) 🕐Independent Assessment Committee 🕐Collingwood General and Marine Hospital
12:30 -13:30	Lunch
13:30 – 15:30	● Collingwood General and Marine Hospital Submission Presentation (1.5 hrs) 🔔Response to questions of clarification by: (0.5 hrs) 🕐Independent Assessment Committee 🕐Ontario Nurses' Association
15:30 – 15:45	●Review of Process for Wednesday March 22, 2023, and Thursday March 24, 2023 by IAC Chairperson
15:45	Adjournment of Hearing

Independent Assessment Committee Hearing

Ontario Nurses' Association / Collingwood General and Marine Hospital

Draft Agenda

Wednesday March 22, 2023

08:00 – 16:00 ***Both parties work on developing their responses to the presentations held On Tuesday March 21, 2022, in preparation for Thursday March 24, 2023***

Independent Assessment Committee Hearing

Ontario Nurses' Association / Collingwood General and Marine Hospital

Draft Agenda

Thursday March 23, 2023

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

08:30 Continuation of Hearing

08:30 – 11:30 ● Collingwood General and Marine 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 Collingwood General and Marine Hospital **(2 hours maximum to present)** 🕐Independent Assessment Committee **(1 hour for questions)** 🕐 Collingwood General and Marine Hospital 🔔Discussion
15:30 – 15:45	●Review of Process for Friday March 24, 2024, 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 Collingwood General and Marine 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 / Collingwood General and Marine Hospital

Draft Agenda

Friday March 24, 2023

08:30	Continuation of Hearing
08:30 – 12:30	●Questions to both ONA and Collingwood General and Marine Hospital by IAC ● ED nurses have opportunity to present their issues/stories
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

Donna Rothwell – IAC Chair

Cindy Gabrielli – ONA Nominee

Stephanie Pearsall – CGMH Nominee

ONA

Sandy Paparoski

Danielle Richard

Lorrie Daniels

DJ Sanderson

Terry McArthur

Joshua Henley

Bernadette Robinson

Erin Ariss

Rebecca Lee Birtwistle

Erica Miller

Diolanda Watt

Chris Heron

Sue Irwin

Peggy Birr

Angela Preocanin

CGMH

Tracey Fletcher

Karina Rankka

Kris Baird

Bryan McNevin

Grant R. Nuttall