# Independent Assessment Committee Report

# Constituted under Article 8.01 of the

# Collective Agreement

# Between

# Kingston Health Sciences Centre

# Inpatient Mental Health and Addictions Program

# And

# Ontario Nurses' Association

**December 5, 2022**

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Professional Practice Specialist
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Jason Hann
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December 5, 2022

Dear Ms. Khadour and Mr. Hann,

The members of the Independent Assessment Committee have concluded our review and respectfully submit the Report of the Independent Assessment Committee which was constituted under Article 8.01 of the Collective Agreement between Kingston Health Sciences Centre-Inpatient Mental Health and Addictions Program and the Ontario Nurses' Association.

This Report contains the Independent Assessment Committee's findings and recommendations regarding the Professional Workload Complaint submitted by the Registered Nurses working in the Inpatient Mental Health and Addictions Program at Kingston Health Sciences Centre.

The members of the Independent Assessment Committee recognize and appreciate the commitment and the efforts taken by representatives of the Hospital, the Ontario Nurses' Association, and the Registered Nurses to prepare and present information and responses to our questions prior to and during the Three-Day Hearing, held on October 18, 20, 21, 2022.

The process undertaken through an Independent Assessment Committee provides a unique opportunity for discussion and dialogue between all parties regarding the complex issues and conditions which underlie a Professional Workload Complaint. The Committee has made sixty-four (64) recommendations in five (5) areas regarding issues that impact the workload of Registered Nurses.

The members of the Independent Assessment Committee unanimously support all recommendations in this Report. The Committee hopes the recommendations will assist the Hospital and the Association, to work together, to find mutually agreeable resolutions with regard to nursing workload issues in the Inpatient Mental Health and Addictions Program at Kingston Health Sciences Centre.

Respectfully Submitted on December 5, 2022

Ella Ferris

Ella Ferris, RN, MBA, Chairperson, Independent Assessment Committee

Sanaz Riahi, RN, PhD,
Nominee for the Hospital

Joan McCollum, RN
Nominee for the Association

# Table of Contents

## PART 1: INTRODUCTION

### 1.1 Organization of the Independent Assessment Committee Report

The Independent Assessment Committee (IAC) Report is presented in five parts:

PART 1: INTRODUCTION

Outlines the referral of the Professional Workload Complaint to the IAC, reviews the IAC's jurisdiction as outlined in the Collective Agreement, and summarizes the Pre-Hearing, Hearing and Post-Hearing processes.

PART 2: PRESENTATION OF THE PROFESSIONAL RESPONSIBILTY WORKLOAD COMPLAINT

This section presents the context of practice relating to the Registered Nurses' Professional Workload Complaint in the Inpatient Mental Health and Addictions Program at Kingston Health Sciences Centre (the Hospital); summarizes the relevant history leading to the referral of the Professional Workload Complaint to the IAC; and reviews the presentations by the Ontario Nurses' Association (the Association), and the Hospital at the Hearing.

PART 3: DISCUSSION, ANALYSIS AND RECOMMENDATIONS

PART 4: CONCLUSION AND SUMMARY OF RECOMMENDATIONS

PART 5: APPENDICES

Supporting data, including all the Submissions and Exhibits of the Ontario Nurses' Association and Kingston Health Sciences Centre are on file with both parties.

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

The nurses in the Inpatient Mental Health and Addictions Program at the Hospital started to report their concerns related to professional responsibility and workload issues in January 2019. Throughout 2019 an increasing number of Professional Responsibility Workload Report Forms (PRWRFs) were completed and by October 2022 a total of 214 PRWRFs had been completed and signed by the nurses working in the Inpatient Mental Health and Addictions Program (MHAP), with no resolution by management.

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

The Association states in their Brief that "All Registered Nurses are held accountable by the College of Nurses of Ontario to advocate on behalf of their clients and to provide, facilitate and promote the best possible care. Nurses in the Mental Health and Addiction Care Program at

Kingston General Hospital (KGH) have met these standards by diligently documenting and reporting their nursing care and practice concerns on Professional Responsibility Workload Report Forms (PRWRFs) to the Program Managers, Operations Manager (OM), Director, and Chief Nursing Executive (CNE) since 2019. Nurses have identified issues of insufficient baseline RN staffing to meet patient acuity and complexity needs, and issues of escalating violence and health and safety issues within the program. The RN staff have reported their inability to meet the acuity and complexity needs of the patients who require constant or increased observation and care, an inadequate and unsafe model of care for the Charge Nurse (CN), a general lack of adequate replacement staff resources, as well as insufficient education, orientation, and mentorship for all staff. In addition, staff report poor communication and poor leadership, and a general lack of staffing resources, resulting in ongoing turnover of staff, declining staff morale and increased reports of burnout, in an unsupportive and toxic work environment."[1]

The Hospital's position as stated in their Brief, "The Hospital, as well as the Ontario Nurses Association ("ONA") and its members, have experienced challenging circumstances from a variety of sources including the COVID-19 Pandemic and limited nursing labour market. However, the Hospital also believes that the parties have addressed the issues in relation to the Inpatient Mental Health and Addictions Program ("MHAP") and have either implemented or are implementing the resources and procedures necessary to provide a workload consistent with proper patient care requirements using current available resources. The process has resulted in substantial changes that are reasonable in the circumstances."[2]

In a letter dated November 8, 2021, (Appendix 1) Ms. Haifaa Khadour, Professional Practice Specialist, ONA, advised Mr. Mike McDonald, Chief Nursing Executive Kingston Health Sciences Centre that despite the Hospital and the Association attempts to resolve the ongoing practice and workload issues at the Hospital Association Committee Meetings, there remains a number of professional responsibility and workload issues identified that remain unresolved. "Accordingly, the Union is forwarding the complaint to an Independent Assessment Committee (IAC) as per Article 8 of the Hospital Central Collective Agreement." The Hospital was advised in the letter that the IAC will proceed with Ella Ferris as Chair.[3]

In the letter, the Association listed the professional responsibility and workload issues that remained unresolved. They are as follows:

1. Inability to maintain baseline staffing
2. Persisting issues with increased acuity and complexity
3. Inadequate RN staffing in the Intensive Observation Area (IOA)
4. Charge Nurses role and their inability to perform duties while being a resource nurse for MHAP nurses
5. Inadequate training for the MHAP staff
6. Ineffective communication and lack of leadership support

[1] ONA Brief, Volume I. September 27, 2022, p.11
[2] Hospital Brief. September 27, 2022, p.3
[3] Letter from the Association to the Hospital, November 8, 2021

### 1.3 Jurisdiction of the Independent Assessment Committee

The IAC is convened under the authority of Article 8.01 on Professional Responsibility in the Central Hospital Collective Agreement between the Ontario Nurses' Association and Kingston Health Sciences Centre (Expiry March 31, 2023) as stated below:[4]

ARTICLE 8 – PROFESSIONAL RESPONSIBILITY

(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.

In the event that 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

[4] Hospital ONA Central Collective Agreement, Expiry March 31, 2023

designate) and the nurse are both working or within ten (10) calendar days whichever is sooner.

When meeting with the manager, the nurse(s) may request the assistance of a Union representative to support/assist them at the meeting.

iv) Complete the ONA/Hospital professional Responsibility Workload Report Form. The manager (or designate) will provide a written response on the *ONA/Hospital Professional Responsibility Workload Report Form* to the nurse(s) within ten (10) calendar days of receipt of the form with a copy to 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.

The IAC's jurisdiction thus relates to whether Registered Nurses are being requested and/or required to assume more work than is consistent with the provision of proper patient care. Workload is influenced by both direct factors (e.g., nurse-patient ratio, patient acuity/complexity of care requirements, patient

volume) and indirect factors (e.g., roles and responsibilities of other care providers, physical environment of practice, standards of practice, and systems of care). The IAC is responsible for examining factors impacting workload and for making recommendations to address workload issues. Concerns outside of workload are beyond the jurisdiction of the IAC.

In the matter of arbitration between Brantford General Hospital and the Ontario Nurses Association both parties acknowledged that while according to the Collective Agreement the IAC's report is not binding upon the parties, the report carries considerable weight and is accepted by the parties as a method of obtaining a final dispute resolution in these difficult areas.[5]

The IAC's jurisdiction ceases with the submission of its written Report. The IAC's findings and recommendations are intended to provide an independent external perspective to assist the Association and the Hospital to achieve mutually satisfactory resolutions to workload issues. The IAC is not an adjudicative panel, and its recommendations are not binding. In accordance with Professional Responsibility Article 8 of the Collective Agreement, the IAC was comprised of three Registered Nurses.

The members of the Independent Assessment Committee were:

| | |
|---|---|
| Chairperson: | Ella Ferris |
| For the Association: | Joan McCollum |
| For the Hospital: | Sanaz Riahi |

### 1.4 Proceedings of the Independent Assessment Committee

#### 1.4.1 Pre-Hearing

On November 8, 2021, the Association notified the Hospital, in a letter, that the Association was referring the Professional Practice and Workload Issues at Kingston Health Sciences Centre, Inpatient Mental Health and Addictions Program to an Independent Assessment Committee (IAC). The Association also advised that Ella Ferris would be Chair of the IAC. (Appendix 1)

On February 11, 2022, the Association notified the Chair of the IAC, in a letter, that Joan McCollum has been appointed as the IAC nominee for the Association. (Appendix 2)

On February 22, 2022, the Hospital notified the IAC Chair, in a letter, that Sanaz Riahi has been appointed as the IAC nominee for the Hospital. (Appendix 3)

On February 25, 2022, the Chair sent a letter to the Hospital acknowledging their nominee and advised that an Introductory Meeting of the IAC will be scheduled, and Hearing Dates will be determined at the meeting. (Appendix 4)

On March 7, 2022, the IAC held an introductory meeting via Zoom and discussed the concerns and issues that led to the IAC, the IAC Process and Guidelines, and Proposed Hearing Dates.

[5] Arbitration Hearing Brantford General Hospital and Ontario Nurses' Association. Paula Knopf, October 6

On April 4, 2022, The IAC Chair sent a letter to the Association and the Hospital, confirming that the Hearing for Kingston Health Sciences Centre Inpatient Mental Health and Addictions Program and the Ontario Nurses Association will take place, via Zoom, on October 18, 20, & 21, 2022. (Appendix 5)

On August 2, 2022, the IAC Chair sent a letter to the newly appointed Executive Vice President, Patient Care and Chief Nursing Executive congratulating him on his appointment and requesting Hospital documents and other relevant information to assist the IAC to conduct its work including analysis, deliberations and analysis. (Appendix 6)

On August 26, 2022, First Class Facilitation (FCF) was confirmed to coordinate and manage the technological requirements during the two and a half day Hearing. The facilitator from FCF, sent a signed Confidentiality Agreement to the Chair. (Appendix 7)

On September 6, 2022, the IAC Chair sent a letter to the Hospital and a letter to the Association requesting that each party submit their Brief Documents no later than September 27, 2022. (Appendix 8)

On September 27, 2022, both the Hospital and the Association submitted their Briefs. On receipt of both parties' Briefs, the IAC Chair simultaneously distributed the Briefs to each party, in compliance with the responsibilities outlined in the IAC Hearing Guidelines.

The IAC met via Zoom on October 3, 2022, to discuss the Hospital's response to the IAC information request; on October 13, 2022, to discuss the Association Brief Submission; and, on October 16, 2022, to discuss the Hospital Brief Submission.

### 1.4.2 Hearing

The Hearing was held virtually via Zoom and the technical aspects were facilitated by a third party. The Hearing convened at 0830 on October 18, 2022.

The Hearing was held over three days:

Tuesday, October 18, 2022: 0830 - 1640 hours

Thursday, October 20, 2022: 0830 - 1530 hours

Friday, October 21, 2022: 0830 - 1230 hours

Participants and observers in attendance for the Association and the Hospital are listed in (Appendix 9)

For Hearing Agendas for October 18, 20, 21, 2022, please see (Appendix 10)

**Hearing Day One: Tuesday October 18, 2022**

The Chair opened the Hearing at 0830. After introducing herself, she welcomed and thanked everyone for their commitment to the IAC process and for setting aside three days to attend the Hearing. She

thanked the Hospital for their thorough response to the IAC's Information Request and the Hospital and the Association for their detailed Brief Submissions.

The Chair then invited the IAC members to introduce themselves, followed by introductions of the representatives from the Hospital and the Association.

The IAC Chair reviewed the jurisdictional scope of the IAC; including the authority under Article 8.01 of the Central Collective Agreement between the Ontario Nurses' Association and the Hospital; the purpose of the IAC; the nature of the non-binding recommendations; and the Ground Rules for the Hearing including confirmation that all participants understood and agreed.

The IAC jurisdiction relates to whether registered nurses are being requested and/or required to assume more work than is consistent with the provision of proper patient care.

Workload is influenced by both direct and indirect factors. Direct being roles and responsibilities of the nurse, nurse to patient ratios, patient acuity/complexity of care requirements and patient volumes. Indirect being roles and responsibilities of other care providers and team members, physical environment, standards of practice, equipment, models of care and leadership.

The Ground Rules were communicated as follows:

- Adhere to the Agenda and the timeframes for presentation;
- Opportunity will be given to ask questions for clarity at the end of each presentation. If either party has a question, please indicate this to the Chair;
- Please speak from your own perspective and experience;
- Do not raise issues related to individuals; the panel is not convened to address any concerns regarding individual performance;
- The proceedings of the Hearing are confidential and not to be discussed outside the Hearing except for the purpose of the IAC Hearing;
- The briefs, presentations, discussion, and any distributed documents in this Hearing are not to be shared with other parties; and
- Maintain a professional demeanor at all times during the IAC Hearing.

The next item on the Agenda was the viewing of a Virtual Tour Video of the Inpatient Mental Health and Addictions Program located at the Kingston General Hospital (KGH) Site of Kingston Health Sciences Centre. The video was produced by the Hospital and was narrated by Nicholas Axes, Program Operational Director, Mental Health and Addictions Care, and Laura-Ashley Detlor RN, KGH Site Vice President, ONA Local 99.

After a break, Ms. Haifaa Khadour, Professional Practice Specialist, presented on behalf of the Association. The Association's presentation was based on their written Pre-Hearing Brief submission and the supporting Exhibits as well as a summary of the 214 Professional Responsibility Workload Report Forms (PRWRFs), from January 2019 to October 2022, submitted by the Registered Nurses in the Mental Health and Addictions Program (MHAP). During the presentation, the Association reaffirmed their position that the nurses in the MHAP have cause to believe that they are being asked to perform more work than is consistent with proper care, and they identified themes of staffing levels below base staffing, violence and safety, patient acuity and complexity, inadequate education and training,

inappropriate management communication and responses to the issues raised. The Association highlighted that these issues continue to occur, without appropriate management action, despite the nurses' continued documentation of their workload concerns and their inability to meet the College of Nurses of Ontario (CNO) Professional Standards.

The Association responded to clarification questions from the IAC Panel and the Hospital.

After a lunch break, Mr. Jason Hann, Executive Vice President, Patient Care and Chief Nursing Executive led the Hospital presentation inviting team members to address specific slides related to their area of responsibility and accountability. The Hospital presentation was based on their Brief Submission and their response to the IAC's information request.

The presentation summarized some key facts about the Hospital, including strategic plan, budget, their regional tertiary mandate and populations served. The Hospital also commented on the number of RN vacancies and challenges with recruiting across all of Ontario.

Specifically, to the MHAP, the Hospital outlined how the 50 Mental Health beds are allocated to specific units caring for a range of patients from child and youth, to marginalized adult populations struggling with drug and/or alcohol dependency and mental health diagnoses, to geriatric patients with dementia.

The Hospital presented their new baseline staffing model and master schedule plan, which was implemented in January 2022. The IAC was informed that due to the high number of RN vacancies they are not able to staff to the baseline staffing despite recruitment efforts. The Hospital advised that they practice "shift levelling" to balance patient needs across the Hospital. The Hospital highlighted that the MHAP has a multidisciplinary team caring for the patients. The Staff Orientation Program was presented, and the expectations of Continuing Education outlined.

Regarding the PRWRF's the Hospital noted the following themes: Staffing levels, Environment Factors, Responding to Codes, Training, Floating, and Workplace Violence. The Hospital stated that there are "gaps in real time identification with hospital management to develop strategies to meet patient care needs using current resources."[6] The hospital presented a proposed PRWRF Process Improvement model.

Finally, the Hospital presented some MHAP staffing improvements and actions taken to improve safety in the MHAP for patients and staff.

The Hospital responded to clarification questions from the IAC Panel and the Association.

Before adjourning, the IAC Chair provided an overview of the Agenda for Hearing Day Two scheduled for Thursday October 20, 2022. The Chair adjourned the Hearing at 1640 hours.

Following adjournment on Day One of the Hearing, the IAC met via Zoom to review and synthesize the information provided, and to identify key issues requiring additional clarification and discussion on Day Two of the Hearing.

[6] Hospital Presentation. Hearing Day One. October 16, 2022, Slide 43

**Hearing Day Two: Thursday October 20, 2022**

The IAC Chair opened the Hearing at 0830 hours welcoming everyone back and reviewed the Ground Rules. Mr. Jason Hann and the KHSC leadership team provided the Hospital's response to the Association's presentation. The Hospital acknowledged that they "recognize, see and hear through Workload Submissions, Employee Experience Survey Responses and Interactions and Observations. We went into nursing to care for our patients and families. We need to care about each other."[7] Further, the Hospital acknowledged that there is work to do and stated a shared commitment to move forward together to make meaningful improvements for nurses and to demonstrate the value of nursing while meeting the needs of their community

The Hospital participants responded to questions from IAC Panel and the Association.

After a lunch break, Ms. Haifaa Khadour provided the Association's response to the Hospital's submission, highlighting that the nurses in MHAP feel that they are not being heard and their concerns related to staffing shortages, staff turnover and workplace violence are not being addressed by management. The Association stated that the acts of violence are being "normalized" and that the incidents of violence must be assessed and actions taken to reduce workplace violence.

The Association responded to questions from the IAC Panel and the Hospital.

The IAC Chair thanked everyone for their participation and reviewed the process for Day Three of the Hearing and adjourned the meeting at 1530 hours.

Following adjournment of Day Two of the Hearing, the IAC met via Zoom to review and synthesize the information provided and to prepare a list of specific questions to be asked, by the IAC members, of both parties on Day Three of the Hearing.

**Hearing Day Three: Friday October 21, 2022**

The IAC Chair opened the Hearing at 0830 hours, reviewed the Ground Rules and welcomed everyone to the third and final Hearing Day.

The IAC Panel asked questions of both parties, to gain clarification and to better understand a range of issues related to the presentations. Responses to the IAC questions were provided by the Hospital and the Association, as appropriate.

After a break, the Chair invited the MHAP nurses to share their impact statements. Ms. Khadour introduced each Registered Nurse, who in turn proceeded to give a personal and emotional testimony of their work experiences in the MHAP. After each nurse spoke the Chair thanked them individually for sharing their lived experience. When the last nurse had presented, the Chair again acknowledged all the nurses who had shared their personal stories and thanked them for adding a very valuable perspective to the IAC Hearing.

Ms. Khadour and Ms. Hann were invited to provide closing remarks on behalf of the Association and the Hospital, respectively. The IAC Chair concluded the Hearing by thanking Joan McCollum, the Association

[7] Hospital Presentation. Hearing Day Two. October 20, 2022, Slide 3

Nominee and Sanaz Riahi, the Hospital Nominee; as well as thanking all the participants for their commitment to the Hearing process and for their active and open discussions during the proceedings. The IAC Chair also communicated the hope that the opportunity for open and transparent discussion during the Hearing and the recommendations in the final IAC Report will enable both parties to move forward together to seek resolution of the outstanding issues. The Chair advised that the IAC Report will be distributed, no later than December 5, 2022, to both parties, in compliance with the 45-day requirement as outlined in Article 8.01 (a) (xiii) in the Collective Agreement.

The IAC Chair closed the Hearing at 1230 hours

On October 21, 2022, in an email exchange between KHSC and the Association, the parties confirmed dates of January 11, 2023, and January 12, 2023 for the Chief Nursing Executive, the Bargaining Unit President, and Hospital-Association Committee to jointly meet to review IAC recommendations and to develop an implementation plan for mutually agreeable changes. This meeting ensures that the requirements of the Hospital Central Collective Agreement between the Ontario Nurses' Association (ONA) and the Ontario Hospital Association (OHA) to meet within 30 calendar days of receiving the IAC Report will be met.

### 1.4.3 Post Hearing

At the close of the Hearing the IAC met via Zoom and had extensive discussion about the themes related to concerns and issues identified and determined priority areas requiring recommendations; We met via Zoom on November 10, 2022, to discuss the first draft of the IAC Report and any required edits. We met via Zoom on November 22, 2022, to review, discuss and revise the second draft of the Report. We reviewed draft three of the Report via email and recirculated draft four of the Report on December 2, 2022, for final comments. All members of the IAC contributed to the final version of the IAC Report. The Final Report was submitted to the Hospital and the Association on December 5, 2022.

## PART 2: PRESENTATION OF THE PROFESSIONAL RESPONSIBILITY WORKLOAD COMPLAINT

### 2.1 Information about Kingston Health Sciences Centre

Kingston Health Sciences Centre (KHSC) is Southeastern Ontario's largest acute-care research and teaching hospital, consisting of two sites, Kingston General Hospital (KGH) and the Hotel Dieu Hospital (HDH), as well as the Cancer Centre of Southeastern Ontario and two research centres. The KGH site serves as the regional referral center for cardiac, stroke, renal, trauma, neurosurgery, pediatrics, neonatal, high-risk obstetrics, mental health and addictions and cancer care. The Hospital has 574 reported beds with 33 over capacity beds for a total of 607 beds. The Hospital serves 500,000 people over a 24,000 square kilometer area and admits 24,000 people each year.

### 2.2 The KHSC Inpatient Mental Health and Addiction Program – Physical Description and Layout

The Mental Health and Addiction Program (MHAP) inpatient unit is located in the Burr Wing at the KGH site and provides mental health and addictions clinical care to adult, child, and adolescents populations. The MHAP consists of four distinct areas (Units A, B, C and Section E in the Emergency Department) with a total of 50 operational beds.

While there are multiple units in the MHAP the four units operate as one cohesive unit with all staff rotating to the different units.

Patients are assessed in the general ED and once cleared medically are moved to Section E for mental health assessment and follow-up by the Emergency Psychiatric team for determination of admission to one of the inpatient mental health units or discharge with supports.

**Section E:** The Mental Health Emergency Services Unit (MHESU) is a specialized section of the Emergency Department with two designated Mental Health beds. There are two short-stay beds in this area that house patients who are in the midst of an active mental health illness or substance-induced psychosis or withdrawal. In the last year nearly 10% of all ED presentations have had a form of mental health or substance-related reason for the visit. Patients are triaged and referred to psychiatry where they are then seen quickly by the team which includes a Nurse Practitioner, Social Worker, Hospital's Patient Navigator, Nurses and Residents. Protection Services (Security) is also present in Section E. Much like the rest of the ED, our MHESU has seen an increase in patients throughout the pandemic with higher acuity and behavioural presentations than in years past.

**Unit A:** The Intensive Observation Area (IOA) is the intensive care unit (ICU) of the MHAP admitting both voluntary and involuntary patients. The IOA has seven Intensive Observation beds and a Short Stay area consisting of two beds that are consistently used for IOA patients, for a total of nine beds. This unit is considered the Hospital's Psychiatric Intensive Care Unit. This area is where the most ill, acute and high-risk patients, those who require increased observation and/or are behaviourally challenged, are admitted. This patient population is unstable, with complex care needs. Their conditions range from new acute onset or exacerbation of mental health conditions to psychosis, mood and personality disorders, anxiety and depression, and trauma and stress related disorders. Patients are provided with psychiatry, nursing and allied care, and are restricted from having passes or participating in group treatment until they can be transferred to Unit B.

Due to the patient's active mental health issues (e.g., acute psychosis, active substance withdrawal, unpredictable behaviours, etc.) this unit's census has been consistently full as the Hospital has seen an increase in acuity and need prior to the pandemic which has only increased due to the impact of COVID-19 on hospitals' Mental Health and Addictions units across the region.

These Mental Health intensive observation patients require the same consideration and level of care as patients in an ICU Unit. The RNs caring for patients in this environment must possess the competencies - the knowledge, skill, and judgement - required to equip them to manage rapidly changing conditions which become emergency situations.[8]

**Unit B**: The Adult Inpatient Unit – is a 31-bed unit that provides care for the admission of voluntary and involuntary patients with mental health and substance-related disorders. Patients admitted to this unit are 18-years old to seniors. Diagnoses can range from depression and anxiety to substance use disorders and mood disorders or psychosis that require a wide range of interventions. Patients are engaged in group-treatment and individual therapy, as needed, while being supported by psychiatry, nursing and allied care.

[8] Canadian Federation of Mental Health Nursing. (2014). Canadian Standards for Psychiatric-Mental Health Nursing (4th Ed.) Author

The census of this unit continued to be at capacity throughout the pandemic, and as the mental health impacts of the pandemic continue to surface, the Hospital has seen the needs continue to grow. Southeastern Ontario provides its own set of unique challenges for the MHAP patients. The high number of Alternative Level of Care (ALC) patients with behavioural issues has warranted the use of Behavioural Science Technologists (BSTs) and Patient Care Assistants (PCAs) to help to manage these patients.

**Unit C:** Child & Youth (C&Y) Inpatient Unit is an 8-bed unit that provides care for the admission of voluntary and involuntary patients 17-years of age and younger with mental health and substance-related disorders. The Hospital offers the only Child & Youth Inpatient Unit between Ottawa and the Greater Toronto Area. Patients are engaged in group-treatment and individual therapy as needed while being supported by psychiatry, nursing and allied care. While the census for Unit C has varied throughout the last few years, there has been an increase in acuity, and a corresponding need for an increase in patient observation (e.g., 1:1 support via Patient Care Attendant (PCA), additional cameras added, etc.). There has been a significant increase in youth with behavioural and neurodevelopmental disorders (e.g., Autism Spectrum Disorder, Oppositional Defiant Disorder, etc.) which requires additional support from BSTs; as these patients often act out with behaviours that require more support. The Hospital has also seen that the community providers and local child welfare agencies have been struggling with securing placements or residential services and often request the Hospital to assist by keeping patients longer, creating a new type of ALC need.

The MHAP is housed on the fourth floor of the Burr building. As shown in the Unit Map below, the program occupies a large multi-unit physical space.

**Figure 1: Burr 4 Unit Map**


## 2.3 Patient Population

The KGH site of KHSC is the tertiary site for mental health and addiction care for Southeastern Ontario, providing acute care inpatient mental health and addiction services. Inpatient admissions to the MHAP include patients experiencing new onset, acute exacerbation, and chronic exacerbation of mental health conditions and disorders. Acute treatment, intervention and care are provided for those with addictions and substance use disorders, developmental disabilities, schizophrenia and psychosis, mood and personality disorders, anxiety and depression, trauma and stress disorders, and Alzheimer's and dementia. The therapeutic interventions provided can include psychiatric, psychosocial, and functional assessment, psychotropic medication, individual therapy, group therapy, psychoeducation, electro-convulsive therapy (ECT) and discharge planning to address all care needs and promote reintroduction to home or community supports.

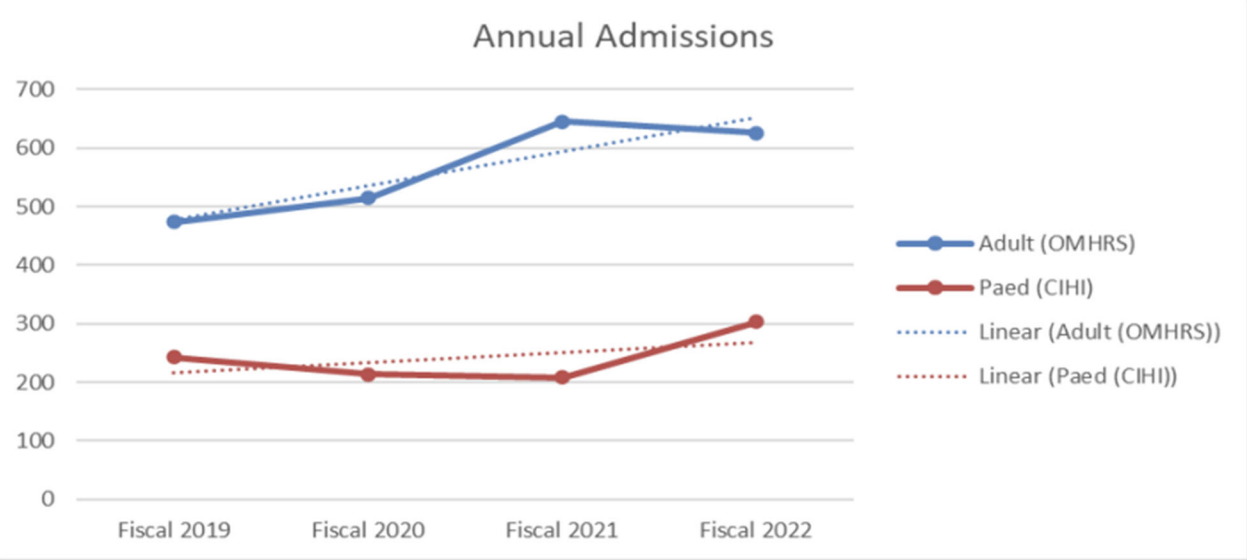
With higher than the average senior's population in the southeast region, geriatric patients with dementia as co- morbid presentation contribute to the increase in patient flow pressures, can create alternative level pf care (ALC), resulting in patient flow pressures for this difficult to place patient population.

The 30-day readmission rate for the MHAP at 15.7% is higher than the Provincial average at 12%. The average occupancy is 85% in 2022/23 with an average length of stay for adults at 16 days and at 7 days for child and youth. KHSC admits 18.5% voluntary patients and 80.8% involuntary patients compared to the Provincial average of 24.6% involuntary and 19.4% involuntary patients.[9]

### 2.4 Statistics about the MHAP

Data is collected on all patients on admission and then on a daily basis by nursing staff. Two separate systems are used for the storage of mental health and addiction data, depending on the age of the patient. Data for patients under 18 years old is stored in the Canadian Institute for Health Information (CIHI) Discharge Abstract Database (DAD). Data for adults (patients 18 and older) is stored in the Ontario Mental Health Reporting System (OMHRS).

The number of admissions for the last four fiscal years are included in the following chart and show an increase in patient admissions over the period with a larger increase among the adult population. Despite increased admissions, the program occupancy has been decreasing in the last 2-3 fiscal years:

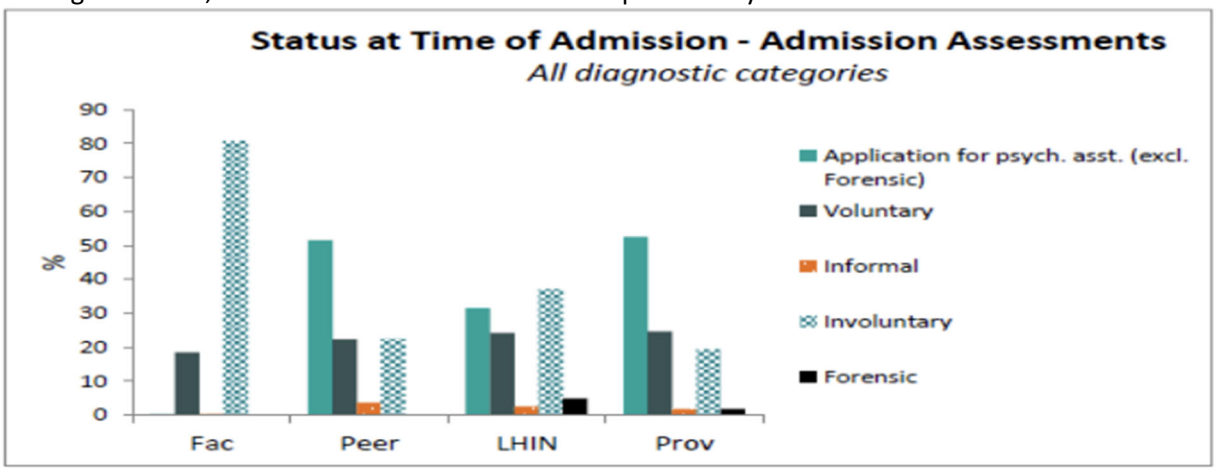



[9] Hospital Presentation, Hearing Day 1. October 18, 2022, Slide 22

| Year | % Occupancy (Avg) on Burr 4 |
|---|---|
| 2019 | 91.3% |
| 2020 | 79.9% |
| 2021 | 72.8% |
| 2022 | 73.1% |
| 2023 YTD (Up to Sept 15, 2022) | 84.0% |

This decrease in average occupancy despite increased admissions can be, in part, attributed to the decreased average length of stay. In Fiscal 2019 the average length of stay was 26.2 days for adults. For the last 2 full fiscal years it has been 15.1-16.0 days. YTD this year, the average length of stay has held at around 16.3 days. The data above includes all units in Burr 4 which causes the numbers to be slightly skewed as Unit C (Child & Youth) tends to have a lower census than Units A and B.[10]

The Chart below illustrates that 80% of the admission at KHSC are involuntary compared to 22.5% at peer organizations, 37.1% across the LHIN and 19.4% provincially.




| Status at Time of Admission | | Fac | Peer | LHIN | Prov |
|---|---|---|---|---|---|
| Application for psych. asst. (excl. Forensic) | % | 0.3 | 51.5 | 31.4 | 52.5 |
| Voluntary | % | 18.5 | 22.3 | 24.2 | 24.6 |
| Informal | % | 0.3 | 3.6 | 2.5 | 1.7 |
| Involuntary | % | 80.8 | 22.5 | 37.1 | 19.4 |
| Forensic | % | 0.0 | 0.2 | 4.9 | 1.8 |
| Total number of admission assessments | N | 626 | 7841 | 1495 | 44685 |

[10] Hospital Brief. September 27, 2022, p. 16.

## 2.5 Professional Responsibility Workload (PRW) Complaint Process and Discussions at the Hospital Association Committee

"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 is meant to promote safe and best possible patient care and also to protect the Ontario Nurses' Association (ONA) members who may identify that patients and staff may be at risk because of improper staffing, skill mix, practice, and workload issues."[11]

The purpose of the Professional Responsibility Workload Report Form (PRWRF), as outlined in the Collective Agreement, is for nurses to document their concerns in writing and to submit the PRWRF to management. Nurses in the Inpatient MHAP at Kingston Health Sciences Centre have met their obligation related to concerns and have documented these issues, as is their professional responsibility. It is only the nurse(s) who can determine, based on their own assessment, whether he/she is providing safe, quality patient care. It is this assessment in which each nurse will determine whether a PRWRF will be completed. Once received management is to respond and seek resolution to the identified issue(s). The Collective Agreement specifies the process for documenting these issues in writing on the 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.

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

"The College of Nurses of Ontario practice standards outline the expectations for nurses that contribute to public safety. They inform nurses of their accountabilities and the public of what to expect of nurses. The standards apply to all nurses regardless of their role, job description or area of practice."[12]

The Hospital Association Committee (HAC) at KHSC and the KGH site is scheduled to meet monthly and at times more often, in accordance with Articles 6.03 and 8.01 of the Central ONA/Hospital Collective Agreement. The CNE or designate, and the Program Manager and Directors join the HAC meeting to discuss workload issues and to propose solutions to resolve the issues. No progress toward resolution to address the workload issues and concerns related to MHAP has been achieved. ONA believes that the key issue is inadequate staffing to meet baseline scheduling requirements. Further, reduction of staff occurs when the Hospital implements its load leveling practices across units and programs.

[11] ONA Brief, Volume I. September 27, 2022, pgs. 11-12.

[12] College of Nurses of Ontario, https://www.cno.org/en/learn-about-standards-guidelines/standards-and-guidelines/

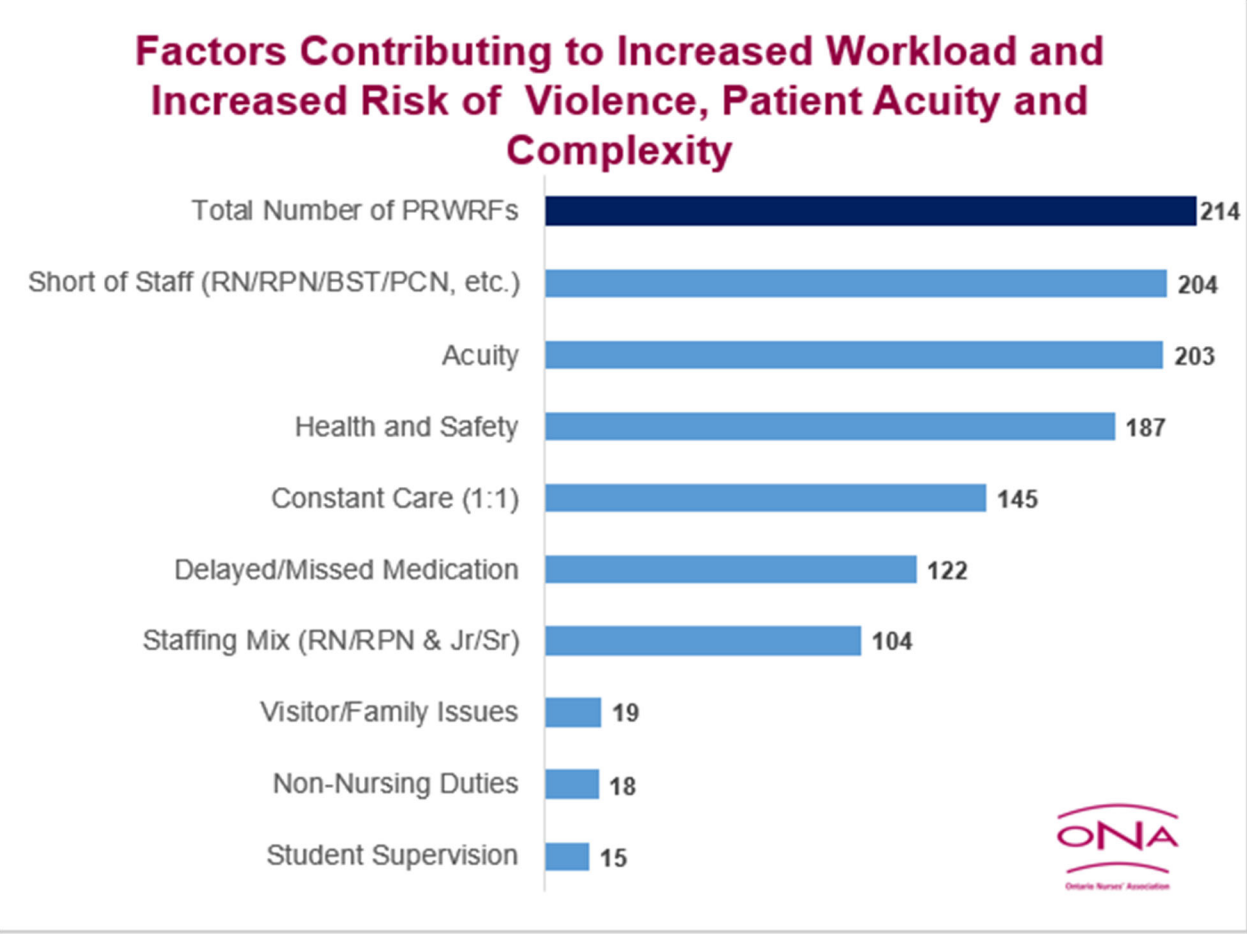
The Employer believes that load leveling and redistributing staff resources to equalize the lack of staff more equitably is the best way to balance risk. The Association believes that reassignment of nurses increases organizational risk and negatively impacts and compromises both patient and staff safety.

Nurses in the MHAP started reporting their professional responsibility and workload issues in 2014. In April 2019, Minutes of Settlement (MOS) for the MHAP were achieved with the Employer. In this MOS the Employer committed to address issues related to staffing shortages and the reported increases in workplace violence incidents in IOA and Section E. The Association agrees that the Hospital has addressed staffing in Section E, however, safe staffing and the ability of staff to manage patient acuity and complexity and the safety of patients and staff remains a concern, therefore the Association states, "To date the Employer has not met its commitment or obligation under the 2019 agreement."[13]

Since 2019 the RNs in MHAP have continued to report their concerns and by October 2022 had submitted 214 PRWRFs to express their ongoing issues related to short staffing, patient acuity, and patient and staff safety. The nurses have expressed their inability to meet the CNO Professional Practice Standards such as Documentation, Medication, Therapeutic Relationships, Ethics, Confidentiality and Privacy, and the RN and RPN Practice Guidelines – The Client, the Nurse and the Environment. In addition to these concerns the nurses express concern about their inability to meet regulatory and legislative requirements and Hospital policies related to the Mental Health Act (1990), Patient Restraints Minimization Act (2001) and the Employer's Patient Behaviour Management and Least Restraint Policy. Although, the Employer expressed interest in resolving the issues they have not committed to creating and implementing any meaningful solutions.

[13] ONA Brief, Volume I. September 27, 2022, p.15.

The graph below illustrates the key concerns raised by nurses in the PRWRFs[14]




Prior to the file moving to ONA's Professional Practice Specialist, the Bargaining Unit Leadership (BUL) attended three HAC Meetings in 2020 on July 20th, September 21st, and October 19th to discuss the nurses' concern and possible solutions with management. The BUL also engaged in discussions outside of HAC to address several PRWRFs concerns related to patient safety.

**HAC Meeting July 20, 2020:** "At the July 20, 2020 HAC Meeting the Employer stated in their review of the PRWRFs that the issues were specifically related to staffing and usually occurred when the unit was not "full"; they expressed that they were "staffing to need not baseline." The Employer stated that they did not replace staff when volumes were down, irrespective of acuity."[15] ONA reinforced their concerns about inadequate staff to manage patient acuity and complexity and the negative impact that is having on the safety of patients and staff. The BUL also reported that when the Charge Nurse on nights has a patient assignment, they are not able to meet their responsibilities and accountabilities to support staff and to establish safe and appropriate assignments, and to coach and mentor staff as needed, while also acting as an expert resource.[16]

[14] ONA Presentation. Hearing Day One, Slide 18.
[15] ONA Brief, Volume I. September 27, 2022, p. 16.
[16] ONA Brief, Volume I, September 27, 2022, p.17.

**HAC Meeting September 21, 2020:** At the September 21, 2020 HAC Meeting the BUL reported that for the period September 14 to October 25, 2020, the posted schedule showed 1,118 unfilled hours. The Union reported 96 vacant RN hours. The Union recommended the Hospital increase the RN staffing and develop a robust recruitment and retention plan.

**HAC Meeting October 19, 2020:** ONA advised the Employer that after discussing the many MHAP PRWRFs at 3 HAC Meetings, with additional discussions and efforts on ONA's behalf made outside of HAC, with no resolution the matter will be advanced to ONA's Professional Practice Specialist.

The inability for the parties to achieve mutually agreed upon resolution of the issues resulted in the file being advanced to ONA's Professional Practice Specialist (PPS) in December 2020. The parties met again on March 2, 2021 to revisit the professional responsibility issues.

**HAC Meeting March 17, 2021:** The PPS attended this sub-HAC Meeting and presented the Employer with an action plan. A second sub-HAC was scheduled for May 7, 2021. The Employer requested this meeting be canceled as they were not prepared to meet. A second meeting took place on July 22, 2021, however, the Employer remained unprepared with no meaningful responses and had taken no actions to address the practice and workload issues.

**On August 9, 2021,** ONA sent a letter to the Employer extending timelines to advance the issues to an IAC. On September 7, 2021 due to the inability to find collaborative solutions and with increasing health and safety concerns raised in the safe reports, such as reports of critical injuries, a lack of staff with non-violent crisis intervention (NVCI) training, the escalating number of code whites, and an ever-increasing use of PINEL restraints, ONA's PPS sent a letter to the CNE, outlining the practice and safety concerns and describing the Unions recommendations for resolutions.

On **September 13, 2021**, the Employer responded disagreeing with ONA's recommendations and that the current staffing was sufficient. The Employer offered no alternate proposals or solutions to resolve the issues. The Employer did acknowledge that the current Fulltime (FT)/Parttime (PT) complement of nurses did not meet the budgeted and baseline staffing and would address this with a master schedule.

**On September 15, 2021,** ONA responded reiterating their position and outlined the expectation that the Employer must post a master schedule with the required and budgeted baseline RN staffing by **September 28, 2021.**

With no further action from the Hospital, on **November 8, 2021,** ONA sent a letter to the Employer advising that the Professional Practice and Workload issues at KHSC Mental Health and Addictions Program was being referred to an Independent Assessment Committee.

## PART 3: DISCUSSION, ANALYSIS AND RECOMMENDATIONS

### 3.1 Human Resources Planning and Nurse Staffing

#### 3.1.1 Staffing and Scheduling

The MHAP has a total of 50 beds across four specialized units operating as one large unit.

Care is provided by a multidisciplinary team of professionals including nurses (RN, NP, Clinical Instructor, RPN), social workers, Behavioural Science Technologists (BST) psychotherapists, psychiatrists, patient care attendants (PCA), unit clerks, occupational therapist, and a pharmacist. Some occupations are direct members of the MHAP while others are assigned from centralized corporate services.[17]

Burr 4 Unit A (Intensive Observation Unit (IOA) is a 7-bed closed observation unit plus 2 short stay beds. It is staffed with a 3:1 patient to RN ratio. The RNs are scheduled to work Monday to Sunday, 24 hours per day. Staffing is based on occupancy and acuity.

Burr 4 Unit B is a 31-bed Adult Unit. It is staffed with a 6:1 patient to nurse ratio, consisting of both RNs and RPNs. The RNs and RPNs staffing are based on acuity. The MHAP Charge Nurse (CN) is based on Unit B and works Monday to Sunday 0700 to 1900 hours. The CN is not to have a patient assignment, however, KHSC acknowledges that there are times when due to staffing shortages the CN takes a patient assignment. In 2020 a NP was added to the staff on Unit B with a focus on Geriatrics/Dementia.

In addition to caring for a heterogeneous mental health and addictions patient population Unit B is now being expected to care for patients with medical needs as well as mental health and addictions needs. Providing medical interventions require a greater level of expertise and following the Three Factor Framework[18] it is important that there is proper skill mix to care for the patient population and provide the exceptional patient care to meet patient care needs.

Burr 4 Unit C is an 8- bed unit (+1 bed under construction) Child and Youth Unit staffed with a 5:1 patient to nurse ratio with 1 RN, 1 RPN and 1 BST Monday to Friday from 0700 to 1900. On weekends and statutory holidays, the unit operates with 1 RN and 1 RPN 24 hours. Staffing is based on occupancy and acuity. The RPN working Monday to Friday was added in 2021. Prior to that the RPN worked nights and weekends only.

As documented on the PRWRFs, staff have reported working with 2 RPNs at times or having to bring the child to the Adult Unit to provide an environment to meet the needs of the patient. The clientele on the C Unit includes children with behavioural issues and special needs who require additional support and closer monitoring. Due the acuity of the patients, the unpredictability of the patients, the Child and Youth Unit must be staffed with at least 1 RN to align with best practices of the Three Factor Framework. (CNO 2018).

Mental Health Emergency Services Unit (Section E) is a 2-bed Unit within the Emergency Department. It is staffed with a 2:1 patient to RN ratio. RNs are scheduled Monday to Sunday, 24 hours per day.

[17] Hospital Brief, Volume I, September 27, 2022, p. 20.
[18] College of Nurses of Ontario. (2018). RN and RPN Practice: The Client, the Nurse, and the Environment. (CNO Practice Guideline, Pub No 41062)

Nurses are not assigned to work in Section E until they have completed 6 months of work on the Burr 4 unit. KHSC acknowledges that due to staffing shortages, staff may be assigned to Section E much sooner than the 6-months recommendation. In 2021 a NP was added with a focus on Emergency Mental Health and Addictions.[19]

**The Association's Perspective:**

The Association states in its submission that the current staffing models are not meeting the needs of the department as identified in the details of the 214 PRWRF submitted by the nurses. Since 2019, 204 of the submissions indicated staffing shortages as a factor impacting the increase in workload.[20]

Although the budgeted staffing for Unit B is a 5:1 patient to nurse ratio, the PRWRFs note that the patient to nurse ratios are often greater than budgeted and, at times, as high as 10:1 due to the chronic and at times critical nursing shortages.[21]

The Association states that the nurses are not able to meet their CNO Professional Practice Standards or to comply with the Hospital policies and procedures when they are constantly working below the baseline staffing complement.

The current posted staff schedule on Burr 4 for the period of October 24 to December 5, 2022, has 20 FT RNs on the working schedule but there are only 11 actual RNs scheduled to work. The staffing shortages that continue result in a posted schedules with many shifts not covered meaning the nurses are working short of budgeted RN Fulltime Equivalents (FTEs) which continues to increase the workload for the nurses working in the inpatient MHAP.

RN staffing levels in the MHAP are gravely inadequate to support the RNs in the delivery of safe, quality, ethical patient care for the volume, acuity, and complexity of the Mental Health patient population served by the KHSC MHAC Program. The primary goal of Mental Health Nursing is the promotion of mental health and the prevention or diminution of mental disorder (Canadian Federation of Mental Health Nurses, 2014); however, the lack of RN resources is preventing RN staff in the MHAP from achieving this goal.[22]

Further, the Association reports the nurses are unable to practice to the expected standards as outlined by the Psychiatric Mental Health Nursing Standards, as follows:

Standard I: Provides Competent Professional Care Through the Development of a Therapeutic Relationship.
Standard II: Performs/Refines Client assessments through the Diagnostic and Monitoring Function.
Standard III: Administers and Monitors Therapeutic Interventions.
Standard IV: Effectively Manages Rapidly Changing Situations.
Standard V: Intervenes through the Teaching-Coaching Function.
Standard VI: Monitors and Ensures the Quality of Health Care Practices.

[19] Hospital Brief. September 27, 2022, p. 21.
[20] ONA Presentation. Hearing Day One. October 18, 2022, Slide 18.
[21] ONA Presentation. Hearing Day One. October 18, 2022, Slide 12
[22] ONA Brief, Volume I. September 27, 2022, p. 24.

Standard VII: Practices Effectively within Organizational and Work-Role Structure[23]

Although management has identified the province-wide nursing shortage as a factor in hospital staffing issues, no effective resolutions have been implemented by the Employer to mitigate risk and ensure the safety of patients and staff.

**The Hospital's Perspective:**

The Hospital agrees that it is important for there to be sufficient RN (and other professional) resources to support the MHAP census, patient acuity, and to cover emerging staffing needs. It is well-documented that hospitals across Ontario are struggling with staffing shortages. This is not a problem unique to KHSC or caused by KHSC's action or inaction.[24]

MHAP staffing positions as of August 30, 2022, are 53 RNs in total as follows: 27 full time (FT) 18 part time (PT), and 8 casuals, plus 2FT Mental Health and Addictions Care (MHAC) Emerge Nurse Navigators and 1 PT MHAC Emerge Nurse Navigator. There were 20 RPNs in total, 11 FT and 9 PT. At that time 12 staff were off on a Leave of Absence (LOA) or sick time. In addition to the LOA and sick time there were 12 RN vacancies (4 Permanent FT), 1 Permanent PT and 7 Temporary PT).

At the time of the Hearing, KHSC shared that the actual staffing is less than reported in their Brief submission and as of October 2022, there are 17 FT, 8 PT and 4 PT filling Temporary Full Time (TFT) vacancies. There are 10 staff off on leave of absence, including medical leave of absences and Workers Safety and Insurance Board (WSIB) leaves.

The Hospital reported that RN vacancies on MHAP have been a challenge over the past five years and they advised that they continue to make efforts to fill position vacancies to ensure the baseline staffing can always be scheduled.

"Unfortunately, there has been an increasing strain in the health human resources labour market over the past several years. As such, the Hospital has struggled to maintain staffing baseline due to ongoing vacancies and absences. This is a common challenge across the province and beyond and has been growing over the past several years".[25]

In March 2022, the Ontario Hospital Association (OHA) reported vacancy rates in the east region in which KHSC operates are higher than the rest of the province at 18.61% for specialty nursing with KHSC's rate at 14.08% compared to the provincial average of 12.63%.

"In addition to the length of time it takes to replace transfers or resignations out of the unit, the temporary vacancies (e.g., maternity leaves) and unplanned incidental absences (e.g., illness and other emergencies) contributed to the staffing challenges. From 2019-2021, the average number of sick days

[23] Canadian Federation of Mental Health Nursing. (2014). Canadian Standards for Psychiatric-Mental Health Nursing (4th Ed.) Author

[24] Hospital Brief. September 27, 2022, p. 29.
[25] Hospital Brief. September 27, 2022, p. 21.

taken within Inpatient Mental Health and Addiction Burr 4 was approximately 18.3 days. Of course, some of these absences were pandemic related but pose a consistent staffing challenge."[26]

**The IAC Perspective:**

The IAC believes that the staffing vacancies over many years has led to a staffing crisis in the MHAP as the posted schedule rarely meets the baseline staffing requirements. This staffing shortage is compounded when there are short-term vacancies due to sick calls as well as the large number of the long-term vacancies due to medical and other LOAs. For many shifts there are inadequate nurses to meet the patient care requirements which leads to unsafe patient care in an unsafe work environment. The RNs are being asked to perform more work than is consistent with proper patient care.

The IAC commends the Hospital for implementing a Master schedule in February 2022 and increasing the baseline staffing by adding 3 FTRNs and 1 PTRN in the MHAP. However, with the high number of RN vacancies. long-term shortages due to LOA and short-term shortages due to high number of sick calls, there is inadequate staff to meet baseline staffing and to fill the master schedule.

The IAC assessed that there is an inadequate number of RNs to fill the master schedule leading to many shifts where it is known by management that the MHAP nurses are challenged to safely meet the patient care requirements. With the large number of gaps in scheduling it is impossible to respond to last minute staffing shortages due to illness.

The Chart below shows an increasing trend in sick-time and the need for overtime to cover some of the staff shortages over the past five years.[27]

| Sum of FTE | | Year | | | | |
|---|---|---|---|---|---|---|
| Cost Centre | OG | 2019 | 2020 | 2021 | 2022 | 2023 |
| MH | RN | 1.2 | 1.2 | 1.2 | 1.3 | 3.1 |
| MHE | RN | 0.0 | 0.0 | 0.0 | 0.1 | 0.3 |
| MHY | RN | 0.5 | 0.4 | 0.5 | 0.1 | 0.2 |
| Grand Total | | 1.7 | 1.6 | 1.7 | 1.4 | 3.6 |

| Sick Time - Sum of Hours | | Year | | | | |
|---|---|---|---|---|---|---|
| Cost Centre | OG | 2019 | 2020 | 2021 | 2022 | 2023 |
| MH | RN | 2329.19 | 2252.13 | 2306.99 | 2525.33 | 6058.65 |
| MHE | RN | 4.57 | 81.87 | 53.05 | 133.90 | 521.08 |
| MHY | RN | 960.04 | 866.55 | 990.30 | 164.16 | 390.00 |
| Grand Total | | | 3200.55 | 3350.33 | 2823.39 | 6969.73 |

| Plan Version | Act |
|---|---|
| HrType | (Mu le Items) |
| | Overtime |

| Sum of FTE | | Year | | | | |
|---|---|---|---|---|---|---|
| Cost Centre | OG | 2019 | 2020 | 2021 | 2022 | 2023 |
| MH | RN | 0.9 | 0.7 | 1.4 | 2.9 | 3.0 |
| MHE | RN | 0.0 | 0.5 | 0.0 | 0.0 | 0.1 |
| MHY | RN | 0.0 | 0.1 | 0.1 | 0.1 | 0.1 |
| Grand Total | | 0.9 | 1.2 | 1.5 | 3.1 | 3.2 |

| Overtime - Sum of Hours | | Year | | | | |
|---|---|---|---|---|---|---|
| Cost Centre | OG | 2019 | 2020 | 2021 | 2022 | 2023 |
| MH | RN | 1717.40 | 1301.81 | 2793.13 | 5713.48 | 5894.59 |
| MHE | RN | 18.75 | 880.03 | 36.36 | 81.93 | 139.10 |
| MHY | RN | 40.38 | 125.70 | 186.03 | 241.67 | 114.83 |
| Grand Total | | 1776.53 | 2307.54 | 3015.52 | 6037.08 | 6148.52 |

Another factor affecting scheduling gaps is the staff turnover which is contributing to a chronically high vacancy rate. The vacancy rate is the primary cause for the shortages, leading to the scheduling gaps.

[26] Hospital Brief. September 27, 2022. P. 25.
[27] Hospital Response to IAC Information Request. Section 3. H., September 19, 2022.

When the nurses in the MHAP could not meet their CNO Practice Standards they met their obligation to report their concerns to management by reporting their concerns in 214 PRWRFs. In fact, 204 of the forms identified staff shortages as a major issue contributing to patient and staff safety concerns.

The Chart below shows a high turnover rate from Fiscal 2019 to Fiscal 2023 YTD.[28]

| Section | Item Description | Notes | Response | | | | | |
|---|---|---|---|---|---|---|---|---|
| 3) Staffing data for four fiscal years: 2018-2019; 2019-2020, 2020-2021, 2021-2022 April 1st to March 31st) and 2022-23 year-to-date | j) RN turnover rate (internal and external) comparison over the last four years | RN turnover includes Charge Nurse Permanent exits | Turnover % | F2019 | F2020 | F2021 | F2022 | F2023Jul |
| | | | Transfer out of Inpatient Mental Health | 9.76% | 4.76% | 11.63% | 4.00% | 0.00% |
| | | | Termination from Inpatient Mental Health | 9.76% | 9.52% | 13.95% | 8.00% | 4.08% |

The Association calculated the turnover to be higher than the Hospital reported. For 2019/20 fiscal year termination from the MHAP was 9.52% (4RNs leaving KHSC) and when adding the 3RNs who transferred within the Hospital it is a 16.7% turnover rate. For 2020/21 fiscal year the termination from the MHAP was 14.28% (6RNs leaving KHSC) and when adding the 4RN transfers out, the turnover rate was 23.8%.[29]

The IAC Panel spent a lot of time discussing the appropriate RN requirements to ensure adequate nursing care hours to deliver high quality patient care and to meet the CNO Professional Practice Standards. We agreed that Unit B Adult should always be staffed with a minimum of 3 RNs with 3RPNs to meet the acuity and complexity of care needs for patients admitted to that Unit. The IAC Panel strongly believed that the MHAP should have a Permanent Night Charge Nurse, seven days a week, with no patient assignment, to ensure smooth functioning of the Unit and to ensure that an expert nurse is available to meet the roles and responsibilities of the CN. This is best practice.

The IAC Panel agreed that since the MHAP has been operating short of nursing staff over many years it is not possible to fully assess and determine if the current budgeted RN complement, if filled, would be adequate to provide the appropriate number of nursing care hours to deliver safe, quality care and to meet the CNO Practice Standards.

Therefore, the Panel has not recommended any additional FTEs beyond those required to fill the CN positions to allow for the assignment of a CN on nights seven days a week without a patient assignment.

The IAC Panel strongly recommends that once baseline staffing is achieved and the master schedule is posted, without gaps, the Employer and Association assess whether the concerns with nursing workload have been addressed.

[28] Hospital Response to the IAC Information Request. 3.J., September 19, 2022.
[29] ONA Presentation. Hearing Day One, October 18, 2022, Slide 10.

**The Chart below shows the Current Staffing and the Proposed Staffing on the Impatient MHAP**

| Department | Current Staffing | Proposed Staffing |
|---|---|---|
| | | |
| Unit A | 3 RNs 24/7 | 3 RNs 24/7 |
| (IOA) | | |
| | | |
| Unit B | 2 RN and 4 RPNs 24/7 OR | 3 RNs and 3RPNs 24/7 |
| (Adult) | 3 RNs and 3 RPNs | always a minimum 3RNs |
| | 1 PCA 0700 - 2300 | 1 PCA 0700 - 2300 |
| | 1 NP 0700 – 1500 (M-F) | 1 NP 0700 – 1500 (M-F) |
| | 1 Unit Clerk 0700 – 2300 (M-F) | 1 Unit Clerk 0700 – 2300 (M-F) |
| | | |
| | | |
| Unit C | 1 RN 24/7 | 1 RN 24/7 |
| (Child & Youth) | 1 RPN 24/7 | 1 RPN 24/7 |
| | 1 BST 0700 - 2300 | 1 BST 0700 - 2300 |
| | | |
| Unit E | 1 RN 24/7 | 1 RN 24/7 |
| (MHEU) | 1 NP 0700 – 1500 (M-F) | 1 NP 0700 – 1500 (M-F) |
| | | |
| | | |
| Charge Nurse | 1 Permanent CN 0700-1900 (Unit B) | 1CN 0700-1900 (Unit B) |
| | with no patient assignment | with no patient assignment |
| | Rotating CN 1900-0700 1RN | Permanent CN 1900-0700 |
| | with patient assignment | with no patient assignment |
| | | |

**Related to Staffing and Scheduling the IAC Recommends:**

1. The following 3 recommendations assume optimal staffing with baseline staffing. During this current time of chronic shortages, until recruitment achieves optimum full-time equivalents, the MHAP unit leadership will work with the charge nurses to create a decision-making tree to guide just in time decision-making related to RN assignments. The goal is to assign the available RN staff to provide the best possible care with the RN staff available for each shift.

2. The Intensive Observation Area, Unit A will be staffed by 3 RNs 24/7 to manage patient acuity and complexity and the high number of patients who are admitted on an involuntary status and require close observation every 15 minutes as per hospital policy.

3. Unit B Adult will be staffed with 3RNs and 3RPNs plus the Charge Nurse who is assigned to Unit B to meet the needs of the acuity and complexity needs of the diverse patient population. Based on acuity the baseline staffing can be increased but it should not be below the baseline.

4. Unit C Child and Youth staffing to be maintained with 1RN, 1RPN and 1BST with the Employer committing that an RN must always be assigned.

5. Section E MHEU staffing be maintained at 2:1 patient:nurse ratio 24/7

6. The Program Manager consult each morning, Monday to Friday, with the Charge Nurse to assess the patient care requirements and to support short term staffing needs for the next 24 hours. On Friday, the consultation to include assessing any known staffing gaps throughout the weekend.

7. The Employer and the Association review the Master Schedule and identify the actual FTRN and PTRN vacancies that need to be filled to meet the budgeted baseline staffing.

8. The Employer to assess the FT and PT staffing complement on an annual basis during the budget cycle to assess that the current budgeted staffing meets the patient care requirements on MHAP. This assessment to include a review of the full time and part time ratio of a minimum 70%/30% in keeping with the Beck Award.

### 3.1.2 Load Levelling

**The Association's Perspective:**

The Employer has initiated a practice of hospital-wide "load leveling" and reassignment of staff to mitigate organizational risk stemming from staffing shortages. The practice of load leveling involves decisions that result in making each unit equally short staffed throughout the Hospital. The process of load leveling entails the implementation of arbitrary hospital-imposed nurse to patient ratios which are unsupported by literature, without consideration of the acuity and complexity of patient needs or the staffing requirement to meet CNO standards for safe patient care, and as reported by the RNs on PRWRFs.[30]

The Association expressed concerns they have related to the "load levelling" practices. Many times, the MHAP was left short and the CN staffing decisions were overridden by the Operational Manager (OM). Many of the PRWRFs report that even when there were staffing shortages on the MHAP or the patient acuity was high the OM would reassign staff from Burr 4 to medical units in other areas of the Hospital. This would occur despite the staff describing the acuity of the unit and the staffing constraints.

**The Hospital's Perspective:**

"One of the major recent issues within the MHAP has been the anxiety of nurses being reassigned from their home unit, commonly referred to as floating. This includes both nurses from MHAP being asked to float to other units within the hospital and nurses from other units being asked to float to MHAP in instances where the Hospital needs distributes staff on shift across inpatient units to provide patient care."[31]

[30] ONA Brief, Volume I. September 27, 2022, p. 28.
[31] Hospital Brief. September 27, 2022, p. 37.

The reassignment of staff requires the exercise of discretion and a considered balancing between the relative needs of different units within the Hospital. Assessing these relative needs is not always easy. The Hospital understands that the MHAP is a dynamic environment where patient volume and acuity can change.[32]

**The IAC Perspective:**

The IAC Panel appreciates the staffing constraints that occur on Burr 4 and other areas of the Hospital and that the Hospital is trying to do their best not to leave units short but to try and level the risk across the organization. By leveling the risk, it puts greater risk on the MHAP staff who are being assigned into departments where they have no experience or expertise and are being expected to perform at the standard set by the CNO. The IAC is concerned that the Oms, are at times, making decisions without fully assessing the acuity and complexity of the patients and the staff available to meet patient care needs. As per the PRWRFs this is at times done over the phone without the OM coming to the unit and witnessing firsthand what the staff are describing. There needs to be a more thoughtful approach, using the Acuity Rating Tool in consultation the CN to make appropriate staffing decisions for the MHAP.

**Related to Load Leveling the IAC Recommends:**

9. That the Employer use "load levelling" as a last resort when reassigning nurses from the MHAP. The Employer reviews the proposed "Acuity Rating Scale" with the Charge Nurses, frontline nurses, and the Association to seek their input prior to implementation. Once finalized, Employer to implement the "Acuity Rating Scale" and measure the impact on how the Operational Managers utilize the assessment completed by the Charge Nurse, and visit the unit on each shift, prior to reassignment of a MHAP nurse.

### 3.1.3 Charge Nurse

**The Association's Perspective:**

The information from the Association describes an environment that prevents the Charge Nurse (CN) from meeting their responsibilities as outlined by KHSC job description. The Burr 4, 2018 risk assessment report completed by Macsim Solutions Inc. ascertained that the CN was not able to or was unavailable to perform their duties in case of an emergency. It was also identified that in their absence the CN role was not delegated to another RN.[33]

The Association's position is that the role of the CN is one of a leader on the unit. They are overseeing the safety of the staff, patients, and visitors to the Burr 4 Unit. They are expected to support staff during a Code and actively participate in the debrief after a Code or violent incident. The CN experiences moral distress and is challenged to meet their college standards when they are not able to support staff in the way they believe they ought to. The CN is expected to oversee the day-to-day operations, mentor, support and educate nurses on Burr 4. One of the CNs is on a leave which leaves their position to be backfilled by a part time RN. On the night shift the CN is assigned on a shift-by-shift

[32] Hospital Brief. September 27, 2022, p. 38.
[33] ONA Brief, Volume II. September 27, 2022, (Macsim Solutions Inc. Report 2018), p. 1107.

basis and the assignment takes minimal consideration of their seniority, skills, knowledge, and ability to perform the position.[34]

Due to staffing shortages on the unit, there are numerous times when the CN on days is required to have a patient assignment. The CN on nights always has a patient assignment and is still expected to perform all the duties of the CN. The PRWRFs submitted by the nurses reflect the additional workload put on all the staff when the CN is not able to focus on the core duties of the role. Further, the CN is challenged to provide quality and meet CNO Professional Practice Standards for his/her assigned patients as his/her time is divided across many roles and responsibilities.

**The Hospital's Perspective:**

The role of a CN is integral to the operations of the mental health department. KHSC acknowledges that there have been revisions to the CN position. In 2016 a CN was scheduled from 0700 to 2300 Monday to Friday. In 2017 there was a model change, and the role went from 8 hours to 12 hours, 7 days a week. In 2020 there was another change to the staffing model for the CN. There was one CN assigned to work 0700 to 1500 on the adult unit and one CN on the Child and Adolescent unit, 0800 to 1600 Monday to Friday. The current model reflects the Charge Nurse staffing model from 2017 which is one CN from 0700 to 1900, 7 days a week.[35]

The Charge Nurse is responsible, as outlined by the Hospital, to ensure safe, high quality patient and family centred care on Burr 4 and to support continuity of care. They are also responsible for the day-to-day resource utilization decisions and effective operations in the patient care areas of Burr 4 and MHESU. The CN is to create a welcoming, professional, supportive, collaborative, patient centered and healing environment in the patient care areas for patients, families, and staff. They are to take a leadership role in developing highly skilled nurses in the patient care area. The CN is expected to take a leadership role in ensuring the highest level of patient, family, and staff safety in the patient care areas. The CN is expected to attend all codes on the Burr 4 and any codes in the MHESU area of emergency and cover the nurses for break.[36]

**The IAC Perspective:**

The IAC believes that the CN is the content expert on the unit. They are the nurse that all staff go to for help, support and just in time learning needs. Given the expectation of the job description of the CN provided by the Hospital, it is an unachievable expectation to expect one person to perform at that level of excellence overseeing 50 beds, and the work of the RNs, RPNs, clerical staff, BSTs and PCAs, while also managing a patient assignment. There is also the expectation to interact with other members of the multidisciplinary team and the medical and nursing students.

This becomes more challenging for all the staff when the CN needs to attend a Code White in the MHESU and must physically go down 4 floors, and across the other side of the hospital to get to the MHESU. The video that was submitted by MHESC for the tour of departments depicts a time period of approximately 7 minutes to get from the emergency department to the Burr 4 Unit if relying on the elevator. There is no express elevator so the length of time it takes to travel in the elevator can vary.

[34] ONA Brief, Volume I, September 27, 2022, p. 71.
[35] Hospital Presentation. Hearing Day Two, October 20, 2022, Slide 50.
[36] Hospital Presentation. Hearing Day Two, October 20, 2022, Slide 51.

Even if the nurses take the stairs from 4 Burr to the MHESU there will be a time delay and they are physically off the unit for a significant amount of time.

The CN is required to attend various meetings during the day to update the organization on staffing and bed status, admission, transfers, and discharges. The CN is also left to address sick calls and try and replace last minute staffing needs. They are to create the daily patient assignment and organize other unit meetings and huddles. They may also be required to attend various program based and organizational committees as a MHAP representative.

Information obtained from the PRWRFs reference to the fact the CN covers the break of staff across the MHAP units. It becomes challenging if the CN is to cover a break for another nurse, but they are attending a Code White, or the CN has their own patient assignment.

On the night shift as previously mentioned the CN has a full patient assignment yet they are still expected to perform at the level of the CN during the day. The CN role on nights is an assignment and if there is only one RN scheduled then that nurse will be assigned the charge duties. There is no consideration for the nurse assigned to be the CN to have worked for a certain period of time, have any leadership experience, or have the skills, knowledge, and ability to perform the role.

For the MHAP to function optimally the IAC believes that there must be a dedicated CN during the day shift and a dedicated CN on night shift to ensure that the CN can achieve the roles and responsibilities assigned to the position. None of the CN's should have a patient assignment, except in cases where severe staffing shortages would impact patient and staff safety. There should also be a requirement to have a required number of years of mental health experience to apply for the position.

**Related to the Charge Nurse the IAC Recommends:**

10. The Employer assigns, immediately, a Permanent Charge Nurse on the night shift from 1900 to 0700 hours, without a patient assignment, seven days a week.

11. The Employer hires the required number of RNs to fill the Permanent Night Charge Nurse position and all RNs hired into the Charge RN role to receive training and orientation, to ensure all are fully trained and oriented to the role.

12. When the MHAP is staffed to baseline the Employer and the Association meet to discuss the benefits of a second Day CN, without a patient assignment.

### 3.1.4 Recruitment and Retention

**The Association's Perspective:**

The staff of Burr 4 feel that are not valued by the organization. This was supported by the survey results conducted by McLean and Company in 2019 and again in 2021. Key results from these surveys indicate low performing scores (<40%) in many categories, as outlined in the section "Morale and Toxic Work Environment."[37]

[37] Hospital Response to the IAC Information Request. Section 6.B. 2019-20, 6.B. 2021-2022, September 19, 2022.

The low staff engagement and satisfaction scores are contributing to an overall negative work environment on the MHAP and is impacting the nurses' ability to provide safe nursing practice and to meet the CNO Professional Practice Standards. This in turn is impacting the high number of nurses resigning their position and leaving the Hospital or transferring to another unit within the Hospital.

**The Hospital's Perspective:**

The Hospital reports that there are challenges to recruitment getting nurses to either remain in Kingston after graduating from Queen's University, School of Nursing or to move from the GTA and other regions in the province to work in Kingston. Data provided by the OHA spring survey 2022, shows total vacancy rate for KHSC as of March 1, 2022, to be 14.05% RN vacancy rate. This is lower than the East Region at 18.61% but higher than the provincial average of 12.63%.[38]

The Hospital has engaged in several recruitment strategies to encourage staff to join the organization. KHSC participates in job fairs, and shared interest groups to get potential employees interested in Kingston to live and work. Kingston is home to Queens University and other College partners and the Hospital endeavours to offer positions to nurses in their final consolidation prior to graduating. KHSC participated in the government sponsored programs New Graduate Guarantee (NGG). They also participated in the Ontario Health and College of Nurses of Ontario approved Program for Internationally Educated Nurses (IENs) called "Supervised Practice Experience Partnership (SPEP). KHSC has four IENs in this program. KHSC has partnered with an external talent acquisition company which guarantees interested prospective nursing candidates. KHSC participated in the government funded program Nursing Retention Fund.[39]

The Hospital provided data that supported placement of 718 nursing student placements and 182 consolidations. They also reach out to regional high schools to encourage high school students to consider a career in nursing.

"To support the retention of nurses at KHSC there has been the creation of nursing engagement sessions, recruitment and retention committee and plans to create and Nursing Engagement Recruitment and Retention Committee. This Committee will include representation from all clinical programs and will be represented by all nursing and support roles in all domains of nursing practice. Meetings are planned to be initiated in November 2022. In June 2022, KHSC created a MH Engagement Survey asking 14 specific questions. There were 6 subgroups created based on the feedback from the survey. Education, Communication, Resident Education, Patient Care Plan, Group Therapy and Burr 4. There have been monthly meetings initiated with the working groups Chairs and they will initiate quarterly meetings with all the members. The result of the survey will be presented to the staff shortly.[40]

**The IAC Perspective:**

The IAC panel strongly believes that more could be done to retain and recruit RNs to work at KHSC. In reviewing the survey report from McLean and Company, the data collected in 2019 does not paint a picture of engaged happy staff. The staff did not feel connected to the senior leadership team scoring at

[38] Hospital Presentation. Hearing Day One. October 18, 2022, Slide 13.
[39] Hospital Presentation. Hearing Day One. October 18, 2022, Slide 27.
[40] Hospital Presentation. Hearing Day Two. October 20, 2022, Slide 7.

20% and feeling recognized and rewarded at 32%. Two years later in 2021 the results were even more concerning, with senior leadership scoring at 14% and reward and recognition at 25%.[41]

It is very clear to the IAC Panel that staff do not feel supported by the management or senior leadership team and trust in leadership has eroded. If the Hospital is to retain the MHAP nurses and create a quality practice setting a change in local and senior leadership behaviours and actions is required.

One of the factors affecting the workload challenges of the RNs in the MHAP is the fact that the Unit is chronically under-staffed without adequate nurses to fill the six-week posted schedule. This adds to the workload of those working the shifts that are unfilled and this has been a contributing factor to the increased PRWRFs. The Panel recognizes that the current nursing shortage is a reality that may be with the healthcare system in Ontario, well into the future and this shortage has resulted in the need to fill vacancies with inexperienced MHAP nurses.

Despite this challenging reality, the MHAP Program Manager is responsible to ensure the adequate number of skilled and competent RNs to provide safe, quality care for all patients presenting at the MHAP. If not addressed in a timely and effective manner, the current issues with nurse shortages and increased workload will lead to more RN sick time, overtime, and turnover.

This in turn will lead to the recruitment of more novice nurses who will be asked to fulfil duties beyond their skill levels before they are fully orientated and competent. As outlined in many of the PRWRFs this places pressure on experienced nurses, taking them away from their patient assignments and creating a stressful work environment, as they feel that they cannot provide safe, quality care consistent with the CNO Standards of Practice.

Nursing retention is focused on reducing nursing turnover and once recruited, making every effort to retain this valuable resource. Job satisfaction is a key to nurse retention and the clinical leader is best positioned to address the concerns of nurses. If not managed effectively, these concerns can lead to nurse dissatisfaction, and a desire to leave their current job. The IAC has observed evidence of high turnover in the MHAP and believes this must be addressed.

"Retaining nurses within the healthcare system is a challenge for hospital administrators. Understanding factors important to nurse retention is essential. Clinical and managerial competence, engagement with their employees, and presence on the unit are key to retaining a satisfied nursing workforce."[42]

The IAC Panel heard evidence of a recruitment strategy during the Hearing, however, the strategies are not addressing the recruitment needs of the MHAP. Nursing leadership needs to partner with the Human Resources and make recruitment a priority and develop a multipronged approach and measure the impact of the strategy.

Nursing is a caring profession built upon nurse-patient relationships. When nursing is reduced to "task and time" mechanistic approaches to care delivery, nurses suffer from emotional and moral distress. Compromised nursing standards are a source of emotional distress and moral distress, with deeper

[41] Hospital Response to IAC Information Request. Section 6. B. 2019-2020, 6.B. 2020-2021. September 19, 2022.
[42] Bugajski, A., Lengerich, A., Marchese, M., Hall, B., Yackzan, S., Davies, C., Brockopp, D. The Importance of Factors Related to Nurse Retention Using the Baptist Health Nurse Retention Questionnaire Part 2. The Journal of Nursing Administration. June 2017, Volume 47, (6), pgs. 302-312.

ethical roots. "…moral distress occurs when the internal environment of nurses—their values and perceived obligations—are incompatible with the needs and prevailing views of the external work environment." "Outcomes from emotional and moral distress include emotional exhaustion/burnout, job dissatisfaction and eventual exit from the profession. Epstein and Delgado recommended that administrators engage nurses in discussions around values conflicts, while Pendry advocated for informal team discussions and formal ethics committees."[43]

The impact to Canadian nurses' mental health and wellbeing in a survey by RNAO Nursing Through Crisis: A Comparative Perspective using Depression Anxiety Stress Scale (DASS -21), surveyed 5,200 nurses from across Canada from May to July 2021, the majority of respondents from Ontario. The study found that 16.7 % of nurses expressed severe (6.4%) and extremely severe (10.3%) depression using DASS-21. 20% of nurses expressed severe (7.0%) and extremely severe (13%) anxiety. 15.5% of nurses expressed severe (10.4%) and extremely severe (5.1%) of stress. 60.3% of nurses expressed severe (28.7%) and extremely severe (31.6%) stress at work. Burnout was measured by exhaustion and disengagement. 75.3% expressed they were burned out (both exhausted and disengaged). When asked if they took time off work to manage stress, anxiety, or other mental health issues, 26.2% reported that they did.[44]

The results of this study echo the moral distress and key messages that the IAC Panel heard from the MHAP nurses when they shared their Impact Statements on Day Three of the Hearing.

The Hospital reported a very high sick time with an average number of sick days per nurse in 2019 at 21.54 days, in 2020 at 15.84 days and in 2021 17.58 days.[45]

The RNAO Best Practice Guideline, Developing and Sustaining Safe, Effective Staffing and Workload Practices provides guidance to employers, "on how the decision-making process must ensure that appropriate structures and supports are in place to maximize the nursing effort resulting in the best possible care and positive outcomes for the patients/clients, nursing personnel, and the organization."[46]

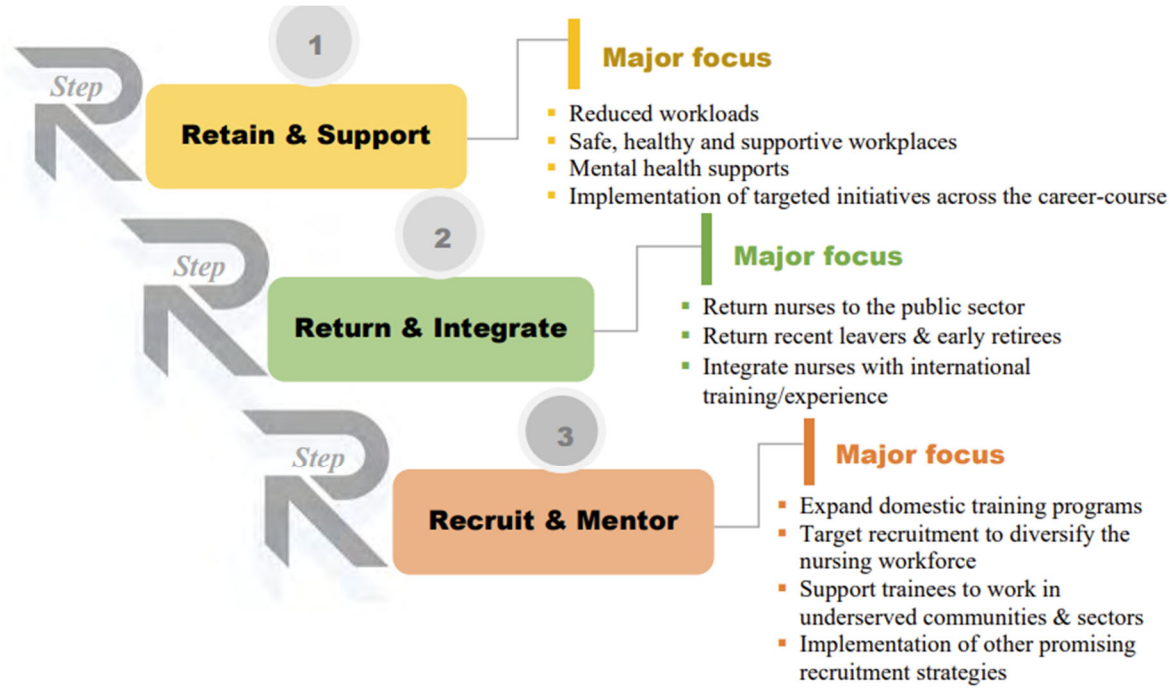
A new Report, Sustaining Nurses in Canada was released in November 2022 by the Canadian Health Workforce Network (CHWN) and the Canadian Federation of Nurses Unions (CFNU).

"Nurses are frustrated and angry. Morale has reached a new low because nurses lack the resources to provide the quality of care they know patients deserve, and there is no clear plan in sight. In this report, the Canadian Federation of Nurses Unions has partnered with health policy and workforce planning expert Dr. Ivy Bourgeault and her team. In the clearest terms, we present the magnitude of the situation and the known solutions to address it. Retaining our experienced nurses will ensure the highest quality of care; returning nurses who have left will bolster our ailing workforce; recruiting and

[43] Epstein, E.G.; Delgado, S. Understanding and addressing morale distress, Online J. Issues, Nurs. 2010, 15. [Google Scholar] [CrossRef
[44] Registered Nurses' Association of Ontario. (2022). Nursing Through Crisis: A Comparative Perspective.
[45] Hospital Response to IAC Information Request. September 27, 2022.
[46] Registered Nurses' Association of Ontario. (2017). Best Practice Guideline: Developing and Sustaining Effective Staffing and Workload Practices, 2nd Ed. Author.

training the nurses of tomorrow will prepare us to meet future needs. Further, the collection and effective use of data will provide the roadmap to avoid recurring and drastic nursing shortages."[47]

The report clearly outlines the "R" steps below with specific best practices and provides guidance on how to retain and support, return and integrate and recruit and mentor.




The IAC believes that Retention and Recruitment is a key area for improvement.

**Related to Recruitment and Retention the IAC Recommends:**

13. The Employer work with the Association to develop a comprehensive Recruitment and Retention Strategy utilizing the evidence-based publications and guidelines to guide the development.

14. The Employer post all MHAP job postings concurrently internally and externally, immediately on receipt of a nurse's resignation or request for transfer. The job selection process in the Central Collective Agreement is still required to be followed.

15. The Employer review the Nursing Graduate Guarantee (NGG) Program and assess how this government funded program can be maximized and leveraged at the Colleges and Universities to support RN recruitment for the MHAP. This Program pays an additional six months of supernumerary funding.

[47] Dr. Houssen Eddie Ben Ahmed, ND, MSc, PhD. Dr. Lynn Bourgeault, PhD, FCAHS. Sustaining Nursing in Canada. Published by the Canadian Federation of Nurses' Unions (CFNU). p. 9 & p. 13.

16. The Employer review the Nursing Clinical Extern Program and develop a plan to recruit nursing students to work as Externs at KHSC. They can work on the units as unregulated health care providers and support the nurses with the ADLs and other tasks. They will become part of the Hospital and upon graduating may see KHSC as an employer of choice.

17. The Employer, in Collaboration with the Association, review and consider the Community Commitment Program for Nurses (CCPN) which is a Program to attract RNs, RPNs, and NPs.

18. The Employer offer education incentives such as providing free on-site preparation classes for CNA Canadian Psychiatric Mental Health Nurse Certification (CPMHNC).

19. The Employer determine how to create a respite room for staff to relax, get a drink, draw, work on word puzzles, relax and get away from the unit.

20. The Program Manager assess the key areas of nurse dissatisfaction within the Inpatient MHAP and develop a corrective action plan, which is to be informed through staff input, to address the issues by April 2023.

## 3.2 Education, Training and Professional Development

### 3.2.1 Orientation, Education and Training New Hires and Resource Pool

**The Association's Perspective:**

The Association describes that the Employer provides limited support to new and novice staff, and insufficient educational opportunities for ongoing staff professional development. Their report suggests that staff in all areas of the Burr 4 unit have expressed the need for ongoing professional development opportunities and health and safety training. Their brief states that "RN staff on Burr 4 have identified gaps in the training of all staff working in MHAP, as well as of staff in the Resource Pool who provide support to cover staffing shortages. The education needs identified include both general overall education and specific focused education for staff working in the various program areas. Required training also includes mandatory health and safety training as well as program specific training.

Specifically, the Employer has been ordered, following a complaint investigation by an inspector of the Ministry of Labour (MOL), to submit an education plan to meet all training mandates as outlined September 6, 2022."[48] The Association also shared that there have been approximately 80 PRWRFs from the MHAP that focused on practice and workload issues related to novice staff, insufficient education, orientation, or training for unit staff and those being reassigned to work in the MHAP when shortage is experienced."[49]

**The Hospital's Perspective:**

The Hospital's Brief has outlined more recent plans on how they plan to support staff to further optimize their knowledge and skills through various training and education programs. Orientation provided to nursing staff as a new hire to the program is a key opportunity for MHAP to build knowledge and expertise. The newly hired RNs receive extensive and comprehensive orientation

[48] ONA Brief, Volume I. September 27, 2022, p. 75.
[49] ONA Brief, Volume I. September 27, 2022, p. 75.

training that includes corporate orientation and 4 days of interprofessional orientation. They must also attend a two-day workplace violence prevention program, as well as a 2-hour Pinel training session and code white simulation.[50] RNs and RPNs receive two 8-hour in-class theory education days and additionally receive 11 'buddy shifts' (mentor/mentee shifts), where a newly hired nurse is co-assigned with an experienced nurse.

These shifts occur across Units A, B, and C, to ensure nurses have some familiarity with each of the units they may be working on. Additionally, RNs who have been with the program for more than six months will be trained for Section E (emergency mental health) which includes four 'buddy shifts'.[51]

The topics covered in orientation by the Hospital include: overview of mental health program, mental health act, mental status assessment, documentation, mood disorders, anxiety disorders, schizophrenia and psychosis, cognitive disorders – 3 D's, psychopharmacology, mental health standards, personality disorders, suicide and self-harm, crisis theory and application of management strategies, substance use, addictions and withdrawal, community resources, and child and adolescent disorders.[52]

The Hospital has also created a new nursing mentorship program that aims to standardize the approach, expectations and evaluation during a new hire's integration. All new hires and internal transfers are enrolled into this program. The program defines clear roles and responsibilities of both the mentor and mentee with regularly scheduled meetings between participants, program managers and unit based CLS to discuss the mentee's progress and any concerns. The Hospital believes that this provides the ability to identify practice needs and/or gaps earlier to support the mentee with additional learning initiatives, training, or an extended mentorship period. This also creates an opportunity for a supportive onboarding and learning environment for both mentor and mentee to improve successful integration. The Hospital states that this program was developed in response to the feedback received from KHSC nurses.[53]

Mental health nursing is a unique specialty with a set of specialized skills and competencies.[54] Both research and professional nursing bodies describe mental health nursing as "a specialized area of practice that uses skillful communication, verbal interchange and interpersonal processes to bring about positive health changes in patients."[55] Most new and existing nurses receive limited formal mental health training to support a wide range of mental health needs they will encounter in practice. Therefore, in the absence of formal academic training, it is essential that hospital settings provide nurses working in their mental health settings with education and training with the goal of ensuring nursing staff have the appropriate knowledge and skills to provide evidence-based quality care to patients.

[50] Hospital Brief. September 27, 2022, p. 22.
[51] Hospital Brief. September 27, 2022, p. 22.
[52] Hospital Response to the IAC Information Request. 1. Ga. Orientation Agenda.
[53] Hospital Presentation. Hearing Day Two, October 20, 2022, Slide 32.
[54] The Canadian Nurses Association. The Psychiatric and Mental Health Nursing Competencies, https://hl-prod-ca-oc-download.s3-ca-central-1.amazonaws.com/CNA/2f975e-4a40-45ca-863c-5ebf0a138d5e/UploadedImages/documents/PMH_2012_Prep_Guide_e.pdf, 2019
[55] McAllister, S., Robert, G. & Tsianakas, N. M. (2019). Conceptualizing nurse-patient therapeutic engagement on acute mental health wards: An integrative review. International Journal of Nursing Studies, p. 93.

**The IAC Perspective:**

The IAC Panel believes that the concerns of the nurses around inadequate education and training is impacting their ability to provide safe competent care for a complex patient population. The Hospital has taken steps to address some of the issues they have heard from the nurses. The IAC Panel encourages the Hospital to follow through and implement these new education, training, mentoring programs and evaluate them to assess if the programs have met the Hospital's and the nurses' expectations and learning requirements.

The IAC panel acknowledges the strong relationship in literature between enhancing knowledge and expertise of nurses with improved outcomes in quality and safety domains for both patients and staff. Literature demonstrates that in inpatient mental health settings qualified staff such as nurses, have a stronger association with experiencing tense interactions or aggressive behaviours from patients as a result of having higher decision-making power or by virtue of enforcing detention in hospital setting.[56] Bowers et al. (2009) state "further support for aggressive incidents as interaction driven is provided by the finding of a positive relationship between aggressive incidents and restrictions on patients…those restrictions are enforced by staff through interactions with patients and are likely to be experienced as an aversive."[57] This highlights the importance of ensuring staff are equipped with knowledge and expertise to better manage the dynamics that are being created among patients and staff simply by being cared for on an inpatient unit.

**Related to Orientation, Education and Training New Hires and Resource Pool the IAC Recommends:**

21. The Employer optimize and adhere to the orientation program for new hire nurses:

a) The Clinical Learning Specialist (CLS) provides a standardized and comprehensive opportunity for new hire nurses and ensures all new hire nurses complete all aspects of their orientation prior to the start of their independent shifts.
b) The CLS optimizes learning and knowledge mobilization by utilizing a variety of modalities for education in addition to the Learning Management System (LMS). Consider role playing, clinical labs, just in time bedside teaching, classroom teaching, simulation and interprofessional educations sessions to allow new staff to engage and interact with the experts to optimize their learning and to enhance their skills and confidence.
c) The CLS ensures orientation education and training includes emergency preparedness training.
d) The CLS develop an onboarding checklist for each new RN hire to be completed between the mentee and mentor during the 'buddy shifts' to ensure key practices and information about the program are reviewed and opportunity is provided for the new hire to ask questions and review these practices. The Checklist should have all orientation education and training to be signed off by the nurse, mentor and CLS.
e) The CLS review the evidence related to therapeutic relationships and engagement and its impact on violence and aggression incidents and provide more focused education to build nurses skills and competencies related to therapeutic engagement and communication.

[56] Bowers, L., Van Der Merwe, M., Paterson, B. & Stewart, D. (2012). Manual restraint and show of force: The City-128 study. International Journal of Mental Health Nursing, 21, pgs. 30-40 and, Mellesdal, L. (2003). Aggression on psychiatric acute ward: A three-year prospective study. Psychological Reports, 92, pgs. 1229-1248
[57] Bowers, L., Allan, T., Simpson, A., Jones, J., Van Der Merwe, M. & Jeffrey, D. (2009). Identifying key factors associated with aggression on acute inpatient psychiatric wards. Issues in Mental Health Nursing, 30(4), p. 1077.

f) The CLS complete an evaluation of the new nursing mentorship program to determine effectiveness and opportunities for improvement.

22. Education and training for nursing resource pool:

a) Clinical Learning Specialist (CLS) will create an education program to meet the needs of the existing nursing resource pool staff to ensure they are equipped with the knowledge and skills necessary to provide safe quality care while assigned on MHAP.
b) As new nurses are hired to the nursing resource pool the CLS and Resource Pool manager will assess their readiness to take the MHAP education program.
c) The CLS will consider how to include the nursing resource pool in ongoing professional development and education activities to support their practice when assigned to MHAP.

23. Just-in-time unit orientation for reassigned nurses to MHAP:

a) The CN to develop a checklist that reviews all key aspects of the unit and the care being provided to aid with orientation of the reassigned nurses.
b) The CN and/or the Program Manager review this checklist with each reassigned staff at the beginning of their shift.
c) When mental health nurses are being reassigned to other units, they will be provided with a formal orientation at the beginning of their shift to ensure safe practices during their shift.
    i) The Employer will develop a practice guideline to support mental health nurses when reassigned to other units to enable appropriate patient care assignments reflective of their skills and competencies.

### 3.2.2. Building Nursing Expertise Through Continuing Education and Professional Development

**The Association's Perspective:**

The Association shared concerns related to the lack of opportunities for nurses to receive ongoing education and training to strengthen their knowledge and skills. The Association described that since 2019 to present, RNs in the MHAP have expressed concerns surrounding their access to and the availability of professional development and educational opportunities.[58] It is believed that RNs in the MHAP units are frequently unable to meet the standards outlined by the CFMHN due to the lack of thorough education within the program.[59]

**The Hospital's Perspective:**

The Hospital shared their strategic approach and planning in assessing the learning needs of their clinicians to meet education and training requests across the organization. This involves being informed by Nursing Practice Council, All-staff and Nursing-specific working groups and committees, ideas/request submitted through Future@KHSC email inbox, and employee experience survey responses. Additionally, program and unit level needs are gathered through various channels such as portfolio meetings/unit-based councils, unit huddles, program-specific working groups and committees

[58] ONA Brief Volume I. September 27, 2022, p. 80.
[59] ONA Brief Volume I. September 27, 2022, p. 81

and Clinical Learning Specialist. The Hospital also shared that education initiatives and remedial training is informed by thematic review of incident reports.[60]

**The IAC Perspective:**

Acknowledging the paucity of specialized mental health training nurses receive in their formal academic education, the IAC Panel recognizes that this it has made it imperative for hospital settings to remedy this gap via ongoing education and training to build evidence-based knowledge and expertise so that nurses can provide safe, competent nursing care.

It is believed that the Hospital is also recognizing this gap with recent leadership changes to the MHAP. This is evident in their plan to explore continued learning opportunities and financial support for the following: micro-credentialing courses for mental health nurses, Canadian Nurses Association certification in psychiatry/mental health, other academic educational offerings, educational offerings from industry leaders/peers in mental health and addictions and Best Practice Spotlight Organizations (BPSO) champion certification.[61]

The IAC panel believes that investing in these types of ongoing education programs is investing in nurses and can have significant positive impact in enhancing nursing knowledge and competencies, improving safety and quality of care for patients and enhancing job satisfaction for nurses.

For example, the micro-credential courses specifically for mental health nurses focuses beyond theoretical knowledge to one that is targeting translating theory into skills, which can be of great value https://ontariotechtalent.ca/skills/mental-health/. Another example would be investing in implementing the provincial Quality Standards in mental health for those specific diagnosis that are most commonly served in the MHAP. There are existing organizations who are providing guidance, resources and training for hospitals to implement the Quality Standards (evidence-based interventions) for various diagnosis in mental health https://www.ontarioshores.ca/ontario-shores-leads-new-quality-initiative-advance-schizophrenia-treatment. This could enable enhancing knowledge and expertise, as well as, ensuring practices and processes in care are aligned with evidence-based practices.

The IAC panel acknowledges the value of advancing the clinical expertise of the clinicians as this would have positive impact on quality of care, patient and staff safety and overall morale and job satisfaction for the nurses.

### Related to Continuing Education and Professional Development the IAC Recommends:

24. The Employer will continue to execute their plans to support nurses in microcredential courses focusing on mental health, as well as, their CNA certification. In partnership with the Association a fair and reasonable cost sharing structure will be developed and implemented to support the nurses in these advanced credentialling opportunities.

[60] Hospital Presentation. Hearing Day Two, October 20, 2022, Slide 53.
[61] Hospital Presentation. Hearing Day Two, October 20, 2022, Slide 56.

25. The Employer will adopt and promote standardized, evidence-based practice to reduce variability in care amongst this heterogenous patient population by implementing the provincial, Health Quality Ontario Quality Practice Standards.

a) The Employer develop and implement a plan to train the MHAP nurses in the Quality Standards relevant to their practice.
b) Develop procedures to embed Quality Standard interventions into the RNs day-to-day practice, in collaboration with all clinical staff.
    i) The Employer will consider levering on existing resources within the province that can provide supports to implement Quality Standards.
c) The Employer will create processes to measure adherence to and clinical outcomes of each Quality Standard implemented.
d) The Employer to develop specialized experts in each of the Quality Standards to act as champions for the unit to help ensure understanding of key diagnosis and adherence to evidence-based care.

### 3.2.3 Optimizing the Clinical Learning Specialist (CLS) Role

**The Association's Perspective:**

The Association Brief indicates that the CLS is often unavailable to support and teach the nurses on the unit with the current allocation of their time: 35% on the unit, 15% in classroom orientation, 20% unit-specific quality improvement projects, and 15% to corporate responsibilities such as accreditation.[62] The Association states "according to this guideline, 35% of the CLS's time is allocated to direct unit coverage. This allocation includes the time needed to deliver education and training to all staff in the program, such as NVCI training, Code White training, PINEL restraint training, Behavioural Crisis Alert (BCA) and risk Reduction Plan (RRP) training, code simulation training, and mental health specific LMS development for tabletop exercises. The required training outlined above stretches thin the amount of time available, if any for the CLS to be on the units to provide "just in time" education. In addition to the required corporate duties and responsibilities which reduce the time available for such education on the unit even further. The CLS is simply too busy and has limited time to support and provide staff with just in time learning, due to the time taken up by corporate initiatives".[63] The Association has also raised that the Hospital has not explored or considered RN staff's input and requests related to their educational needs, although the RN staff have spoken directly to their leadership team identifying their needs.

**The Hospital's Perspective:**

The CLS role supports the delivery of interprofessional, quality patient care and excellence in professional and clinical nursing by facilitating staff development, through orientation, continuing education and performance review in the clinical setting. At KHSC a dedicated mental health and addiction specialized CLS supports both nurses within the MHAP and throughout KHSC to provide just-in-time education related to caring for this vulnerable patient population, with the aim to enhance abilities as an organization to provide safe, reliable and high-quality care.[64] In 2021, the Hospital

[62] ONA Brief Volume I. September 27, 2022, p. 83.
[63] ONA Brief Volume I. September 27, 2022, pgs. 83-84.
[64] Hospital Presentation. Hearing Day Two, October 20, 2022, Slide 54.

increased the CLS role by 0.2 FTE to create one full time position.[65] The Hospital shared with the panel that the CLS role is currently shared amongst the Mental Health Addictions Care (MHAC) program and not just the inpatient units. The CLS also liaisons with other units within the Hospital who may have patients requiring transfer to the mental health units.

**The IAC Perspective:**

The IAC believes that the CLS role has the potential to positively impact nursing practice and improve patient care outcomes in the MHAP. By refocusing the role with a greater on unit FTE allocation the CLS can support critical functions related to the orientation of new staff and just-in-time hands-on teaching and skills development as well as ongoing education and professional development. This will enhance the nursing knowledge and enable safe practice and improvements to quality patient care, as well as improving nurses' job satisfaction. Additionally, the IAC encourages leadership to provide support to the CLS and to maximize the role to ensure that current gaps in education, training, and professional development are addressed.

**Related to the Clinical Specialist Role the IAC Recommends:**

26. The Employer increase the CLS unit allocation to 75% for a minimum of one year, to support orientation, just-in-time education, training and ongoing professional development on the inpatient mental health units.

27. The Employer review the current responsibilities of the CLS role and implement the following:

a) Work collaboratively with the CLS to develop a workplan for each area of focus in alignment with the needs of MHAP.
b) Support the CLS to obtain CNA Certification in psychiatry/mental health to demonstrate expertise. The CLS would then be authorized to teach the CNA course content to the RNs working in MHAP and support them as they work towards obtaining their CNA certification.
c) Support the CLS to consistently mentor and support the skills development of nursing staff (from novice to expert levels), newly hired staff, returning staff, and other members of the health-care team in meeting the care needs of the patient population.
d) Support the CLS to work collaboratively with the Program Manager and the nurses to evaluate various program initiatives and to develop innovative approaches to address learning gaps and to lead the change required to address the current gaps.
e) Support the CLS to consult and collaborate with members of the health-care team to develop quality-improvement and risk-management strategies related to staff education and training.

28. The CLS develops a mechanism to ensure that all staff are educated on new or revised policies in advance of the effective date.

29. The CLS takes a leadership role in measuring adherence to the Quality Standards and reporting on clinical outcomes. Where deficiencies are identified, the CLS will work with nurses and other clinical staff to develop corrective action plans and interventions, such as training and education, to improve practice and ultimately adherence and clinical outcomes.

[65] Hospital Presentation. Hearing Day Two, October 29, 2022, Slide 50.

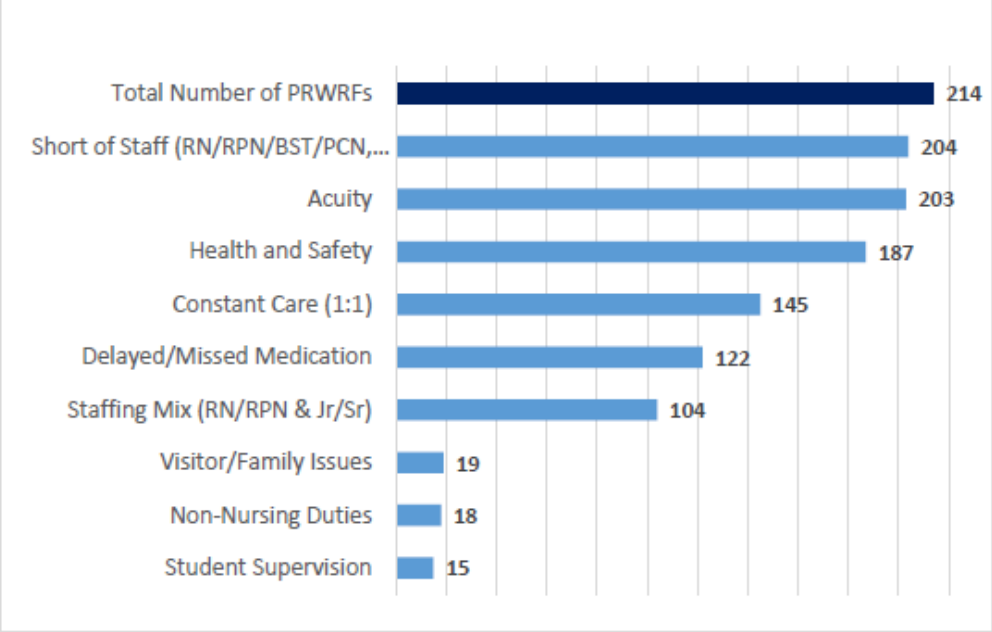
### 3.3 Violence Risk, Patient Acuity and Complexity

**The Association's Perspective:**

The Association presented details of violence risk and patient acuity and complexity stating that the RNs have reported on more than 200 PRWRFs issues related to increased acuity and complexity of the patients. The specific issues reported include the following: insufficient RN resources to safely care for patients with varying medical needs and unpredictable acuity and complexity; high numbers of patients with risk for violent behaviours that require constant observation; high numbers of patients with risk of self-harm that require increased or constant observation; high incidents of geriatric patients with history of dementia and a propensity for agitation and aggression, who require total patient care needs.[66] The Association describes that in many of the PRWRFs submitted, the RNs have reported a greater number of patients exhibiting increased levels of acuity and varying levels of complexity, however, despite these reports where the RNs cite the importance of adequate RN staffing to safely manage patient care, the employer continues to load level and reassign nurses from the MHAP to staff other units in the Hospital.[67]

The Association based on PRWRF details has identified the patient factors impacting the risk of violence in the unit and the impact on nursing workload and patient safety (see chart below).[68]

**Figure 7: Factors Contributing to Increased Workload and Increased Risk of Violence, Patient Acuity and Complexity**




[66] ONA Brief Volume I. September 27, 2022, p. 45.
[67] ONA Brief Volume I. September 27, 2022, p. 50.
[68] ONA Brief Volume I. September 27, 2022, p. 53.

"The chart illustrates acuity and complexity of patients, and the higher violence risk as primary patient factors impacting the level of care nurses are able to provide with poor staffing resources. More than 220 incidents are reported in the PRWRFs highlighting the increased risk of violence, violent events and harm to patients and staff. The elevated risk of violence is reported by nurses with increased episodes of code whites and incidents of self-harm. The increased level of care required to mitigate the escalating violence on the unit is reflected in multiple PRWRFs documenting patients requiring one-to-one observational care and patients need for locked seclusion, which at times cannot be provided"[69]

**The Hospital's Perspective:**

"The Hospital has provided information with respect to violence risk and patient acuity and complexity. The Hospital provides training to nurses working in the MHAP in the form of Workplace Violence Prevention Program, as well as a 2-hour Pinel Training session and Code White Simulations. Regular audits of Risk Reduction Plans and Behavioural Crisis Alert have been completed to aid in better understanding the educational needs for staff."[70]

"The Hospital also introduced a Security Ambassador role in April of 2022 that is assigned to the central monitoring station located at the entrance of Burr 4 near the visitation lockers. These Security Ambassadors are security professionals who have additional training in mental health, addiction and stigma issues."[71] Their purpose is to provide a welcoming presence for the patients, families and visitors, as well as, provide contraband management, central monitoring of all Burr 4 CCTV, and an additional security presence to respond to codes or events on the unit."[72]

As part of the Hospital's workplace violence prevention focus, the MHAP Violence Risk Working Group (VRWG) and Risk Registry was initiated in January 2019.[73] Membership included direct care staff, management, corporate services and JHSC representatives (ONA, CUPE, OPSEU). A number of activities have been implemented stemming from the work of this group such as: improvements to Section E (redesign of space, reduction to 2 beds from 3, installation of panic button and video footage in nursing station), separate patient and staff violence reporting forms created in SAFE Reporting, assessment and documentation optimization to capturing and understanding patients at increased risk of violence and aggression, a new 2-day workplace violence prevention training for MHAP, ED and other staff who float to these areas, and added a new code white e-learning specific to code white response in MHAP. The number of code white event on MHAP has decreased over the last number of years 2018/19 (97), 2019/20 (61), 2020/2021 (56), and 2021/22 (46).[74] The Hospital also reports that the incidents of patient-to-staff violence is on the decline (see below table).

[69] ONA Brief Volume I. September 27, 2022, p. 53.
[70] Hospital Brief. September 27, 2022, p. 39.
[71] Hospital Brief Volume I. September 27, 2022, p. 39.
[72] Hospital Brief. September 27, 2022, p. 40.
[73] Hospital Presentation. Hearing Day Two, October 20, 2022, Slide 40.
[74] Hospital Presentation. Hearing Day Two, October 20, 2022, Slide 57.

| MHAP Unit | 2017/18 | 2018/19 | 2019/20 * | 2020/21 | 2021/22 |
|---|---|---|---|---|---|
| Unit A (IOA) | 94 | 38 | 58 | 34 | 34 |
| Unit B (Adult) | 60 | 41 | 85 | 36 | 37 |
| Unit C (C&Y) | 11 | 30 | 40 | 71 | 36 |
| Section E - MHESU | 11 | 16 | 15 | 15 | 12 |

*2019-20 was our organizational *Workplace Violence Awareness Campaign*

"KHSC has also conducted internal and external reviews related to violence risk which has resulted in 67 recommendations on a risk registry. Many of the recommendations (43) identified have been implemented."[75] There are also a number of safety practices in place with the goal to providing a patient-centred care environment and fostering a safe environment for staff, patients, families and visitors. These include: daily safety huddles, twice daily handovers, clinical rounds, staffing checkpoints, vocera and panic alarm devices.[76]

The Hospital has made several changes based on the recommendations by the Macsim report (2018), and critical incidents that occurred on the Burr 4 Units. They are in the process of completing additional quiet space for nurses to chart. A few of the beds in the acute mental health unit have been replaced by specially designed electric beds with short cords. There are also wooden weighted beds that are used in some of the patient rooms to try and prevent patients from barricading themselves in their room. The hospital has installed CCTV cameras and additional 360-degree cameras with full surveillance capacity.[77]

It is not clear whether the Hospital has a mandatory education policy and what their practices are in measuring adherence. With respect to Burr 4 KHSC has provided the IAC panel with compliance rates for a number of trainings considered mandatory for staff as of July 2022: Nonviolent Crisis Intervention (NVCI) at 77%, Pinel training at 72% and Code White Simulation at 30%.[78] KHSC leverages a Learning Management System (LMS) to provide several of their mandatory training for RNs such as suicide risk assessment, Dynamic Appraisal of Situational Aggression, Workplace Violence Prevention, Pinel training, preventing and managing patient violence and aggression, patient behaviour management and least restraint policy.[79]

**The IAC Perspective:**

Organizations usually develop policies and procedures related to mandatory education to promote compliance with all relevant legislative requirements to keep patients and staff safe. Adherence to such policies is critical to ensuring staff have the knowledge to create a safe work environment for all.

The IAC panel was not able to appreciate the depth to which the various training (mandatory and non-mandatory) has been translated into practice. Given the high number of violence and aggression incidents and the nurses expressed concerns in gaps in knowledge and non-adherence to mandatory

[75] Hospital Presentation. Hearing Day Two, October 20, 2022, Slide 27.
[76] Hospital Presentation. Hearing Day Two, October 20, 2022, Slide 34.
[77] Hospital Presentation. (Macsin 2018) Hearing Day One, October 18, 2022, Slides 53-54.
[78] Hospital Response to IAC Information Request. Section 4D., September 19, 2022.
[79] Hospital Response to IAC Information Request. Section 4C., September 19, 2022.

training for all staff, it will be critical for the Hospital to optimize their training practices, adherence and oversight.

In relation to violence and aggression in mental health, literature has increasingly recognized that the quality of the therapeutic relationship between the clinician and patient as an important predictor of outcomes in mental health service delivery.[80] A key aspect of the therapeutic relationship is the therapeutic alliance or working alliance between the clinician and patient. Therapeutic alliance describes the patient and clinician working together with shared responsibility for achieving treatment goals and has been shown as a major factor in effective outcomes. The weaker the therapeutic alliance during the initial evaluation of the patient, the greater the risk of patients exhibiting violence or aggression or fear-inducing behaviour during the inpatient hospitalization. Furthermore, nurse-patient therapeutic engagement has been identified as being fundamental to acute mental health inpatient care.[81]/[82] Studies have consistently demonstrated positive correlation between engagement and improved outcomes[83], improved perceptions of care[84] and greater nursing job satisfaction[85]

Over the last number of decades there has been an international shift towards restraint minimization which has been a driver for the development of a number of evidence-based models to assist health care organizations in planning and implementing strategies to reduce the use of coercive practices, including restraint and seclusion. One model is the Six Core Strategies to Reduce the Use of Seclusion and Restraint (Six Core Strategies), adopted by some organizations to address the multidimensional approach required to minimize such practice."[86]

<u>The model identifies six overarching strategies which include:</u>

1) leadership toward organizational change;
2) using data to inform practice;
3) workforce development;

[80] Stanhope, V., Barrenger, S. L., Salzer, M. & Marcus, S, C. (2013). Examining the relationship between choice, therapeutic alliance and outcomes in mental health services. Journal of Personalized Medicine, 3, Pgs. 191-202. And Beauford, J., McNeil, D. & Binder, R. (1997 Utility of the first therapeutic alliance in evaluating psychiatric patients' risk of violence. American Journal of Psychiatry, 154. Pgs. 1271-1276.
[81] McAllister, S., Robert, G. & Tsianakas, N. M. (2019). Conceptualizing nurse-patient therapeutic engagement on acute mental health wards: An integrative review. International Journal of Nursing Studies, 93, pgs. 106-118.
[82] Sweeney, A., Fahmy, S., Nolan, F., Morant, N., Fox, Z., Lloyd-Evans, B., Osborn, D., Burgess, E., Gilburt, H., McCabe, R., Slade, M., Johnson, S. (2014). The relationship between therapeutic alliance and service user satisfaction in mental health inpatient wards and crisis house alternatives: a cross-sectional study. PLoS One, 9 (7) e100153 doi:http://dx,doi.org/10.1371/journal.pone.0100153.
[83] Farrelly, S., Brown, G., Szmukler, G., Rose, D., Birchwood, M., Marshall, M., Waheed, W., Thornicroft, G., (2014). Can the therapeutic relationship predict 18 month outcomes for individuals with psychosis? Psychiatry Res, p. 220. Doi: http://dx.doi.org/j.pschres.2014.07.032
[84] Cspike. E., Flach, C., McCrone, P., Rose, D., Tilley, J., Wykes, T., Craig, T., (2014). Inpatient care 50 years after the process of deinstitutionalisation. Social Psychiatry and Psychiatric Epidemiology, 49 (4), pgs. 665-671. Doi:http://dx.doi.org/10.1007/s00127-013-0788-6
[85] Moreno-Poyato, A., Delgado-Hito, P., Suarez-Perez, R., Lluch-Canut, T., Roldan-Marino, J. F. & Monteso-Curto, P. 2018. Improving the therapeutic relationship in inpatient psychiatric care: assessment of the therapeutic alliance and empathy after implementing evidenced-based practices resulting from participatory action research. Perspective Psychiatry Care, 54 (2), pgs. 300-308. Doi:http://dx.doi.org/10.1111/ppc.12238.
[86] Huckshorn, K. A. (2004). Reducing Seclusion and Restraint Use in Mental Health Settings: Core Strategies for Prevention. Journal of Psychosocial Nursing and Mental Health Services, 42 (9), pgs. 22-33.

4) use of preventive/proactive tools;
5) patient roles in the organization; and
6) debriefing techniques[87]

Internationally, evidence has demonstrated that the incorporation of the Six Core Strategies© into practice has resulted in: decreased incidents and hours of restraint and seclusion; decrease in staff injury, absenteeism, and turnover; decrease in patient injury, length of stay, medication use, and incidents of rehospitalization; and increase in staff satisfaction.[88]

Another model that focuses more broadly on conflict and containment in psychiatric settings is the *Safewards* Model.[89] This model includes ten interventions that aim to modify patient and staff interactions, experiences, and perceptions and essentially develop better relationships between patients and staff. The interventions focus on engagement as opposed to containment.

<u>The ten interventions include:</u>

1) mutually agreed and publicized standards of behaviour by and for patients and staff;
2) short advisory statements ('soft words' – such as being respectful and polite) on handling flashpoints, hung in the nursing office and changed every few days;
3) a de-escalation model used by the best staff de-escalator to expand the skills of the remaining ward staff – this champion essentially reviews de-escalation skills with their colleagues;
4) a requirement to say something good about each patient at nursing shift handover;
5) scanning for the potential bad news a patient might receive from friends, relatives or staff, and intervening promptly to talk it through;
6) structured, shared, innocuous, personal information between staff and patients via 'know each other' folder kept in the patients day room;
7) a regular patient meetings to bolster, formalize and intensify inter-patient support;
8) a cart/box of distraction and sensory modulation tools to use with agitated patients;
9) reassuring explanations to all patients following potentially frightening incidents; and
10) a display of positive messages about the ward from discharged patients[90]

The Safewards model has been demonstrated to decrease conflict incidents by 14.6% and containment by 23.6% in psychiatric units.[91] This is related to the identification of clinical scenarios and situations reaching 'flashpoints' – points in time that can lead to conflict and containment. These interventions

[87] Lebel, J., Duxbury, J. A., Putkonen, A., Sprague, T., Rae, C., & Sharpe, J. (2014). Multinational Experiences in Reducing and Preventing the Use of Restraints and Seclusion. Journal of Psychosocial Nursing, 52 (11), pgs. 22-29.
[88] Lebel, J., Duxbury, J. A., Putkonen, A., Sprague, T., Rae, C., & Sharpe, J. (2014). Multinational Experiences in Reducing and Preventing the Use of Restraints and Seclusion. Journal of Psychosocial Nursing, 52 (11), pgs. 22-29.
[89] Bowers, L. (2014). Safewards: A new model of conflict and containment on psychiatric wards. Journal of Psychiatric & Mental Health Nursing, 21, 499-508.
[90] Bowers, L., James, K., Quirk, A., Simpson, A., SUGAR, Stewart, D., & Hodsoll, J., (2015). Reducing conflict and containment rates on acute psychiatric wards: The Safewards cluster randomized controlled trail. International Journal of Nursing Studies, 52, Pgs. 1412-1422.
[91] Bowers, L., James, K., Quirk, A., Simpson, A., SUGAR, Stewart, D., & Hodsoll, J., (2015). Reducing conflict and containment rates on acute psychiatric wards: The Safewards cluster randomized controlled trail. International Journal of Nursing Studies, 52. Pgs. 1412-1422.

are meant to shift the culture of care from one that entails coercive practices towards one of focusing on partnering with patients and supporting recovery.

The IAC panel understands that there continues to be significant concerns related to increased patient acuity and complexity which may be related to the fact that on Burr 4 nurses are providing care for a very heterogenous population where diagnosis could have a wide range including those with psychotic disorders as well as cognitive impairments resulting from dementia. Quality and safe care of the various diagnosis would significantly vary both from a clinical intervention, as well as, environmental needs – as evidenced in the Health Quality Ontario's Quality Standards in mental health https://www.hqontario.ca/Evidence-to-Improve-Care/Quality-Standards/View-all-Quality-Standards

It is the opinion of the IAC Panel that if the nurses had more time and were able to intervene earlier in the escalation of the aggressive behaviour continuum there would be a reduction in violence incidents and less deterioration in the nurse patient relationship.

The IAC panel believes that without further specialization of clinicians' expertise in the various diagnosis, it is very challenging to safely manage the care of this heterogenous population. It is critical for the Hospital to promote standardized evidence-based practice and reduction in variability in care by implementing Quality Standards in mental health.

**Related to Violence Risk, Patient Acuity and Complexity the IAC Recommends:**

30. The Employer, with the appropriate stakeholders, review and determine the Health Quality Ontario Quality Standards that are most relevant to implement in the Inpatient MHAP to meet the clinical care needs of this heterogenous patient population. This would allow education and training for nurses on how to best care for each of the various diagnosis.
    a) Train all the nurses in the Quality Standards relevant to their practice.
    b) Develop procedures to embed Quality Standard interventions into day-to-day practice in collaboration with clinical staff.
        i. Consider leveraging on existing resources within the province that provide supports to implement Quality Standards.
    c) Create processes to measure adherence and outcomes to each Quality Standard implemented.

31. The MHAP develop specialized experts in each of the Quality Standards to act as champions for the unit to help ensure understanding of key diagnosis and adherence to evidence-based care.

32. The Employer develops and implements a strategy to increase and sustain adherence to mandatory patient and workplace safety education and training for all nurses working on MHAP.
    a) The Employer will ensure MHAP nurses adherence to organizational policy related to mandatory training.
    b) The Program Manager will be accountable to ensure all clinicians are provided with annual training in workplace violence and prevention training.

33. The Program Manager and the Clinical Learning Specialist, in collaboration with the staff, review the list of mandatory education and training to assess its continued relevance for the operations of the program and update with any identified gaps.

a) The Program Manager identifies policies that are critical to practice for nurses and includes this as part of their annual education and training.

34. The Employer develop a formal organizational structure that will enable nurses to provide input and feedback into all policies that impact on their work. Nursing Council and Unit Based Councils can facilitate this process.

35. The Program Manager and Clinical Learning Specialist monitor adherence to safety practices currently in place and consider creating a process to measure adherence that can be shared at the Mental Health Violence Risk Working Group.

36. The Lead/Committee Chair of the Mental Health Violence Risk Working Group re-establish the Working Group with an expression of interest group to ensure opportunity for nurses to join. Once re-established the VRWG will review the 43 recommendations that have been completed and measure the outcomes and the sustainability. Are the changes that have been implemented making a difference and addressing the concerns related to workplace violence? What are the learnings? And develop a continuous quality improvement process. Minutes of meeting to be posted and circulated through e-mail.

37. The Employer assess and consider the implementation of one of the two evidence-based models used to reduce the use of coercive practices including restraints and seclusion in admitted patients. The two models are Six Core Strategies and Safewards.

38. The Clinical Learning Specialist, through training and education, to ensure nurses are integrating risk assessments and care plan interventions into practice.

39. The Employer and all employees will comply with the Occupational Health and Safety Act.

40. The Employer purchase manual beds on the IOA unit, with removable crank that can be bolted to the floor for safety.

41. The Employer instal Velcro strips (hook) outside of all patient rooms with interior windows facing hallway/nursing station. Purchase vinyl, cut to the size of the windows and secure Velcro (loop) to the interior of vinyl. Vinyl coverings can be placed over the windows at night to reduce hallway light entering patient room to promote sleep hygiene and can be removed during the day. They can also be used during the day to decrease patient stimulation if required. This is in response to comments made during the MHAP virtual tour where linens were being hung over door and windows to reduce the light entering the room.

42. The Employer provide all nurses with a lock key to carry on their person. This is a best practice in Mental Health Inpatient Units.

43. The Employer authorize immediately that disposable ligature cutting tools be discarded after each use, as per the manufacturer's recommendation, to support safe practice.

### 3.4 Morale and Toxic Work Environment

**The Association's Perspective:**

The Association describes their current concerns related to the fact that the MHAP RNs at KHSC have reported their workload and practice issues to management on 214 PRWRFs since 2019 and have received no meaningful response or tangible solutions from management. Therefore, the nurses are left feeling unsupported and unheard. "Leadership practices like "load leveling" and reassignment have resulted in increased risk to staff and patients, and nurses are feeling demoralized, like there is no way out of this crisis situation. Responses to the PRWRFs that reiterate shift details and patient census or deflect responsibility and reference to the province wide nursing shortage, do nothing meaningful to support nursing staff."[92]

The Association perspective is that staff feel 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 overwhelming numbers of Code Whites and the care of complex patients. Staff have identified issues of inadequate resources and insufficient RNs to fill the schedule. Despite inadequate staff the RNs on MHAP are reassigned by the Operational Manager (OM) based on patient census without consideration of the acuity and complexity of patients.

"Finally, the lack of effective and meaningful communication and effective and transformational leadership to support staff and evidenced in the PRWRF responses, has eroded relationships between staff and leadership and created a poor-quality workplace environment. Staff morale is abysmal. The ongoing strain and burden of managing very high workloads has caused increased stress and burnout among staff and led to decreased job satisfaction. This in turn has resulted in the loss and ongoing exodus of qualified and established RN staff and created an even more unstable workforce. The outstanding practice and workload issues relating to insufficient staffing, increased workload, high patient acuity, and high risk of violence are further contributing to staff morale, injury, and concerns about risks to patient and staff safety. These issues, while eroding staff morale and exacerbating staff burnout, have also created a toxic workplace environment. This Employer has failed to resolve the issues raised by the RNs in the MHAC Program, who have diligently reported their workload and practice concerns since 2018. The Union has continued to make efforts with the Employer to reach resolution via MOS and has reinforced the Employer's responsibility to uphold the 2019 MOS. ONA has also continued to advocate to resolve ongoing and future workload concerns brought forward by members in PRWRFs, but the Employer is unwilling to commit to core staffing recommendations or to demonstrate their accountability in providing a safe work environment for the nurses."[93]

**The Hospital's Perspective:**

"KHSC provides a full range of supports ranging from health, safety and wellness resources, training supports and internal resources that augment nursing care. Examples specifically of roles that enhance a "culture of care" include those described below: Due to the focus and improvements on safety for patients and staff, KHSC has also created a FT Safety, Quality and Project Coordinator to assist the MHAP Program Manager in continuing to monitor and implement needed changes on the floor. This individual will assist to complete and track audits for RRPs, BCAs and Environmental Checklists, support the timely

[92] ONA Brief Volume I. September 27, 2022, p. 88.
[93] ONA Brief Volume I. September 27, 2022, p. 22.

completion of SAFE Reports, review CCTV footage weekly, liaise with Protection Services and OHSW, be the lead in creating and maintaining program policies and procedures, order sets and forms, and help implement Quality Improvement initiatives."[94]

"KHSC has a number of Corporate Departments that support clinical operations. The following are key corporate partners for the MHAP:

(a) Occupational Health, Safety & Wellness: An interprofessional team including nurses with occupational health specialization. The department is responsible for a comprehensive array of wellness resources and health and safety policies.

(b) People Services Centre: Schedulers and staffing clerks work closely with operational management of those KHSC areas on the centralized Hospital's Submissions to the Independent Assessment Committee IAC Page 19 staff scheduling and time capture system to manage the posted scheduling cycles and respond to unplanned absences.

(c) Professional Practice: An interprofessional team who provide expert guidance to clinical operations for the safe, ethical and effective practice within each professions' legislated scope of practice and college practice standards.

(d) Protection Services: In addition to responsibility for emergency preparedness, Heliport services, life safety, parking and shuttle services, the team of over 70 uniformed security personnel provide security services across multiple KHSC work locations and oversee related security technologies.

(e) Recruitment: Responsible for organization wide talent acquisition strategy development and implementation and execution of recruitment. There is a dedicated nurse recruiter on the team."[95]

In addition to the above, the Hospital provides resources at a corporate level for staff to promote well-being. Some examples are: The Employee and Family Assistance Program (EFAP); Promoting Physical Activity with discounted gym memberships; Wellness Centres at both sites; and the hiring of a new Workplace Mental Wellness Practitioner.

The MHAP leadership have completed the Mental Health Leadership Certificate Program and the Program also offers wellness initiatives such as the Trauma Informed education focused on secondary trauma, empathetic strain, and other topics necessary to help frontline workers.

**The IAC Perspective:**

The IAC Panel has considered the Association's and the Hospital's Brief Submissions and what we heard during the presentations at the Hearing. We agree that the above stated actions by the Hospital are all good strategies to support a "Culture of Care" and should impact positively on the work environment of the nurses. However, the concerns expressed by the Association in their Brief and their Hearing

[94] Hospital Brief. September 27, 2022, p. 15.
[95] Hospital Brief. September 27, 2022, p. 18-19

presentations and what we heard from the nurses during their Impact Statements on Day Three of the Hearing, would suggest that these strategies are not having a positive impact at the local level and have failed to achieve their intended outcomes.

Further, the IAC Panel reviewed the Staff Survey results, for Inpatient Mental Health Burr 4, from 2019 and 2021 and observed that the results indicate that the staff in the MHAP are very dissatisfied in most categories measured. The response rate in 2019 was 49% and in 2021 was 23%.

Some key results of note are that in both years the only high performing score (above 60%) was in Coworker Relationships, with a 2019 result of 74% and a 2021 result of 81%. This is a good indication that the staff on Burr 4 feel supported by their coworkers. This creates an opportunity for management to focus on how to maximize this finding to enhance the work environment in the areas of the survey that reflected low satisfaction.

Key results that are of concern to the IAC Panel are the low performing scores (<40%) in many categories. The IAC believes that these low scores are contributing to an overall negative work environment and is impacting the nurses' ability to provide safe nursing practice and to meet the CNO Professional Practice Standards. The survey scores are listed below:[96]

| | |
|---|---|
| Manager Relationships: | 2019 30% and 2021 33% |
| Senior Management Relationships | 2019 20% and 2021 14% |
| Customer Focus | 2019 30% and 2021 20% |
| Learning and Development | 2019 32% and 2021 32% |
| Work Life Balance | 2019 44% and 2021 27% |
| Employee Empowerment | 2019 39% and 2021 30% |

Subsequent to these surveys, the Hospital advised, during the Hearing, that the MHAP had completed a local MHAP Engagement Survey in June 2022. There were 61 responses with 19 nurses responding. Based on the results, six working groups have been established to address the findings. These are:

1) Nurses' Education
2) Communication
3) Residents' Education
4) Patients' Care Plan/Quality of Care
5) Group Therapy & and Activities for Patients
6) BURR 4 Operational Structure[97]

While the IAC Panel acknowledges that the offering of these corporate and program initiatives is important and should continue, we believe that these programs have done little to address the core

[96] Hospital Response to IAC Request for Information. Section 6. B., September 19, 2022.
[97] Hospital Presentation. Hearing Day Two, October 20, 2022, Slide 10-13.

concerns and issues of the MHAP nurses working on Burr 4 and have not created a local healthy work environment or a quality practice setting.

Therefore, the IAC presents some evidenced based strategies that can help to bridge the corporate commitment to developing a "Culture of Care" at the local level to meet the needs of the nurses working in the MHAP and lead to a high-quality practice environment.

The RNAO Healthy Work Environments (HWE) Best Practice Guidelines (BPG) are designed to support healthcare organizations in creating and sustaining positive work environments. "A healthy work environment for nurses is complex and multidimensional, comprised of numerous components and relationships among the components. A comprehensive model is needed to guide the development, implementation and evaluation of a systematic approach to enhancing the work environment of nurses. Healthy work environments for nurses are defined as practice settings that maximize the health and well-being of the nurse, quality patient/client outcomes, organizational performance and societal outcomes."[98]

Healthy work environments that maximize nurses' health and well-being are essential to achieving the best outcomes for nurses and their patients, and for health-care organizations and the health-care system as a whole. Nurses are essential for achieving and sustaining affordable access to high-quality, timely health care for Canadians and the quality of nurses' work environments affects nurses' physical and psychological health, patient outcomes, and the wider health system.[99]

A quality practice setting is the responsibility of both the Employer and the nurse. It is a shared responsibility which will support nurses in providing safe, effective and ethical care. A nurse in an administrative role demonstrates the Accountability Standard by, advocating for a quality practice setting that supports nurses' ability to provide safe, effective and ethical care.[100]

A quality practice setting will provide resources, including appropriate staffing to support nurses to establish a therapeutic relationship with their patients. Promote positive collegial/interprofessional relations by role modeling and promoting an organizational culture of respect.[101]

By making a healthy work environment a priority, it is possible to create a quality practice environment that values the unique contribution, skill, knowledge, and experience of the MHAP nurses. This will set the nurses up for success and result in an environment where patients receive safe, quality care in a quality practice setting. A setting where nurses feel confident that they will meet the CNO Professional Practice Standards each and every shift that they work. If management looks after the needs of the nurses and provides the appropriate education and resources, the nurses will be capable of meeting patient care needs and the Hospital will achieve its mission: "We care for our patient, families and each other through everyday actions, significant moments and exciting breakthroughs."[102]

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[98] Registered Nurses of Ontario (RNAO), Best Practice Guideline: Workplace Health, Safety & Wellbeing of the Nurse, 2008, p. 14.
[99] RNAO BPG Developing and Sustaining Safe, Effective, and Workload Practices. Second Editions, p. 18.
[100]College of Nurses of Ontario (2002). Professional Standards, Revised 2002. https://www.cno.org/globalassets/docs/prac/41006_profstds.pdf.
[101] College of Nurses of Ontario. (2019; Rev. 2006). Therapeutic Nurse-Client Relationship. (CNO Practice Standard, Pub. No. 41033).
[102] Hospital Response to IAC Information Request. Strategic Plan, Section 9. September 19, 2022

**Related to Morale and Toxic Work Environment the IAC Recommends:**

44. The Association and the Employer work together to develop a healthy work environment based on mutual respect and trust to mitigate safety risks for staff while promoting quality care for patients.

45. The Association and the Employer review the results of the Staff Engagement Survey from 2019 and 2021 and together with the nurses identify themes requiring improvement and develop a corrective action plan, with specific outcome measures and timelines.

46. The Employer and the Association review the results of the local MHAP Engagement Survey in partnership with the six established working groups and include frontline RNs in the discussion and recommendations put forward from the working groups.

47. The Employer and the Association review the RNAO Best Practice Guidelines (BPGs): Workplace Health, Safety, & Wellbeing of the Nurse and Developing and Sustaining Safe, Effective, and Workload Practices (Second Edition) and implement those recommendations that both parties agree will be appropriate to create a healthy work environment and improve the morale of the nurses working in the Inpatient MHAP.

48. The Employer develop an evaluation process to monitor and measure the impact of implementing changes within the MHAP that affect the nurses work life, scheduling, or practice environment. This can be done through surveys and/or focus groups.

49. The Hospital continue its Mental Health and Wellness initiatives and focus on initiatives that result in positive change at the local level on Burr 4.

50. The Employer review Terms of Reference of the Nursing Practice Council to include a RN representative from the Inpatient MHAP and to ensure alignment between the work of the Corporate Nursing Council with the unit through a Unit Based Council (UBC). The UBC to be led by the corporate Nursing Practice Council Representative to ensure that local issues are being considered at the corporate Council and that Corporate initiatives are shared at the local level.

51. The Employer follow the Occupational Health and Safety Act, and the Employer ensures all managers, supervisors, and designates complete supervisor training.

52. When a staff member is injured while on duty, the Chief Nursing Executive will call to talk with the nurse to assess how he/she is feeling, to discuss the incident and to offer support and resources as appropriate.

### 3.5 Leadership and Communication

**The Association Perspective:**

The Association states: "While the Employer has claimed interest in resolving the issues through joint recommendations, they have demonstrated a lack of commitment to creating and implementing meaningful and sustainable plans for resolution. The documented issues identify concerns related to

increased census, escalation of violence and acuity of patients, and risks to the provision of safe quality patient care. The responses from management have failed to provide solutions or actions to resolve the issues raised. Often, responses are delayed and dismissive, and comments made place the burden of responsibility on the staff, when it is the manager and nursing leadership who hold responsibility for operational functions such as recruitment, retention, and increasing resource capacity, as well as the insurance of quality of care and patient safety. Management is well informed of the issues reported in the PRWRFs submitted."[103]

The Association has expressed concern with the new role description of the Operations Manager (OM). "The OM oversees the organization's day to day activities and makes staffing decisions related to load leveling and reassignment, among other operational decisions that impact the work environment and safety. Unlike the unit director and manager's role, coverage by an OM is provided on the day and night shift 24/7. The OM is the ultimate decision maker for staffing needs, with authority to override decisions made by the manager."[104]

Staff have expressed safety concerns, through email communication and in PRWRFs, outlining the OM's overall lack of understanding of the patient acuity and complexity of the inpatient MHAP patient population. "The leadership actions and the influence of the OM is contributing to a negative and toxic workplace environment. Decisions by the OM to override agreed to, and safe staffing determined by the team and the manager, creates difficult, unsafe, and unmanageable assignments and the OMs rarely, consult or collaborate with staff regarding reassignment of staff when needs exist."[105]

Many PRWRFs indicate that the OM no longer makes routine rounds on the units, nor do they attend Code calls, on a routine basis, leaving staff feeling unsupported and feeling that the OMs do not have information about the patients on the unit when making staffing decisions. The PRWRFs often state that the OMs communicate in a demeaning and derogatory way with staff in the MHAP Program. These actions have contributed to eroding relationships between nurses and management and have led to poor staff morale and burnout.

The Employer did initiate an inquiry in August 2021 to investigate concerns raised by staff regarding the OMs behaviors toward staff. When the employer failed to share any outcomes or actions taken because of the investigation, ten months later, on June 10, 2022, the ONA Bargaining Unit Leader sent an email to the Employer. The Human Resource Director responded that KHSC leadership has "confidence in the knowledge and skills of [their] OM team and the after-hours management structures in place to support them."[106] No further action or resolve was achieved and to date no behaviour change has been noted or experienced by the RN staff.

**The Hospital Perspective:**

Management Reporting Structure

"The hospital is based on a modified program management structure. Programs are co-led by a Program Operational Director (POD) and a Program Medical Director (PMD). Each program reports to

[103] ONA Brief Volume I. September 27, 2022, p. 16.
[104] ONA Brief Volume I. September 27, 2022, p. 88.
[105] ONA Brief Volume I. September 27, 2022, p. 89.
[106] ONA Brief Volume I. September 27, 2022, p. 90,

the Executive Team through their portfolio executive and ultimately up to the President and Chief Executive Officer. In turn, the KHSC Board of Directors and sub-committees provide leadership and direction to the hospital' executive, while overseeing key aspects of performance and management. In the case of MHAC, the portfolio has a co-PMD model with one PMD focused on the KGH site and one PMD focused on the HDH site. On an individual basis, the POD reports to Executive Vice President (EVP) Quality, Partnerships & Regional Vice President Cancer Care and the Co-PMDs report to the EVP of Medical and Academic Affairs and Chief of Staff.

Within the structure, Program Managers report to the POD. The Program Managers are the front-line operational managers for employees and among other things, are responsible for performance management, scheduling staffing resources, reviewing attendance management, coordinating the delivery and evaluation of patient care, professional practice, safety & risk management, continuous quality improvement and compliance with statutory and regulatory requirements.

Twenty-four hours per day, seven days per week, there is a Charge Nurse (CN) on duty or assigned working on BURR 4. The CN manages the daily work assignments and oversees the coordination of patient care on the unit. This includes patient flow, assignment of patients to staff based on patient need and knowledge, skill and ability of scheduled nurses, ensures break coverage, and facilitates coordination and communication with interprofessional team. Any concerns with the operations of the unit and delivery of patient care (e.g. staffing levels, safety concerns) are escalated to the Program Manager on days and to Operations Managers after-hours and weekends for problem solving and resolution.

Operations Managers are Registered Nurses required to maintain current registration with the College of Nurses of Ontario and are typically recruited from within the KGH-site for their understanding of the clinical environment and related demands.[107]

"The Hospital listed the following Frontline Engagement forums for employee feedback, input, suggestions, communication and input on policy and procedures:

- Nursing Practice Council
- Employee Open Forums
- Intranet Content
- Posters, Newsletters
- Decentralized Staff Meetings, Forums and Huddle Discussions
- Hospital Association Committee
- Generic Intake Email
- Joint Health and Safety Committee
- MHAP Violence Risk Working Group
- Corporate Violence Working Group"[108]

In their Brief the Hospital highlighted that communication is provided in a multi-method format including electronically, verbally and through written communication. General communication for all staff is primarily performed through email. All staff members have an email account and access to KHSC email at any Hospital computer or from home if desired.

[107] Hospital Brief, September 27, 2022, p. 17-18.
[108] Hospital Presentation. Hearing Day Two, October 20, 2022, Slide 6.

In addition, a shared drive for the MHAP is available on computers utilized by the CN and Unit Clerks, and all RNs have the ability to log in under their own accounts to access the shared drive which includes written communication, information from the various committees, practice guidelines, any research protocols, learning guides and Hospital info-memos. Written communication is also provided through poster boards located in various places in the units or the floor (for safety communication, quality improvement, etc.). There are team huddles daily to discuss activities and concerns of the day on each unit. Managers also use this time to pass on any needed information to the CN for further communication to the unit team.

In 2006/2007, Kingston General Hospital introduced a mobile communication system, Vocera which is a system that allows users to communicate directly with other badge users. The system allows for group calls and message management as well as panic calls to security.

The Hospital informed the IAC, during the Hearing, that they have implemented the LEADS in a Caring Environment Framework which "is a leadership capabilities framework representing an innovative and integrated investment in the future of health leadership in Canada. It provides a comprehensive approach to leadership development for the Canadian health sector, including leadership within the whole-system, within the health organizations, and within individual leaders."[109]

There are five competencies related to the LEADS framework: Lead Self, Engage Others, Achieve Results, Develop Coalitions, and Systems Transformation and there is evidence that this is a leadership development approach that advances leadership competencies.

The Hospital states an acknowledgement in its Presentation on Day Two of the Hearing that, "We recognize, see and hear through: Workload Submissions, Employee Engagement Survey Responses, Interactions and Observation. We went into nursing to care for our patients & families. We need to care about each other."[110]

"Further the Hospital states it will continue its journey to create meaningful improvement for our nurses while meeting the needs of our community through:

- A shared commitment to move forward together
- A positive work environment through our relationships, communication, and opportunities to grow professionally
- Demonstrate the value of the nursing role"[111]

**The IAC Perspective:**

The IAC Panel acknowledges that the Hospital has provided examples of good communication strategies however, at this time, it is important for management to understand the core issues driving the nurses' dissatisfaction and to make efforts to mend the broken relationship. The MHAP nurses express

[109] Canadian College of Health Leaders, Professional and Leadership Development, Https://leadsCanada.net/site/framework
[110] Hospital Presentation. Hearing Day Two, October 20, 2022, Slide 3.
[111] Hospital Presentation. Hearing Day Two, October 20, 2022, Slide 4.

concerns related to gaps in leadership communication and a repeating theme that the Employer fails to recognize their concerns and to work towards solutions. The nurses have lost trust in their leadership.

Until the concerns expressed by the nurses related to disrespectful and demeaning communication and the lack of responses to nurses' patient safety and workload issues are addressed in a more personal open and transparent manner, these more formal communication strategies do not appear to be improving the situation. "Building trust is imperative in increasing job satisfaction, increased organization commitment, quality of care and retention."[112]

The IAC Panel is concerned with the breakdown in communication between the Employer and the nurses. An area of major concern relates to how this communication breakdown has negatively impacted the dialogue required to address the nurses concerns with workload related to high patient acuity and inadequate staff, which has resulted in their inability to consistently meet their CNO Professional Practice Standards. It appears that there is an inability of management and staff to effectively communicate with one another in a collaborative and collegial manner to meet common goals and resolve issues at the unit level.

Effective communication is key to effective leadership and an essential skill and requirement of nursing managers and leaders, to promote excellence in nursing practice. Effective nursing leaders should possess excellent communication skills to foster effective communication and collaboration among staff. It is important that nurse leaders pay attention to staff's well-being, demonstrate emotional intelligence and transformational leadership to support staff in their work. Leaders must be aware of the issues and take corrective actions to address and resolve concerns in a meaningful way.

An article published in the Journal of Psychiatric Nursing presented the findings of a grounded theory informed study exploring the attributes and characteristics required for effective clinical leadership in mental health nursing, specifically the views of nurses working in mental health about the importance of effective communication in day-to-day clinical leadership. "Participants identified that clinical leadership in mental health nursing requires effective communication skills, which enables the development of effective working relationships with others that allows them to contribute to the retention of staff, improved outcomes for clients, and the development of the profession."[113]

The impact of the COVID 19 pandemic and the escalating nursing shortage, along with multiple leadership changes since 2019 at the Hospital have created a significant degree of instability for nursing staff. Leadership changes include the turnover of three CNEs, with a period of an interim CNE earlier this year, as well as the promotion of a CN to Program Manager.

The IAC Panel acknowledges that the appointment of a new and permanent Executive Vice President, Patient Care and Chief Nursing Executive in May 2022, (effective July 25, 2022) creates a new opportunity for the Employer and the Association to work together to address the relationship between local leadership and the nurses. Stable leadership creates an opportunity for a new beginning, with a

[112] RNAO Healthy Work Environment: International Affairs and Best Practice Guideline Developing and Sustaining Nursing Leadership, 2nd Edition, 2013

[113] Gary Ennis , RN, B Sci (Prac Dev), Cert Ed, Brenda Happell, RN, BA (Hons), Dip Ed, B Ed, M Ed, PhD, Marc Broadbent, RN, PhD & Kerry Reid-Searl, RN, Mid, BHlth Sc (UCQ), MClin Ed, PhD. The Importance of Communication for Clinical Leaders in Mental Health Nursing: The Perspective of Nurses Working in Mental Health, Journal of Psychiatric Nursing, Published online: 16 Oct 2013. Pgs. 814-819.

focus on transformational leadership, to build trusting relationships between management and the RNs working in the MHAP. Transformational leaders have the ability to inspire confidence, build trust and create positive change to improve staff morale and increase job satisfaction. This leads to a positive work environment where nurses can practice safely and meet their CNO Practice Standards.

The Executive Vice President, Patient Care and Chief Nursing Executive (CNE) is responsible for maintaining clinical and patient-care standards, ensuring that patient safety and access to the right care by the right provider is maintained. The CNE reports to the Chief Executive Officer (CEO).

If patients seeking care in the MHAP are to receive the highest quality standard of care, the MHAP nurses must be supported to enable them to contribute their skills, knowledge and judgement in a manner that significantly contributes to the best quality outcome possible for each and every patient.

On many occasions the Program Manager's response to the PRWRF was interpreted as dismissive and derogatory in tone suggesting to the RNs problem-solving in the moment is strongly encouraged, implying that the nurses were not effectively problem-solving. The nurses felt that this type of response was condescending and implied that the nurses are not using every possible resource appropriately to improve the workload situations. Registered Nurses are accountable to use their judgement in challenging patient care situations and it seemed evident that the CN, in the majority of PRWRFs, called for additional resources appropriately and on many occasions called the OM, often with no support offered to resolve the issue at hand.

The IAC believes that RNs in leadership positions are essential to promote quality patient care and create a quality practice environment. Strategies to address the current gaps in quality leadership and communication are essential to the success of MHAP. Further, the IAC believes that the Hospital nursing leadership has the same goal, that of ensuring each patient coming to the MHAP receives safe, quality care from skilled and knowledgeable nurses who feel supported in meeting their CNO Standards of Practice. The Nursing leadership team has the responsibility and capability to make this a reality. There are many resources available to support nurse leaders. The IAC Panel presents the following for review and consideration by the Employer.

**The CNO Professional Standard (2002) outlines leadership accountabilities for all nurses and additional accountabilities for nurses in administrative roles.**

A nurse in an administrative role demonstrates the (leadership) standard by:

- Identifying goals that reflect CNO mission and values and facilitate the advancement of professional practice;
- Guiding/coaching nursing projects;
- Providing feedback and support to staff about nursing issues at the individual and organizational level;
- Creating opportunities for nurses to assume various leadership roles;
- Involving nursing staff in decisions that affect their practice;
- Supervising and coordinating the development of client programs and services

The CNO standards articulate how a nurse in a formal leadership position can support nurses, in the practice environment, to meet their professional standards.[114]

The Registered Nurses Association of Ontario (RNAO) Best Practice Guideline *Developing and Sustaining Nursing Leadership* identifies five evidence-based transformational leadership practices which nurse leaders need to embrace and model in their behaviours to effectively support nurses and create a quality work environment for nurses. Leadership practices that help create a healthy work environment can ultimately improve patient and client experiences and outcomes.

This Best Practice Guideline identifies and describes:

- leadership practices that result in healthy outcomes for patients/clients, organizations and systems;
- system resources that support effective leadership practices;
- organizational culture, values and resources that support effective leadership practices;
- personal resources that support effective leadership practices; and
- anticipated outcomes of effective nursing leadership.[115]

**The five practices of transformational leaders:**

1. Building relationships and trust is a critical leadership practice, the foundation on which the other practices rest. Relationships include those formed between individual nurses, on teams and in internal and external partnerships.

2. Creating an empowering work environment depends on respectful, trusting relationships among people in a work setting. An empowered work environment has access to information, support, resources, and opportunities to learn and grow, in a setting that supports professional autonomy and strong networks of collegial support.

3. Creating a culture that supports knowledge development and integration involves fostering both the development and dissemination of new knowledge and instilling a continuous-inquiry approach to practice, where knowledge is used to continuously improve clinical and organizational processes and outcomes.

4. Leading and sustaining change involves the active and participative implementation of change, resulting in improved clinical and organizational processes and outcomes.

5. Balancing the complexities of the system, managing competing values and priorities entails advocating for the nursing resources necessary for high-quality patient care, while recognizing the multiple demands and complex issues that shape organizational decisions.

Organizational Supports influence whether leadership practices will succeed and produce strong, visible nursing leadership. They include:

[114] College of Nurses of Ontario (2002). Professional Standards, Revised 2002. https://www.cno.org/globalassets/docs/prac/41006_profstds.pdf.
[115] RNAO Healthy Work Environment: International Affairs Best Practice Guideline Developing and Sustaining Nursing Leadership, Second Edition, 2013.

- valuing nurses' critical role in providing patient/client care;
- supplying sufficient and appropriate human and financial resources;
- providing necessary information and decision support; and
- Creating a culture and climate conducive to effective, efficient nursing care. RNAO HWE

The IAC believes that the nursing leadership must adopt these leadership best practices if the culture on the MHAP is to change into a high functioning clinical practice environment where all clinicians can function to their full potential and patients can receive safe, high-quality care.

The IAC commends the Hospital for implementing the LEADS in a Caring Environment Capabilities Framework and encourages the Hospital to maximize the benefit of this robust and comprehensive model designed for Health Leaders.

Leadership development reaches beyond positional leaders that have budget accountabilities and direct reports and does not have a specific start and end point. The journey of self-examination, reflection, action, feedback, learning, sharing, and coaching is an expectation for many in their roles and the leadership work is rooted in the LEADS in a Caring Environment Capabilities framework.[116] LEADS provides a comprehensive approach to leader development for the Canadian health sector, focusing at a system, organizational and individual level that crosses five domains; Lead Self, Engage Others, Achieve Results, Develop Coalitions, and System Transformation.

The Hospital should ensure that all nursing leaders and other leaders who are accountable for nursing practice are measured against the competencies of the LEADS framework. Upon evaluation, when the nurse leader has not demonstrated evidence of behaviours that align with the expectations, the supervising manager should work with the individual leaders to develop, implement and evaluate corrective action plans to address them and ensure that leadership behaviours model the LEADS framework.

"Healthcare workers are often in stressful situations and environments in the course of their jobs. Some of the risks to psychological health and safety in the workplace include factors such as workload, engagement, balance, safety, recognition, civility and respect, and psychological and social support."[117]

"The importance of the employee experience is the sum of all experiences an employee has with their employer over the duration of their relationship – from recruitment, to onboarding and career development, to exiting the organization. As organizations increasingly recognize people as their greatest assets, they're investing in the employee experience as well. With unprecedented changes from the pandemic in our society, economy, and businesses, the way employees experience work has become more important than ever before. It is critical to an organization's ability to navigate disruption, transformation, and economic uncertainty."[118]

Research suggests that a highly engaged workforce benefits patients and leads to better patient outcomes alongside improving overall organizational performance. The call for engagement is outlined in the leadership standards from Accreditation Canada and included in our new strategic plan which embeds objectives to create a healthy workplace, engaging teams to drive quality and fostering

[116] Hospital 2021-22 Year-End Review, People Services Report. p. 33.
[117] Hospital 2021-22 Year-End Review, People Services Report. P.9.
[118] Hospital 2021-22 Year-End Review, People Services Report. P. 15.

innovation. To fully achieve the Institute for Healthcare Improvement (IHI) 'Quadruple Aim' we need to focus on not only improving the individual experience of care, improving the health of populations, and reducing the per capita cost of healthcare, we need to focus on improving the experience of providing care. This is where workforce engagement will strengthen this aim.[119]

LEADS Self of the LEADS Framework highlights the importance of leaders to recognize their own emotions and determine their impact on others. Emotionally intelligent leaders are aware of their emotions and understand how their emotions impact their decisions, their behavior, their interactions with others and their performance. An emotionally intelligent leader is empathetic to other people and understands what leads other people to feel what they do, use their emotional knowledge to make important decisions, control their emotions as needed and use emotional information and expression of their emotions to connect with their teams and inspire peak performance in others.

Engaging Others: Engaging leaders foster development of others, support and challenge others to achieve professional and personal goals, contribute to the creation of healthy organizations and they create engaging environments where others have meaningful opportunities to contribute and ensure that resources are available to fulfill their expected responsibilities. When a leader communicates effectively, they listen well and encourage open exchange of information and ideas using appropriate communication tools to build teams to work in collaboration and cooperation to achieve results. **https://leadscanada.net/uploaded/web/Resources/LEADS_Corporate_Brochure_2016_final.pdf**

**Related to Leadership and Communication the IAC Recommends:**

53. All nursing leadership, including the Executive Vice President, Patient Care and Chief Nursing Executive, Program Operational Director, Program Managers, and Clinical Learning Specialist, increase their visibility in the Inpatient MHAP to understand the daily stresses of the RNs and to support their work and decision making at the point of care.

54. The Program manager round daily in the MHAP to be visible and to engage with staff to hear and understand their concerns that are impacting workload and safe practice.

55. The Program Manager participates in daily "huddles" led by the Charge Nurse to assess what can be done to assist the team to meet their CNO Professional Practice Standards throughout the next 24 hours.

56. The Program Manager implements monthly staff meetings with nursing input into the agenda. Schedule these at a time when staff can attend. Meeting minutes to be documented and emailed to all staff and posted on the unit.

57. Nursing Leadership and the Association review the RNAO International Affairs and Best Practice Guideline (BPG): Developing and Sustaining Nursing Leadership, Second Edition (2013) and determine practices outlined in the BPG that could be adopted to develop nursing leaders at all levels of the organization from the bedside to the boardroom.

[119] Hospital 2021-22 Year-End Review, People Services Report. p.18.

58. Nursing leadership engage positively in the Professional Responsibility Process to create a positive culture, to establish collaboration, problem-solving and open and effective communication to achieve mutually agreeable action plans that lead to timely solutions to workload and practice issues.

59. The Employer and the Association commit to a new, open and transparent communication style by demonstrating a renewed commitment to using the Hospital Association Committee (HAC) as a forum for open dialogue aimed at addressing and resolving issues and concerns that are impacting nursing workload and safe, quality patient care.

60. The Operational Manager round, on a regular basis, to the Inpatient MHAP to assess patient care acuity prior to reassigning nurses from that MHAP.

61. The Operational Manager attend all Code Whites on MHAP to assess patient and staff safety and to take corrective actions as required. If not possible due to other Hospital priorities, the OM should visit the MHAP, as soon as possible, after the Code White to ensure that patients and staff are safe and to offer support, as required.

62. Management and staff agree to adhere to all Hospital Policies and Procedures.

63. The Employer resume biweekly Violence Risk Working Group meetings immediately, with nursing input into the agenda. Meeting minutes will be printed and posted on the unit bulletin board and emailed to all staff.

64. The Employer maximize the LEADS in a Caring Environment framework and evaluates the performance of nurse leaders and other leaders, who are accountable for nursing practice, against the competencies within the five domains. This will help to achieve the goal of "Cultivating People, Enabling Performance and Building Leaders" as stated in the Hospital's 2021-22 Year-End Review, People Services Report.

## PART 4: CONCLUSION AND SUMMARY OF RECOMMENDATIONS

The Independent Assessment Committee has completed a thorough review and analysis of the Pre-Hearing documentation received from the Hospital and the Association and the presentations by both parties at the Hearing held on October 18, 20, 21, 2022. We considered and deliberated on the materials before us and with our own knowledge and experiences and the use of relevant literature the IAC has made sixty-four (64) recommendations in five (5) areas that impact nurses' workload.

The IAC members unanimously support all recommendations in this Report. The IAC hopes that the recommendations and this process will assist the Hospital and the Association to find mutually agreeable resolutions to the nurses' workload concerns and create a quality practice environment in the Inpatient Mental Health and Addictions Program at Kingston Health Sciences Centre. A practice environment where nurses can provide high quality patient care while meeting the College of Nurses of Ontario Practice Standards.

## I. Human Resources Planning and Registered Nurses Staffing: Twenty (20) Recommendations (TOTAL)

### a. Staffing and Scheduling: Eight (8) Recommendations

1. The following 3 recommendations assume optimal staffing with baseline staffing. During this current time of chronic shortages, until recruitment achieves optimum full-time equivalents, the MHAP unit leadership will work with the charge nurses to create a decision-making tree to guide just in time decision-making related to RN assignments. The goal is to assign the available RN staff to provide the best possible care with the RN staff available for each shift.

2. The Intensive Observation Area, Unit A will be staffed by 3 RNs 24/7 to manage patient acuity and complexity and the high number of patients who are admitted on an involuntary status and require close observation every 15 minutes as per hospital policy.

3. Unit B Adult will be staffed with 3RNs and 3RPNs plus the Charge Nurse who is assigned to Unit B to meet the needs of the acuity and complexity needs of the diverse patient population. Based on acuity the baseline can be increased but it should not be below the baseline.

4. Unit C Child and Youth staffing to be maintained with 1RN, 1RPN and 1BST with the Employer committing that an RN must always be assigned.

5. Section E MHEU staffing be maintained at 2:1 patient:nurse ratio 24/7

6. The Program Manager to consult each morning, Monday to Friday, with the Charge Nurse to assess the patient care requirements and to support short term staffing needs for the next 24 hours. On Friday, the consultation to include assessing any known staffing gaps throughout the weekend.

7. The Employer and the Association review the Master Schedule and identify the actual FTRN and PTRN vacancies that need to be filled to meet the budgeted baseline staffing.

8. The Employer to assess the FT and PT staffing complement on an annual basis during the budget cycle to assess that the current budgeted staffing meets the patient care requirements on MHAP. This assessment to include a review of the full time and part time ratio of a minimum 70%/30% in keeping with the Beck Award.

### b. Load Levelling: One (1) Recommendation

9. That the Employer use "load levelling" as a last resort when reassigning nurses from the MHAP. The Employer reviews the proposed "Acuity Rating Scale" with the Charge Nurses, frontline nurses, and the Association to seek their input prior to implementation. Once finalized, Employer to implement the "Acuity Rating Scale" and measure the impact on how the Operational Managers utilize the assessment completed by the Charge Nurse, and visit the unit on each shift, prior to reassignment of a MHAP nurse.

**c. Charge Nurse: Three (3) Recommendations**

10. The Employer assigns, immediately, a Permanent Charge Nurse on the night shift from 1900 to 0700 hours, without a patient assignment, seven days a week.

11. The Employer hires the required number of RNs to fill the Permanent Night Charge Nurse position and all RNs hired into the Charge RN role to receive training and orientation, to ensure all are fully trained and oriented to the role.

12. When the MHAP is staffed to baseline the Employer and the Association meet to discuss the benefits of a second Day CN, without a patient assignment.

**d. Recruitment and Retention: Eight (8) Recommendations**

13. The Employer work with the Association to develop a comprehensive Recruitment and Retention Strategy utilizing the evidence-based publications and guidelines to guide the development.

14. The Employer post all MHAP job postings concurrently internally and externally, immediately on receipt of a nurse's resignation or request for transfer. The job selection process in the Central Collective Agreement is still required to be followed.

15. The Employer review the Nursing Graduate Guarantee (NGG) Program and assess how this government funded program can be maximized and leveraged at the Colleges and Universities to support RN recruitment for the MHAP. This Program pays an additional six months of supernumerary funding.

16. The Employer review the Nursing Clinical Extern Program and develop a plan to recruit nursing students to work as Externs at KHSC. They can work on the units as unregulated health care providers and support the nurses with the ADLs and other tasks. They will become part of the Hospital and upon graduating may see KHSC as an employer of choice.

17. The Employer, in Collaboration with the Association, review and consider the Community Commitment Program for Nurses (CCPN) which is a Program to attract RNs, RPNs, and NPs.

18. The Employer offer education incentives such as providing free on-site preparation classes for CNA Canadian Psychiatric Mental Health Nurse Certification (CPMHNC).

19. The Employer determine how to create a respite room for staff to relax, get a drink, draw, work on word puzzles, relax and get away from the unit.

20. The Program Manager assess the key areas of nurse dissatisfaction within the Inpatient MHAP and develop a corrective action plan, which is to be informed through staff input, to address the issues by April 2023.

**II. Education, Training and Professional Development: Nine (9) Recommendations (TOTAL)**

**a. Orientation, Education & Training New Hires and Resource Nurse Pool: Three (3) Recommendations**

21. The Employer optimize and adhere to the orientation program for new hire nurses:

a) The Clinical Learning Specialist (CLS) provides a standardized and comprehensive opportunity for new hire nurses and ensures all new hire nurses complete all aspects of their orientation prior to the start of their independent shifts.
b) The CLS optimizes learning and knowledge mobilization by utilizing a variety of modalities for education in addition to the Learning Management System (LMS). Consider role playing, clinical labs, just in time bedside teaching, classroom teaching, simulation and interprofessional educations sessions to allow new staff to engage and interact with the experts to optimize their learning and to enhance their skills and confidence.
c) The CLS ensures orientation education and training includes emergency preparedness training.
d) The CLS develop an onboarding checklist for each new RN hire to be completed between the mentee and mentor during the 'buddy shifts' to ensure key practices and information about the program are reviewed and opportunity is provided for the new hire to ask questions and review these practices. The Checklist should have all orientation education and training to be signed off by the nurse, mentor and CLS.
e) The CLS review the evidence related to therapeutic relationships and engagement and its impact on violence and aggression incidents and provide more focused education to build nurses skills and competencies related to therapeutic engagement and communication.
f) The CLS complete an evaluation of the new nursing mentorship program to determine effectiveness and opportunities for improvement.

22. Education and training for nursing resource pool:

a) Clinical Learning Specialist (CLS) will create an education program to meet the needs of the existing nursing resource pool staff to ensure they are equipped with the knowledge and skills necessary to provide safe quality care while assigned on MHAP.
b) As new nurses are hired to the nursing resource pool the CLS and Resource Pool manager will assess their readiness to take the MHAP education program.
c) The CLS will consider how to include the nursing resource pool in ongoing professional development and education activities to support their practice when assigned to MHAP.

23. Just-in-time unit orientation for reassigned nurses to MHAP:

a) CN to develop a checklist that reviews all key aspects of the unit and the care being provided to aid with orientation of the reassigned nurses.
b) The CN and/or the Program Manager reviews this checklist with each reassigned staff at the beginning of their shift.
c) When mental health nurses are being reassigned to other units, they will be provided with a formal orientation at the beginning of their shift to ensure safe practices during their shift.
    i) The Employer will develop a practice guideline to support mental health nurses when reassigned to other units to enable appropriate patient care assignments reflective of their skills and competencies.

**b. Building Nursing Expertise Through Continuing Education and Professional Development: Two (2) Recommendations**

24. The Employer will continue to execute their plans to support nurses in microcredential courses focusing on mental health, as well as, their CNA certification. In partnership with the Association

a fair and reasonable cost-sharing structure to be developed and implemented to support the nurses in these advanced credentialling opportunities.

25. The Employer will adopt and promote standardized, evidence-based practice to reduce variability in care amongst this heterogenous patient population by implementing the provincial, Health Quality Ontario Quality Practice Standards.

a) The Employer develop and implement a plan to train the MHAP nurses in the Quality Standards relevant to their practice.
b) Develop procedures to embed Quality Standard interventions into the RNs day-to-day practice, in collaboration with all clinical staff.
    i) The Employer will consider levering on existing resources within the province that can provide supports to implement Quality Standards.
c) The Employer will create processes to measure adherence to and clinical outcomes of each Quality Standard implemented.
d) The Employer to develop specialized experts in each of the Quality Standards to act as champions for the unit to help ensure understanding of key diagnosis and adherence to evidence-based care.

### c. Optimizing the Clinical Learning Specialist (CLS) Role: Four (4) Recommendations

26. The Employer increase the CLS unit allocation to 75% for a minimum of one year, to support orientation, just-in-time education, training and ongoing professional development on the inpatient mental health units.

27. The Employer review the current responsibilities of the CLS role and implement the following:

a) Work collaboratively with the CLS to develop a workplan for each area of focus in alignment with the needs of MHAP.
b) Support the CLS to obtain CNA Certification in psychiatry/mental health to demonstrate expertise. The CLS would then be authorized to teach the CNA course content to the RNs working in MHAP and support them as they work towards obtaining their CNA certification.
c) Support the CLS to consistently mentor and support the skills development of nursing staff (from novice to expert levels), newly hired staff, returning staff, and other members of the health-care team in meeting the care needs of the patient population.
d) Support the CLS to work collaboratively with the Program Manager and the nurses to evaluate various program initiatives and to develop innovative approaches to address learning gaps and to lead the change required to address the current gaps.
e) Support the CLS to consult and collaborate with members of the health-care team to develop quality-improvement and risk-management strategies related to staff education and training.

28. The CLS develop a mechanism to ensure that all staff are educated on new or revised policies in advance of the effective date.

29. The CLS take a leadership role in measuring adherence to the Quality Standards and reporting on clinical outcomes.
    a) Where deficiencies are identified, the CLS will work with nurses and other clinical staff to develop corrective action plans and interventions, such as training and education, to improve practice and ultimately adherence and clinical outcomes.

## III. Violence Risk, Patient Acuity and Complexity: Fourteen (14) Recommendations

30. The Employer, with the appropriate stakeholders, review and determine the Health Quality Ontario Quality Standards that are most relevant to implement in the Inpatient MHAP to meet the clinical care needs of this heterogenous patient population. This would allow education and training for nurses on how to best care for each of the various diagnosis.
    a) Train all the nurses in the Quality Standards relevant to their practice.
    b) Develop procedures to embed Quality Standard interventions into day-to-day practice in collaboration with clinical staff.
        i. Consider leveraging on existing resources within the province that provide supports to implement Quality Standards.
    c) Create processes to measure adherence and outcomes to each Quality Standard implemented.

31. The MHAP develop specialized experts in each of the Quality Standards to act as champions for the unit to help ensure understanding of key diagnosis and adherence to evidence-based care.

32. The Employer develops and implements a strategy to increase and sustain adherence to mandatory patient and workplace safety education and training for all nurses working on MHAP.
    a) The Employer will ensure MHAP nurses adherence to organizational policy related to mandatory training.
    b) The Program Manager will be accountable to ensure all clinicians are provided with annual training in workplace violence and prevention training.

33. The Program Manager and the Clinical Learning Specialist, in collaboration with the staff, review the list of mandatory education and training to assess its continued relevance for the operations of the program and update with any identified gaps.
    a) The Program Manager identifies policies that are critical to practice for nurses and includes this as part of their annual education and training.

34. The Employer develop a formal organizational structure that will enable nurses to provide input and feedback into all policies that impact on their work. Nursing Council and Unit Based Councils can facilitate this process.

35. The Program Manager and Clinical Learning Specialist monitor adherence to safety practices currently in place and consider creating a process to measure adherence that can be shared at the Mental Health Violence Risk Working Group.

36. The Lead/Committee Chair of the Mental Health Violence Risk Working Group re-establish the Working Group with an expression of interest group to ensure opportunity for nurses to join. Once re-established the VRWG will review the 43 recommendations that have been completed and measure the outcomes and the sustainability. Are the changes that have been implemented making a difference and addressing the concerns related to workplace violence? What are the learnings? And develop a continuous quality improvement process. Minutes of meeting to be posted and circulated through e-mail.

37. The Employer assess and consider the implementation of one of the two evidence-based models used to reduce the use of coercive practices including restraints and seclusion in admitted patients. The two models are Six Core Strategies and Safewards.

38. The Clinical Learning Specialist, through training and education, to ensure nurses are integrating risk assessments and care plan interventions into practice.

39. The Employer and all employees will comply with the Occupational Health and Safety Act.

40. The Employer purchase manual beds on the IOA unit, with removable crank that can be bolted to the floor for safety.

41. The Employer install Velcro strips (hook) outside of all patient rooms with interior windows facing hallway/nursing station. Purchase vinyl, cut to the size of the windows and secure Velcro (loop) to the interior of vinyl. Vinyl coverings can be placed over the windows at night to reduce hallway light entering patient room to promote sleep hygiene and can be removed during the day. They can also be used during the day to decrease patient stimulation if required. This is in response to comments made during the MHAP virtual tour where linens were being hung over door and windows to reduce the light entering the room.

42. The Employer provide all nurses with a lock key to carry on their person. This is a best practice in Mental Health Inpatient Units.

43. The Employer authorize immediately that disposable ligature cutting tools be discarded after each use, as per the manufacturer's recommendation, to support safe practice.

## IV. Morale and Toxic Work Environment: Nine (9) Recommendations

44. The Association and the Employer work together to develop a healthy work environment based on mutual respect and trust to mitigate safety risks for staff while promoting quality care for patients.

45. The Association and the Employer review the results of the Staff Engagement Survey from 2019 and 2021 and together with the nurses identify themes requiring improvement and develop a corrective action plan, with specific outcome measures and timelines.

46. The Employer and the Association review the results of the local MHAP Engagement Survey in partnership with the six established working groups and include frontline RNs in the discussion and recommendations put forward from the working groups.

47. The Employer and the Association review the RNAO Best Practice Guidelines (BPGs): Workplace Health, Safety, & Wellbeing of the Nurse and Developing and Sustaining Safe, Effective, and Workload Practices (Second Edition) and implement those recommendations that both parties agree will be appropriate to create a healthy work environment and improve the morale of the nurses working in the Inpatient MHAP.

48. The Employer develop an evaluation process to monitor and measure the impact of implementing changes within the MHAP that affect the nurses work life, scheduling, or practice environment. This can be done through surveys and/or focus groups.

49. The Hospital continue its Mental Health and Wellness initiatives and focus on initiatives that result in positive change at the local level on Burr 4.

50. The Employer review Terms of Reference of the Nursing Practice Council to include a RN representative from the Inpatient MHAP and to ensure alignment between the work of the Corporate Nursing Council with the unit through a Unit Based Council (UBC). The UBC to be led by the corporate Nursing Practice Council Representative to ensure that local issues are being considered at the corporate Council and that Corporate initiatives are shared at the local level.

51. The Employer follows the Occupational Health and Safety Act, and the Employer ensures all managers, supervisors, and designates complete supervisor training.

52. When a staff member is injured while on duty, the Chief Nursing Executive will call to talk with the nurse to assess how he/she is feeling, to discuss the incident and to offer support and resources as appropriate.

## V. Leadership and Communication: Twelve (12) Recommendations

53. All nursing leadership, including the Executive Vice President, Patient Care and Chief Nursing Executive, Program Operational Director, Program Managers, and Clinical Learning Specialist, increase their visibility in the Inpatient MHAP to understand the daily stresses of the RNs and to support their work and decision making at the point of care.

54. The Program manager round daily in the MHAP to be visible and to engage with staff to hear and understand their concerns that are impacting workload and safe practice.

55. The Program Manager participates in daily "huddles" led by the Charge Nurse to assess what can be done to assist the team to meet their CNO Professional Practice Standards throughout the next 24 hours.

56. The Program Manager implements monthly staff meetings with nursing input into the agenda. Schedule these at a time when staff can attend. Meeting minutes to be documented and emailed to all staff and posted on the unit.

57. Nursing Leadership and the Association review the RNAO International Affairs and Best Practice Guideline (BPG): Developing and Sustaining Nursing Leadership, Second Edition (2013) and determine practices outlined in the BPG that could be adopted to develop nursing leaders at all levels of the organization from the bedside to the boardroom.

58. Nursing leadership engage positively in the Professional Responsibility Process to create a positive culture, to establish collaboration, problem-solving and open and effective communication to achieve mutually agreeable action plans that lead to timely solutions to workload and practice issues.

59. The Employer and the Association commit to a new, open and transparent communication style by demonstrating a renewed commitment to using the Hospital Association Committee (HAC) as a forum for open dialogue aimed at addressing and resolving issues and concerns that are impacting nursing workload and safe, quality patient care.

60. The Operational Manager round, on a regular basis, to the Inpatient MHAP to assess patient care acuity prior to reassigning nurses from that MHAP.

61. The Operational Manager attend all Code Whites on MHAP to assess patient and staff safety and to take corrective actions as required. If not possible due to other Hospital priorities, the OM should visit the MHAP, as soon as possible, after the Code White to ensure that patients and staff are safe and to offer support, as required.

62. Management and staff agree to adhere to all Hospital Policies and Procedures.

63. The Employer resume biweekly Violence Risk Working Group meetings immediately, with nursing input into the agenda. Meeting minutes will be printed and posted on the unit bulletin board and emailed to all staff.

64. The Employer maximize the LEADS in a Caring Environment framework and evaluates the performance of nurse leaders and other leaders, who are accountable for nursing practice, against the competencies within the five domains. This will help to achieve the goal of "Cultivating People, Enabling Performance and Building Leaders" as stated in the Hospital's 2021-22 Year-End Review, People Services Report.

**PART 5: APPENDICES**

Appendix 1

Letter from the Association to the Hospital November 8, 2021

www.ona.org

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

November 08, 2021

Mike McDonald
Chief Nursing Executive
Kingston Health Sciences Centre
76 Stuart Street
Kingston, ON K7L 2V7

Dear Mr. McDonald,

**Re: Referral of Professional Practice and Workload Issues at Kingston Health Sciences Centre – Mental Health and Addictions Program (ONA File # 201809160) to an Independent Assessment Committee**

The Registered Nurses (RNs) working in the Mental Health and Addictions Program (MHAP) at Kingston Health Sciences Centre have consistently identified ongoing practice and workload issues as evidenced by the data submitted on over 90 Professional Responsibility Workload Report Forms (PRWRFs) since 2019.

The RNs have documented that their current workload and practice environment does not allow them to meet the College of Nurses of Ontario Standards of Practice and Practice Guidelines. They believe they are being asked to perform more work than is consistent with proper patient care.

The parties have attempted to resolve the issues at Hospital Association Committee meetings by discussing the issues and recommendations documented in our action plan(s). Despite this, a number of the professional responsibility and workload issues identified by ONA members remain unresolved including but not limited to:

- Inability to maintain baseline staffing
- Persisting issues with increased acuity and complexity
- Inadequate RN staffing in the Intensive Observation Area (IOA)
- Charge Nurse role and their inability to perform duties while being a resource for MHAP nurses
- Inadequate training for all MHAP staff
- Ineffective communication and lack of leadership support.

The Union has grave concerns regarding the potential of negative patient outcomes and historical events that have resulted in actual negative patient outcomes. We are seeking resolution of the practice and workload issues on behalf of our members, the patients, and community for which they provide care. Timely and effective resolution of the Professional Responsibility and Workload Issues is vital to enable the RNs to deliver safe,

competent and ethical patient care. Accordingly, the Union is forwarding the complaint to an Independent Assessment Committee (IAC) as per Article 8 of the Hospital Central Collective Agreement.

The Ontario Nurses' Association nominee's information for the Independent Assessment Committee will be forth coming.

David McCoy of the Ontario Hospital Association has been contacted to confirm the next IAC Chairperson rotation in accordance with Appendix 2 will be Ms. Ella Ferris. I have confirmed with Ms. Ella Ferris that she is available to Chair this hearing.

The Union remains willing to continue to work with the Hospital to further resolve the outstanding issues and believe that the money spent on the IAC could be better utilized to improve the practice and workplace environment for our members and patients.

Sincerely,

**ONTARIO NURSES' ASSOCIATION**

Haifaa Khadour RN, BScN, BMSc.
Professional Practice Specialist

C: Annette Saccon, Bargaining Unit President and Local Coordinator
Mandy Wilson, Servicing Labour Relations Officer
Susan Delisle Gosse, Manager II, Professional Practice
David Cheslock, Manager, East DST
Dr. David Pichora, President and CEO, Kingston Health Sciences Centre
Mike McDonald, Chief Nursing Executive, Kingston Health Sciences Centre
Vicki McKenna, Provincial President of the Ontario Nurses' Association
Cathryn Hoy, First Vice-President of Ontario Nurses' Association
Bernadette Robinson, Ontario Nurses' Association, Regional 2 VP

Appendix 2

Letter from the Association to the IAC Chair February 11, 2022

www.ona.org

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

February 11, 2022

SENT BY EMAIL

Ella Ferris, RN, BScN, M.B.A

Dear Ella,

Thank you for accepting the nomination to chair the Independent Assessment Committee (IAC) investigating a complaint in the Mental Health and Addictions Program (MHAP) at for Kingston Health Science Centre. Mr. David McCoy, Director, Labour Relations at the Ontario Hospital Association have been contacted and the parties have agreed to you chairing this IAC.

I have provided you with 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. ONA requests that the Employer provide you with information for their nominee within the timeframes set out in the Collective Agreement.

The Ontario Nurses' Association's nominee to the IAC is Joan McCollum.

Joan's contact information is:

Joan McCollum, RN, BScN.
Phone - (647) 382- 6489
Email - wmoslerpres@ona.org

Please set dates with the nominees, based on their availability and the availability of the respective parties.

Yours truly,

**ONTARIO NURSES' ASSOCIATION**

Haifaa Khadour,

www.ona.org

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

Professional Practice Specialist

x Haifaa Kh

C: Annett Saccon, ONA Bargaining Unit President, Local 99
Laura-Ashley Detlor, Site Vice President, Local 99
Joan McCollum, ONA Nominee
Mandy Wilson, ONA Servicing Labour Relations Officer
Thomas Hart, Chief Nursing Executive Officer
David Pichora, Hospital President and CEO
Clarence Willms, Director, Employee and Labour Relations
David McCoy, Director of Labour Relations
Susan Delisle Gosse, ONA Professional Practice Manager

Appendix 3

Letter from the Hospital to the IAC Chair February 22, 2022

Kingston Health Sciences Centre
Centre des sciences de la santé de Kingston

February 22, 2022

**BY EMAIL ONLY:**
**ella.ferris@outlook.com**

Ella Ferris, RN, BScN, M.B.A.

Ms. Ferris,

Thank you for accepting the nomination to Chair the Independent Assessment Committee (IAC) regarding the workload issues raised by the Ontarion Nurses' Association within the inpatient Mental Health and Addictions Program (MHAP) at Kingston Health Sciences Centre.

Further to ONA's letter of February 11, 2022, the Employer is providing you with its nominee for the IAC. The Hospital's nominee is Dr. Sanaz Riahi.

Dr. Riahi's contact information is as follows:

Sanaz Riahi RN, PhD
Vice President, Practice, Academics & Chief Nursing Executive
Lecturer, Department of Psychiatry
University of Toronto
Ontario Shores Centre for Mental Health Sciences
700 Gordon Street, Whitby, Ontario L1N 5S9

T: 905.430.4055 ext. 6798
E: riahis@ontarioshores.ca

Please contact Dr. Riahi to set dates for the upcoming IAC.

Yours truly,

Clarence Willms
Director, Employee and Labour Relations
Kingston Health Sciences Centre

Kingston Health Sciences Centre
Centre des sciences de la santé de Kingston

cc: Annette Saccon, ONA Bargaining Unit President, Local 99
Laura-Ashley Detlor, Site Vice President, Local 99
Dr. Sanaz Riahi, KHSC IAC Nominee
Joan McCollum, ONA IAC Nominee
Mandy Wilson, ONA Servicing Labour Relations Officer
Thomas Hart, Chief Nursing Executive Officer
Dr. David Pichora, KHSC President and CEO
Clarence Willms, Director, Employee and Labour Relations
David McCoy, OHA Director of Labour Relations
Susan Delisle Gosse, ONA Professional Practice Manager

Appendix 4

Letter from the IAC Chair to the Hospital February 25, 2022

Ella Ferris
Ella.ferris@outlook.com

February 25, 2022

**SENT VIA EMAIL ONLY**

Clarence Willms
Director, Employee and Labour Relations
Kingston Health Sciences Centre

**Re: Kinston Health Sciences Centre Employer Nominee for the Independent Assessment Committee**

Dear Mr. Willms,

As Chair of the Independent Assessment Committee (IAC) between Kingston Health Sciences Centre (KHSC) and the Ontario Nurses' Association (ONA), regarding workload issues raised by the inpatient Mental Health and Addictions Program (MHAP), I am writing to acknowledge receipt of your letter dated February 22, 2022.

I am pleased to welcome Dr. Sanaz Riahi to the KHSC-ONA IAC as the Employer Nominee. I will reach out to Sanaz Riahi and Joan McCollum, ONA's Nominee and together we will propose potential dates for the KHSC-ONA Hearing.

Thank you very much for your attention to this important matter.

I look forward to working with you and the KHSC team as we look for resolution to the concerns raised by the nurses in the Inpatient MHAP at the Hospital.

Yours truly,

Ella Ferris

Ella Ferris, RN, MBA
Chair Independent Assessment Committee

Copy: Susan Delisle Gosse, ONA Professional Practice Manager
Laura-Ashley Detlor, Site Vice President, Local 99
Thomas Hart, Chief Nursing Executive Officer
Haifaa Khadour, ONA Professional Practice Specialist
Joan McCollum, ONA IAC Nominee
David McCoy, OHA Director of Labour Relations
Dr. David Pichora, KHSC President and CEO
Dr. Sanaz Riahi, KHSC IAC Nominee
Annette Saccon, ONA Bargaining Unit President, Local 99
Mandy Wilson, ONA Servicing Labour Relations Officer

Appendix 5

Letter from the IAC Chair to the Association and the Hospital April 4, 2022

Ella Ferris
Ella.ferris@outlook.com
(647)290-8547

Sent VIA EMAIL

April 4, 2022

Thomas Hart
Executive Director Patient Care & Chief Nursing Executive (Interim)
Kingston Health Sciences Centre
76 Stuart Street
Kingston, Ontario
K7L 2V7

Haifaa Khadour
Professional Practice Specialist
Ontario Nurses' Association
85 Grenville Street
Toronto, Ontario
M5S 3A2

Dear Thomas Hart and Haifaa Khadour,

**RE:** Kingston Health Sciences Centre (KHSC) Inpatient Mental Health and Addictions Program (MHAP) and the Ontario Nurses' Association (ONA) Independent Assessment Committee Dates

As Chair of the Independent Assessment Committee (IAC) for Kingston Health Sciences Centre (KHSC) Inpatient Mental Health and Addictions Program (MHAP) and the Ontario Nurses' Association (ONA), I am writing to confirm the dates for the Hearing.

The Hearing will be held virtually, and all parties have agreed to hold the Hearing on the following dates, October 18th, 20th, & 21st, 2022. A full detailed Agenda will be provided to all parties closer to the Hearing dates, however, I wish to explain the rationale for the unscheduled day on October 19th.

On Day-1 of the Hearing, October 18th, each party will have the opportunity to present their submission overview and to answer clarification questions. On Day-2 of the Hearing, October 20th, KHSC will have two hours to respond to ONA's presentation and ONA will have two hours to respond to KHSC's presentation. The intent of leaving October 19th unscheduled is to offer a day between Hearing Day-1 and Hearing Day-2, to allow adequate time for each party to prepare their response to the other's Day-1 presentation.

The IAC trusts that this arrangement will meet everyone's needs and will support an effective Hearing process. Thank you to all parties for working together to find mutually agreeable dates for the Hearing.

Yours truly,

Ella Ferris

Ella Ferris RN, MBA
Chair Independent Assessment Committee

Appendix 6

Letter from the IAC Chair to the Hospital (with attachment) August 2, 2022

Ella Ferris
Ella.ferris@outlook.com

August 2, 2022

**SENT VIA EMAIL: Jason.hann@khsc.ca**

Jason Hann
Executive Vice-President, Patient Care and Chief Nursing Executive
Kingston Health Science Centre
76 Stuart St. Room JM6-042-1
Kingston, ON K7L 2V7

**Re: Independent Assessment Committee Hearing Inpatient Mental Health and Addiction Program, Kingston Health Science Centre**

Dear Mr. Jason Hann,

May I start by congratulating you on your appointment as Executive Vice-President, Patient Care and Chief Nursing Executive at Kingston Health Sciences Centre. I wish you much success in your new position.

I am writing to introduce myself to you, as the Chair of the Independent Assessment Committee (IAC) between Kingston Health Sciences Center (KHSC), Inpatient Mental Health and Addictions Program (MHAP) and the Ontario Nurses' Association (ONA) and to request information from the Hospital.

The IAC has been constituted in alignment with Article 8.01 of the Hospital-ONA collective agreement.

Attached you will find a document outlining a list of information and data, requested by the IAC, from KHSC. This information, with the relevant documents is required to assist the IAC to conduct our work, including our analysis, deliberations, and recommendations. We request submission of the Hospital's response no later than September 19, 2022.

Knowing that this is your second week, in your new role, I apologize for sending this request, at this time, however, the IAC wishes to ensure that the Hospital has adequate time to prepare and submit this very important information.

I wish to advise you that the IAC Hearing has been scheduled for October 18, 20, and 21, [2022]. This was confirmed in a letter, dated April 4, 2022, to Thomas Hart, ED Patient Care and Interim Chief Nursing Executive KHSC, and Haifaa Khadour, Professional Practice Specialist, ONA. (Attached for your files).

It is my goal to achieve a successful IAC review and a Final Report for the Hospital and ONA. I will work with the Hospital's IAC Nominee, Sanaz Riahi, ONA's IAC Nominee, Joan McCollum, and all relevant parties in the best interest of ONA and the KHSC to complete the IAC.

Thank you in advance, for your consideration and attention to this request.

Yours sincerely,

Ella Ferris

Ella Ferris
Ella.ferris@outlook.com

Ella Ferris, RN, MBA
Chair Independent Assessment Committee

Copy: Lorrie Daniels, ONA, Manager, Professional Practice Learning and Development
Laura-Ashley Detlor, ONA Site Vice President, Local 99
Haifaa Khadour, ONA, Professional Practice Specialists,
Joan McCollum, ONA IAC Nominee
Dr. Sanaz Riahi, KHSC IAC Nominee
Annette Saccon, ONA Bargaining Unit President and Local Coordinator
Clarence Willms, Director, Employee and Labour Relations, KHSC

**Independent Assessment Committee (IAC) Information Request for Kingston Health Sciences Centre: Inpatient Mental Health and Addictions Program (MHAP)**

Information requested on August 2nd, 2022, with a request that the data be submitted to Ella Ferris, Chair IAC, no later than September 19th, 2022.

**Please provide the data/information for four fiscal years: 2018-19, 2019-20, 2020-2021, 2021-2022, (April 1st to March 31st) and 2022-2023 year-to-date (YTD)**

1) **Unit Organization/Functioning**

    a) Structural drawing of the unit layout for all the inpatient MHAP
    b) Number of beds in the unit (physical capacity); number of beds staffed and operational.
    c) Description of how the MHAP is organized, areas and functions (single rooms, double rooms, isolation rooms etc.)
    d) Organization Chart for Inpatient MHAP
    e) Job Descriptions for all professional regulated staff: Team Leader/Charge Nurse, Registered Nurse, Registered Practical Nurse Practitioner, Advanced Practice Nurse, Nurse Educator, any other registered staff including all allied health professionals.
    f) Does the Team Leader/Charge Nurse have a patient assignment?
    g) Orientation Program for RNs including number of weeks with a preceptor/buddy.
    h) Job Description for all support roles, such as, but not limited to Personal Support Workers, Ward Clerk/Clerical Assistants, Housekeeping/Environmental Services, other?
    i) Copy of typical chart format/template for inpatient mental health and addictions patients
    j) Charting guidelines and/or policies
    k) Changes or initiatives that impact inpatient mental health and addictions program in the last four years:
        i. External issues that impact patient flow/patient volumes
        ii. Major internal process changes such as model of care changes, technology implementations, special unit or corporate projects -other?

2) **Patient information for the Inpatient Mental Health and Additions Program (MHAP) for the past four fiscal years: 2018-2019, 2019-2020, 2020-2021, 2021-2022 and 2022-23 YTD.**

    a) Number of admissions by day of the week
    b) Number of discharges by day of the week
    c) Daily patient census
    d) Average length of stay
    e) % Occupancy
    f) % Alternative level care (ALC) patients
    g) Number of Form 1 patients, Form 3 patients and Form 4 patients
    h) Number of consent and capacity board hearings in the last three years

i) Data about how many police or correction officers are on the units for patients in custody
j) Number of patients on close and constant observation by day
k) Frequency of patient passes, (day, overnight, weekend)
l) How long do patients wait in the Emergency Department after decision to admit?
m) Any patient activity rooms, off unit areas? Who supervises these areas?
n) Where are patient belongings stored and who is responsible for recording the belongings and valuables?
o) Does the MHAP use Care Paths, Standard Care Plans, and Medical Directives to manage specific patient populations?

3) **Staffing data for four fiscal years: 2018-2019; 2019-2020, 2020-2021, 2021-2022 (April 1st to March 31st) and 2022-23 year-to-date**

a) What is the model of care in the inpatient MHAP? Nurse to patient ratio?
b) Budgeted Full-time Equivalents (FTEs) for all staff categories in the inpatient MHAP
c) Actual FTEs expenditures versus budgeted
d) Total paid hours in FTEs for RNs full-time (FT), part-time (PT), casual, agency
e) Number of actual (headcount) FT, PT (please provide FTE commitment for each PT), and causal RNs (include average FTE worked by each casual), agency worked hours
f) Number of RN budgeted positions in the last fiscal year 2021-22
g) Retirement projection for 2022/23 and 2023/24
h) Sick-time, overtime in FTEs for RNs and a comparison over last four fiscal years
i) Current RN vacancies, and vacancy rate comparison the last four fiscal years
j) RN turnover rate (internal and external) comparison over the last four years
k) Experience profile – number of RNs in MHAP with Mental Health experience (under 1 year, 2 years, 3 to 5 years, 5 to 10 years, 10 to 15 years, greater than 20 years)
l) Number of RNs on modified work or permanent accommodations
m) Copy of local agreement
n) Master schedule: copy of the posted schedules for RNs for the past four years and a copy of daily assignment sheets for the past year
o) Number of Nurse Practitioners, Advanced Practice Nurses, Educators, and other non-bedside leadership positions
p) Number of Allied Health Professionals (Social Workers, Dietitians, Pharmacists, Physiotherapists, Physician Assistants, other?
q) Number of support staff, such as, but not limited to, Personal Support Workers, Ward Clerks/Clerical Assistants, Housekeeping/Environmental Services, other?
r) If utilized by the MHAP, the size and utilization of a nursing float pool.
s) How many non mental health nurses pick-up shifts in the MHAP from the nursing pool or from outside the nursing staffing/resource pool?
t) Who does the scheduling for the unit?
u) Who is accountable to cover the unfilled shifts in the schedule?
v) Who is accountable for calling in replacement staff?
w) Are RNs responsible for non-nursing duties? If yes, please provide list of these non-nursing duties.

x) If available, please provide any FTE information on how KHSC Inpatient MHAP RN staffing complement compares to other hospital inpatient MHAP on a shift-by-shift basis

**4) Nursing Orientation and Ongoing Professional Development**

a) How many weeks is you orientation/onboarding program for new RN hires? Please provide a copy of your RN orientation program
b) What Mental Health and/or Addictions certifications or specialty training is required to work in the Inpatient MHAP at KHSC? Does the hospital support the cost these of certifications/training programs?
c) What is your continuing education program for RNs in the inpatient MHAP? Please provide aby documentation related to continuing education for the nurses.
d) Training stats for Burr 4 staff and resource pool staff (RNs, RPNs, PCAs) – please include Non-violent crisis intervention (NVCI), Code White, Pinel restraint training, and Intensive Observation Area (IOA) training and any other safety training programs offered to Burr 4 staff.

**5) Budget and Performance Indicators for the past four fiscal years: 2018-2019, 2019-20, 2020-21, 2021-22 (April 1st to March 31st) and 2022-23 YTD**

a) Total planned and expended budget for the MHAP including staffing, equipment, and supplies
b) Staff and bed budget breakdown
c) Does the MHAP receive any targeted (specific to Mental Health Services) funding from the Provincial Government or other sources?

**6) Quality of Care, Safety, and Performance Indicators – for the past four fiscal years, 2018-2019, 2019-20, 2020-21, 2021-22 and 2022-23 YTD**

a) Patient Satisfaction results for the Inpatient MHAP
b) Staff and Physician Satisfaction results
c) Staff related safe reports – including Musculoskeletal Injuries, and other workplace injuries, RN time lost due to workplace injury
d) Patient related staff reports – including patient injury, self-harm, medication errors and near misses, falls, other safety data collected and severity of outcomes
e) Number and type of critical incidents in the Inpatient MHAP
f) Rapid Assessment of Critical Events (RACE) data
g) Restraint usage including seclusion, type of restraints used, number of points (3 point, 4 point, 6 point), frequency of restraint use
h) Chemical restraint usage

i) Number and type of all reported patient and staff incidents reported in organizational quality tracking system
j) Code white incidents
k) Security Violence Stats disclosures – the monthly reports produced by the security team
l) Number of patients transfer to Intensive Observation Area (IOA)
m) Annual Health and Safety Reports
n) Number of patients transferred from MHAP to medicine, ICU and surgery
o) Description of Quality Improvement Projects/Initiatives related to nursing and nursing practice and patient care
p) Program Quality Committee Minutes and/or Department or Program Meetings related to staffing and change processes
*q)* All MHAP level reviews – please include descriptions/report of incident, outcomes, and corrective action plans. *PATIENT IDENTIFIERS to be removed/redacted.*
r) Any other reports and/or indicators being utilized to monitor and evaluate efficiency, effectiveness, and quality of care in the Inpatient MHAP

**7) Hospital Association Committee (HAC) Agendas and Minutes from 2018, 2019, 2020, 2021, 2022 (year-to-date) and any other Agendas and Minutes of meetings regarding workload complaints in the Inpatient MHAP.**

**8) Inpatient MHAP Staff Meeting Minutes for 2018, 2019, 2020, 2021 and 2022 (year-to-date)**

**9) Corporate Strategic Plan and MHAP Strategic Plan**

Appendix 7

Confidentiality Agreement First Class Facilitation August 26, 2022

**2022-08-26**

Confidentiality Agreement:

I promise, when acting as a facilitator for Ella Ferris for online Zoom mediations/arbitrations, to keep everything I see, read, hear, and learn strictly confidential except as may be required by law. I understand that confidentiality is essential to the mediation/arbitration process and will, except as may be required by law, never discuss or refer to any aspect of any mediation/arbitration, including the names of any of the parties or their counsel, that I participate in as a facilitator.

Shayan Shadpour

Name (print)

DocuSigned by:
Shayan Shadpour
BF8960A19B8C48F...

Signature

2022-08-26

Date

Appendix 8

Letter from the IAC Chair to the Association
September 6, 2022

Letter from IAC Chair to the Hospital
September 6, 2022

Ella Ferris
Ella.ferris@outlook.com

September 6, 2022

**SENT VIA EMAIL: haifaak@ona.org**

Haifaa Khadour
Professional Practice Specialist
Ontario Nurses' Association
85 Grenville Street
Toronto, Ontario, M5S 3A2

**Re: Ontario Nurses' Association (ONA) Brief to the Independent Assessment Committee (IAC)**

Dear Ms. Haifaa,

I am writing to request that ONA submit their Brief to me, electronically, no later than September 27th, 2022.

This request for ONA's Brief is in accordance with the requirements outlined in the Independent Assessment Hearing Guidelines, and in particular the accountabilities of the Chairperson, item number 4 which states that:

> "At an agreed to date, not more than three (3) weeks in advance of the hearing, the Union and the Employer will distribute, via courier, their briefs to the Chairperson. Once the Chairperson of the Independent Assessment Committee has received both parties' briefs, the Chairperson will distribute the briefs to each party simultaneously."

Please note that although item number 4 above states that the Brief is to be sent via courier, I am requesting that it be sent electronically to ensure timely distribution to all parties. On receipt of both the Union's and the Hospital's Briefs on September 27th, 2022, I will distribute the briefs to each party simultaneously, as well as to members of the IAC, in compliance with my responsibility as Chairperson.

Thank you for your attention to this request.

Yours truly,

Ella Ferris

Ella Ferris, RN, MBA
Chair Independent Assessment Committee

Copy: Lorrie Daniels, ONA, Manager, Professional Practice Learning and Development
Laura-Ashley Detlor, ONA Site Vice President, Local 99
Jason Hann, Executive Vice President, Patient Care and Chief Nursing Executive
Joan McCollum, ONA IAC Nominee
Indira Naraine, Director, Employee and Labour Relations, KHSC
Dr. Sanaz Riahi, KHSC IAC Nominee
Annette Saccon, ONA Bargaining Unit President and Local Coordinator

Ella Ferris
Ella.ferris@outlook.com

September 6, 2022

**SENT VIA EMAIL: Jason.hann@KingstonHSC.ca**

Jason Hann
Executive Vice-President, Patient Care and Chief Nursing Executive
Kingston Health Science Centre
76 Stuart St. Ofc: JM6-042-1
Kingston, ON K7L 2V7

**Re: Kingston Health Sciences Centre (KHSC) Brief to the Independent Assessment Committee (IAC)**

Dear Mr. Jason Hann,

I am writing to request that the Hospital submit their Brief to me, electronically, no later than September 27th, 2022.

This request for the Hospital's Brief is in accordance with the requirements outlined in the Independent Assessment Hearing Guidelines, and in particular the accountabilities of the Chairperson, item number 4 which states that:

> "At an agreed to date, not more than three (3) weeks in advance of the hearing, the Union and the Employer will distribute, via courier, their briefs to the Chairperson. Once the Chairperson of the Independent Assessment Committee has received both parties' briefs, the Chairperson will distribute the briefs to each party simultaneously."

Please note that although item number 4 above states that the Brief is to be sent via courier, I am requesting that it be sent electronically to ensure timely distribution to all parties. On receipt of both the Hospital's and the Union's Briefs on September 27th, 2022, I will distribute the briefs to each party simultaneously, as well as to members of the IAC, in compliance with my responsibility as Chairperson.

Thank you for your attention to this request.

Yours truly,

Ella Ferris, RN, MBA
Chair Independent Assessment Committee

Copy: Lorrie Daniels, ONA, Manager, Professional Practice Learning and Development
Laura-Ashley Detlor, ONA Site Vice President, Local 99
Haifaa Khadour, ONA, Professional Practice Specialists,
Joan McCollum, ONA IAC Nominee
Indira Naraine, Director, Employee and Labour Relations, KHSC
Dr. Sanaz Riahi, KHSC IAC Nominee
Annette Saccon, ONA Bargaining Unit President and Local Coordinator

Appendix 9

Hearing Agendas October 18, 20, 21, 2022

# Kingston Health Sciences Centre Mental Health & Addictions Program (KHSC MHAP) - Ontario Nurses' Association (ONA) Independent Assessment Committee (IAC) Hearing

**AGENDA DAY ONE**
**Tuesday, October 18, 2022**
**Zoom Meeting**

| Time | Item | Participants |
|---|---|---|
| 0830-0845 | Welcome and Introductions | Ella Ferris IAC Chair/All |
| 0845-0900 | Review of Proceedings by Chairperson | IAC Chair |
| 0900-1100 | Watch Virtual Tour of Kingston Health Sciences Centre Mental Health & Addictions Program | All |
| 1100-1115 | Break | All |
| 1115-1315 | Ontario Nurses' Association Submission Presentation<br><br>ONA Response to clarification questions from:<br>• Independent Assessment Committee<br>• Kingston Health Sciences Centre | IAC, ONA, and KHSC |
| 1315-1415 | Lunch Break | All |
| 1415-1615 | Kingston Health Sciences Centre Submission Presentation<br><br>KHSC Response to clarification questions from:<br>• Independent Assessment Committee<br>• Ontario Nurses' Association | IAC, KHSC, ONA |
| 1615-1630 | Review of Process for Thursday, October 20, 2022 | IAC Chair |

# Kingston Health Sciences Centre Mental Health & Addictions Program (KHSC MHAP) – Ontario Nurses' Association (ONA) Independent Assessment Committee (IAC) Hearing

## AGENDA – DAY TWO
## Thursday, October 20, 2022
## Zoom Meeting

| Time | Item | Participants |
|---|---|---|
| 0830-0835 | Welcome | Ella Ferris IAC Chair |
| 0835-0845 | Review of Proceedings by Chairperson | IAC Chair |
| 0845-1045 | Kingston Health Sciences Centre Response to Ontario Nurses' Association Submission | IAC, KHSC, ONA |
| 1045-1100 | Break | All |
| 1100-1200 | KHSC Response to questions from:<br>• Independent Assessment Committee<br>• Ontario Nurses' Association<br>• Discussion | IAC, KHSC, ONA |
| 1200-1300 | Lunch Break | All |
| 1300-1500 | Ontario Nurses' Association Response to Kingston Health Sciences Submission | IAC, KHSC, ONA |
| 1500-1515 | Break | All |
| 1515-1615 | ONA Response to questions from:<br>• Independent Assessment Committee<br>• Kingston Health Sciences Centre<br>• Discussion | IAC, KHSC, ONA |
| 1615-1630 | Review of Process for Friday October 21, 2022 | IAC Chair |
| 1630 | Adjournment | IAC Chair |

# Kingston Health Sciences Centre Mental Health & Addictions Program (KHSC MHAP) – Ontario Nurses' Association (ONA) Independent Assessment Committee (IAC) Hearing

## REVISED AGENDA DAY THREE
## Friday, October 21, 2022
## Zoom Meeting

| Time | Item | Participants |
|---|---|---|
| 0830-0835 | Welcome and Review of Proceedings | Ella Ferris IAC Chair |
| 0835-0955 | Questions to both Parties by the Independent Assessment Committee | IAC, ONA and KHSC |
| 0955-1010 | Break | |
| 1010-1210 | Opportunity for MHAP Nurses to make comments | MHAP Nurses |
| 1210-1215<br><br>1215-1220<br><br>1220-1230 | Closing Remarks – ONA<br><br>Closing Remarks - KHSC<br><br>Closing Remarks and Identification of Next Steps by Chairperson and Closure of Hearing | Haifaa Khadour<br><br>Jason Hann<br><br>Ella Ferris |
| 1230 | Adjournment | IAC Chair |

Appendix 10

List of Association and Hospital Hearing Participants and Observers
October 18, 20, 21, 2022

**ONA's Attendee List for IAC Hearing October 18, 20, 21, 2022 as per Haifaa Khadour, October 9, 2022**

**ONA Board of Directors:**

- Angela Preocanin, ONA vice President
  - AngelaP@ona.org

**ONA Central Professional Practice Team**

- Haifaa Khadour, Professional Practice Specialist
  - HaifaaK@ona.org
- Benjamin Ramirez Jimenez, Professional Practice Specialist
  - BenjaminRJ@ona.org
- Margarita Klerides, Professional Practice Specialist
  - MargaritaK@ona.org
- Lorrie Daniels, Manager, Professional Services Learning and Development
  - LORRIED@ona.org
- Jackie Kehoe-Donaldson, Manager of Professional Practice Team
  - JackieK@ona.org
- DJ Sanderson, Executive Lead, Provincial Services
  - DJS@ona.org
- Mandy Wilson, ONA Labour Relations Officer
  - MandyW@ona.org

**Members of the Local Bargaining Unit - KGH**

- Annette Saccon, Bargaining Unit President
  - khscbup@onalocal99.org
- Laura-Ashley Detlor, KGH Site Vice President
  - kghsitevp@onalocal99.org
- Ellen Mulville, Chair of Hospital Association Committee
  - khschac@onalocal99.org
- Amy Brook, Registered Nurse on the MHAP
  - ambhudson17@gmail.com
- Jen Cook, Registered Nurse on the MHAP
  - jen.cook95@live.com
- Brittany Tulk, Registered Nurse on the MHAP
  - lamorreb@yahoo.ca
- Elizabeth, Priestley, Registered Nurse on the MHAP
  - lizpriestley3@gmail.com
- Linda Brennan, Registered Nurse on the MHAP
  - lindamrbrennan@hotmail.com
- Lori Sheedy, Registered Nurse on the MHAP
  - cdnnurse1978@gmail.com

Kingston Health Sciences Centre
Centre des sciences de la santé de Kingston

# IAC Attendees- Kingston Health Sciences Centre

| Name | Title | Email |
|---|---|---|
| Taris Lamont | Administrative Assistant, People Services | Taris.Lamont@kingstonhsc.ca |
| Joanna Noonan | Director, Occupational Health, Safety & Wellness | Joanna.Noonan@kingstonhsc.ca |
| Indira Naraine | Director, People Services | Indira.Naraine@KingstonHSC.ca |
| David Mutch | Manager, Employee & Labour Relations | david.mutch@kingstonhsc.ca |
| Nicholas Axas | Program Operational Director, Mental Health & Addiction Care | Nicholas.Axas@kingstonhsc.ca |
| Lucas Mott | Program Manager, Inpatient Mental Health & Addiction Care Program, KGH | Lucas.Mott@kingstonhsc.ca |
| Jennifer Achim | Director, Professional Practice | Jennifer.Achim@KingstonHSC.ca |
| Thomas Hart | Executive Director, Patient Care and Deputy Chief Nurse Executive | Thomas.Hart@kingstonhsc.ca |
| Jason Hann | Executive Vice President, Patient Care and Chief Nursing Executive | jason.hann@KingstonHSC.ca |
| Brenda Carter | Executive Vice President Quality, Partnerships and RVP Cancer Care | Brenda.Carter@kingstonhsc.ca |
| Tyler Hands | Program Operational Director, Patient Care – Medicine Program | Tyler.Hands@kingstonhsc.ca |
| Carol McIntosh | Director, Emergency Services | Carol.mcintosh@kingstonhsc.ca |
| Kathryn Meehan | KHSC Legal Counsel – Hicks Morley | Kathryn-Meehan@hicksmorley.com |