Independent Assessment Committee Report

Constituted under Article 8.01 of the

Collective Agreement

Between

Connell 10
Kingston Health Sciences Centre

and

Ontario Nurses' Association

January 17, 2024

Haifaa Khadour
Professional Practice Specialist
Ontario Nurses Association
HaifaaK@ona.org

Jason Hann
Executive Vice President Patient Care & Chief Nurse Executive
Kingston Health Sciences Centre
jason.hann@KingstonHSC.ca

January 17, 2024

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 the Kingston Health Sciences Centre 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 General Medicine Program, Connell 10 at Kingston Health Sciences Centre.

The members of the Independent Assessment Committee recognize and appreciate the efforts taken by representatives of KHSC, 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 November 20, 22, and 23, 2023.

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 Report includes a number of unanimously submitted recommendations which we hope will assist all parties to mutually agreeable resolutions with regards to nursing workload issues on Connell 10 at Kingston Health Sciences Centre.

Respectfully Submitted,

Claire Mallette, RN PhD
Chair

Cindy Gabrielli, RN (EC) MSN
Nominee for the Ontario Nurses Association

Debra A. Bournes, RN, PhD
Nominee for the Hospital

TABLE OF CONTENTS

APPENDICES:

FIGURES:

TABLES:

PART 1: INTRODUCTION

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

PART 1: INTRODUCTION

Part 1 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 Responsibility Workload Complaint on Connell 10 at Kingston Health Sciences Centre (KHSC); and summarizes the relevant history leading to the referral of the Professional Responsibility Workload Complaint to the IAC.

PART 3: DISCUSSION, ANALYSIS AND RECOMMENDATIONS

In this section, the Committee's findings and recommendations regarding the Professional Workload Complaint will be discussed with supporting evidence.

PART 4: CONCLUSION AND SUMMARY OF RECOMMENDATIONS

The conclusions and summary of the recommendations are included in this section.

PART 5: APPENDICES

Supporting data, including the submissions and exhibits of both parties are on file with both ONA and KHSC.

1.2 Referral to the Independent Assessment Committee

On April 3, 2023, Haifaa Khadour, an Ontario Nurses Association (ONA) Professional Practice Specialist submitted a letter (Appendix A) to Jason Hann, the Chief Nursing Executive (CNE) at KHSC outlining the professional responsibility and workload issues on Connell 10 and advising that these concerns were being forwarded to an Independent Assessment Committee (IAC) for resolution. In the Referral of Professional Practice and Workload Issues at KHSC-Connell 10 to an Independent Committee letter, ONA

highlighted that since 2018, there have been over 340 Professional Responsibility Workload Report Forms (PRWRFs) being submitted with concerns occurring in the following areas:

1. Chronic understaffing and challenges with retention and recruitment strategies;
2. Large turnover of staff;
3. Unsafe nurse to patient ratios due to KHSC's model of care;
4. Missed and delayed care;
5. Charge Nurse's inability to perform required duties;
6. Inadequate training and support for staff; and
7. Ineffective communication and lack of leadership.

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 as stated below:

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 issues 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(s) at the time of occurrence or if the issue(s) is ongoing the nurse(s) will discuss the issue with their manager (or designate) on the next day that the manager (or designate) and the nurse are both working or within ten (10) calendar days whichever is sooner.

When meeting with the manager, the nurse(s) is/are entitled to be represented by a Union representative if requested by the nurse(s) 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) is/are entitled to be represented by a Union representative if requested by the nurse(s) 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.

Hospital Central Agreement – March 31, 2025

Article 8.01 (xiii) states, ‘The Assessment Committee shall render its decision, in writing to the parties within forty-five (45) calendar days following completion of its hearing’. However, as the IAC hearing was conducted from November 20 to November 23, 2023, the 45 days following completion of the hearing, occurred during the holiday season. The IAC requested that the report submission date be extended until January 18, 2024, and both parties agreed (Appendix B).

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 the Arbitration between Brantford General Hospital and the Ontario Nurses Association (1986), 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*.

The IACs' jurisdiction ceases with submission of its written Report. The IACs' findings and recommendations are intended to provide an independent external perspective to assist the Registered Nurses, ONA and KHSC to achieve mutually satisfactory resolutions. 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 were:

For the Ontario Nurses Association:
Cindy Gabrielli

For Kingston Health Science Centre:
Debra A. Bournes

Chairperson:
Claire Mallette

1.4 Proceedings of the Independent Assessment Committee

1.4.1 Pre-Hearing

On April 3, 2023, KHSC received a letter from ONA stating that a Referral of Professional Practice and Workload Issues at KHSC Connell 10 was made to an Independent Assessment Committee (Appendix A). On April 13, 2023, ONA confirmed the IAC Chair as Dr. Claire Mallette, identified Cindy Gabrielli as the IAC ONA Representative, and that Mr. David McCoy, Director Labour Relations at ONA had been notified (Appendix C). KHSC confirmed that Dr. Debra Bournes would be the IAC Hospital Representative on May 2, 2023 (Appendix D). The IAC dates for the hearing were decided upon by email in the week of May 15th with November 20, 22, and 23, 2023 being agreed upon by all parties for the IAC Hearing.

On July 17, 2021, the IAC members met by Zoom and discussed the following:

- Introductions;
- Overview of the IAC process and timeframes;
- Discussion of the type of information required in the briefing documents. Specific information was requested in KHSC's briefing documents. Examples of the type of information requested were:
    - staffing model pre and post-pandemic including nurse-patient ratios, budgeted numbers of FTE, PTE, and Casual RNs and RPNs, RN and RPN years of experience, vacancies, and supports ad education of staff;
    - agency use;
    - overtime and sick time;
    - unit occupancy rate;
    - frequency of nurses being floated;
    - leadership team;
    - safety issues;
    - retention strategies;
    - onboarding strategies; and
    - patient outcomes

An email was sent to both ONA and KHSC parties on July 31, 2023 with an attached document outlining next steps and information needed in preparation for the IAC hearing (Appendix E). A request was also made by the IAC to receive the documents on October 23, 2023 to provide the IAC adequate time to review the submissions. Subsequently, ONA identified the precedent of submitting the briefing documents three weeks in advance, which changed the date of submission of the brief to Monday October 30, 2023.

The IAC received an email from ONA's Professional Practice Specialist, Haifaa Khadour, on August 8, 2023, with 5 attachments including a Tracker of 300 workload forms, an Action Plan, Minutes of Settlement, Items of Agreement, and the Notice of Advancement to IAC, to assist the panel in developing well-informed recommendations. The IAC met to discuss these submissions and made the decision to not open or read the attachments. An email was sent to Ms. Khadour saying that the IAC would not review any documents from either party prior to receiving the briefing documents on October 30, 2023 and asked that ONA's submissions be as complete as possible in identifying the issues with evidence (Appendix F).

On September 19, 2023, First Class Conferencing Facilitation was confirmed to coordinate the virtual technology during the IAC Hearing. Segan Permell, a web conference technician, was assigned to facilitate the technology for the IAC. She sent an email (Appendix G) on November 16, 2023, stating that she read and understood the conditions outlined in the confidentiality statement and agreed to all terms and conditions requested by KHSC and the IAC (Appendix H).

On October 30, 2023, both ONA and KHSC submitted their documents. There were no requests made by either party to submit supplementary documents.

The virtual tour recording of Connell 10 was done on November 8, 2023.

On November 9 and 15, 2023, the IAC reviewed the information from the submitted documents via Zoom and prepared for the IAC Hearing. An email was sent to the KHSC CNE for additional documents on November 13, 2023 (Appendix I).

On November 15, 2023, the IAC Chair received an email from Tyler Hands, Program Operational Director, Patient Care Medicine Program & Neurosciences stating that the KHSC Privacy Office at KHSC required that all non-KHSC viewers of the Connell 10 video, were required to provide a verbal disclosure for confidentiality prior to viewing the video on the first day of the Hearing. The form was shared with all non-KHSC participants prior to the Hearing (Appendix H).

On November 15, 2023, both ONA and KHSC were sent the Final Agenda for the 3 days (Appendix J), the Attendee Lists (Appendix K & L) and the KHSC Confidentiality Statement (Appendix H).

1.4.2 Hearing

The Hearing was held virtually via Zoom and was facilitated by a third party (First Class Conferencing Facilitation). Attendance was taken each day (Appendix M). The Hearing was held over 3 days.

Monday November 20, 2023 08:30-16:00

Wednesday November 22, 2023 08:30-15:00

Thursday November 23, 2023 08:30-13:15

Hearing Day One: Monday November 20, 2023

The Chair opened the Hearing at 8:30 and thanked everyone for being present and for their commitment to the IAC process over the Hearing dates. Introductions then occurred with the Chair Inviting the IAC members to introduce themselves. When the ONA and IAC members introduced themselves, they also provided a verbal disclosure for confidentiality.

Following the introductions, the Chair reviewed the purpose of the IAC, and IAC Guidelines. The Chair highlighted the IAC's commitment to ensure voices are heard and to facilitate the process with the overarching principle that the IAC is a:

> *Collaborative process where the two parties come together to discuss the issues and collectively identify ways to move forward in providing quality patient care in a safe and healthy work environment and the IAC's commitment was to ensure voices are heard and to facilitate the process.*

The Chair also acknowledged as quoted by Mallette (2016) that, the IAC is responsible for examining factors impacting workload, and for making recommendations to address workload issues. Concerns identified outside of workload were recognized by the Committee as being beyond the jurisdiction of the IAC. However, issues related to workload are complex and are beyond staffing.

The IAC Guidelines which were then reviewed are listed below:

1. Adhere to the agenda and timeframes for presentations.

2. Opportunity will be given to ask questions for clarity at the end of each presentation. If you have a question, indicate this to the chairperson.

3. Speak from your own perspective and experience.

4. Do not raise issues related to individuals; the panel is not convened to address any concerns regarding individual performance.

5. The proceedings of the Hearing are confidential and not to be discussed outside of the Hearing except for the purpose of preparing for the IAC meeting.

6. The briefs, presentations, discussion and any distributed documents in this Hearing are not to be shared with other parties.

7. Observers cannot participate in the Hearing and are asked to enter or leave at the beginning or ending of a session. A list of expected observers must be provided to the Chair prior to the Hearing each day if it will change.

8. Maintain a professional demeanor at all times during the Hearing.

The virtual video tour of Connell 10 coordinated by KHSC was then viewed. Tyler Hands, the Director Medicine & Neurosciences, was introduced at the beginning of the tour and then the tour was led by Alyson Lazier (Charge Nurse) and Colton Halligan (Connell 10 Program Manager). Following viewing the video, the IAC asked clarification questions such as about where the Charge Nurse works, the medication room and the medication delivery process, documentation process, supplies and equipment, hallway patients, and telemetry.

After a short break, Haifaa Khadour, ONA Professional Practice Specialist, presented on behalf of ONA. ONA's presentation was based on their written pre-Hearing submission and began with giving an overview of Connell 10 and the patient profile. The issues of work environment were then presented that included staffing and ratios; model of care; Charge Nurse model; workplace violence and ancillary support; and retention and recruitment. The presentation ended with an overview of the nursing recommendations being submitted. Following the presentation, ONA responded to clarification questions from the IAC Panel and KHSC members.

After a break for lunch, the KHSC's presentation was shared by Jason Hann (Executive Vice President Patient Care and Chief Nurse Executive), Thomas Hart (Executive Director Patient care and Deputy CNE), Tyler Hands (Director Medicine & Neurosciences), and Colton Halligan (Program Manager, Connell 10). The presentation first described Connell 10, patient demographics, acuity and complexity and then provided a focus on the issues outlined in the referral to the IAC related to workplace safety, recruitment and retention, communication, and leadership, and PRWRF Forms and actions taken. After the presentation, the IAC and ONA representatives asked follow-up questions.

Prior to adjourning the meeting, the Chair reviewed the process for the next day. The Chair also requested both parties to share their presentations with the IAC and each other. The Hearing ended at 16:00 hrs. Following adjournment, the IAC met to review and synthesize the information provided, and to identify key issues requiring clarification and discussion on the remaining two days of the Hearing.

Hearing Day Two: Wednesday November 22, 2023

Day 2 of the hearing occurred on Wednesday, instead of Tuesday, to allow both parties to prepare for their response to the presentations and questions on Monday. The Chair opened the Hearing at 08:30 welcoming everyone back. The Chair then provided a review of the previous day and an overview of the agenda for Day Two. All participants were the same as the previous day except Jennifer Kasaboski, KHSC Clinical Learning Specialist, did not attend Day 2 and 3 of the Hearing, while Joanna Noona, KHSC Director of Occupational Health, Safety & Wellness attended both Day 2 and 3. The ONA attendees remained the same for both Day 2 and 3.

Members of the KHSC leadership team provided their response first to ONA's submission on Day 1. They reaffirmed the position of KHSC and provided more data and information in the areas of patient acuity and complexity, staffing plan and nurse-to-patient ratios, safer nursing care tool, supportive roles, environmental services, Charge Nurse model, workplace safety, recruitment and retention, PRWRF submissions, Operations Manager decision making/reassignment, staff engagement and education uptake, and Lumeo-Cerner Future. Following the KHSC's response, discussion ensued with questions being asked by ONA and IAC members. After a short break, Ms. Khadour from ONA responded to KHSC's submission, highlighting the employer's perception vs. the nursing reality on Connell 10 in the areas of retention and recruitment, the new documentation system and how it needs to be implemented in an effective manner, safety issues, staffing, safer nursing care tool, Charge Nurse program, load levelling, support staff, and communication. Following the presentation, questions by the IAC and KHSC representatives were asked after a lunch break. The Chair reviewed Day Three's agenda at the end of the day, and the meeting was adjourned at 15:00.

The IAC met after the Hearing to review and synthesize the information presented during the past two days to identify key areas requiring clarification and related questions to ask both the ONA and KHSC's participants on the final day of the Hearing.

Hearing Day Three: Thursday November 23, 2023

The Chair opened the final day of the Hearing at 08:30 welcoming the attendees and reviewing the day's proceedings. The participants remained the same as Day 2. The agenda was reviewed, and then the IAC panel members asked further questions to understand a range of issues such as

nurse mentorship, supports for novice nurses, the RN-Patient Care Assistant (PCA) relationship, safety huddles, and communication. The IAC listened to responses from both parties.

After the break the Chair invited registered nurses from Connell 10 to share their personal experiences and give voice to their concerns. Following the presentation the Chair thanked the nurses for their courage and for providing a very valuable and important perspective to the IAC Hearing.

Ms. Khadour and Mr. Hann then provided closing remarks on behalf of ONA and KHSC respectively.

The Chair concluded the Hearing by thanking the IAC panel members Cindy Gabrielli, ONA's nominee and KHSC's nominee, Debra Bournes, as well as thanking all the participants for their commitment to the Hearing process and their active and open discussions during the proceedings. The IAC Chair communicated the hope that the opportunity for open and transparent discussions during the Hearing and the recommendations in the IAC Report will enable both parties to move forward collaboratively to seek resolution of the outstanding issues.

The Chair closed the Hearing at 13:15.

The IAC met after the Hearing to review and synthesize the information presented during the past three days to identify key areas for IAC recommendations.

1.4.3 Post-Hearing

The IAC panel members met via Zoom in preparing the Final Report on December 3, 14, January 8, 11, 14, and through emails. All members of the IAC contributed to the final version of the report. The Final report was submitted to ONA and KHSC on January 17, 2024.

PART 2: PRESENTATION OF THE PROFESSIONAL RESPONSIBILITY and WORKLOAD COMPLAINT

2.1 Information on Kingston Health Sciences Centre (KHSC)

KHSC is southeastern Ontario's largest acute-care academic hospital with a catchment area that extends beyond Kingston to encompass the broader Eastern Ontario region. KHSC consists of Hotel Dieu Hospital site, Kingston General Hospital (KGH) site, the Cancer Centre of Southeastern Ontario, community programs, and a research institute. KHSC provides health care for more than 500,000 patients and families from across the region. It is the regional tertiary care

centre and plays an important role in the community and across the southeastern region including its role to support secondary and tertiary care. KHSC employs almost 6,000 staff, supports the learning of more than 2,000 health care provider students, and numerous volunteers, who together support patients and families to ensure high quality, compassionate care is provided. The Kingston General Hospital site has approximately 500 beds and provides health care to people with cardiac, stroke, renal, trauma, neurosurgery, pediatrics, neonatal, high-risk obstetrics, acute in-patient mental health and cancer health care needs.

2.2 General Medicine Program on Connell 10

The Medicine Program units at KHSC, includes over 200 inpatient beds at the KGH site. Connell 10 is one of them, with a population that consists of anyone 18 years of age and older, who requires general internal medicine care, or medical care in partnership with respirology, cardiology, nephrology, endocrinology, hematology, and gastroenterology. The 5 most frequent diagnoses of people receiving care on Connell 10 are chronic obstructive pulmonary disease exacerbations (COPDE), pneumonia, acute renal failure, congestive heart failure, and urinary tract infections. Other types of diagnoses of people receiving care on Connell 10 are people requiring, for example, telemetry in stable populations, peritoneal dialysis, receiving MAID, acute kidney injury, pre/post renal transplant, requiring paracentesis during admission, patients requiring radioactive iodine therapy for thyroid cancer or hyperthyroidism, cirrhosis of the liver, and palliative care.

Connell 10 is a 38 bed unit distributed across 20 rooms (Appendix N). There are 9 single rooms, 6 double bed rooms, 3 ward rooms with three beds each, and 2 ward rooms with 4 beds each. Any room on this unit can transition into being an isolation room, with 2 being equipped to be negative pressure rooms for patients requiring airborne isolation. There are also 2 rooms that are equipped with lead-lined materials to accommodate radioactive iodine patients. Connell 10 has spaces designated for 2 hallway beds according to KHSC's overcapacity protocol.

History of Nurse Staffing and the Model of Care on Connell 10

The nurses on Connell 10 have historically used a total patient care model with assistance from a small number of patient care assistants (PCAs) when available. In 2018, in response to workload and patient care concerns brought forward by the staff and ONA, additional nursing care hours/FTEs were added to the budget on Connell 10, which in turn improved the nurse-to-patient ratios. The staff mix and scheduling model in place on Connell 10 from 2018 to March 2022 was comprised of mostly RNs, a small number of RPNs (ranging from 22% to 25% of planned nurses per shift), and a range of one to three unregulated patient care assistants (PCAs) depending on the shift.

Based on the number of nurses planned to be available for 38 beds, the targeted nurse to patient ratios and the planned staffing mix are outlined in Tables 1 to 3. The plan outlined in Tables 1 to 3 is also the *baseline target* that the hospital shared it has been trying to achieve. Since 2022 however, the severe shortfall of nurses (vacancies and/or unfilled leaves of absence) on Connell 10 has prevented the use of the *baseline* targeted ratios and staff mix.

Table 1.
Planned Nurse-to-Patient Ratios on Connell 10 (2018- March 2022)

Time Period	Monday to Friday	Saturday and Sunday
0700-1500	1: 3.8	1: 4.2
1500-1900	1: 3.8	1: 4.2
1900-2300	1:3.8	1: 3.8
2300-0700	1: 5.4	1: 5.4

Table 2.
Staff Mix Planned to Achieve Target Nurse to Patient Ratios Per Shift: Monday to Friday

Shift	RNs	RPNs	Total Registered Nursing Staff	PCAs
0700-1500	9*	2	11	3
1500-1900	9*	2	11	2
1900-2300	8	2	10	2
2300-0700	6	1	7	1

* = includes Charge Nurse

Table 3.
Staff Mix Planned to Achieve Target Nurse to Patient Ratios Per Shift: Saturday and Sunday

Shift	RNs	RPNs	Total Registered Nursing Staff	PCAs
0700-1500	8*	2	10	2
1500-1900	8*	2	10	2
1900-2300	8	2	10	2
2300-0700	6	1	7	1

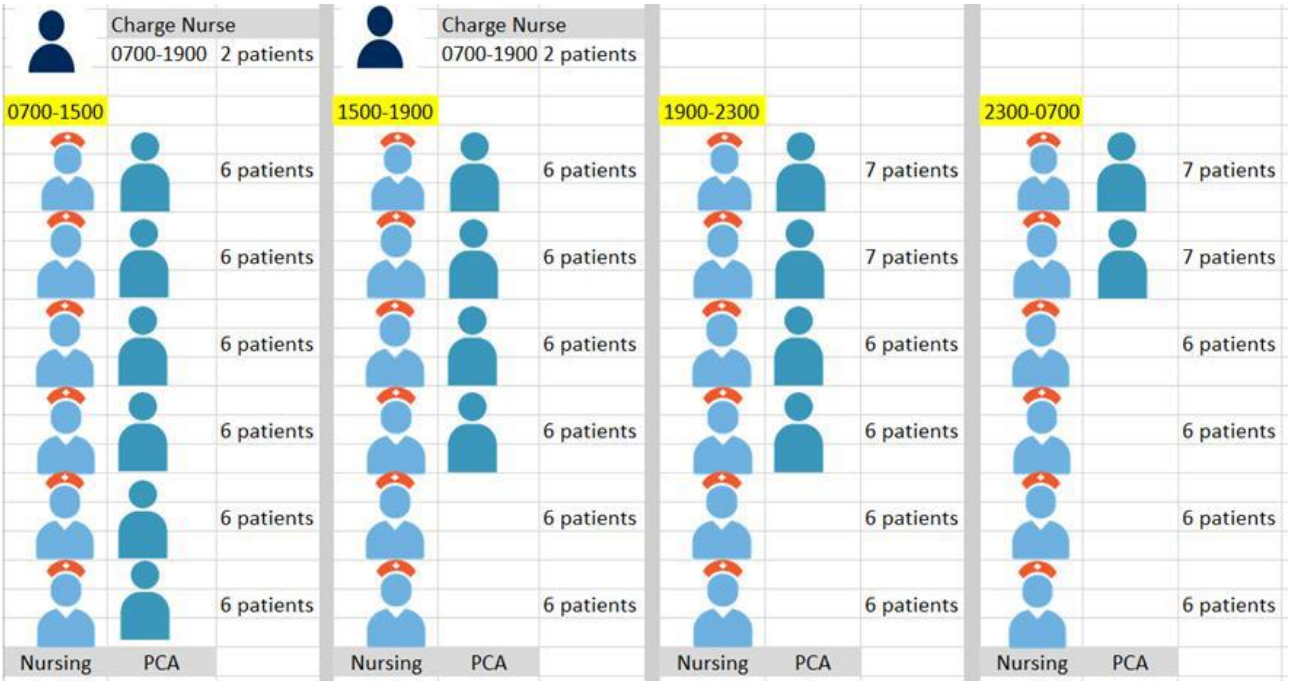
* = includes Charge Nurse

Interim Nurse Staffing Plan and Model of Care (March 2022 – Present)

An Interim Nurse Staffing Plan and staff mix configuration (Figure 1) was implemented on Connell 10 in March 2022. It was developed in collaboration with ONA, Charge Nurses, Professional Practice, and People Services in response to a significantly increased shortfall of nurses on Connell 10 that made the baseline nurse-to-patient ratios and staff mix impossible to achieve.

In this interim plan (Figure 1), the intended nurse to patient ratio ranges from 1:6 to 1:7. The nurses, using the total patient care model, work in collaboration with patient care assistants (PCAs) to meet the care needs of their patient assignment. The hospital has increased the scope and abilities of the PCAs to enable them to do more direct patient care activities that are helpful to the nurses. When there is a full complement of staff available (according to the interim plan), the nurses and PCAs are paired for the duration of the shift during the day (0700-1500).

Figure 1. Interim Nurse Staffing Plan on Connell 10 (from KHSC brief p. 23)



There is still a significant shortfall of nurses on Connell 10. It peaked in the summer of 2022 when 36 out of 43 RN (83.7%) permanent full time and permanent part-time positions were either permanently or temporarily (unfilled leaves of absence) vacant. In October 2023, the shortfall of RNs had improved to 39.5% (17 out of 43 RN positions) and there was also a 42.9%

shortfall of RPNs on Connell 10 (6 out of 14 RPN positions are either permanently or temporarily vacant).

In the briefing materials submitted to the IAC, it was noted that with the persisting shortfall of nurses across KHSC, the interim model is not always achievable. Some days the nurse-to-patient ratios are higher than intended and nursing workload is at a difficult level.

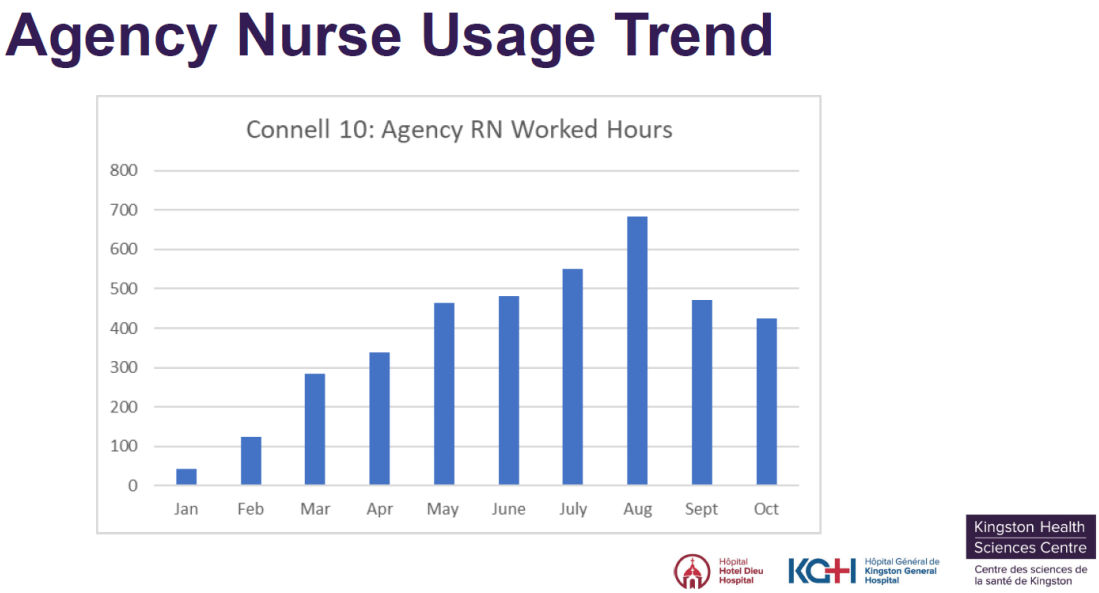
In order to mitigate this to the greatest extent possible, the hospital has:

1) Introduced a "load levelling" reassignment process across KHSC to ensure patients have equitable access to nursing care. In this process, patient needs (occupancy, acuity, complexity) and team knowledge and scope are considered when making decisions to move nurses from one unit to another to balance resources (e.g. workload, optimal use of available staff, and ability to support planned and unplanned time off). Load levelling will be discussed in further detail in 3.1.3 Load Levelling section.

2) Introduced recruitment incentives (described in section on recruitment and retention) to attract new nurses into permanent positions.

3) Contracted, carefully selected, and oriented agency nurses to help bridge the gap across the organization and allow KHSC nurses to take some vacation during the summer months. The number of hours worked by nurses from the agency steadily increased on Connell 10 from January to August 2023. As noted in Figure 2, the number of agency nurse hours on Connell 10 began to decline in September and October 2023. The hospital indicated to the IAC that its goal is to gradually reduce use of agency nurses as more nurses are recruited and retained.

Figure 2: Agency Nurse Usage Trend



4) Implemented or strengthened programs with other professional staff to support nursing workload and patient care on Connell 10 and throughout the hospital including:

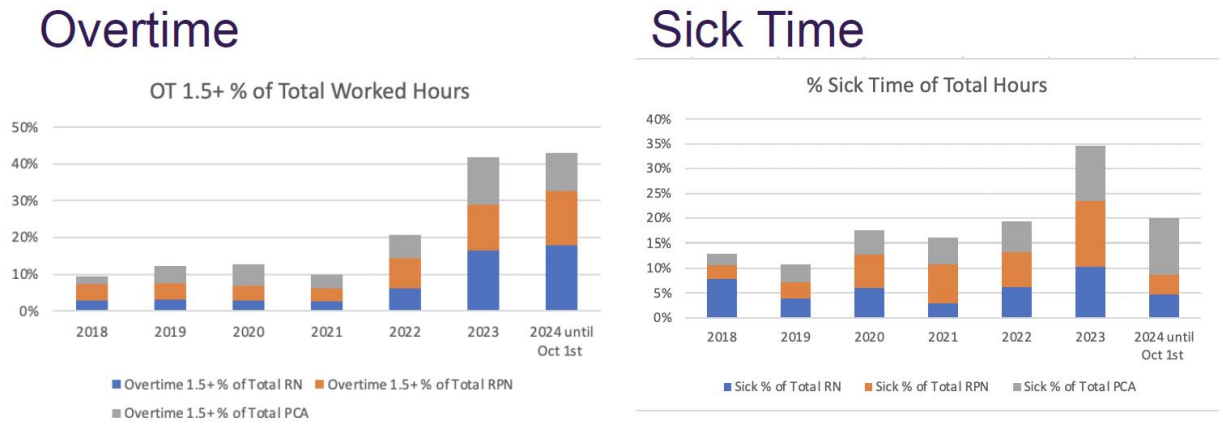
    a. Manager dedicated solely to Connell 10.
    b. Clinical Learning Specialist (educator) dedicated to the unit
    c. Mobility Team that supports patients with ambulation and other activities (average of 8 patients/3 times a day/unit)
    d. Hospital Elder Life Program with a dedicated Program Manager and PCAs to reduce the rate of conversion to ALC through purposeful mobilization and assistance with activities of daily living
    e. Patient Observation Manager that helps develop care plans and mobilize resources
    f. Multidisciplinary team to support care – including Healthcare Aides and expanded role Clinical Externs (nursing students in summer months).
    g. Team of navigators who oversee discharge planning.
    h. Corporate Support Teams for Professional Practice Leadership with Clinical Resources, Occupational Health and Wellness, Protection Services, People Services Centre, and others.
    i. Clinical Nurse Scholar Program that includes 4 temporary full-time nurses to support novice nurses with skill development and practice changes (available to contact for help all shifts)
    j. Medicine Focused Nurse Practitioner team focused on asthma, COPD, ALC designation, and neurosurgery
    k. Diabetic consult team (RN & NP)

The Interim Nurse Staffing Plan and Model of Care is currently mitigating the gap created by the unprecedented shortfall of nurses on Connell 10 with mixed results for nurses and patients. Staff engagement scores from a hospital survey in April 2023 on Connell 10 (n= 9, 17%) have improved dramatically since last measured in 2021. Scores related to their work environment, empowerment, career advancement, coworker relationships, inclusion, culture, and manager relationships made the most significant improvements, while patient focus, work life balance, department collaboration and senior leadership scores went up, but there is still room for improvement.

The results of a staff survey conducted by ONA in Fall 2023 (n=14, 27%), demonstrate that there is still work to be done to recover from the effects of the nursing shortage post pandemic, and to address unit workload challenges that have been noted for multiple years. Nurses who responded to ONA's survey described having to rush their care and wanting more time to complete assessments and documentation thoroughly. They also described the need for time to provide

emotional support to patients, and worrying about missing something, letting patients down, being sued, or upsetting patients. Some respondents also said staff are burned out and indicated that they need more resources (staff, clerks, support for novice nurses, and others) and more information about supports available to them. Since the mitigation plan partially relies on and provides incentives for RNs to work overtime, the rate of overtime worked by nurses has spiked (though to some degree it is related to all RNs being paid OT when they are reassigned to another unit, and to part-time RNs being paid overtime to work additional hours once they have reached 60 hours in a pay period). The rate of sick time also spiked in 2022-2023, but it has decreased substantially in 2023-2024 year to date (Figure 3).

Figure 3. RN, RPN & PCA Overtime & Sick Time Hours as a % of Total Worked Hours



For patients, the interim model has ensured continued access to care on Connell 10. Thirty-eight beds continue to be operational. The occupancy rate from April 2022-April 2023 was 94% and, based on data shared by the hospital, it was 91.4% for 2023-2024 up until September year to date. The addition of agency nursing hours, the progress made up until October 2023 in reducing the shortfall of RNs on Connell 10, and the addition of a higher number of PCAs into the care model has ensured that the hours of care per patient day (HPPD) provided by this team has been above the budgeted HPPD for almost a year, albeit with fewer HPPD being provided by RNs.

Nevertheless, there is evidence that quality of care on Connell 10 has been maintained and/or has continued to improve since the introduction of both the Interim Nurse Staffing Plan and Model of Care and the additional supports for staff and patient care. In its submissions, KHSC provided data that demonstrated reductions in patient falls (42% reduction in first 6 months), delirium acquired in hospital, medication safety incidents, hospital acquired pressure injuries, and overall code calls (codes White, Blue, 99, and Race). Of note, significant reductions in Code White calls

have been maintained since 2019. Patient complaints have also begun trending down since they rose in early 2022-23 and peaked in January-March 2023. Similarly, there was an increase in Catheter Associated Urinary Tract Infections in 2022 (0.8%), but the incidence has lowered again (0.6%) in 2023 year to date. The hospital also reported results of a random audit of physical restraint use in 150 patient charts in 2023. They reported that only two had documented physical restraint use.

2.3 Professional Responsibility Workload (PRW) Complaint Process and Meetings between the Association and Hospital Prior to the IAC

Article 8:01 of the ONA Collective Agreement (2023) provides a process for both the nurses of the bargaining unit and the administration of the hospital to address workload issues. The PRWRF is a documentation tool to identify and report workload and practice issues, and to demonstrate ongoing trends and barriers to the provision of safe, competent, and ethical care and any contributing workplace issues. The PRW process was developed to enable collaboration between the nurse and the employer 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 the concerns in a timely and effective manner.

Documenting these types of issues in writing, enables KHSC and ONA to come together to mutually resolve issues in the best interest of safe and ethical patient care. When resolution does not occur, the issues are brought to the Hospital-Association Committee (HAC).
The HAC is where the Hospital and Association come together to work through the issues and attempt to resolve them.

Since 2018, 378 PRWRFs have been submitted by nurses related to patient care and acuity, fluctuating workloads and staffing, and professional practice challenges influencing nurse's ability to provide safe, quality and ethical care. ONA identified chronic lack of staff on Connell 10 as a primary concern. However, with the introduction of the Interim Nurse Staffing Plan and Model of Care in 2022, and the decrease of PWRFs following the spike in numbers when the model was first implemented in summer 2022, indicates that the delivery of nursing care appears to be improving. In 2022, there were a total of 141 PRWRFs submitted and in 2023, up until November 15, 29 PRWRFs have been submitted (Figures 4 & 5). The top reported areas were related to staffing shortages, acuity, exceptional patient factors, medication delays, lack of equipment, and orientation (Figure 6). Figure 7 demonstrates the decrease in PRWRFs in 2022 & 2023 on the day and night shifts.

Figure 4: Number of PRWRFs submitted January 2020-Jul 2023

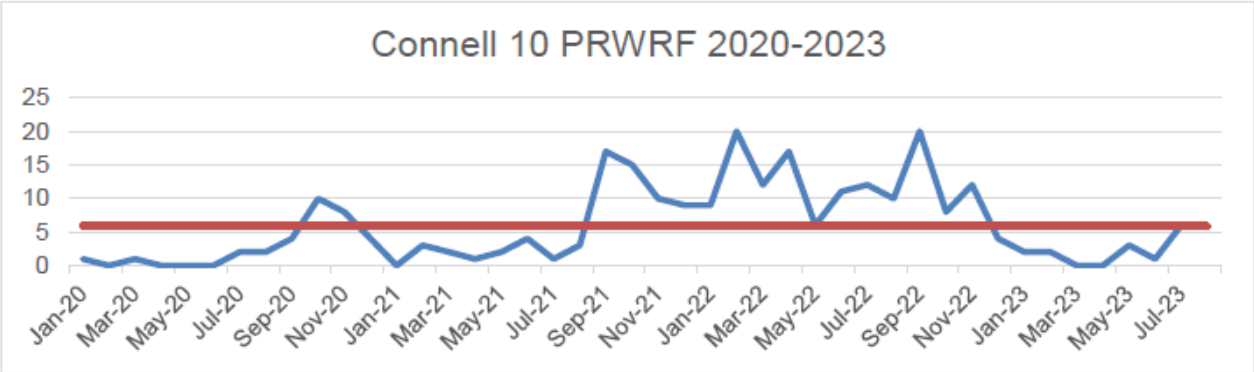


Figure 5: Number of PRWRFs submitted January to October 2023

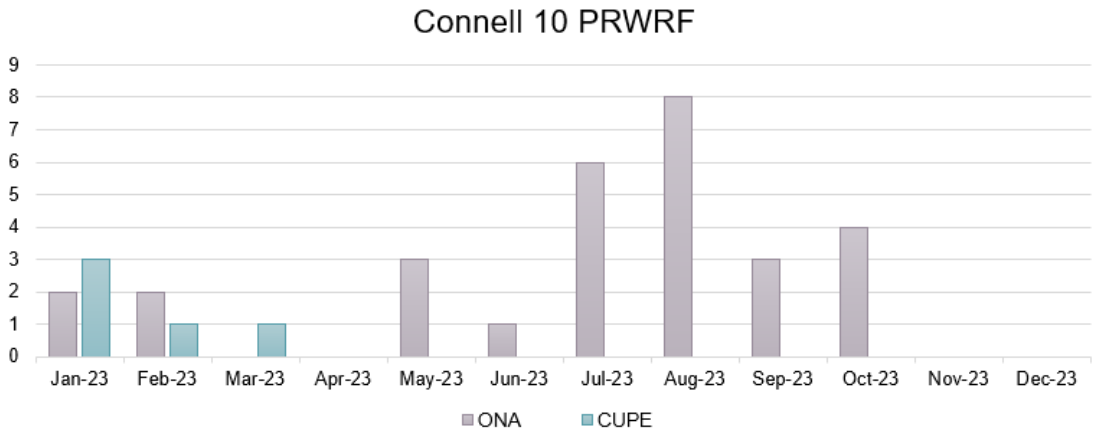


Figure 6: 2022-23 PRWRFs Top Reported Themes

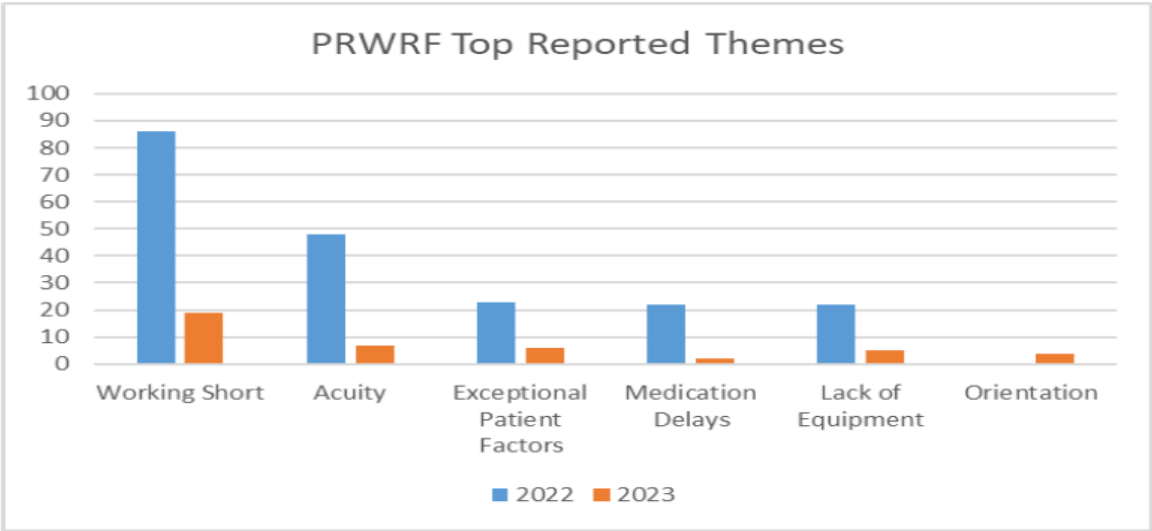
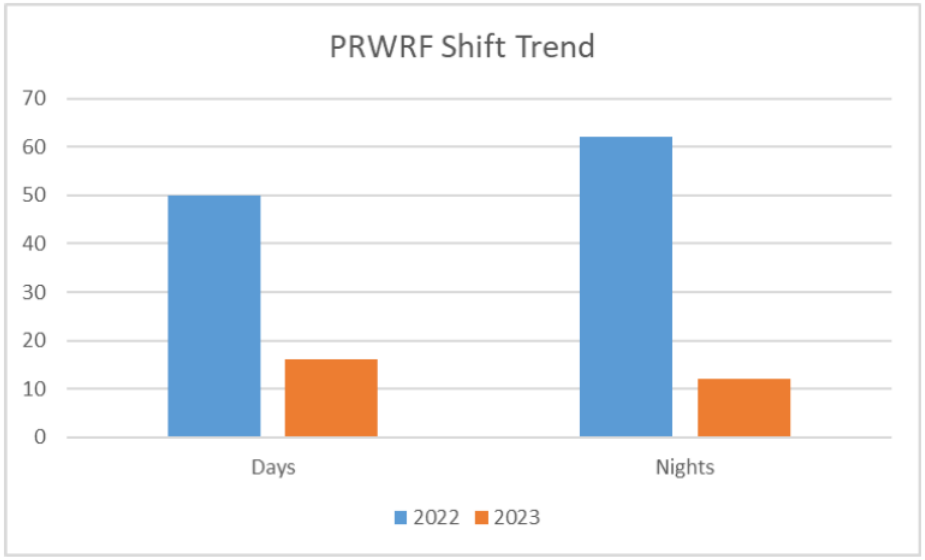


Figure 7: 2022-23 PRWRF Shift Trends



PART 3: DISCUSSION, ANALYSIS AND RECOMMENDATIONS

Based on all the evidence provided through the virtual site tour, submissions and presentations, the IAC will address the following issues and make recommendations:

1) Staffing
    1.1 Ratios
    1.2 Charge Nurse
    1.3 Load Leveling
    1.4 Safer Nursing Care Tool
2) Recruitment & Retention
3) Communication
    3.1 Operations Manager Communication Process
4) Leadership
    4.1 Leadership at the Point of Care
    4.2 Unit Based Councils
    4.3 Charge Nurse Leadership Development
    4.3 Program Manager
    4.4 Senior Leadership Team
5) Professional Development
6) Risk Reduction and Workplace Violence
7) Professional Responsibility and Workload Reporting Form (PRWRF) Process
8) Equipment
9) Non-nursing Tasks

1.0 Staffing

1.1 Ratios

For at least two decades there have been research studies (for example, Aiken, et al., 2002; Carthon, et al., 2021; Dierkes, et al., 2022; Lasater, et al. 2021; McHugh, et al., 2021) and stakeholder consensus reports (for example, Ahmed & Bourgeault, 2022; Tomblin-Murphy, et al., 2022) that have investigated and made recommendations to address the effect of varying nurse staffing levels on outcomes of patient care and employers' ability to maintain a stable nursing workforce. Since Aiken et al. (2002) first reported their research findings (which demonstrated that hospitals with higher nurse to patient ratios had a greater risk of patient mortality, failure to rescue, nurse burnout, and nurse job dissatisfaction), researchers have continued to build a substantial body of evidence on the positive effects on patient outcomes (e.g. 30-day mortality rate, length of stay, failure to rescue rate, 7-day readmission rate) when nurses have a reasonable number of patients in their care. One study specifically found that if participating hospitals had staffed at a 1:4 nurse to patient ratio during the one-year period studied, deaths would have been substantially reduced, and there would have been a cost savings to the organizations (Lasater et al., 2021). There is similarly strong evidence that when staffing levels improve, nurses experience less burnout and job dissatisfaction, and hospitals are better able to maintain a stable nursing workforce (Dierkes et al., 2022; McHugh et al., 2021; Spetz, Chu, & Blash, 2022).

In the United States, California led the way in 1999 by passing a law that mandated the nation's first nurse to patient staffing ratio. They implemented the minimum nurse to patient ratios in 2004. Queensland, Australia is another jurisdiction where this has happened on a large scale. In both cases, there have been extensive evaluations of the effect of the minimum baseline nurse to patient ratios.

In 2016, Queensland's government legislated the minimum number (baseline) of nursing staff that a hospital must provide on a prescribed ward during a morning (1 nurse: 4 patients), afternoon (1 nurse: 4 patients), and night (1 nurse: 7 patients) shift. Individual nurse assignments are allowed to vary within the total prescribed number of nurses available (Queensland Health, 2023). In order to evaluate the effectiveness of their policy mandate, it was initially only implemented on medical-surgical wards in 27 hospitals, leaving 28 other hospitals available for comparison (McHugh et al., 2021). McHugh et al. (2021) conducted a quasi-experimental study to assess the effects of the policy on staffing levels and patient outcomes and whether both were related. They found that in contrast to the comparator hospitals at the hospitals with the nurse-to-patient ratio mandate: nurse staffing improved more significantly, there were greater patient outcome improvements, the positive changes in staffing (toward 1:4 ratio) on the medical-surgical wards (where it was mandated) accounted for a significant share of the improved

outcomes, and cost estimates suggested that the policy resulted in significant cost savings (McHugh et al., 2021).

In California, evaluations have resulted in similar conclusions (Aiken, et al., 2010). In addition, researchers have been able to demonstrate that commitment to optimal nurse to patient ratios has a stabilizing effect on the nursing workforce that has helped California mitigate economic and pandemic-related critical staffing shortages much better than in other jurisdictions (Aiken, et al., 2010; Dierkes et al, 2022; Spetz, et al., 2022). The higher the proportion of nurses with patient assignments in compliance with the mandated ratios the better the results (Aiken et al., 2010). The mandated ratios in California are 1:4 for telemetry units and 1:5 for medicine units (Holowell, 2023).

Currently, several more American states have either implemented nurse to patient ratios in some settings, or they are waiting on pending legislation to do so (Roberts, 2023). In Canada, previously hesitant nursing professional associations and leaders have joined nursing unions in the call for Canadian governments (provincial and federal as applicable) to implement policies to mandate minimum staffing requirements in hospitals (Ahmed & Bourgeault, 2022; Tomblin-Murphy et al., 2022). After recent negotiations, British Columbia is planning to implement minimum nurse to patient ratios, and Quebec has done so in select health settings to improve workloads (Ahmed & Bourgeaut, 2022). While there is no imminent initiative to mandate nurse to patient ratios in Ontario, there is a strong imperative to ensure that there are enough nurses to provide care in hospitals.

The COVID 19 pandemic, which began in 2020, has wreaked havoc on an already strained workforce. It has exacerbated widespread critical shortages of nursing staff across the country. At Kingston Health Sciences Center interim nurse staffing models have been created to fill the gap with some success. The interim model has allowed patient and staff outcomes to stabilize and it has improved some patient and nurse outcomes (to be discussed below), but long term commitment to recruiting and retaining enough nurses to achieve a targeted nurse to patient ratio that is supported by decades of evidence is critical to moving forward in ways that continue to optimize patient outcomes and send a message to nurses that the system is supportive and that Connell 10 is a desirable place to work.

Key Findings:

1. There is a significant amount of quality research evidence that, compared to those that do not, hospitals that implement baseline nurse-to-patient ratios of (e.g. 1:4 during the day and 1:6 at night have: a) better patient outcomes and less costs on medical units, and b) a more stable nursing workforce that experiences less burnout and job dissatisfaction.

2. Examples of mandated nurse to patient ratios:

    a. California has mandated 1:4 for telemetry (or other specialty care) units and 1:5 for medicine units 24 hours/day.
    b. Queensland has mandated 1:4 for days and 1:7 at night.

3. In Ontario, several hospitals were surveyed by the IAC and their planned nurse to patient ratios varied minimally among two large multi-site academic health science centres (one reported ratios of 1:4 during the day and 1:5-1:6 on nights; one reported ratios of 1:4 during the day and 1:6 at night), a multi-site community teaching centre (1:4-1:5 days; 1:5-6 at night) and a large community hospital (1:4 days, 1:6 nights). In cases where the stated ratios varied (e.g. 1: 5-6), it was often to account for unit size and/or flexibility in assignment making based on patient needs.

4. The specific daytime and nighttime nurse-to-patient ratios that were reported to be optimal in the research evidence reviewed for this report had small variations across publications. Similarly, there was a small variation in nurse-to-patient ratios on medicine units that were reported by the peer hospitals surveyed by the IAC. Based on all of the information reviewed, the IAC has concluded that the optimal nurse staffing plan for an acute medicine unit where some patients may require telemetry and other specialty care is one that has enough nurses on the unit so that the overall nurse-to-patient ratios are 1:4 during the day and 1:6 at night, while allowing acuity-based differences in assignments in which individual nurses may a have greater (or lesser) number of patients than the recommended ratio.

5. The baseline staffing model that the hospital is trying to achieve has planned nurse-to-patient ratios that are supported by the evidence reviewed. There are times in the baseline schedule (e.g. 1900-0700) when the nurse-to-patient ratio is lower than necessary, and there are also times when the planned nursing staff resources are not the same on weekends as they are Monday to Friday, yet medicine unit occupancies do not often drop on weekends. The baseline plan would benefit from realignment of resources.

6. The Interim Nurse Staffing Plan and Model of Care (with the additional supports for patient care in place) has temporarily mitigated the gap caused by the severe shortage of nurses on Connell 10. Patient outcomes shared with the IAC have been maintained or have continued to improve; however, despite improved engagement scores, nurses are still reporting challenges with workload, feelings of burnout, and a perceived inability to provide good care that causes them stress.

7. The hospital has made progress in reducing the shortfall of nurses on Connell 10 and will continue its efforts to recruit and retain nurses. As of October 2023, there are 70% FT RN positions available (9 out of 33 unfilled) and 30% PT positions (8 out of 10 unfilled) on the unit. In light of the reality that there is a country-wide shortage of nurses that makes recruitment difficult, open communication of commitment to and progress toward implementing a model of care with evidence-based beneficial nurse-to-patient ratios will help KHSC to attract and retain nurses.

IAC RECOMMENDATIONS:

1.1.1 Work toward implementing a new staffing plan (Table 4) by January 15, 2025. This is in recognition that most of the recruitment of full-time nurses will be new graduates who are not available until their graduation in June 2024 or September 2024.

1.1.2 Calculate and work toward achieving the number of RN and RPN FTEs required to implement the recommended nurse-to-patient ratios in Table 4. Include the "relief factor" in the calculation. That is, build in sufficient FTEs to cover relief for vacation, sick, and other leaves of absence.

1.1.3 Create and fully implement a new master schedule for full and part-time nurses (maintaining at least 70% full-time positions) with the nurse-to-patient ratios outlined in Table 4 by January 15, 2025 or sooner.

1.1.4 Endeavour to balance the master rotation with both novice and experienced nurses on staffing lines.

1.1.5 Add an additional PCA 2300-0700 immediately (n = 3 total) to help offset the absence of a clerk and to bridge the gap to when the clerical work will be substantially reduced at night when the KHSC electronic medical record is implemented. The PCA, directed by the CN, can take on some of the stocking and other tasks that the night nurses currently take on.

1.1.6 Hold monthly staff forums on Connell 10 to communicate progress with reducing the shortfall of nurses, the intention to develop and implement a new master schedule, and to achieve a new baseline staffing plan.

Table 4. New Staffing Plan Recommendation and Guidelines (Monday – Sunday)

Shift	RN Charge Nurse no Assignment	RN Charge Nurse Reduced Assignment	RN	RPN	Total Registered Nursing Staff	Recommended Nurse to Patient Ratio	PCA
Monday to Sunday							
0700-1500	1		8	2	11	1:4	3
1500-1900	1		8	2	11	1:4	2
1900-2300		1 (2 pts)	5	2	8	1:5 to 1:6	2
2300-0700		1 (2 pts)	5	1	7	1:6	2
Guidelines							
1. The nurse-to-patient ratios recommended are the number of nurses on the unit in relation to the total number of patients on the unit. Normally, on Connell 10 there are 38 beds and 38 patients. 2. The Charge Nurse may vary individual nurse assignments (e.g. 1:3-1:5), depending on patient requirements. 3. During the day, the actual numerical ratios (1: 3.8) allow for adjustment of assignments between 1:3 and 1:5. This creates some flexibility to cover if the unit is at overcapacity. There is also flexibility to create a reduced assignment for one or two RNs with a particularly acute patient requiring more attention. For example, two RNs may have a 1:3 patient assignment because of high acuity or specialization needs (e.g. PD, oncology), and the other nurses would then have 1 nurse to 4.25 patients on average. 4. At night, the Charge Nurse will normally have two patients. When necessary, this can be increased by the Charge Nurse to provide flexibility and/or to vary other nurses' assignments (example, reduce to 1: 5) as necessary to address patient care requirements or staff experience challenges. 5. This recommendation assumes that nurses on Connell 10 will continue to use a Total Patient Care Model in their day-to-day practice.							

1.2 Charge Nurse

The Charge Nurse (CN) role is imperative in the management of the daily complex operations of the nursing unit. The CN works in collaboration with the nurse manager and staff to provide quality nursing practice and optimal patient care (Breedlove et al., 2022). Jubinville et al. (2023) identified 5 key CN clinical-administrative responsibilities, which are: leadership, interpersonal communication, problem solving, clinical administrative responsibilities and knowledge and understanding of the healthcare environment. Other CN knowledge, skills, and abilities identified necessary for the role are conflict resolution, delegation, support of staff, being an educator, advocate for patients and staff, and the ability to make safe patient assignments (Cathro, 2016; Spiva et al., 2020). The literature also indicates that a high

functioning CN can contribute the reduction of staff stress and improved staff satisfaction, and overall better staff and patient outcomes (Breedlove et al.; Spiva et al.).

Based on the KHSC Charge Nurse's job description, the CN's primary day to day responsibilities on Connell 10 include but are not limited to patient care, the safety and quality of the experience for the patients and staff, and flow outcomes of the patient care area. The CN provides clinical leadership in the planning, implementation, and evaluation of care for patients. The CN is also accountable for contributing to the delivery of KHSC strategy and responsible for actively promoting and supporting patient-family-centred engagement and supports continuity of care. The principle CN responsibilities and duties outlined in the job description include: taking primary responsibility for day-to-day resource utilization decisions and effective operations in the patient care area; creating a welcoming, professional, supportive, collaborative, patient-centred and healing environment in the patient care area for patients, families, and staff; taking a leadership role in developing highly skilled nurses in the patient care area; and in ensuring the highest level of patient, family, and staff safety in the patient care area.

Currently the new Interim Nurse Staffing Plan of Care developed in 2022, includes a permanent CN from 07:00-19:00, but it is indicated in the plan, that the CN will have 2 patients. In February, 2023, to support the CNs in fulfilling their duties and responsibilities, the Hospital also introduced 2 non-charge RN positions to follow the CN line who have experience as CNs. This role was introduced to ensure that the CNs have resources to rely on, and it allows for last minute needs to fill the CN vacancy with a nurse with confidence and the experience to assume the CN role.

KHSC stated during the Hearing and in their submission that, their goal is for the CN not to have a patient assignment between the hours of 07:00-15:00. However it is important to recognize that during the time period between 15:00-19:00, while support staff, for example the patient navigator and physiotherapists leave for the day, support staff duties with patients will continue into the evening. Depending on the CN's patient assignment, they may need to assume these type of care activities on top of preparing for the end of shift and handover to the incoming CN.

KHSC's submission also includes that it is beneficial for CNs to have a patient assignment so that they remain directly involved in nursing practice. However, ONA's submission identified that the CNs are unable to perform their CN duties and ensure that they provide quality care with a patient assignment. The PRWRFs submitted by ONA to the IAC also indicate that on several occasions the CN has been responsible for more than 2 patients.

In summary, with a patient assignment during the day, the CN will have less time to guide other staff, fulfill their accountabilities and responsibilities, or address any problems in the moment while trying to provide quality nursing care for the patients assigned to them. The literature indicates that the CN role is an imperative nursing leadership role that can influence the

reduction of staff stress and improve staff satisfaction, and overall better staff and patient outcomes (Jubinville et al., 2023). The focus of the CN role should be on being a leader, resource, coordinator, and support for staff, particularly with so many new nurses on the unit. Therefore, the IAC recommends the following:

IAC RECOMMENDATIONS:

1.2.1 Permanent CN will remain from 07:00-19:00, 7 days per week.

1.2.2 The CN from 0700-1900 will not have a patient assignment once the new staffing model (Table 4) is implemented. Until then, the IAC recognizes that the CN may be required to take maximum 2 patients under extenuating circumstances.

1.2.3 The CN is expected to help with patient care when requested by nurses or when in their professional judgement it is necessary.

1.2.4 The night CN will have a 2-patient assignment with additional patients when necessary (per Table 4).

1.2.5 Normally, nurses assuming the CN role for incidental times will be registered nurses working on Connell 10.

1.2.6 Nurses working on a temporary license should never be in charge.

1.2.7 Nurses' with less than 1 year experience, should not be assigned the CN role.

1.3 Load Levelling

As described previously, in order to mitigate the persisting shortfall of nurses across KHSC, the Hospital introduced a load leveling reassignment process. The load levelling process is to ensure patients on all units have equitable access to nursing care. Load levelling has been described in the literature primarily as floating or redeployment. This process is not a new practice and has existed historically to address staffing shortages and is used to balance varying patient census and acuity needs through optimal staffing (Kennedy et al., 2022; Walden et al., 2020).

During the COVID-19 pandemic, research on redeployment intensified due to the increased use of this strategy to address staffing shortages and the delivery of healthcare needs. Findings indicated the need for a process to balance meeting clinical unit needs with redeployed staff who have similar skill sets and capabilities. An assigned point of contact for the redeployed nurses is necessary to assess the redeployed nurse's knowledge skills, and abilities and assist with the

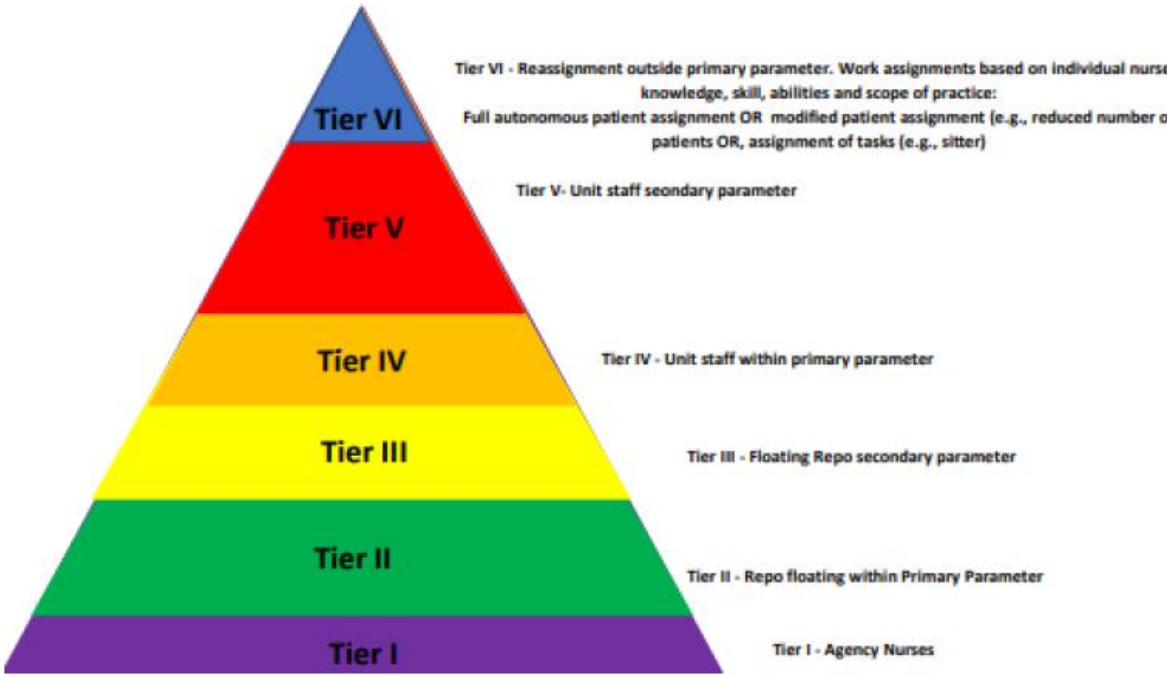
onboarding to the unit. Transparency is also required by the leadership team in communicating why and how the decisions are being made in relation to load leveling. During this process it is imperative to have strategies in place to address the reassigned nurse's anxiety and stress related to delivering nursing care on another and perhaps unfamiliar unit and patient population. (Kennedy et al., 2022; Panda et al., 2022; Walden et al. 2020).

In the KHSC submission, load levelling processes were described as being used to balance patient need, the nurse-to-patient ratios across all units, and services across programs. Load levelling decisions are guided by several factors such as patient needs (occupancy, acuity, complexity, and predictability), the interdisciplinary team and their knowledge and scopes, environmental and corporate supports, allocated budget plan, and peer benchmarking. In the KHSC submission it was also stated that, when reassigning nurses, the goal is to reassign them to a similar unit. For example, Connell 10 nurses would, when possible, be reassigned to units with similar patient populations.

Load leveling is done either through the scheduler or the Operations Manager on call (OM). There are multiple levels of input and frequent reassessments each day to balance patient needs and workload, optimize available staff, and support staff time off (planned and/or unplanned). The decision to reassign staff includes adherence to the relevant collective agreement, and input from the Charge Nurse, Program Manager, Operations Manager, and Directors. There are also several checkpoints to review the decision making related to load leveling of staff. These include management and leadership team's daily huddles at 09:30 and 14:00, every Thursday assessing needs for the next 7 days, and on Friday, to plan for staffing needs over the weekend. Once the decision has been made to reassign a nurse, the Program Manager or Charge Nurse is notified of which unit the nurse is to work for their shift.

KHSC outlined tools and protocols to guide decision making as it relates to load leveling within the Hospital. Reviewing the tool, agency nurses are used first for load levelling first (Figure 8). If the reassignment is outside the primary parameter (in the case Connell 10, medical program), work assignments will be based on the individual nurse's knowledge, skill, abilities and scope of practice. A reassignment may include a full assignment, a modified assignment with a reduced patient load, or just assignment of tasks.

Figure 8: Load Levelling Tool & Protocol



Patient care areas are both recipients and providers of additional staff. The number of hours worked by nurses in reassigned situations peaked across KHSC in 2022-2023 with the highest amount in August 2022 at 91,082 hours (Figure 9). The reassignment hours across KHSC has significantly reduced in 2023, with the lowest being reported in September 2023 with 7526 hours (Figure 10). Connell 10 has received reassigned staff, and the nurses on Connell 10 have also had to provide care on other units when necessary. Figure 11 outlines the frequency of the clinical areas where Connell 10 nurses have been reassigned to.

The load leveling process has been both helpful and stressful for nurses on all units, including Connell 10. At the IAC hearing, nurses from Connell 10 expressed, that they have been reassigned to units where they have felt the assignment was not within their knowledge base or abilities. When nurses are reassigned to another unit, it can be a stressful experience working in an unfamiliar environment with different routines, patient populations, and staff (O'Connor, 2017; Walden et al. 2020). Strategies to mitigate the stress and anxiety of being reassigned to an unfamiliar environment include, providing orientation to the new unit, developing orientation guides, and assigning a nurse on the unit to assist the reassigned nurse. By using the acronym WOOT, Walden et al. described a system of 4 interventions to use with reassigned nurses as welcoming, orientating, offering help, and thanking.

Figure 9: KHSC Total Reassignment (RN + RPNs)

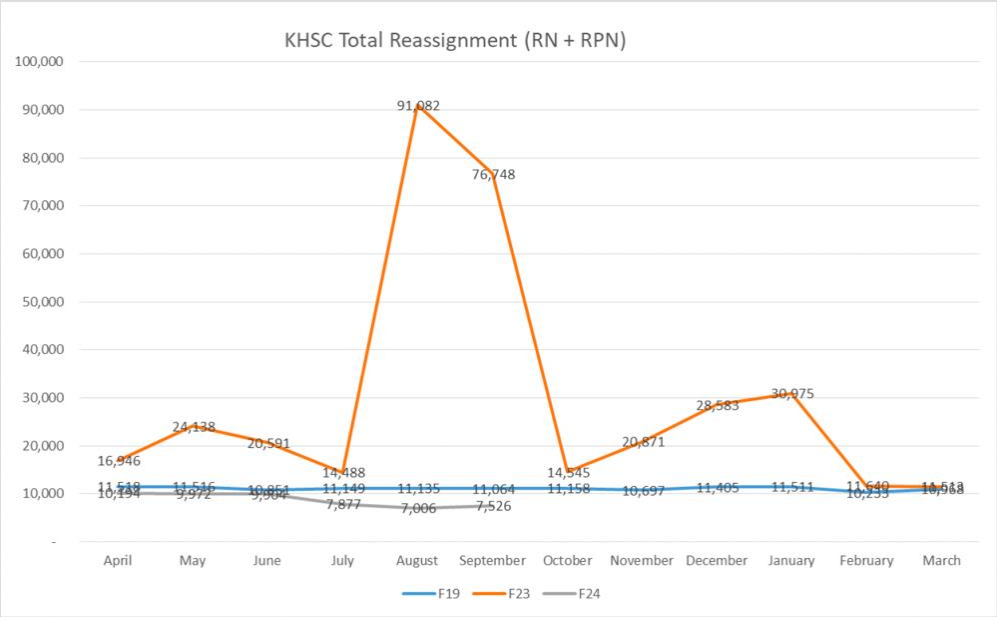


Figure 10: Total KHSC RN & RPN Reassignment Hrs. in 2022 & 2023

Total KHSC RN & RPN Reassignment (Hrs.)

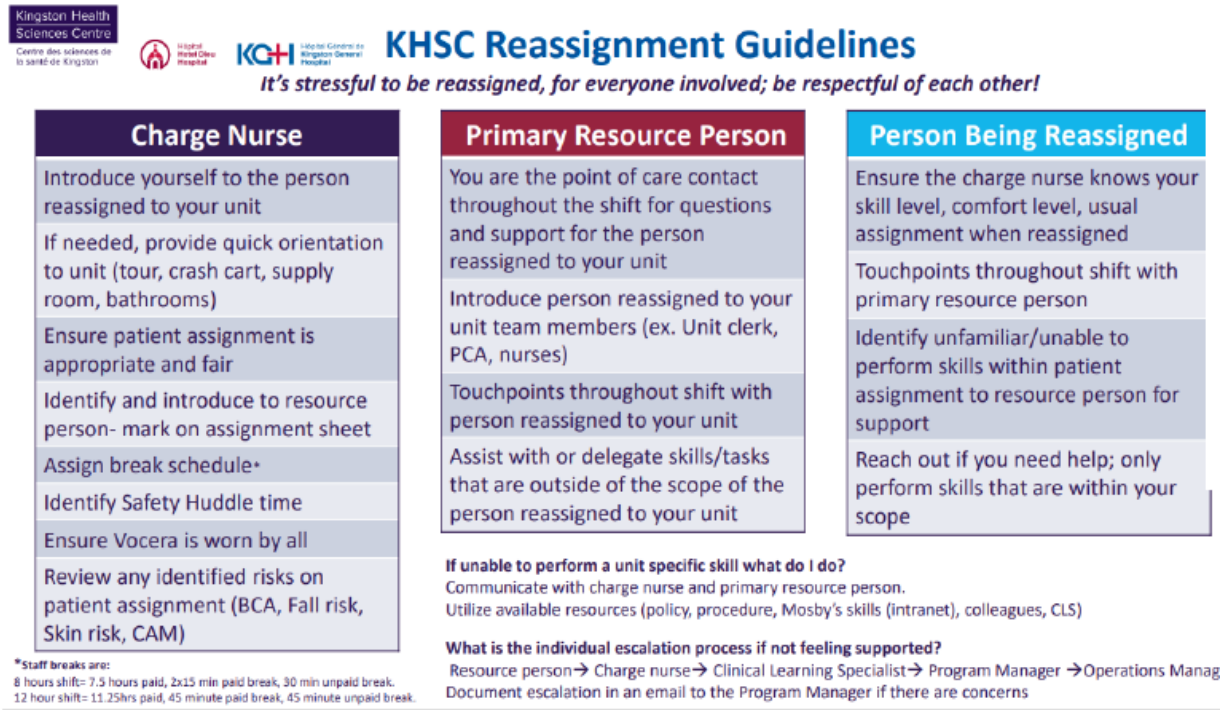
Reassignment Totals (Hrs.)	April	May	June	July	Aug	Sept
2022	16,946	24,138	20,591	14,488	91,082	76,748
2023	10,194	9,972	9,904	7,877	7,006	7,526
% Change 2022 to 2023	↓40%	↓59%	↓52%	↓46%	↓92%	↓90%

Figure 11: Reassignment from Connell 10

Program	F19	F23	F24
Medicine	91%	90%	77%
Surgery	0%	3%	14%
Women & Children (W&C)	0%	0%	0%
Oncology (Onc)	6%	3%	1%
Cardiac	0%	3%	7%
Mental Health (MH)	3%	1%	0%
Admission Transfer Unit (ATU)	0%	0%	2%

In supporting reassigned nurses at KHSC, reassignment guidelines have been developed outlining the role of the CN and Primary Resource Person on the reassigned unit (Figure 12). There are also Unit Guidelines with the unit description, contact information and multidisciplinary team members. While these guidelines have been developed, it is important to ensure nurses, especially the CN, are enacting them, when a nurse is reassigned. This is particularly important on nights when there are fewer support systems. Other strategies and resources should also be developed to support reassigned nurses.

Figure 12: Supporting Reassignment at KHSC Guidelines



At times, the effects of load leveling on Connell 10 has left the nurses struggling to meet their patient care needs resulting in care such as medication and/or treatments being delayed. On occasion, a PRWRF has documented that Connell 10 may have already been working below their baseline staffing level when they had to send one of their nurses to another unit. This causes increased stress and frustration with nurses on the unit and highlights the importance of communication and visibility of leadership when these decisions are made.

IAC RECOMMENDATIONS:

1.3.1 Continue to follow the pyramid protocol guiding decisions.

1.3.2 The OM will take into consideration acuity on Connell 10 prior to reassigning a nurse, not just the number of nurses on each unit.

1.3.3 A process will be developed and implemented in which the staffing clerk or the Operations Manager will verify and document the registration status of the nurse who is being considered for reassignment. Nurses with a temporary license should not be reassigned to another unit.

1.3.4 Normally, novice nurses (with a full license who are less than 9 months post-graduation) should not be reassigned to another unit and/or be in charge of another unit.

1.3.5 The ONA local bargaining unit and KHSC will discuss when it would be appropriate to safely reassign a new graduate nurse to another unit.

1.3.6 The Operations and/or Program Manager will communicate with the CN, the reasons for why a Connell 10 nurse needs to be reassigned to another unit or that Connell 10 will not be receiving a reassigned nurse.

1.3.7 The CN will contact the Operations and/or Program Manager to further discuss the load levelling decision if the CN believes the leveling decision may be inappropriate based on the acuity and complexity of the unit. The Operations and/or Program Manager will then either follow up in person or by phone with the CN to discuss the decision.

1.3.8 When the CN and/or nurses perceive the Operations Manager's reassignment decisions were inappropriate based on the acuity and complexity of the unit, the CN and/or the nurses will follow up with the Program Manager on the next day to discuss their concerns.

1.3.9 To support reassigned nurses, each unit will develop a competency list outlining the most common patient diagnoses and knowledge and skills needed to care for patients on the unit. This list will be developed with input from the CN, staff, Program Manager, and Clinical Learning Specialist and then communicated to all staff through email, staff meetings, huddles, and through internal communication. This will be done by February 29, 2024.

1.3.10 The CN will welcome the reassigned nurse to the unit and review the competency list with them to assess their knowledge, competence, and ability to care for patients on the unit.

1.3.11 Based on the assessment in 1.3.10, the CN will make the decision to give the reassigned nurse an autonomous or modified assignment, or only assist nurses with assigned tasks.

1.3.12 If the reassigned nurse feels they do not have the competency, knowledge and skill required to do the patient assignment, they must talk to the CN and together they should come up with a plan of care.

1.3.13 Reassigned nurses must have the ability to contact the Operations Manager or another support person, if they have concerns related to their patient reassignment and they feel that their concerns are not being heard.

1.3.14 The reassigned nurse will be provided with an orientation of the unit and a resource/buddy nurse who they can ask for support during the shift.

1.3.15 If a reassignment occurs at any time during the shift, the nurse being reassigned will always be given the time to complete all their documentation and give report prior to leaving the unit.

1.4 SAFER NURSING CARE TOOL

The Safer Nursing Care Tool (SNCT) was developed in the United Kingdom (UK) and is used widely across the National Health Service (NHS) hospitals to make evidence-based decisions on staffing. It has also been used outside the UK, including in some healthcare organizations in, for example, Ontario (e.g. at The Ottawa Hospital, Sunnybrook, University Health Network, and others) and Quebec in Canada (Caron et al., 2020; The Shelford Group, 2023). The SNCT estimates the number of nurses needed to staff a unit based on classification of patients' acuity and their dependency on nursing care. Patients are classified into categories aligned with weightings (numerical multipliers) that consider staffing interventions and quality indicators

linked to nursing care. It is easy to use by frontline staff but must be applied correctly and consistently to be reliable and valid (Fenton & Casey, 2015). The SNCT provides a recommended number of nursing staff needed to be employed to meet the needs of the patients on a unit (The Shelford Group).

In Quebec, a university-affiliated hospital conducted initial testing of the validity of the SNCT in Canada (Caron et al., 2020). They reported that the Canadian wards had higher occupancy and acuity/dependency than the UK comparators. They also noted that overall, staff activity was comparable between UK and Canadian wards. The researchers concluded that the SNCT is a valid tool that can be used in Canadian hospitals. When combined with *professional judgement* it can be used to help managers establish safe staffing levels in acute care units (Caron et al.). The necessity of combining SNCT results with *professional judgement* when making a decision about what constitutes a safe staffing level for an adult acute care unit has been emphasized by many researchers who reported evaluations of the SNCT between 2020 and 2021 (Griffiths et al., 2020; Griffiths et al., 2021; Saville & Griffiths, 2021; Griffiths et al., 2020).

In one study (Saville & Griffiths, 2021) to assess whether the SNCT accurately predicts staffing requirements, a secondary analysis of 69 wards in 3 acute care hospitals was used to assess the precision of the estimated staffing, variation of estimates, correspondence with professional judgement, and achieved staffing levels. Nursing workforce leads made suggestions about factors associated with poor fit. The results showed that 39% of the wards were frequently understaffed, while being overstaffed was less common. In addition, 24% of the wards needed to have collected SNCT data for over 182 days (not 20 days as suggested in the instructions that accompany the tool) to estimate the required staffing for safe nursing care. Like others (Caron et al., 2020; Griffiths et al., 2020), the authors' conclusion was that this tool must be used in conjunction with professional judgement and/or triangulated with other methods of estimating staffing needs, or else the recommended staffing levels may not be optimal (Griffiths et al., 2020). Potential reasons reported for poor fit included high turnover on a unit, high levels of 1:1 care, cancer care, small ward size, and high within day demand. (Saville & Griffiths, 2021).

A review of the original SNCT was commissioned in 2018 to ensure that it was current and applicable. The review undertaken was to account for "the ageing population's impact on inpatient acuity and dependency, single room ward design, care hours per patient day and proportion across the day and nights and supporting inpatients with increasing care requirements due to risk of falls, confusion, or mental health needs" (The Shelford Group, 2023). As a result, a new version was released in 2023 and incorporates refreshed multipliers, more interventions and quality indicators than the previous version. It also provides "updated patient care levels descriptors aligned to refreshed nursing resource multipliers. They provide for traditional ward layout with a separate module for single roomed wards as well as levels of care for one-to-one care and two-to-one care" (The Shelford Group, 2023). All previous versions of the SNCT are no

longer valid (The Shelford Group, 2023). No research was located that reports on the evaluation of the 2023 version of the SNCT.

The SNCT at Kingston Health Sciences Centre

The SNCT was used to complete a 20-day assessment on Connell 10 between May and June 2023. Nursing Assessors with over 30 years of clinical knowledge gathered the data. Reliability of the data gathered was ensured through use of huddles during the initial roll out. The huddles were used to compare findings and reach consensus about patient scores. The Director of Professional Practice and a Professional Practice Leader documented and reviewed qualitative findings which were not described to or shared with the IAC. The SNCT has since been used to assess additional units across the organization. Figure 13 is a copy of the SNCT version used on Connell 10. The SNCT Findings for Connell 10 are captured in Figure 14. Based on the data collected, 63% of the patient population are categorized with a SNCT level of 0, which is labeled as Stable where patients require hospitalization with their needs being met by provision of normal ward care, while 35% are grouped as a 1b which means they are stable but are dependent on nursing care to meet most of their activities of daily living. Only 2% of the Connell 10 patient population were categorized as 1a which means they are unstable and acutely ill requiring interventions and their condition have the potential of deteriorating.

Figure 13. SNCT Used on Connell 10

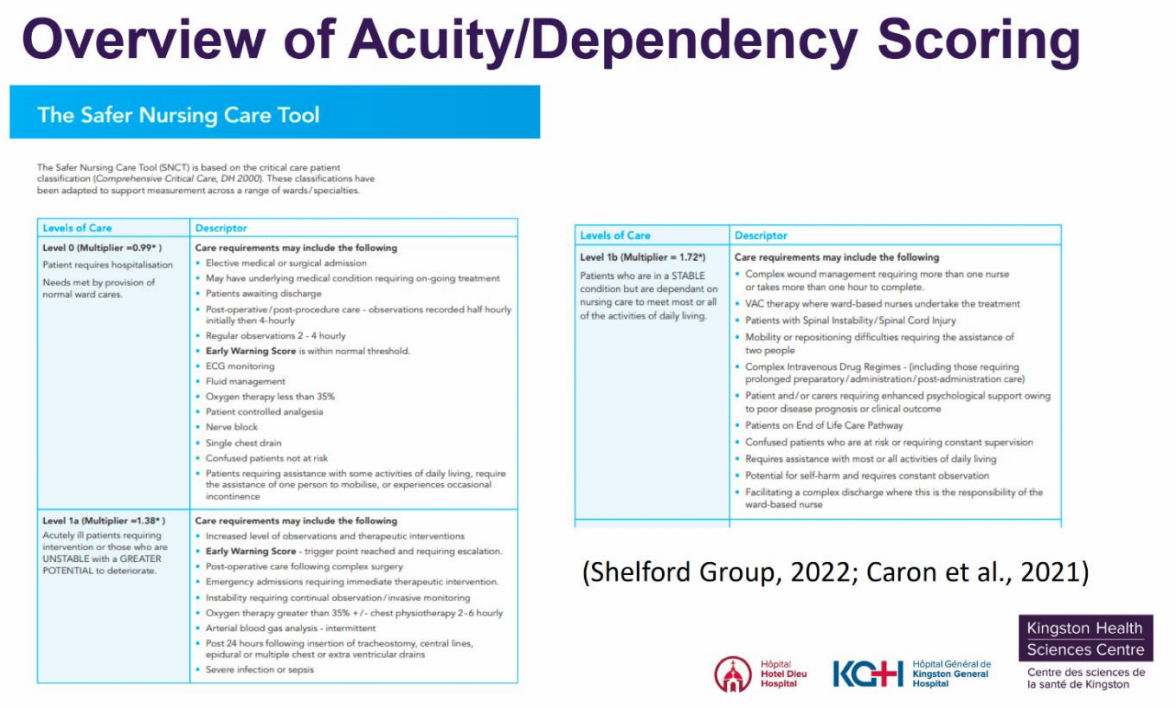


Figure 14. SNCT Patient Classification Results on Connell 10.

SNCT Findings: Connell 10

SNCT Level	Stable or Unstable	Definition (Shelford Group, 2020)	% of C10 Patients	Qualitative Findings by SNCT Level
0	Stable	Patient requires hospitalization; needs met by provision of normal ward care	63%	Planned or possible discharge home, IV antibiotics, dialysis, independent or assist x1,telemetry as per order set
1a	Unstable	Acutely ill patients requiring intervention or those who are UNSTABLE with a GREATER POTENTIAL to deteriorate	2%	Sepsis, acute cardiac work-up, work-up for malignancy involving management of GI bleed, liver failure, respiratory work-up and management
1b	Stable	Patients who are in a STABLE condition but are dependent on nursing care to meet most or all ADLs	35%	Palliative pathway or end of life care, assist x2, planned for rehab, constant observation

*No patients met criteria for SNCT level 2 or level 3

Hôpital Hotel Dieu Hospital · KGH Hôpital Général de Kingston General Hospital · Kingston Health Sciences Centre / Centre des sciences de la santé de Kingston

KHSC intend to use the resultant data to inform resource allocation and promote "a harmonious and educative work environment, allowing team members to work to their full scope of practice for their position." They shared that there is a plan to present findings from across KHSC in January 2024 to get feedback on operationalization prior to selecting pilot units (and educating staff on the tool and the trial). If successful, the pilot will be expanded beyond pilot units and incorporated into bed huddle discussions. The impact of the SNCT on decision-making will be evaluated.

Key Findings:

1. The SNCT has been widely used in the NHS to make evidence-based decisions on nurse staffing. It has also been used to assess units in other countries, including in academic health science centers in Ontario and Quebec. The validity of the SNCT in Canada was investigated and confirmed by a research team in Quebec.

2. The SNCT calculates "clinical staffing requirements based on patients' needs (acuity and dependency) which, together with professional judgement, guides chief nurses in their safe staffing decisions" (The Shelford Group, 2023).

3. Several evaluations of the accuracy of the SNCT in predicting safe staffing levels have been published. The authors reported findings that suggest versions of the SNCT prior to 2023 underestimate the number of staff needed for safe care on units almost 40% of the time and that data needs to be collected for over 182 days for accuracy (not 20).

4. The SNCT was reviewed (beginning in 2018), and a new version was released in 2023. The 2023 version has updated patient care levels descriptors that are aligned to updated nursing resource multipliers. Older versions of the tool are no longer valid.

5. Based on submitted materials with references to 2021 and 2022 the Shelford Group and other reference materials, KHSC may still be using an older version of the SNCT.

6. KHSC has not clearly shared how they intend to use the SNCT to inform resource allocation. Based on information shared, it may be used as a common language to classify all patients daily and to inform nurse assignment and/or load leveling decisions.

7. The hospital may also plan to use the calculated clinical staffing requirements to make resource allocation decisions.

IAC RECOMMENDATIONS:

1.4.1 The Hospital should confirm that they are using the 2023 version of the SNCT and notify ONA and staff of their findings.

1.4.2 The Hospital should ask the Shelford Group for any evaluation updates available that may indicate whether this version more accurately predicts staffing requirements in the 20 allotted assessment days.

1.4.3 The Hospital should ensure that all conclusions and recommendations about overall unit resource allocation of FTEs and nurse-to-patient ratios undergo a validation process that enlists the *professional judgement* of the Program Manager and Clinical and Professional Practice leaders.

1.4.4 The Hospital should ensure that all conclusions and recommendations about overall unit resource allocation of FTEs and nurse-to-patient ratios take into consideration the evidence-based positive outcomes of mandated safe staffing levels in medical/surgical units outlined in the Staffing Section of this report.

1.4.5 The Hospital should ensure that the pilot units have extensive training on how and why to use the SNCT to ensure that patient classifications are reliably assigned and that the staff have a full understanding of the intended use of the results.

2.0 Recruitment & Retention

The critical shortage of nurses in healthcare organizations across the country is at the forefront of health system priorities. The challenges that have driven nurses from patient care units, organizations, and the profession have been documented for decades (e.g. O'Brien-Pallas et al., 2001), but they are now more acute than ever – having been exacerbated by the effects of the COVID-19 pandemic on nurses' work. The critical staffing shortage has intensified nurses' job demands, increased hours of work, required redeployment to new patient care settings, and increased job dissatisfaction, job strain, and burnout (Tomblin-Murphy et al., 2022).

It has been well documented that nurses want to work in environments where they are able to, for example, provide quality patient care, pursue professional development opportunities, experience respect and feel safe and satisfied at work, have job security, receive fair compensation, work in a positive organizational climate, and develop supportive and communicative relationships with co-workers and leaders (Haddad et al., 2020; Lowe, 2002; O'Brien-Pallas et al., 2001; Tomblin-Murphy, et al., 2022). In fact, based on a meta-analysis, Tomblin-Murphy et al. (2022) suggested that "a supportive work environment is the optimal recommendation to reduce voluntary turnover" (p. 16).

To stabilize the nurse staffing crisis, healthcare institutions have to create innovative structures and models that address both organization and unit-specific nursing recruitment and retention challenges. They can begin with urgent implementation of strategies aimed at:

- Establishing ***safe staffing levels***
- Developing policies and programs designed to protect the ***physical and psychological safety*** of nurses
- Adopting ***supportive management and leadership practices***, including engagement of nurses in policy and decision-making
- Offering desirable and competitive ***working contracts***
- Providing ***education, and professional development*** opportunities; and
- Coordinating ***mentorship & peer support*** programs (Tomblin-Murphy et al., 2022, p. 42).

Safe Staffing Levels

In their separate briefing materials, KHSC and ONA both expressed concerns about safe staffing levels on Connell 10. As described in the Staffing Section of this report, KHSC is in the midst of mitigating and addressing a severe nursing shortage on Connell 10 that peaked in summer 2022. In October 2023, the shortfall of RNs had improved to 39.5% (17 out of 43 RN positions), with part-time RN positions being the most difficult to fill. Although maintaining a strong part-time

workforce is critical to having flexible coverage for the unit, there are currently 8 out of 10 RN permanent part-time positions unfilled.

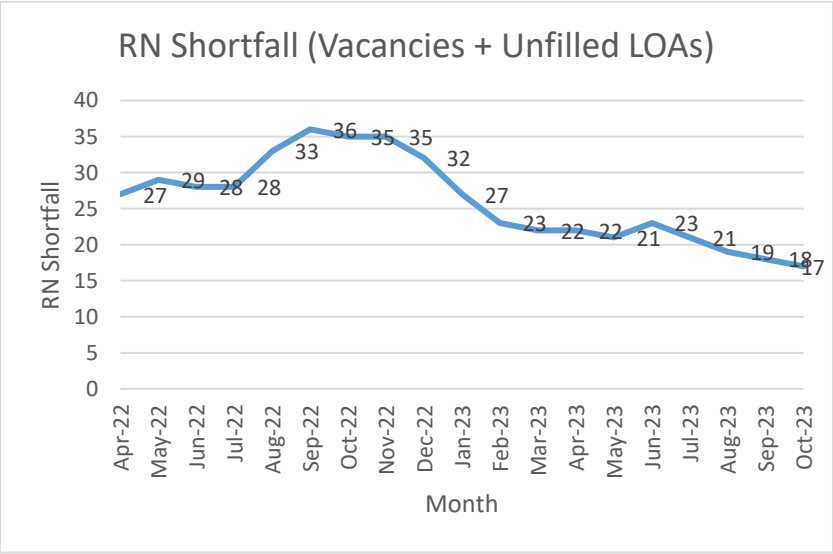
The staffing models used on Connell 10, strategies used to mitigate the effects of the shortage while recruitment continues, patient and staff-related outcomes of the mitigation strategies, and the IAC's recommendations regarding current and future staffing models and nurse-to-patient ratios are all outlined in detail in the Staffing Section of this report. The following sections are specific to successes and challenges with recruitment and retention initiatives on Connell 10 at KHSC.

Recruitment on Connell 10 at Kingston Health Sciences Centre

In their briefing materials, ONA expressed concern that KHSC has not been taking necessary steps to recruit enough nurses on Connell 10. In particular, that the hospital has not properly posted RN positions to enable recruitment. In response, KHSC described how nursing positions are posted to optimize efficiency for both the hospital and the applicants. They have a continuous internal and external posting for most RN positions so that applicants do not have to submit multiple applications. It also helps the recruitment team more efficiently screen and sort the applicants based on their preferences and their fit with different units, without sorting through multiple applications from the same person. The collective agreement is always followed when filling positions.

The hospital also shared data that demonstrates that they have made steady progress, and they are committed to recruiting nurses and to reducing the nursing shortfall on Connell 10 (Figure 15).

Figure 15: RN Shortfall Trend



To accomplish this, they have established a variety of recruitment tactics to help them achieve their goal of closing the nurse staffing gap. These include:

1. Introducing recruitment incentives that have been successful in bringing 34 RNs and 3 RPNs into the medicine program with eligibility to receive recruitment incentives (9 RNs and 2 RPNs were specifically recruited to Connell 10) by the time KHSC submitted their report to the IAC. The incentives include:
    - A recruitment sign on bonus of $10,000 for permanent full-time RNs and RPNs recruited to a medicine position.
    - A one-time signing bonus of $5000 for permanent part-time RNs and RPNs recruited to a medicine position.
    - Relocation assistance of up to $15,000 dollars for recruitment in addition to the sign-on bonus if applicable (e.g. for those also living more than 200 km away).
    - Additional funding (on top of KHSC funding) provided through Ontario Health under the Community Commitment Program ($25,000 incentive to RNs who had not worked in Ontario for at least 6 months)
    - Referral incentives ($3000) for current KHSC staff who assist in filling vacant full time and part-time positions in designated areas through successful applicant referral.
2. Being the first in Ontario to introduce (in September 2023) the Undergraduate Nursing Employee (UNE) position. This paid position was developed to attract and recruit students to select inpatient medicine for their final consolidation placement of nursing programs. The program will be evaluating all students hired into the program and will assess the success of this method of recruitment. The program had 7 students that started in September 2023 and is expecting another 29 in January 2024. All participants will be offered jobs.
3. Partnering with a talent acquisition company, which guarantees interested prospective nursing candidates.
4. Increasing participation in the Nursing Graduate Guarantee Program (20 in 2023-24 vs 10 in 2022-23).
5. Implementing a Recruitment and Retention Steering Committee that provides oversight and reviews strategies to prioritize staffing issues and vacancies. Connell 10 has two RN representatives on this committee.

6. Assigning responsibility to a Corporate Department for an organization wide talent acquisition strategy development and implementation and execution of recruitment activities. There is a dedicated nurse recruiter on the team.
7. Attending job fairs and using alternative promotion means to expand geographic and occupational reach beyond traditional sources including partnership with other groups to create interest in Kingston as an attractive place to live and work.
8. Extending job offers to final semester nursing consolidation students early in final placement.
9. Participating in the Government Internationally Educated Nurse (IEN) fast track program. A KHSC collaboration with St. Lawrence College's School of Nursing on IEN program customizations, offerings, and increased uptake of IEN class and clinical programs has allowed for more IEN hires to be introduced into medicine over the past fiscal year.
10. Launching a, *This is the Place*, recruitment campaign viewed in Figure 16.

Figure 16: ***This is the Place*** Recruitment Campaign

The hospital's stated recruitment goal is to reduce the shortfall of RNs on Connell 10 to less than 5% by October 2024 and to continue to keep it at a minimum by using a proactive process for predicting upcoming vacancies and/or leaves of absence. A human resources representative shared that KHSC is creating a formal framework for proactive health human resources planning and it will encompass both planned periodic workforce planning meetings and more frequent meetings at managers' request. They aim to roll out the framework in January 2024, with the plan and resources to follow. Currently directors share reports on headcounts and vacancies with the management group, managers meet with schedulers to look ahead, and there is an effort to

fill positions ahead of time if there is knowledge that someone is leaving. People services will also be having quarterly sessions on trends that exist in leaves of absence.

Retention Initiatives on Connell 10 at Kingston Health Sciences Centre

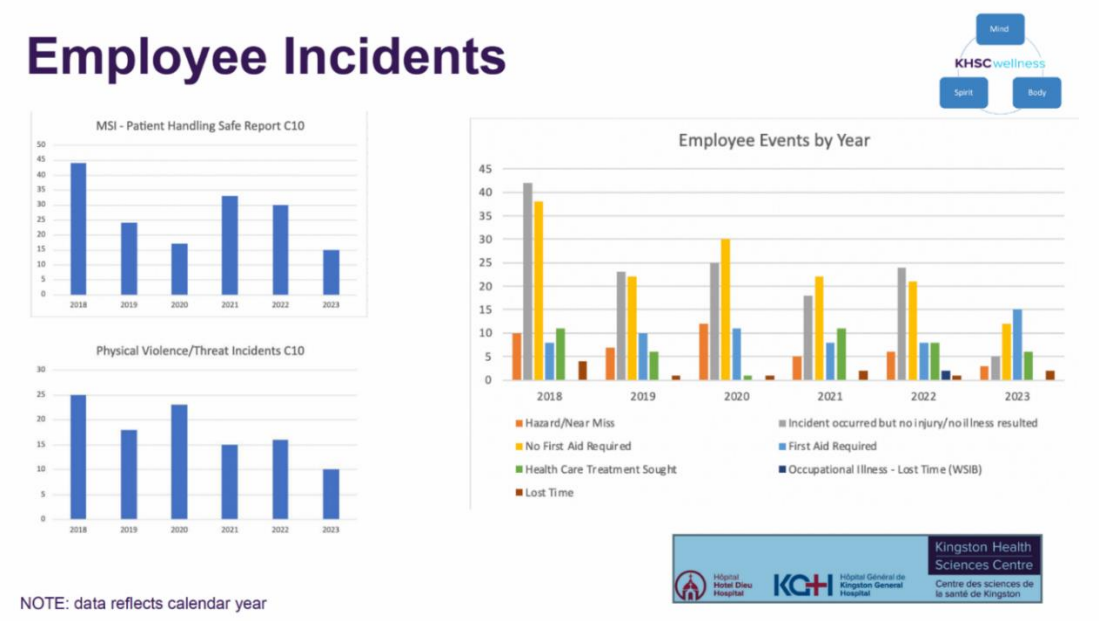
The IAC heard from both ONA and KHSC that there is agreement that recruiting lots of nurses alone will not address the staffing shortfall on Connell 10. Current nurses and new recruits will only stay if Connell 10 is a supportive work environment that fosters professional practice excellence. In addition to focusing on ***establishing safe staffing levels*** (Tomblin-Murphy et al., 2022), the hospital shared many initiatives aimed at creating a quality work environment. In many cases, ONA representatives and clinical nurses present at the IAC hearing indicated that they were not aware of the initiatives described.

For example, KHSC has developed policies and programs to protect the ***physical and psychological safety of nurses*** (Tomblin-Murphy et al., 2022) and other staff. In their presentation, the hospital shared some highlights of a health and safety program designed to ensure the physical safety of nurses and others. The programming includes, for example, incident reporting and stakeholder notification, prevention of musculoskeletal injuries, reduction of workplace violence, non-violent crisis intervention training (q. 2 years on medicine), risk reduction plans for all patients flagged with a behavioral crisis alert, smoking cessation, discounted local fitness memberships and onsite fitness facilities, onsite massage therapy, and other initiatives.

KHSC also described a staff wellness program with resources linked to an employee assistance program with extensive psychological support programs (e.g. counselling, cognitive behavioral, peer partner program, service navigation assistance, digital staff wellness platform, animal therapy). They have also launched the Canadian Mental Health Association's *Your Health Space* program for health care workers. In addition, they have sponsored leaders to attend a Workplace Mental Health Leadership program at Queens University, created wellness spaces on both sites, and have multiple programs and communication tools that are in place (or about to be launched) to provide psychological support to staff. Leaders will undergo training in December 2023 and January 2024 on how to manage traumatic/distressing situations. A toolkit of supporting resources will be launched with the training. Overall, employee health-related incidents have trended down over the last 5 years (Figure 17).

The ability of the hospital to improve the work environment by offering ***desirable and competitive working contracts*** (Tomblin-Murphy et al., 2022) is interconnected with employee collective agreements. For example, development of master schedules, implementation of creative scheduling arrangements, or flexibility in proportions of an FTE position given to part-time workers (currently, permanent part-time positions for RNs must be 0.6 FTE) are items that may help to make working on Connell 10 more desirable in the long-term.

Figure 17: Employee Incident Trends



The ability of the hospital to improve the work environment by offering ***desirable and competitive working contracts*** (Tomblin-Murphy et al., 2022) is interconnected with employee collective agreements. For example, development of master schedules, implementation of creative scheduling arrangements, or flexibility in proportions of an FTE position given to part-time workers (currently, permanent part-time positions for RNs must be 0.6 FTE) are items that may help to make working on Connell 10 more desirable in the long-term.

Supportive management and leadership practices (Tomblin-Murphy et al., 2022) are critical to creating an environment that is able to retain nurses. In just over two years, there was a complete turnover in the leadership and management teams associated with Connell 10: September 2021 (new Executive Director), January 2022 (new Operations Director), July 2022 (new Chief Nurse Executive), and May 2022 (new Program (unit) Manager). The leaders on Connell 10 have been focused on improving staff engagement on the unit and leading it through the critical nursing shortage it is experiencing. There have been some promising results (e.g. reduced nursing shortfall, improved staff engagement scores, and improved patient outcomes as outlined in the Staffing Section of this report), and a general agreement from ONA and clinical nurse representatives at the IAC hearing that the new Program Manager has made a positive difference to the morale and to enabling a supportive culture on Connell 10. However, positive support and leadership from more senior leaders is less visible to nurses. *Supportive management and leadership practices* are discussed in more detail and with recommendations in a separate section of this report.

The Hospital described a wide variety of *educational* (both onboarding and continuing education) *and professional development* opportunities as well as *mentorship and peer support programs* (Tomblin-Murphy et al., 2022) that are available to nurses on Connell 10 and their leaders. They also sponsor recognition events and awards. The ONA representatives and clinical nurses present at the IAC hearing did not know about a lot of the retention and ongoing development opportunities available to nurses on Connell 10. Very few Connell 10 nurses had participated in the education and mentorship opportunities because they either did not know about them, or they did not have the time or energy to participate.

IAC RECOMMENDATIONS:

2.1 Continue to focus on recruitment and retention and reduce the nurse staffing shortfall (actual vacancies plus unfilled leaves of absence) on Connell 10 to less than or equal to 5% by November 1, 2024.

2.2 Develop and post a visual chart of the progress made on reducing the shortfall of nurses on Connell 10. Update the chart monthly.

2.3 Collaborate with the local ONA bargaining unit to ensure that permanent part-time positions are more attractive to potential candidates. For example, explore flexible FTEs for interested applicants. Rationale: A robust part-time nursing workforce will maintain flexibility in scheduling to facilitate coverage of vacation, sick, and other personal leave time.

2.4 Explore (with the local ONA bargaining unit) the possibility of offering improved TEP incentives for new part-time hires. Rationale: A robust part-time nursing workforce will maintain flexibility in scheduling to facilitate coverage of vacation, sick and other personal leave time.

2.5 Recognize the contributions of the nurses who have chosen to work in casual positions and recruit additional casual nurses if candidates do not want permanent full or part-time positions. Engage casual nurses in all professional development and mentorship activities available to full and part-time staff in recognition that some nurses prefer the flexibility that a casual position provides.

2.6 Complete and implement the Proactive Health Human Resources Planning Framework described at the IAC hearing.

2.7 Ensure resources are assigned to the proactive health human resources planning process to enable recruitment to proceed ahead of when vacancies or leaves of absence occur whenever possible.

2.8 Ensure the leaders (including Charge Nurses) on Connell 10 take part in the planned training on how to manage traumatic/distressing situations.

2.9 Work with nurses on Connell 10 to establish a process for better communication of what is available to them (e.g. psychological supports, education, mentorship, and other opportunities), including knowing how to access updates from senior leaders.

2.10 Develop a process of scheduling nurses (and backfilling if necessary) to attend annual 4-hour continuing education sessions on multiple topics important to all nurses on Connell 10.

2.11 Conduct "stay interviews" that are proactive relationship building structured interviews. Leaders conduct these interviews with their staff to foster a culture focusing on nurse engagement and retention. During the interview, leaders explore with staff members why they stay and what actions could be taken to strengthen their engagement and retention on the unit and organization. To learn more about stay interviews process refer to Wang et al., 2023.

2.12 Conduct an exit interview/survey for all nurses who leave Connell 10 –for both internal and external opportunities. Review the results semi-annually to identify trends that may need addressing.

3.0 Communication

Communication practices of leaders are essential to build and maintain positive working relationships (Tomblin-Murphy et al., 2022). This includes actively listening and openly communicating in order to improve: trust, engagement, job satisfaction, and organizational commitment (Begstedt et al., 2020; Fowler et al., 2021)). Leader communication effectiveness is also associated with improved patient outcomes and organizational performance (Fowler et al., 2021; Mabona et al., 2022). Literature findings indicate there is a relationship between positive patient and staff outcomes with leaders who exhibit high communication skills (Fowler et al, 2021). Healthy work environments that maximize the health and well-being of nurses are essential in achieving good patient outcomes as well as optimal organizational performance.

Fowler et al. (2021) identify that a leader's communication competence is based on use of clear language, the medium that messages are conveyed in, and the behaviour used to convey the

message such as through motivating, openness, transparency, and/or coaching. Leaders' behaviours should also convey being open, empathetic, and honest, while encouraging feedback and open communication (Wu et al. 2020). It is imperative that leaders be visible either in person or electronically to listen and develop transparency with their frontline nurses. Without these communication tools, there can be a lack of trust and feelings of not being valued by nurses.

Staff need to have access to communication, resources, and/or relevant information. Internal communication provides information and can create positive relationships among the leadership team and staff (Ewing et al., 2019). There are many ways to communicate, especially within the digital world and through use of hospital intranet sites. With the changing demographics of more Generation, X, Y and Millennial staff, organizations are exploring using social media mediums beyond using email to push messages and information out.

When using social media, leaders should consider staff as active participants and co-creators in the engagement process. This can foster collaboration, mutual understanding and facilitate communication within the organization (Ewing et al., 2019). Mediums to convey messages and engage staff could be through videos, webcasts, e-newsletters, blogs, Facebook, WhatsApp, Instagram, YouTube, and/or the development of a mobile app. When creating social media sites, it is important to consider that the content must be relevant, practical, and of interest to staff rather than overloading them with information. Providing clear social media policies, guidelines, and training on how to appropriately participate on social media and maintain privacy is also very important (Ewing et al.). Lastly, it is important to be aware of generational preferences in communication strategies within the workforce and use a variety of mediums to communicate the same message (Ewing et al.).

Communication at KHSC and Connell 10

There have been a number of changes in KHSC's and Connell 10 leadership team prior to 2022. This frequent change in leadership has led to inconsistency in communication with staff and nurses' perceived lack of support by the leadership team. However, with now having a Program Manager solely responsible for Connell 10, which is new to the organization, staff are having a more positive experience. KHSC recognizes the continuity of managers within a team fosters stability and consistency in team dynamics and is crucial for building trust and rapport among team members. A positive relationship with the manager has been found to mitigate some of the common issues within work environments (Fowler et al., 2021). The Program Manager on Connell 10 spends approximately 25% of the day (2 hours/day) engaging with staff at the point of care. The staff appear to have a good rapport with the Program Manager and feel he is approachable with concerns on the unit. The manager has also adopted an open door policy for staff and provides formal and informal meetings. There is also a Clinical Learning Specialist (who works with Connell 10 staff to meet their educational needs) and the new Clinical Nurse

Scholar role. Both could support the communication of KHSC initiatives and resources in their interactions with staff.

The hospital has used different avenues to communicate with the staff, including emails, monthly Charge Nurse meetings, and with safety huddles three times weekly on Connell 10. The Program Manager also sends out weekly update emails in collaboration with the Clinical Learning Specialist group. These emails often contain updates on clinical guidelines, procedural changes, training opportunities and reminders about upcoming events or initiatives. However, there is no evidence of whether staff read the emails on a regular basis. During the Hearing, it appeared as if staff were unaware of changes and initiatives being implemented at KHSC.

The senior leadership team have also implemented strategies to increase visibility such as nursing engagement forums and councils with senior leadership and social opportunities. There are also monthly 'CNE Open Mic' forums for staff to virtually drop by for an informal discussion with the Executive Vice President Patient Care/CNE and Executive Directors for Patient Care.

On Connell 10, staff meetings were used in the past, as another avenue for communication. Since COVID-19, they have not consistently occurred. The use of staff meetings on a regular basis could bring everyone together to discuss successes, challenges, and individual and unit needs. Staff meetings can also serve as a venue to communicate hospital wide initiatives. These types of meetings ensure people hear the same message at the same time and increase accountability, engagement, team building, and problem solving. Minutes of the meeting should be taken, to ensure that those who could not attend the meeting, have access to the information discussed.

Huddles are a short meeting, involving interdisciplinary health team members which last no more than 10 minutes. The ultimate purpose of these huddles is to share information and highlight concerns to be followed up, not to solve issues. Safety issues are also part of the everyday huddle on the unit. Research has found that when huddles are consistently implemented, communication amongst healthcare team members improves and it is an effective way to share information (Di Vincenzo, 2017). Implementing huddles can also engage and empower frontline staff while promoting problem identification and a culture of collaboration and quality in the delivery of care (Shaikh, 2020). While safety huddles are currently being implemented 3 times/week on Connell 10, huddles are not being implemented on a daily basis with staff members.

It became clear throughout the Hearing, that staff were unaware of organizational changes, available resources, or not completely aware of changes and initiatives and/or how to access them. Staff also appeared to be unaware of the many professional development opportunities and resources on the Staff Wellness Website. While it is important for the leadership team to foster increased awareness of the organizational changes, opportunities and resources, nurses also have

the professional responsibility to seek out relevant standards, policies and resources related to their practice.

Another method of communication between leaders and nursing units is through the Nursing Practice Council. The hospital-wide Nursing Practice Council meets monthly and discusses professional practice issues. The Nursing Practice Council also serves as a venue to learn about and provide feedback on corporate-wide nursing initiatives, and participate in the development, implementation, and evaluation of quality improvement initiatives. The unit representatives on the Practice Council can then share this information with the nurses on their unit. Presently there is not a Connell 10 representative on the Nursing Practice Council.

IAC RECOMMENDATIONS:

3.1 The Hospital should explore social media strategies with staff, for example through WhatsApp. Staff would be co-creators to foster engagement, collaboration, and communication on the unit and within the organization.

3.2 Policies, procedures, and education are in place, on how to use social media apps appropriately ensuring privacy.

3.3 Multiple communication strategies to facilitate nurses' awareness of changes, initiatives and opportunities be implemented.

3.4 Daily huddles will occur every day in the morning lasting no more than 10 minutes. These will begin immediately. The huddles should be held at the same time daily. The time will be determined with input from the staff. Attending the daily huddles should be a priority for all staff, recognizing this is dependent on workload.

3.5 The Program Manager (Monday-Friday) and/or the CN (Saturday and Sunday and as necessary Monday to Friday) will lead the huddles, items may include safety issues, patient issues and goals, and/or staffing.

3.6 The Program Manager will ensure unit issues are brought forward to organizational load leveling huddles and addressed as needed.

3.7 Staff meetings are to be held on a monthly basis, at a time convenient for staff, i.e. during the day, evening, or through Zoom. Minutes will be taken during the meeting and shared with staff within 5 business days of the meeting.

3.8 A week before the meeting, staff will be asked for input on the agenda items to be discussed.

3.9 The Clinical Learning Specialist and Clinical Nursing Scholar actively communicate relevant KHSC initiatives and resources in their interactions with staff beginning immediately.

3.10 Establish a corporate Professional Practice Committee with ONA and KHSC Professional Practice team to discuss non-operational initiatives, with the focus on practice, research, education, recruitment and retention, and communication initiatives.

3.11 Identify a Connell 10 nurse who will represent the unit on the Professional Practice Council.

Operations Manager

During the IAC Hearing, an area of concern raised by ONA and staff members was the load levelling communication process related to the reassignment of Connell 10 nurses. Nurses expressed concern when a decision was made by the Operations Manager (OM) to reassign a Connell 10 nurse when they were already short staffed on the unit. Nurses stated that their voices were often not being heard when they tried to advocate for the Connell 10 nurse to remain on the unit.

The OM's role is to manage and direct all patient flow 24/7 at KHSC and be responsible for all leadership and management from 15:00-07:00 Monday to Friday and 24/7 on the weekends. As previously discussed, load levelling is used to balance patient need, the nurse-to-patient ratios across all units, and services across programs and there are multiple levels of input and frequent reassessments each day to balance patient needs and workload, optimize available staff and support staff time off.

While the IAC recognize the need for load levelling, the communication process could be improved by the following recommendations:

IAC RECOMMENDATIONS:

3.12 The OM will take into consideration acuity on both the sending and receiving units prior to reassigning a nurse, not just the number of nurses on each unit.

3.13 The OM/Manager will communicate to the Charge Nurse the reasoning behind the reassignment in order for the unit to better understand the decision-making process. If they are on site, they could communicate this in-person.

3.14 The CN will contact the Operations and/or Program Manager to further discuss the load levelling decision if the CN believes the leveling decision may be inappropriate based on

the acuity and complexity of the unit. The Operations and/or Program Manager will then either follow up in person or by phone with the CN to discuss the decision.

4.0 Leadership

Background

From 2017-2023, there have been multiple leadership changes at the manager and senior management levels. For example, Connell 10 has had 5 Program Operational Directors and 3 Program Managers since 2017. The current Program Manager on Connell 10 has been in the position since May 2022, and has been in the role, alongside the current Program Operational Director for the longest amount of time on the unit since 2017. The Program Operational Director has been in the role since January 2022 reporting to the Executive Director Patient Care, who assumed accountability for the Medicine portfolio since September 2021. In both the KHSC submission and presentations it was emphasized and demonstrated that the present Program Manager fosters an open-door office policy, demonstrates authentic and transformational leadership, and has an on-unit presence that promotes staff to provide feedback and share their concerns with them.

In March 2022, the Charge Nurse role changed. On Connell 10, a two-Charge Nurse model to support Charge Nurse coverage 7 days/week from 07:00-19:00 was implemented. Both roles are presently filled with nurses who have more than 15 years of seniority. During the IAC Hearing, the committee heard other Connell 10 nurses describe how they had been assigned to assume a Charge Nurse assignment on Connell 10 when the Charge Nurse was off and/or when assigned to another unit as a result of load levelling. The nurses conveyed their concerns of not having the knowledge to be a Charge Nurse resulting in emotions such as anxiety, fear, distress, and frustration.

The KHSC submission identified that in the past, there was an active Unit Based Council on Connell 10 that developed guiding principles for nursing assignments that are being used by the unit's Charge Nurses. However, the Unit Based Council has since dissolved. The IAC asked the nurses why there was a lack of interest in re-establishing the Unit Based Council. The nurses described that at this time, their exhaustion has led them to not being able to do any more than work their shifts.

Leadership occurs at all levels in formal and informal roles. The College of Nurse of Ontario (CNO) identifies that leadership occurs in all practice settings regardless of a nurse's role or title through advocating for clients, promoting quality practice settings, building and sharing knowledge, and reflecting on their leadership (CNO, 2023a). The Government of Canada (2023) Nursing Retention Toolkit, highlights the importance of inspired leadership where nurses are

empowered at, “all levels, roles, and settings to experience fulfillment in their work and become leaders within their organizations.”

There have been several initiatives developed and implemented at KHSC to foster leadership at all levels of practice. However, during the IAC Hearing and within both ONA and KHSC’s submissions, leadership at the point of care, Charge Nurse, manager and senior leadership were identified as areas for further development.

4.1 Leadership at the Point of Care

Presently on Connell 10 more than half of the nurses on Connell 10 have less than 6 years’ experience with many having less than 3 years’ experience. Novice nurses, require support in transitioning from the student role to a novice RN, especially in the first year as they go through what has been described as Transition Shock, which will be discussed more in the Continuous Professional Development recommendations. However, it is important to note, that each novice nurse has different learning and professional development needs. The assumption cannot be made that all nurses between 0 to 3 years are inexperienced and cannot or do not want to develop their professional leadership role. There are nursing students who have strong leadership roles within their nursing programs, sitting on academic committees, leading nursing student associations, advocating for nursing students and social issues, who then graduate and express discouragement and frustration that there appears to be limited opportunities to implement their leadership abilities within practice. This can result in them looking for other opportunities such as applying to be a nurse practitioner after 2 years full-time nursing practice, transferring to another unit, or leaving the profession.

IAC RECOMMENDATIONS:

4.1.1 Following the first three months on the unit, the Program Manager, Clinical Learning Specialist and where appropriate the Clinical Nursing Scholar meet with new hires individually to explore what their professional goals are and discuss with them, leadership opportunities on the unit and within the organization.

4.1.2 The Manager, Clinical Learning Specialist, and Clinical Nurse Scholar encourage and support nurses on the unit who demonstrate emergent leadership abilities to become more involved in such opportunities as the Unit Based Council, Nursing Practice Council, and the Charge Nurse role.

4.2 Unit Based Councils

During the IAC Hearing, the IAC also heard of opportunities for nurses to develop their leadership at the point of care through Unit Based Councils and the Nursing Practice Council. At the time of the Hearing, Connell 10 nurses were not participating in either.

Unit Based Councils have been found to develop nurses' leadership skills at the point of care, foster critical thinking, autonomy, foster collaboration, and communication and problem-solving skills, increased job satisfaction and retention (Berta & Ceriani; Jordan, 2016; Kanninen et al., 2021). The overall purpose of Unit Based Councils is to foster the nursing staff to collaboratively work together to make decisions and develop practices in relation to patient care, unit-specific policies, effective communication, development of evidence-based nursing practice, quality improvement, professional development initiatives, and point of care leadership and mentorship (Berta & Ceriani, 2022).

In developing Unit Based Councils, support from the nursing leadership on the unit and organization is imperative. Jordan (2016) describes the first step in forming a Unit Based Council is to establish a planning team to brainstorm ideas about the Unit Based Council's structure and function, leadership, marketing, and target dates to keep the Unit Council development on track. In developing the plan, being flexible and open to colleagues' ideas and input is recommended.

When creating a Unit Based Council, it is important that nurses develop guidelines to identify the work of the Council (Kanninen et al., 2021). The unit-based guidelines should focus on purpose, membership, leadership, nurse manager role, meeting frequency functions and responsibilities (Jordan, 2016). While the Unit Based Council membership should be led by the nurses on the unit, consideration should be made for including members of the interprofessional team, to inform other aspects of patient care on the unit.

To launch a Unit Based Council, it is also important to identify champions to market and generate excitement about the purpose and benefits of having a Unit Based Council. Concerns related to the role of the council, staffing constraints, and participation may be voiced. These concerns can be addressed through strategies of brainstorming what will work for their unit, flexible meeting times, scheduling staff to be working on the days of the meetings, and the use of electronic communication such as Teams or Zoom (Jordan, 2016). These concerns can be raised with the Manager to provide support in addressing them. Nurses from units that have an established Unit Based Councils could meet with the nurses on the unit to describe how they got their Unit Based Council started, and strategies they are using to ensure the effectiveness of it.

It is also important to support the Chair of the Unit Based Council. The chair should have a mentor and attend sessions with other chairs of unit councils focusing on leadership styles, communication, leading meetings and agenda setting, quality improvement techniques, project management and goal development (Jordan, 2016). A shared governance model where there is a co-chair from a formal leadership position, such as a Manger or Clinical Learning Specialist on the unit, is also an effective way to help council members facilitate the process, and to serve as a support and resource person for the work of the council.

IAC RECOMMENDATIONS:

4.2.1 The Program Manager meets with the nurses to gain a better understanding of their reluctance to develop a Unit Based Council and to discuss the advantages and barriers to developing a Unit Based Council on Connell 10 by March 31, 2024.

4.2.2 Based on this discussion, begin to address the barriers to creating a Unit Based Council.

4.2.3 Identify nurses on the unit with emerging leadership skills, who would consider being champions in developing a Unit Based Council.

4.2.4 Identify a clinical nurse and a nurse in a formal leadership role (other than the CN) on Connell 10 to co-chair the unit council.

4.2.5 Provide paid time and/or adequate staffing for interested nurses to be off the unit to plan the development and implementation of the Unit Based Council activities.

4.2.6 Have nurses from a unit with a Unit Based Council meet with the Connell 10 nurses to discuss their journey in establishing the Council, and the advantages and challenges to having one during the staff meeting in March, 2024.

4.2.7 Provide the time for nurses who are interested in developing a Unit Based Council on Connell 10 to attend Council meetings on other units. This will enable them to gain a better understanding of how to conduct the meetings, the processes to be followed, and the type of initiatives to improve nursing practice that can be explored by a Unit Based Council.

4.2.8 Professional Practice team develops a workshop for nurses interested in leading the development of Unit Based Councils, focusing on leadership skills, how to conduct meetings, goal setting, communication skills, and project management by June 30, 2024.

4.2.9 Engage the Clinical Learning Specialist and/or Professional Practice Lead to support the nurses developing the Connell 10 Unit Based Council.

4.2.10 Provide a resource person/contact for the Unit Based Council Chairperson from the centralized KHSC Professional Practice team.

4.2.11 As this process is occurring, the Program Manager should also be exploring interest in being a member of the Nursing Practice Council with nurses demonstrating emerging leadership skills. To begin this process, interested nurses could attend a Nursing Practice Council meeting, to gain a better understanding of what the Nursing Practice Council does and how the nurses from Connell 10 could have a voice and participate in decision making on the Council.

4.2.12 Ensure the Connell 10 Nursing Practice Council representative has the paid time to attend the meetings, or if they are working, that there is replacement staff to enable them to attend meetings.

4.3 Charge Nurse Leadership Development

Charge nurses (CN) are unit leaders with the responsibility of ensuring nursing care is provided and issues are resolved. The leadership knowledge and skills to promote success as a Charge Nurse include communication, conflict resolution, delegation, and the ability to support health work environments and service excellence (Spiva et al., 2020). CNs are also often the "go-to-person" for questions and support by less experienced nurses (Liesel & Hall, 2023). During the IAC Hearing, the CN described the responsibility of supporting the team, many of them novice nurses, alongside ensuring the nursing care was being delivered and the Charge Nurse responsibilities were being completed.

The evidence outlined in the literature highlights the importance of leadership training. One of the areas identified for CNs to develop is their own self-awareness. Self-awareness is a person's ability to understand their own personal strengths, weaknesses, and influence on others (Shirey, 2015). Research has demonstrated that having self-awareness, facilitates better decision making, building stronger relationships, communicating more effectively, understanding others better, being a better leader, and being happier in performing the role. (Eurich, 2018; Macleod, 2019).

Leadership training is imperative in a CN's development (Delamater & Hall, 2018). Managing a team is one of the areas of importance including how to facilitate teamwork, collaboration, and managing others. Other areas to focus on in leadership development are conflict resolution, delegation, creating healthy work environments, and service excellence (Delamater & Hall, 2018).

KHSC's submission highlights the creation of a corporate CN program that consists of an 8-hour in-class day for novice nurses, two buddy shifts with an expert Charge Nurse, a self-assessment competency checklist, and a roles and responsibilities tool that outlines key tasks of the Charge Nurse on days and nights. There are also monthly CN meetings that allow for Charge Nurses to meet and discuss unit specific topics, corporate changes and planning, changes to patient flow, professional development related to leadership, and the development of a Charge Nurse resource binder.

IAC RECOMMENDATIONS:

4.3.1 Ensure there is adequate staffing on the unit on the day of the monthly CN meeting, so that the nurse in the shadow CN role can assume the Charge Nurse duties while the Charge Nurse attends the meeting.

4.3.2 Promote the availability of the corporate CN program for all nurses interested in being a Charge Nurse (permanently or as needed).

4.3.3 The Program Manager and/or the Clinical Learning Specialist will, as part of professional development discussions with nurses on Connell 10, inquire about their interest in being assigned to the CN role on an as needed basis. This would increase the pool of registered nurses willing to fill the role. This would also ensure continuity of the role.

4.3.4 Those nurses who may wish to replace the Charge Nurse for incidental times, i.e. vacation, sick time will be provided with the CN Education program already in place at the hospital.

4.4 Program Manager

Many nurses are placed in leadership positions, without the proper support and education in the knowledge and skills necessary to be an effective leader (Cope & Murray, 2017). The nurse manager or Program Manager (PM) which is the title used at KHSC, plays a critical role in job satisfaction, retention of point of care nurses and patient satisfaction and outcomes (Cave et al., 2023). In the KHSC IAC Hearing submission, the Program Manager's job description identifies the PM is, "fully accountable for the operations of their unit and meeting specific objectives through: safe and effective patient care; staff engagement and personnel management; financial management; and organization and system collaboration. The PM is also responsible for "developing and monitoring policies and budgets, managing human resources, promoting best practices and using clinical knowledge and leadership skills for actively promoting and supporting patient and family centred engagement and care". Based on the KHSC submission and during the IAC Hearing, the Program Manager on Connell 10 demonstrated transformational

leadership attributes, is highly visible, approachable, and committed to fostering a quality and healthy work environment.

Cave et al. (2023) performed a scoping review of organizational supports for nurse managers. Their review identified that in order for the nurse manager to be successful, they require a comprehensive orientation to the role. Competency and professional development in leadership and being a nurse manager should also focus on becoming a transformational leader, problem solving, strategic planning, and business and relational leadership skills. Support in performing the administrative roles of the position, for example in HR and finance related workload, can provide more time for the nurse manager to be present with staff, and improving job satisfaction for the manager and staff (Cave et al., 2023). The support of higher management was imperative in supporting the nurse manager in such areas as providing professional development opportunities, regular check-ins, communication of organizational initiatives, mentorship, and coaching in addressing difficult situations and conversations (Cave et al., 2023).

In the KHSC submission, the importance of a consistent managerial presence was highlighted as it provides staff with a sense of security, positive work environment and facilitates the team's decision making and problem-solving capabilities. During the IAC hearing, leadership development and support of formal leaders were outlined through the leadership and talent development team. Examples were given of resources such as a toolkit to focus on leadership frameworks such as LEADS (lead self, engage others, achieve results, develop coalitions and system transition), LIFT and RISE (reach, inspire, succeed, excel) were promoted to develop KHSC's formal leaders. Continuing education is also offered through Queen's University in providing a quality improvement certification and developing leadership presence program and obtaining and Masters in Nursing through the University of Ottawa.

IAC RECOMMENDATIONS:

4.4.1 The Program Manager reviews with the staff, KHSCs and Connell 10's organizational structures and communication processes to ensure successes and challenges are being identified and heard.

4.4.2 The Program Manager continues their authentic, active listening, and transformational leadership and communication with staff.

Senior Leadership Team

KHSC's submission and the information presented during the IAC Hearing, indicates a more stable senior leadership team. This began in 2021, with the Executive Director Patient Care, assuming accountability for the Medicine portfolio, the Program Operational Director beginning

the role since January 2022, and the Program Manager being in the role as of May 2022, who reports directly to the Program Operational Director. The Executive Vice President Patient Care and Chief Nurse Executive has been in the position since July 2022. Since the stabilization of the senior management team over the past year and a half, many corporate initiatives have been implemented to focus on the development and support of staff and delivery of patient care.

The senior leadership team have also implemented strategies to increase visibility such as nursing engagement forums and councils with senior leadership and social opportunities. There are also monthly 'CNE Open Mic' forums for staff to virtually drop by for an informal discussion with the Executive Vice President Patient Care/CNE and Executive Directors for Patient Care.

Transformational leaders focus on listening, effective staff engagement, empowerment and open communication, and high visibility. Authentic leaders demonstrate honesty and integrity and build trust and hope with the people they work with while encouraging shared decision making. (Bergstedt & Wei, 2020). Examples of attributes and behaviours of effective leaders are being critical thinkers, emotionally intelligent, inspirational, innovative, and present and available (Cope & Murray, 2017). Evidence indicates that leaders who are transformational and authentic lead to improved job satisfaction, recruitment and retention, and patient outcomes on their units (Fischer, 2017).

IAC RECOMMENDATIONS:

4.5.1 While senior leadership has stabilized, and corporate initiatives have been implemented, it is imperative that the leadership team continue to focus on being visible, listening, and implementing qualities of transformational and authentic leadership in their daily interactions with staff.

4.5.2 Evaluate leadership initiatives within the organization on an annual basis, to identify effectiveness and areas for improvement to support the implementation of patient care, patient outcomes, staff supports, and quality work environments.

5.0 Professional Development

Overview of Continuing Professional Development:

Continuing Professional Development (CPD) is a lifelong learning process that can improve the quality of nursing practice; increase job satisfaction, recruitment, and retention; and improve patient health outcomes (Vazquez-Calatayud et al., 2021). Hakvoort et al., 2022 defined CPD as,

"a life-long process of active participation by nurses in learning activities that assist in developing and maintaining their continuing competence, enhancing their professional practice and supporting achievement of their career goals" (p. 2). CPD is also essential to meet the professional regulatory requirements of keeping nurses' knowledge and skills current and up to date (Miambo et al., 2021; Vazquez-Calatayud et al.).

Factors Influencing CPD:

King et al., (2022) did a scoping review examining the factors that influence CPD over a nursing career and identified 5 key factors that influence CPD. They are self-motivation, relevance to practice, workplace learning, strong supportive leadership, and a positive organizational learning culture. It is important to remember that these 5 factors are inter-related, with the whole being greater than the sum of the individual factors. An example of this would be that, even if nurses are motivated to participate in a CPD opportunity, such as crucial conversations, if there is not a supportive workplace for learning, the ability to take the course, and strong supportive leadership, the uptake of this learning opportunity will, in all likelihood, not be good.

Self-motivation includes nurses 'willingness to learn, increase their professional knowledge, improve quality of care, improve practical skills, and advance their professional career (King et al., 2022; Miambo, et al., 2021; Vazquez-Calatayud et al., 2021). The CPD opportunity's relevance to nurses' practice will influence their self-motivation. If nurses see that the CPD opportunity will enhance their nursing practice and/or help them to meet their standards of practice, they will be more self-motivated in participating in the learning opportunity (King et al., 2022; Vazquez-Calatayud et al., 2021). Ease of access to the CPD opportunities also increases nurses' self-motivation (Miambo et al., 2021).

Workplace learning is also an important influence on nurses' CPD, as it can support a transfer of knowledge into practice. Having supports such as a mentor, or coaching from more experienced nurses are also effective workplace learning practices. Nurses also find that learning at the point of care is very effective for developing new psychomotor tasks and knowledge application (King et al., 2022).

Strong leadership through being change agents and role models, is imperative in enabling nurses' access to CPD opportunities (Hakvoort et al., 2022). Within the organization, Program Managers and other leaders such as Clinical Learning Specialists and/or Clinical Nurse Scholars, can encourage individual nurses to identify their own learning needs and professional goals. They can then support the nurses in seeking out and accessing professional development learning opportunities to meet their goals (King et al., 2022; Miambo et al., 2021).

A positive learning environment and workplace culture , adequate resources (time and staffing), administrative support, a variety of easily accessible learning opportunities, and financial support

where necessary, also fosters nurses' self-motivation to access CPD opportunities (Hakvoort et al., 2022, King et al., Miambo et al,. 2021).

Barriers for nurses accessing CPD learning opportunities have been identified as staffing shortages, workload, work schedule, unsupportive colleagues and leadership, and lack of time. These barriers can lead to decreased self-motivation and ability to access CPD opportunities (King et al., 2022). Fatigue/burnout and/or trying to achieve a balance between family and professional life can also be major barriers to nurses' self-motivation in accessing CPD activities (Miambo et al., 2021; Vazquez-Calatayud et al., 2021). When personal time is required for CPD learning, this time can conflict with family life and commitments that can lead to resentment and not wanting to pursue the CPD opportunities (Vazquez-Calatayud et al., 2021).

CPD Learning Opportunities across the Lifespan

Nurses have different CPD needs depending on where they are at in their nursing career, their knowledge, skills, experience and their personal and professional goals (Hakvoort et al., 2022; Vazquez-Calatayud, 2021).

Novice Nurses:

In the IAC Hearing, KHSC acknowledged that there have been significant RN vacancies on Connell 10 since 2018. Over the past 18 months there has been an increase in newly hired RNs to Connell 10. However, ONA emphasized that the majority of nurses on Connell 10 had from 0 to 3 years of seniority. The distribution of RN seniority is found in Figure 18. As experience does not equal seniority, since the nurse may have been hired from another organization with previous experience, Figure 19 highlights the RN experience on Connell 10. Both graphs indicate that in 2023, more than half the nurses have less than 6 years' experience, with many of them having less than 3 years of seniority.

Figure 18: RN Seniority Distribution on Connell 10 in 2023

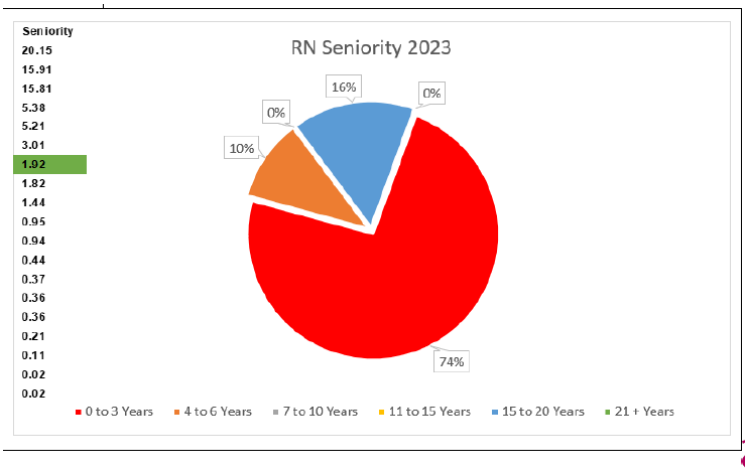
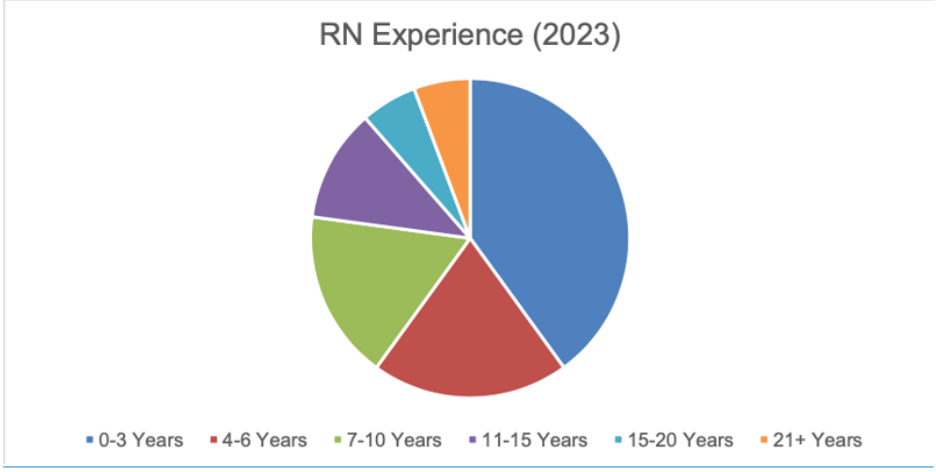


Figure 19: RN Experience Distribution on Connell 10 in 2023



KHSC's onboarding of newly hired nurses includes, participating in 56 hours of in-class orientation as well as 152 hours of on floor orientation as a minimum. They are also enrolled in the nursing mentorship program that was introduced on July 22, 2023 for the 12 shifts where the new hires work alongside a mentor (nurse on the unit). Education and support are provided to the mentors. New hires are required to meet key competencies outlined on a competency checklist throughout the onboarding program. New hires also meet at pre-scheduled touch points with the unit Clinical Learning Specialist and Program Manager where a standardized Mentorship Program Progress Report is followed to ensure the new hire is successful and that any learning needs are identified and proactively addressed. If there is a need identified by the Program Manager and Clinical Learning Specialist to extend the orientation period, this can be identified and arranged in a timely manner. KHSC also has created a new Clinical Nurse Scholar role where 4 temporary full-time expert nurses support novice nurses with skill development and practice challenges beyond the orientation period.

Novice nurses require support in transitioning from the student role to a novice RN. Benner's novice to expert theory identifies being a novice and advanced beginner occurs within the first year of practice. Duchscher's stages of transition theory identify that in the first three months, new graduates move from focusing on doing tasks to adjusting to being a registered nurse. In the second phase (4-8 months) the new nurse completes the tasks with more confidence and begins to accept responsibility in their critical thinking and decision making. They may no longer require a preceptor and are more independent in their practice. However, they are not yet ready to assume an informal or formal leadership roles. In the third phase (9-12 months), the nurse feels confident implementing independent practice. Both Benner's and Duchscher's transition

model highlights the importance of effective support and mentorship over the first year following graduation not just during the initial orientation period (Graf et al., 2020).

Experienced Nurses:

Experienced nurses have intrinsic and extrinsic motivation to access CPD opportunities to improve their clinical practice, knowledge, skills, and confidence; and to enhance their career by improving their readiness for new or different job requirements. The CPD opportunities need to be relevant to improving their nursing practice and professional goals.

The Medicine Program has sponsored numerous paid professional development opportunities since January of 2022 such as CNA certifications, LEAP palliative care education courses, BCLS, ACLS and PALS courses, quality improvement programs through Queens University, crucial conversations courses, dementia care courses, stroke symposiums, venipuncture and IV insertion training, and palliative care conferences. However, there has been minimal uptake of these opportunities by Connell 10 nurses.

Connell 10 has revitalized unit specific peritoneal dialysis (PD) upskilling and training, with biannual education provision provided to staff by current unit Clinical Learning Specialist's and Renal Program Clinical Learning Specialist's. Connell 10 has been working with the Hospital's Professional Practice department to roll out monthly "hot topic" education sessions in collaboration with the Clinical Learning Specialist, placing emphasis on reinforcing skills and education for relevant and timely skills.

Connell 10 CPD Needs

While KHSC does provide good onboarding of new nurses within the first 3 months of employment, there does not appear to be any other formal resources following this other than the Clinical Learning Specialist and in the implementation of Clinical Nurse Scholar role, but there are only 4 temporary Clinical Nurse Scholars across the organization. During the Hearing, the nurses identified that the Connell 10 Clinical Learning Specialist was very good, although addressing the learning needs of all the nurses on the unit, is difficult. One way to assist with this could be engaging staff on Connell 10 through peer support activities.

Peer Support

The concept of informal mentorship or peer support has been found to assist nurses' transition into new roles, improve retention and recruitment of staff, improve job satisfaction, and promote evidence-based care (Calaguas, 2023; Venkatesa Perumal & Singh, 2022). There are different types of peer support with the most often thought of, as being done in a dyad that is occurring

with the new hires on Connell 10. Mentoring in a dyad occurs when an experienced and knowledgeable nurse supports someone new to their role and responsibilities.

There are other forms of peer support that can engage more staff on the unit in supporting learning needs and practice. Peer support occurs when nurses at the same point of learning in their role, support one another through sharing their experiences. This type of peer support has been found to foster collegiality, confidence, and collaboration (Calaguas, 2023). Functional peer support focuses on specific skill development, for example seeking out someone to assist in the development of an initiative or who is an expert in a specific area supporting other staff in their knowledge of that area. Constellation peer support involves different peers with different areas of expertise for the nurse to learn from (Caluguas). For example, a novice nurse manager could learn from an experienced nurse manager alongside an expert Professional Practice leader and/or Clinical Learning Specialist. A novice nurse could have an assigned experienced nurses as a support, a peer who started at the same time to support one another as they become more independent in their practice, and the Charge Nurse to answer questions about policies and procedures. While in all likelihood, these types of peer supports are occurring informally, formalizing the process could provide staff with the acknowledgement of how they are contributing to strengthening social connections amongst staff and fostering a positive learning culture on Connell 10.

Resilience

Nurses at the Hearing also identified that the staff shortages, inability to leave the unit, and overall fatigue and/or burnout, have influenced nurses' self-motivation and ability to take CPD opportunities. Research during the COVID-19 pandemic indicates an increasing deterioration in health care providers' mental health resulting in higher levels of anxiety, stress, and burnout (Labrague, 2021). Resilience has been identified as serving as a protective role against anxiety, stress, fatigue and insomnia (Labrague, 2021). Resilience is a process in which people can adapt to adversities and remain hopeful despite adverse circumstances (Duncan, 2020).

Resilience can be developed through strategies such as finding meaningful purpose in life, and the belief that one can influence one's surroundings and the outcome of events (Duncan, 2020; Wei et al., 2019). Work based education programs that teach resilience techniques and support personal development have been shown to improve resilience (Duncan). One strategy to facilitate resilience is promoting positivity within the workplace rather than focusing on all that is negative (Wei et al.). A way to do this, is to have the staff identify things that went well during the shift, rather than all that went wrong. Practicing self-compassion and compassion and gratitude of others, can also contribute to a more positive work environment (Duncan). Increasing social support and interactions amongst team members is important to strengthen resilience and can strengthen teamwork, reduce stress, and improve the well-being of staff (Wei et al.).

Individual and group skill training programs have been found to increase resilience and coping skills through such activities as mindfulness, and reinforcement of positive coping strategies to manage stress, anxiety, fatigue and/or burnout (Labrague, 2021). Fostering mindfulness on the unit can be done through taking breaks on the unit to do mindfulness strategies such as journaling, colouring, drawing, and listening to music. Doing deep breathing exercises during the day such as three deep breaths while washing hands or entering a patient's room can also contribute to increased well-being in the moment (Wei et al., 2019). Improving physical health including sleep, exercise, and diet also contributes to increased resilience and coping strategies.

In order to develop resilience, nurses need to be self-aware of their personal triggers for stress, coping strategies and how others can support during these times (Tomlin et al., 2020). Self-awareness is the ability of an individual to see themselves clearly and understand their own personal strengths, weaknesses and influence on others (London et al., 2023; Shirey, 2015). Self-awareness can be developed through self-reflection, feedback and coaching. (London et al.).

KHSC has developed a KHSC Wellness program that encompasses mind, spirit and body initiatives and programs. There is a staff wellness website that promotes physical and mental wellness in the workplace and provides employees with a variety of resources and tools that encourage healthy eating, active living, stress management and healthy lifestyle practices. There is a monthly blog and tip sheets available to staff focusing on mindful moments. Example of physical well-being programs are smoking cessation, discounted local gym memberships, and massage therapy on every Wednesday at the KGH site with a registered massage therapist.

While all these are all excellent programs to promote nurses' mind, spirit and body well-being, they all require the individual to be self-motivated to reach out and access them when they are not working or being able to leave the unit. During the Hearing, nurses described how they were too tired to do anything related to work on their days off and family commitments took priority over doing any professional development, while some nurses appeared to not be aware of all that is being offered and how to access opportunities.

Summary:

Continuous professional development CPD) is a lifelong learning process that can improve the quality of nursing practice, increased job satisfaction, recruitment, and retention, and improve patient health outcomes. However, offering different CPD opportunities and expecting nurses to take advantage of them on their own initiative is complex. The 5 factors of self-motivation, relevance to practice, workplace learning, strong supportive leadership, and a positive organizational learning culture need to be considered as they all interact and influence nurses' ability to take advantage of the CPD opportunities. Nurses also have different CPD needs depending on where they are in their nursing career and their personal and professional goals.

While KHSC offers many excellent CPD opportunities and well-being programs, the barriers that presently exist on Connell 10 (staffing shortages, access to the learning opportunities, time, family commitments, financial resources if required for the activity, and an overall sense of fatigue/burnout) are contributing to decreases in nurses' self-motivation and uptake of the learning opportunities. In order for nurses to take advantage of the different CPD opportunities the IAC recommends the following:

IAC RECOMMENDATIONS:

5.1 The Program Manager, Clinical Learning Specialist, and/or Clinical Nurse Scholar discuss with nurses individually about their personal and professional goals and the type of learning opportunities and access they would need to assist in meeting them.

5.2 When developing CPD opportunities, ensure the 5 factors of self-motivation, relevance to practice, workplace learning, strong supportive leadership, and a positive organizational learning culture are taken in account to improve nurses' uptake of the different opportunities.

5.3 To improve access to professional development activities, develop a process of scheduling nurses (and backfilling if necessary) to attend annual 4-hour continuing education sessions on multiple topics important to all nurses on Connell 10. The 4-hour sessions could be repeated on 2-3 different days or on the same day to maximize availability of nurses to attend.

5.4 Engage nurses in identifying the topics that they would like explored during the education sessions and combine them with continuing education specifically needed on Connell 10.

5.5 Include sessions on mind-spirit-body within these blocks to assist nurses in acquiring self-awareness and mindfulness strategies to build their resilience. The massage therapist who is presently available once a week, could also go to the different units at scheduled times or during these educational sessions to offer nurses a massage, rather than nurses having to be able to leave the unit to access this service.

5.6 Ensure learning opportunities and support of novice nurses continues for their first year of employment, not only in the first 3 months with the present onboarding activities.

5.7 Formalize the development of the different forms of peer support to promote different learning opportunities on the unit and a positive learning culture.

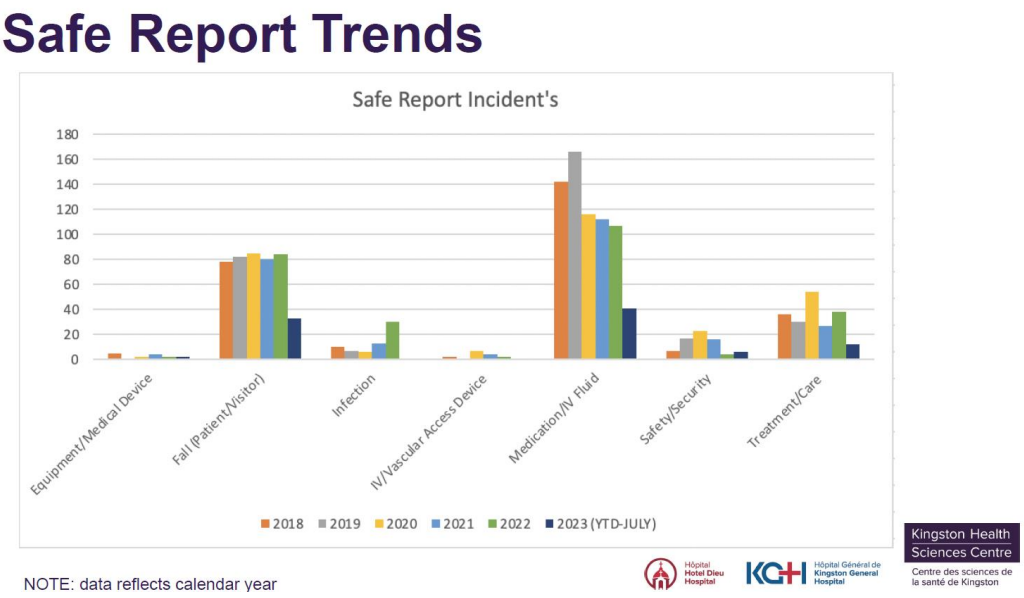
6.0 Risk Reduction and Workplace Violence

ONA's submission and presentation indicated that workplace violence on Connell 10 was being under-reported, as there were discrepancies in the number of Security Incident Reports generated and the SAFE tool reports used for both patient and staff events and hazards.

The SAFE tool was implemented by KHSC to eliminate the need for staff to submit both a patient and staff incident report and gathers data not only on Code White data, but other incidents. For example, data is obtained on employee affiliated incidents, use of restraints, falls, adverse drug reaction etc. The Security Incident Report encompasses a number of incident categories other than Code White, such as stand-by, code yellow, request for assistance, harassment, patient watch, arrest etc. The Code White code is also used for other situations beyond staff feeling physically at risk or threatened. Examples of this are when patient exit seeking behaviour occurs, patient harm, or a visitor who has coded in the elevator bay on Connell 10. Lastly, if staff and/or security are able to de-escalate the situation, and staff do not feel at risk of harm, a SAFE report does not have to be completed.

The SAFE Report Trends (Figure 20) indicate that safety and security issues have been 20 incidents or less since 2018 on Connell 10, with less than 5 in 2023 up until July. In an audit of 150 randomly selected patient charts for patient admissions on Connell 10 in 2023, 2 had documented restraint use (1.3%).

Figure 20: SAFE Report Trends



KHSC has a Code White debrief process that is in the process of being revised where the manager will lead (whenever on site) the debriefing with staff in examining strategies, precautions, and/or changes in clinical interventions or approaches that could be used to reduce behavioural escalation. Broader organizational improvements are also explored to reduce the risk of workplace violence. As well, a feedback loop in SAFE reporting has been developed that allows a staff member to go into the SAFE report on the RL, which is KHSC's incident reporting software, where they can view the report they submitted to see what follow-up and actions have been taken. During the Hearing, staff indicated they were unaware of how to access SAFE reports.

KHSC has instituted a number of initiatives to address issues related to risk reduction and workplace violence. For example, a patient behaviour management and least restraint policy is currently followed. A Patient Observation Manager role has been instituted, to provide support to staff in enhancing patient safety with patients who may require constant observation. This manager works with the interdisciplinary team including the CN and/or the assigned nurse to develop a care plan based on patient need, resources, and tools available. Nonviolent Crisis Intervention Training (NVCI) is provided to new hires on the final day of their in-class orientation to provide them with necessary tools to de-escalate situations and reduce harm to patients, staff, and other healthcare team members. In addition, Gentle Persuasive Approach (GPA) training, Vocera phones, and violence risk screening tools have also been implemented. Risk re-assessments are planned across KHSC for the upcoming fiscal year once changes in SAFE reporting are completed that will allow mangers to build their violence action plan into the SAFE tool.

On Connell 10, safety huddles are implemented 3 times/week with all health care team members. These huddles allow time for discussions and updates on safety-related issues, and proactively identifying and addressing potential safety concerns and real time problem solving in promoting safety. During the IAC video presentation, a magnetic Behavioural Crisis Alert (BCA) exclamation point on the whiteboard beside a patient's name was pointed out. This signage indicates the behaviour of the patient meets violence risk criteria so that all health care team members are aware. This signage is also in place in front of the patient room, kardex, and chart.

Overall, employee health-related incidents have trended down over the last 5 years (Figure 17). The PRWRF submissions comparison are primarily as a result of staff shortages followed by patient acuity. Of note in 2023, up until the time of the IAC report submission, there were 20 PRWRFs with only one being related to a combative and confused patient. The rest were due to staffing issues and the impact on patient assignments and care.

Therefore, the IAC have concluded that at the present time there are no further recommendations other than staff be made aware of how to access the submitted SAFE reports and to continue the risk reduction and safety strategies that are currently being implemented. The IAC commends

KHSC leaders and staff for their continuing work on systems and processes to identify potential and mitigate workplace violence on Connell 10 and within the organization.

7.0 Professional Responsibility and Workload Reporting Form (PRWRF) Process

The PRWRF is a documentation tool to identify, report, and make recommendations to the employer related to workload and practice issues, and to demonstrate ongoing trends, and barriers to the provision of safe, competent, and ethical care (ONA Submission). In ONA's submission and presentation, it was highlighted that since 2018, there have been over 378 PRWRFs on Connell 10 related to patient care and acuity, fluctuating workload and staffing and professional practice. In 2022, there were 141 PRWRFs (19% submission rate/12 hour shift) submitted, and in 2023, there were 29 (4%s submission rate/12 hour shift) up until November 15th. In both 2022 and 2023, the top related issues identified were related to working short, patient acuity, exceptional patient factors, medication delays, lack of equipment and orientation.

When a PRWRF is submitted to the manager, the issue/theme is initially addressed in the workload response email to the submitting RN. Themes are then entered into a Workload Related Action excel file (Figure 21), identifying the theme, specific issue related to the theme, who is responsible to address the issue, the status of where it is at in being addressed, and the outcome, if completed. This file is circulated to all Connell 10 staff quarterly.

Figure 21: PRWRF Manager Related Action Excel File

Lack of Vital Signs Towers/Cuffs/Thermometers	BP Cuffs Ordered, Equipment Audit completed. New portible SP02 probes ordered and in use on unit. VS tower routine repair schedule proposed to clinical engineering.	C.Halligan	Complete	Portable equipment aligned to each iso room similar to K9M. Increased general unit supply.
Hire Agency Nurses	Agency nurses being introduced to KHSC	Organization	Complete	Agency nurses introduced to C10. Goal is to reduce floating from home units and stabilize lines in greatest need.
ECG/Phlebotomy Overnight	Not enough consistent and predicable demand to justify hour modification	Organization	Not Currently	
Resource Nurse (Days) for Admission and Break Coverage	Trialed atypical off hour shifts for RN staff on floor. Not successful as staff either floated or required to take patient assignment. X2 new program wide jobs created, currently accepting applications.	C.Halligan	In progress	Idea is to assist in break coverage support, care of deteroating patients, and general extra hands when needed for the program as a whole.

While ONA identifies issues in 78 PRWRFs that have not been addressed, KHSC states that all workload issues have been responded to that have occurred, since the new Senior Leadership team was introduced starting in May 2022.

IAC RECOMMENDATIONS:

7.1 The RNs on Connell 10 will communicate their concerns to the Program Manager/Operational Manager to give the opportunity to resolve the issue prior to submitting a PRWRF.

7.2 Every effort will be made to resolve issues at the unit level with staff and the Program Manager before and after a PRWRF is submitted.

7.3 While it is recognized that there is a provincial, national, and global nursing shortage, avoid using this as the primary response to the PRWRF issues, as it does not support the staff in resolving the issues.

8.0 EQUIPMENT

Having required equipment available to the nurses is an important aspect in providing quality nursing care. KHSC has recently purchased equipment for Connell 10 including but not limited to Vocera batteries and units, pulse oximeters, walkers, bariatric beds, and Broda chairs. The Program Manager of Connell 10 makes rounds of the equipment regularly and the Program Director and Program Manager participate in formal quarterly unit inspections. Equipment issues are also discussed during the safety huddle and should also be brought up in the daily huddles. Equipment requiring maintenance is flagged and sent for repair. However, from the nurses' perspective it appears the maintenance of some equipment and the turnaround time, causes some frustration when the equipment is needed. KHSC does have a process for identifying equipment nearing end-of-life throughout the hospital.

IAC RECOMMENDATIONS:

8.1 A list of equipment out for repair, should be posted for all staff to see in a common area (for example break room, supply room) with date in which the equipment was sent out.

8.2 The process for reporting equipment needing repair should be reviewed with staff at the next staff meeting or safety huddle.

8.3 The Program Manager updates staff at the huddles re maintenance of equipment, especially for the equipment which seems to be having a long turnaround time.

9.0 NON-NURSING TASKS

Non-nursing tasks, consist of: a) Tasks with an administrative nature such as replenishing charts and forms, and answering phones; b) Ancillary tasks that could be delegated to nurses' aides such as personal care assistants (PCA), for example patient's activities of daily living, delivering or retrieving food trays, escorting patients, searching and retrieving equipment; and c) Tasks that belong to other healthcare professionals, such as physiotherapists, that are assigned to nurses to perform when they are not working (Grosso et al., 2021).

The ONA submission identified that Connell 10 nurses are engaged in non-nursing duties such as replenishing charts and forms on nights, re-stocking, and care related to activities of daily living that can be done by PCAs. While PCAs can assist in completing routine daily living activities with patients, the IAC strongly believes that nurses should participate in carrying out activities of daily living where appropriate and to assist in the assessment of their patients.

Research has indicated that nurses performing non-nursing tasks can contribute to the risk of missed or delayed care and contribute to burnout and job dissatisfaction (Grosso et al., 2019). Having PCA's focusing on these non-nursing tasks would allow the time for nurses on Connell 10 to practice to their full scope implementing assessments, interventions, and their advanced competencies in caring for their patients.

Personal Care Assistants

At KHSC, the PCA role is to perform assigned tasks under the direction of nurses which support in assisting patients in activities of daily living and the effective operations of patient care areas (KHSC PCA Job descriptions). Examples of PCA responsibilities and duties include assisting with basic hygiene, ambulation, turning and positioning; preparing patients' meals and assisting with low-risk oral feeding as assigned; recording the patient care performed; assisting in general tidiness and safety of the work/care areas by stocking patient care areas and removing and disposing of equipment and supplies as appropriate or directed. While performing these tasks, PCAs need to effectively communicate with the nurses in a timely objective manner concerning patient information specific to assigned activities and when changes in patients' conditions or findings are observed. The PCA job description also highlights how PCAs can work collaboratively with the nurses in completing the non-nursing tasks related to patient care and administrative tasks such as replenishing charts and forms, and restocking supplies. KHSC has expanded the role of PCAs, beyond performing the activities of daily living. Following training and competency sign off, as per the CNO standards of working with an unregulated health care provider, PCAs can perform vital signs, fluid balance (ins and outs) and documentation.

The CNO (2023b) outlines that when working with unregulated health care providers, the nurse has the responsibility to follow CNO Standards in assessing whether the PCA has the knowledge and competencies to perform the tasks assigned to them, and then delegate appropriately with follow up once the task is completed.

The ONA submission described how in the past few years there have been vacancies in PCAs on Connell 10 which subsequently had an impact on nurses' workload. In the KHSC presentation, it was highlighted that there has been a significant increase in full and part-time PCAs to support the changes in the implementation of the nursing care model. As of November 23, 2023, there was a pool of 11 full-time PCAs with no vacancies, and there were 6 of 10 part-time PCAs hired.

During the Hearing, the IAC heard that the PCAs have their own huddle at the beginning of the shift to discuss how to complete tasks, listed on a task-based assignment sheet, created by a PCA on the previous shift or the CN. Based on this discussion, it appeared that the PCAs and nurses were working independently of each other, and not as a team in completing the care for a group of patients.

IAC RECOMMENDATIONS:

9.1 Clinical Learning Specialist review with nurses the CNO Guideline: Working with unregulated care providers and the delegation process.

9.2 Nurses and PCAs work collaboratively together on patient assignments, with each working to their full scopes.

9.3 At the beginning of the shift, the nurse and PCA establish how they will work together to provide quality patient care to their assigned patients.

9.4 Nurses participate in carrying out activities of daily living where appropriate and to assist in the assessment of their patients.

Unit Clerk:

Connell 10 is supported by a unit clerk and environmental services. There is a unit clerk on Connell 10 from 07:00-2300, 7 days per week. The unit clerk has many duties per the job description including and not limited to performing reception and clerical duties to support the operation of the unit, transcribing orders, coordination and timely communication of information and patient flow related to admissions and discharges, transfers, procedures, and consults.

The Medicine Program piloted a temporary implementation of a full-time unit clerk from 23:00-07:00 in 2022 on Connell 10. The role was filled temporarily, however, remained vacant over 8 months. Historically, it has also been difficult to recruit and sustain people in this role. The pilot

of a unit clerk from 23:00-07:00, additionally demonstrated that there were low amounts of workload to sustain the position. The Hospital is moving towards an electronic medical record in a year's time which may alleviate some of the workload associated with admitting a patient. However, until then the IAC recommends:

IAC RECOMMENDATION:

9.5 PCA's assist the unit clerk and CN on evening and night shifts in administrative tasks such as replenishing charts and forms, other required administrative tasks, and restocking of supplies.

Environmental Services

In ONA's submission, the concern was identified that nurses have been tasked with cleaning up bodily fluids prior to the arrival of housekeeping. Environmental Services have an identified role in gross contaminate clean up either by assisting in containing a spill or cleaning the area after the initiation clean-up process has been completed. In KHSC's presentation, they highlighted that the priority is to having the clean-up done as quickly as possible in accordance with proper IPAC standards. As Environmental Services are not always immediately available on the unit, clinical staff have the responsibility to attend to the risk.

IAC RECOMMENDATION:

9.6 The Program Manager and/or Clinical Learning Specialist review with staff the environmental services policies and procedures in relation to the clean-up of bodily fluids.

PART 4: CONCLUSIONS AND SUMMARY OF RECOMMENDATIONS

This report contains the IAC's findings and 9 areas of recommendations regarding the Professional Responsibility and Workload Complaints submitted by registered nurses on Connell 10 at KHSC, that impact their ability to provide quality and safe patient care. The process taken through an IAC Hearing provides a unique opportunity for discussion and dialogue between all parties regarding the complex issues and conditions that underlie a Professional Responsibility and Workload Complaint.

The members of the IAC unanimously support all recommendations in the report. The Committee hopes that the recommendations will assist KHSC, ONA and nurses to find mutually agreeable resolutions with regard to nursing workload issues at KHSC. The IAC also hopes that in the future, all parties collaboratively develop processes and communication strategies that can address and resolve concerns relating to professional practice in a timely and effective way, to enhance patient care and quality work environments.

IAC RECOMMENDATIONS:

1.0 STAFFING

1.1 Ratios

1.1.1 Work toward implementing a new staffing plan (Table 4) by January 15, 2025. This is in recognition that most of the recruitment of full-time nurses will be new graduates who are not available until their graduation in June 2024 or September 2024.

1.1.2 Calculate and work toward achieving the number of RN and RPN FTEs required to implement the recommended nurse-to-patient ratios in Table 4. Include the "relief factor" in the calculation. That is, build in sufficient FTEs to cover relief for vacation, sick, and other leaves of absence.

1.1.3 Create and fully implement a new master schedule for full and part-time nurses (maintaining at least 70% full-time positions) with the nurse-to-patient ratios outlined in Table 4 by January 15, 2025 or sooner.

1.1.4 Endeavour to balance the master rotation with both novice and experienced nurses on staffing lines.

1.1.5 Add an additional PCA 2300-0700 immediately (n = 3 total) to help offset the absence of a clerk and to bridge the gap to when the clerical work will be substantially reduced at night when the KHSC electronic medical record is implemented. The PCA, directed by the CN, can take on some of the stocking and other tasks that the night nurses currently take on.

1.1.6 Hold monthly staff forums on Connell 10 to communicate progress with reducing the shortfall of nurses, the intention to develop and implement a new master schedule, and to achieve a new baseline staffing plan.

1.2 Charge Nurse

1.2.1 Permanent Charge Nurse will remain from 07:00-19:00, 7 days per week.

1.2.2 The CN from 0700-1900 will not have a patient assignment once the new model (Table 4) is implemented. Until then, the IAC recognizes that the CN may be required to take maximum 2 patients under extenuating circumstances.

1.2.3 The CN is expected to help with patient care when requested by nurses or when in their professional judgement it is necessary.

1.2.4 The night CN will have a 2-patient assignment with additional patients when necessary (per Table 4).

1.2.5 Normally, nurses assuming the CN role for incidental times will be registered nurses working on Connell 10.

1.2.6 Nurses working on a temporary license should never be in charge.

1.2.7 Nurses' with less than 1 year experience, should not be assigned the CN role.

1.3 Load Levelling

1.3.1 Continue to follow the pyramid protocol guiding decisions.

1.3.2 The OM will take into consideration acuity on Connell 10 prior to reassigning a nurse, not just the number of nurses on each unit.

1.3.3 A process will be developed and implemented in which the staffing clerk or the Operations Manager will verify and document the registration status of the nurse who is being considered for reassignment. Nurses with a temporary license should not be reassigned to another unit.

1.3.4 Normally, novice nurses (with a full license who are less than 9 months post-graduation) should not be reassigned to another unit and/or be in charge of another unit.

1.3.5 The ONA local bargaining unit and KHSC will discuss when it would be appropriate to safely reassign a new graduate nurse to another unit.

1.3.6 The Operations and/or Program Manager will communicate with the CN, the reasons for why a Connell 10 nurse needs to be reassigned to another unit or that Connell 10 will not be receiving a reassigned nurse.

1.3.7 The CN will contact the Operations and/or Program Manager to further discuss the load levelling decision if the CN believes the leveling decision may be inappropriate based on the acuity and complexity of the unit. The Operations and/or Program Manager will then either follow up in person or by phone with the CN to discuss the decision.

1.3.8 When the CN and/or nurses perceive the Operations Manager's reassignment decisions were inappropriate based on the acuity and complexity of the unit, the CN and/or the nurses will follow up with the Program Manager on the next day to discuss their concerns.

1.3.9 To support reassigned nurses, each unit will develop a competency list outlining the most common patient diagnoses and knowledge and skills needed to care for patients on the unit. This list will be developed with input from the CN, staff, Program Manager and Clinical Learning Specialist and then communicated to all staff through email, staff meetings, huddles, and through internal communication. This will be done by February 29, 2024.

1.3.10 The CN will welcome the reassigned nurse to the unit and review the competency list with them to assess their knowledge, competence, and ability to care for patients on the unit.

1.3.11 Based on the assessment in 1.3.10, the CN will make the decision to give the reassigned nurse an autonomous or modified assignment, or only assist nurses with assigned tasks.

1.3.12 If the reassigned nurse feels they do not have the competency, knowledge and skill required to do the patient assignment, they must talk to the CN and together they should come up with a plan of care.

1.3.13 Reassigned nurses must have the ability to contact the Operations Manager or another support person, if they have concerns related to their patient reassignment and they feel that their concerns are not being heard.

1.3.14 The reassigned nurse will be provided with an orientation of the unit and a resource/buddy nurse who they can ask for support during the shift.

1.3.15 If a reassignment occurs at any time during the shift, the nurse being reassigned will always be given the time to complete all their documentation and give report prior to leaving the unit.

1.4 Safer Nursing Care Tool

1.4.1 The Hospital should confirm that they are using the 2023 version of the SNCT and notify ONA and staff of their findings.

1.4.2 The Hospital should ask the Shelford Group for any evaluation updates available that may indicate whether this version more accurately predicts staffing requirements in the 20 allotted assessment days.

1.4.3 The hospital should ensure that all conclusions and recommendations about overall unit resource allocation of FTEs and nurse-to-patient ratios undergo a validation process that enlists the *professional judgement* of the Program Manager and clinical and professional practice leaders.

1.4.4 The hospital should ensure that all conclusions and recommendations about overall unit resource allocation of FTEs and nurse-to-patient ratios take into consideration the evidence-based positive outcomes of mandated safe staffing levels in medical/surgical units outlined in the Staffing Section of this report.

1.4.5 The hospital should ensure that the pilot units have extensive training on how and why to use the SNCT to ensure that patient classifications are reliably assigned and that the staff have a full understanding of the intended use of the results.

2.0 Recruitment and Retention

2.1 Continue to focus on recruitment and retention and reduce the nurse staffing shortfall (actual vacancies plus unfilled leaves of absence) on Connell 10 to less than or equal to 5% by November 1, 2024.

2.2 Develop and post a visual chart of the progress made on reducing the shortfall of nurses on Connell 10. Update the chart monthly.

2.3 Collaborate with the local ONA bargaining unit to ensure that permanent part-time positions are more attractive to potential candidates. For example, explore flexible FTEs for interested applicants. Rationale: A robust part-time nursing workforce will maintain flexibility in scheduling to facilitate coverage of vacation, sick, and other personal leave time.

2.4 Explore (with the local ONA bargaining unit) the possibility of offering improved TEP incentives for new part-time hires. Rationale: A robust part-time nursing workforce will maintain flexibility in scheduling to facilitate coverage of vacation, sick and other personal leave time.

2.5 Recognize the contributions of the nurses who have chosen to work in casual positions and recruit additional casual nurses if candidates do not want permanent full or part-time positions. Engage casual nurses in all professional development and mentorship activities available to full and part-time staff in recognition that some nurses prefer the flexibility that a casual position provides.

2.6 Complete and implement the Proactive Health Human Resources Planning Framework described at the IAC hearing.

2.7 Ensure resources are assigned to the proactive health human resources planning process to enable recruitment to proceed ahead of when vacancies or leaves of absence occur whenever possible.

2.8 Ensure the leaders (including Charge Nurses) on Connell 10 take part in the planned training on how to manage traumatic/distressing situations.

2.9 Work with nurses on Connell 10 to establish a process for better communication of what is available to them (e.g. psychological supports, education, mentorship, and other opportunities), including knowing how to access updates from senior leaders.

2.10 Develop a process of scheduling nurses (and backfilling if necessary) to attend annual 4-hour continuing education sessions on multiple topics important to all nurses on Connell 10.

2.11 Conduct "stay interviews" that are proactive relationship building structured interviews. Leaders conduct these interviews with their staff to foster a culture focusing on nurse engagement and retention. During the interview, leaders explore with staff members why they stay and what actions could be taken to strengthen their engagement and retention on the unit and organization. To learn more about stay interviews process refer to Wang et al., 2023.

2.12 Conduct an exit interview/survey for all nurses who leave Connell 10 –for both internal and external opportunities. Review the results semi-annually to identify trends that may need addressing.

3.0 Communication

3.1 The Hospital should explore social media strategies with staff, for example through WhatsApp. Staff would be co-creators to foster engagement, collaboration, and communication on the unit and within the organization.

3.2 Policies, procedures, and education are in place, on how to use social media apps appropriately ensuring privacy.

3.3 Multiple communication strategies to facilitate nurses' awareness of changes, initiatives and opportunities be implemented.

3.4 Daily huddles will occur every day in the morning lasting no more than 10 minutes. These will begin immediately. The huddles should be held at the same time daily. The time will be determined with input from the staff. Attending the daily huddles should be a priority for all staff, recognizing this is dependent on workload.

3.5 The Program Manager (Monday-Friday) and/or the CN (Saturday and Sunday and as necessary Monday to Friday) will lead the huddles, items may include safety issues, patient issues and goals, and/or staffing.

3.6 The Program Manager will ensure unit issues are brought forward to organizational load leveling huddles and addressed as needed.

3.7 Staff meetings are to be held on a monthly basis, at a time convenient for staff, i.e. during the day, evening, or through Zoom. Minutes will be taken during the meeting and shared with staff within 5 business days of the meeting.

3.8 A week before the meeting, staff will be asked for input on the agenda items to be discussed.

3.9 The Clinical Learning Specialist and Clinical Nursing Scholar actively communicate relevant KHSC initiatives and resources in their interactions with staff beginning immediately.

3.10 Establish a Professional Practice Committee with ONA and KHSC Professional Practice team to discuss non-operational initiatives, with the focus on practice, research, education, recruitment and retention, and communication initiatives.

3.11 The OM will take into consideration acuity on both the sending and receiving units prior to reassigning a nurse, not just the number of nurses on each unit.

3.12 The OM/Manager will communicate to the Charge Nurse the reasoning behind the reassignment in order for the unit to better understand the decision-making process. If they are on site, they could communicate this in-person.

3.13 The CN will contact the Operations and/or Program Manager to further discuss the load levelling decision if the CN believes the leveling decision may be inappropriate based on the acuity and complexity of the unit. The Operation and/or Program Manager will then either follow up in person or by phone with the CN to discuss the decision.

4.0 Leadership

4.1 Leadership at the Point of Care

4.1.1 Following the first three months on the unit, the Program Manager, Clinical Learning Specialist and where appropriate the Clinical Nursing Scholar meet with new hires individually to explore what their professional goals are and discuss with them, leadership opportunities on the unit and within the organization.

4.1.2 The Manager, Clinical Learning Specialist, and Clinical Nurse Scholar encourage and support nurses on the unit who demonstrate emergent leadership abilities to become more involved in such opportunities as the Unit Based Council, Nursing Practice Council, and the Charge Nurse role.

4.2 Unit Based Councils

4.2.1 The Program Manager meets with the nurses to gain a better understanding of their reluctance to develop a Unit Based Council and to discuss the advantages and barriers to developing a Unit Based Council on Connell 10 by March 31, 2024.

4.2.2 Based on this discussion, begin to address the barriers to creating a Unit Based Council.

4.2.3 Identify nurses on the unit with emerging leadership skills, who would consider being champions in developing a Unit Based Council.

4.2.4 Identify a clinical nurse and a nurse in a formal leadership role (other than the CN) on Connell 10 to co-chair the unit council.

4.2.5 Provide paid time and/or adequate staffing for interested nurses to be off the unit to plan the development and implementation of the Unit Based Council activities.

4.2.6 Have nurses from a unit with a Unit Based Council meet with the Connell 10 nurses to discuss their journey in establishing the Council, and the advantages and challenges to having one during the staff meeting in March, 2024.

4.2.7 Provide the time for nurses who are interested in developing a Unit Based Council on Connell 10 to attend Council meetings on other units. This will enable them to gain a better understanding of how to conduct the meetings, the processes to be followed, and the type of initiatives to improve nursing practice that can be explored by a Unit Based Council.

4.2.8 Professional Practice team develops a workshop for nurses interested in leading the development of Unit Based Councils, focusing on leadership skills, how to conduct meetings, goal setting, communication skills, and project management by June 30, 2024.

4.2.9 Engage the Clinical Learning Specialist and/or Professional Practice Lead to support the nurses developing the Connell 10 Unit Based Council.

4.2.10 Provide a resource person/contact from KHSC Professional Practice team for the Unit Based Council Chairperson in implementing the role.

4.2.11 As this process is occurring, the Program Manager should also be exploring interest in being a member of the Nursing Practice Council with nurses demonstrating emerging leadership skills. To begin this process, interested nurses could attend a Nursing Practice Council meeting, to gain a better understanding of what the Nursing Practice Council does and how the nurses from Connell 10 could have a voice and participate in decision making on the Council.

4.2.12 Ensure the Connell 10 Nursing Practice Council representative has the paid time to attend the meetings, or if they are working, that there is replacement staff to enable them to attend meetings.

4.3 Charge Nurse Leadership Development

4.3.1 Ensure there is adequate staffing on the unit on the day of the monthly CN meeting, so that the nurse in the shadow CN role can assume the Charge Nurse duties while the Charge Nurse attends the meeting.

4.3.2 Promote the availability of the corporate CN program for all nurses interested in being a Charge Nurse (permanently or as needed).

4.3.3 The Program Manager and/or the Clinical Learning Specialist will, as part of professional development discussions with nurses on Connell 10, inquire about their interest in being assigned to the CN role on an as needed basis. This would increase the pool of registered nurses willing to fill the role. This would also ensure continuity of the role.

4.3.4 Those nurses who may wish to replace the Charge Nurse for incidental times, i.e. vacation, sick time will be provided with the CN Education program already in place at the hospital.

4.4 Program Manager

4.4.1 The Program Manager reviews with the staff, KHSCs and Connell 10's organizational structures and communication processes to ensure successes and challenges are being identified and heard.

4.4.2 The Program Manager continues their authentic, active listening, and transformational leadership and communication with staff.

4.5 Senior Leadership Team

4.5.1 While senior leadership has stabilized, and corporate initiatives have been implemented, it is imperative that the leadership team continue to focus on being visible, listening, and implementing qualities of transformational and authentic leadership in their daily interactions with staff.

4.5.2 Evaluate leadership initiatives within the organization on an annual basis, to identify effectiveness and areas for improvement to support the implementation of patient care, patient outcomes, staff supports, and quality work environments.

5.0 Professional Development

5.1 The Program Manager, Clinical Learning Specialist, and/or Clinical Nurse Scholar discuss with nurses individually about their personal and professional goals and the type of learning opportunities and access they would need to assist in meeting them.

5.2 When developing CPD opportunities, ensure the 5 factors of self-motivation, relevance to practice, workplace learning, strong supportive leadership, and a positive organizational learning culture are taken in account to improve nurses' uptake of the different opportunities.

5.3 To improve access to professional development activities, develop a process of scheduling nurses (and backfilling if necessary) to attend annual 4-hour continuing education sessions on multiple topics important to all nurses on Connell 10. The 4-hour sessions could be repeated on 2-3 different days or on the same day to maximize availability of nurses to attend.

5.4 Engage nurses in identifying the topics that they would like explored during the education sessions and combine them with continuing education specifically needed on Connell

5.5 Include sessions on mind-spirit-body within these blocks to assist nurses in acquiring self-awareness and mindfulness strategies to build their resilience. The massage therapist who is presently available once a week, could also go to the different units at scheduled times or during these educational sessions to offer nurses a massage, rather than nurses having to be able to leave the unit to access this service.

5.6 Ensure learning opportunities and support of novice nurses continues for their first year of employment, not only in the first 3 months with the present onboarding activities.

5.7 Formalize and support the development of the different forms of peer to promote different learning opportunities on the unit and a positive learning culture.

6.0 Risk Reduction and Workplace Violence

The IAC concluded that at the present time there are no further recommendations other than staff be made aware of how to access the submitted SAFE reports and to continue the risk reduction and safety strategies that are currently being implemented. The IAC commends KHSC leaders and staff for their continuing work on systems and processes

to identify potential and mitigate workplace violence on Connell 10 and within the organization.

7.0 Professional Responsibility and Workload Reporting Form (PRWRF) Process

7.1 The RNs on Connell 10 will communicate their concerns to the program manager/Operational Manager to give the opportunity to resolve the issue prior to submitting a PRWRF.

7.2 Every effort will be made to resolve issues at the unit level with staff and the manager before and after a PRWRF is submitted.

7.3 While it is recognized that there is a provincial, national, and global nursing shortage, avoid using this as the primary response to the PRWRF issues, as it does not support the staff in resolving the issues.

8.0 Equipment

8.1 A list of equipment out for repair, should be posted for all staff to see in a common area (for example break room, supply room) with date in which the equipment was sent out.

8.2 The process for reporting equipment needing repair is reviewed with staff at the next staff meeting or safety huddle.

8.3 The Program Manager updates staff at the huddles re maintenance of equipment, especially for the equipment which seems to be having a long turnaround time.

9.0 Non-Nursing Tasks

9.1 Clinical Learning Specialist review with nurses the CNO Guideline: Working with unregulated care providers and the delegation process.

9.2 Nurses and PCAs work collaboratively together on patient assignments, with each working to their full scopes.

9.3 At the beginning of the shift, the nurse and PCA establish how they will work together to provide quality patient care to their assigned patients.

9.4 Nurses participate in carrying out activities of daily living where appropriate and to assist in the assessment of their patients.

9.5 PCA's assist the unit clerk and CN on evening and night shifts in administrative tasks such as replenishing charts and forms, other required administrative tasks, and restocking of supplies.

9.6 The Program Manager and/or Clinical Learning Specialist review with staff the environmental services policies and procedures in relation to the clean-up of bodily fluids.

REFERENCES

Ahmed, H. E. B., & Bourgeault, I. L. (2022). *Sustaining nursing in Canada: Set of coordinated evidence-based solutions targeted to support the nursing workforce now and into the future*. Canadian Federation of Nurses Unions. https://nursesunions.ca/wp-content/uploads/2022/11/CHWN-CFNU-Report_-Sustaining-Nursing-in-Canada2022_web.pdf

Aiken, L.H., Clarke, S.P., Sloane, D.M., Sochalski, J., Silber, J.H., (2002). Hospital nurse staffing and patient mortality, nurse burnout, and job dissatisfaction. Journal of the American Medical Association, 288 (16), 1987–1993. https://doi.org/ 10.1001/jama.288.16.1987

Aiken, L. H., Sloane, D. L., Cimiotti, J. P., Clarke, S. P., Flynn, L., Seago, J. A., Spetz, J., & Smith, H. L. (2010). Implications of the California nurse staffing mandate for other states. Health Services Research, 45(4), 904-921. https://doi.org/10.1111/j.1475-6773.2010.01114.x

Bergstedt, K. & Wei, H. (2020). Leadership strategies to promote frontline nursing staff engagement. *Nursing Management, 51* (2), 48-53. DOI:10.1097/01.NUMA.0000651204.39553.79.

Berta, E. & Ceriani, B. (2022). Developing tomorrow's leaders through unit-based councils. *Nurse Leader,* 20 (6), 565-568. https://doi.org/10.1016/j.mnl.2022.08.002

Breedlove, D. W., Amiri,A., & Arris, L. (2022). Evaluating the efficacy of an evidence-based charge Nurse professional development activity at a highly complex Veterans Affairs medical center. *Journal of Nurses in Professional Development, 38* (2), E19-24. DOI: 10.1097/NND.0000000000000824

Calaguas, N.P. (2023). Mentoring novice nurse educators: Goals, principles, models, and key practices. *Journal of Professional Nursing, 44*, p. 8-11. https://doi.org/10.1016/j.profnurs.2022.11.002

Caron, I., Gelinas, C., Boileau, J., Frunchak, V., Casey, A., & Hurst, K. (2021). Initial testing of the use of the Safer Nursing Care Tool in a Canadian acute care context. *Journal of Nursing Management, 29*, 1801-1808. https://doi.org/10.1111/jonm.13300

Carthon, M. B., Brom, H., McHugh, M., Sloane, D. M., Berg, R., Merchant, R., Girotra, S., & Aiken, L. H. (2021). Better nurse staffing is associated with survival for black patients and diminishes racial disparities in survival after in-hospital cardiac arrests. *Medical Care*, *59*(2), 169-176. https://doi.org/ 10.1097/MLR.0000000000001464

Cathro, H. (2016). Navigating through chaos: charge nurses and Patient Safety. *Journal of Nursing Administration, 46* 94), 208-214. DOI: 10.1097/NNA.0000000000000326

Cave, J., Rohatinsky, N., & Berry, L. (2023). Organizational supports for nurse managers in a North American context: A scoping review. *Nursing Leadership, 36* (2), 27-43. DOI: 10.12927/cjnl.2023.27205

College of Nurses of Ontario (2023a). *Leadership in nursing practice.* College of Nurses of Ontario website. https://www.cno.org/en/learn-about-standards-guidelines/educational-tools/ask-practice/leadership-nursing-practice/

College of Nurses of Ontario (2023b). *Working with Unregulated Care Providers.* College of Nurses of Ontario website. https://www.cno.org/en/learn-about-standards-guidelines/educational-tools/ask-practice/working-with-ucps/

Cope, V. & Murray, M. (2017). Leadership styles in nursing. *Nursing Standard, 31* (43), p. 64-70. DOI: 10.7748/ns.2017.e10836.

Delamater, L. & Hall, N. (2018). Charge nurse development: What does the literature say? *Nursing Management, 49* (7, 34-40. doi-10.1097/01.NUMA.0000538914.53159.fc

Dierkes, A., Do, D., Morin, H., Sloane, D., & McHugh, M. (2022). The impact of California's staffing mandate and the economic recession on registered nurse staffing levels: A longitudinal analysis. *Nursing Outlook*, *70*(2), 219-227. https://do i.org/10.1016/j.outlook.2021.09.007

Di Vincenzo, P. (2017). Team huddles: A winning strategy for safety. *Nursing, 47* (7), 59-60. DOI-10.1097/01.NURSE.0000520522.84449.0e

Duncan, D. (2020). What the COVID-19 pandemic tells us about the need to develop resilience in the nursing workforce. *Nursing Management, 27* (3), 22-27. DOI: 10.7748/nm.2020.e1933

Eurich, T. (2018). What self-awareness really is (and how to cultivate it). *Harvard Business Review*, January 04, 2018. https://hbr.org/2018/01/what-self-awareness-really-is-and-how-to-cultivate-it

Ewing, M., Men, L.R., O'Neill, J. (2019). Using social media to engage employees: Insights from internal communication managers. *International Journal of Strategic Communication, 13* (2), 110-132. https://doi.org/10.1080/1553118X.2019.1575830

Fenton, K., & Casey, A. (2015). A tool to calculate safe nurse staffing levels. *Nursing Times, 111*(3), 12-14.

Fischer, S. A. (2017). Developing nurses' transformational leadership skills. *Nursing Standard, 31*, 9510, 54-61. DOI:10.7748/ns.2017.e10857

Fowler, K. R., Robbins, L. K., & Lucero, A. (2021). Nurse manager communication and outcomes for nursing: An integrative review. *Nursing* Management, *29* 96), 1486-1495. DOI: 10.1111/jonm.13324.

Graf, A. C., Jacob, E., Twigg, D., & Nattabi, B., (2020). Contemporary nursing graduates' transition to practice: A critical review of transition models. *Journal of Clinical Nursing, 29,* 3097-3107. https://doi.org/10.1111/jocn.15234

Griffiths, P., Saville, C., Ball, J., Culliford, D., Pattison, N., & & Monks,T. (2020). Performance of the safer care nursing tool to measure nurse staffing requirements in acute hospitals: A multicentre observational study. *BMJ Open, 10*: e035828. https://doi.org/10.1136/bmjopen-2019-035828

Griffiths, P., Saville, C., Ball, J. E., Jones, J., & Monks, T. (2021). Beyond ratios – flexible and resilient nurse staffing options to deliver cost effective hospital care and address staff shortages: A simulation and economic modelling study. *International Journal of Nursing Studies*, 117, 103901. https://doi.org/ 10.1016/j.ijnurstu.2021.103901

Griffiths, P., Saville, C., Ball, J., Jones, J., Pattison, N., Monks, T., & Safer Nursing Care Study Group. (2020). Nursing workload, nurse staffing methodologies and tool: A systematic scoping review and discussion. *International Journal of Nursing Studies, 103*, 1034287. https://doi.org/10.1016/j.ijnnurstu.2019.103487

Government of Canada (2023). *Nursing retention toolkit: Improving the working lives of nurses in Canada.* Government of Canada Website. https://www.canada.ca/en/health-canada/services/health-care-system/health-human-resources/nursing-retention-toolkit-improving-working-lives-nurses.html

Grosso, S., Tonet, S., Bernard, I., Corso, J., De Marchi, D., Dorigo, L, Funes, G., Lussu, M., Oppio, N., Pais dei Mori, L., & Palese, A. (2019). Non-nursing tasks as experienced by nurses: A. descriptive qualitative study. *International Nursing Review, 66,* (2), 259-268. DOI: 10.1111/inr.12496.

Grosso, S. Longhini, J., Tonet, S., Bernard, I., Corso, J., De Marchi, D., Dorigo, L, Funes, G., Lussu, M., Oppio, Grasetti, L., N., Pais dei Mori, L., & Palese, A. (2021). Prevalence and reasons for non-nursing tasks as perceived by nurses. Findings from a large cross-sectional study. *Journal of Nursing Management, 1-16.* DOI: 10.1111/jonm.13451.

Hakvoort, L., Dikken, J., Cramer-Kruit, J., Molendijk-van Nieuwenhuyzen, van der Schaaf, M., & Schuurmans, M. (2022). Factors that influence continuing professional development over a nursing career: A scoping review. *Nurse Education in Practice, 65*, 103481, 1-8. https://doi.org/10.1016/j.nepr.2022.103481

Haddad, L. M., Annamaraju, P., & Toney-Butler, T. J. (2020). *Nursing shortage*. StatPearls. https://www.ncbi.nlm.nih.gov/books/ NBK493175/

Holowell, A. (2023). California's mandatory nurse staffing ratios: Key lessons 2 decades in. https://www.beckershospitalreview.com/nursing/californias-mandatory-nurse-staffing-ratios-key-lessons-2-decades-in.html#:~:text=Right%20now%2C%20California's%20ratios%20for,to%2D3%20in%20step%20down

Jordan, B. A. (2016). Designing a unit practice council structure. *Nursing Management,* 47 (1), 15-18. DOI: 10.1097/01.NUMA.0000475633.98128.4D

Jubinville, M., Nguemeleu Tchouaket, E., Longpre, C. (2023). Scoping review protocol examining charge nurse skills: Requirement for the development training. *BMJ Open, 13*, e067307. DOI:10.1136/bmjopen-2022-067307

Kanninen, G., Haggman-Laitila, A., Tervo-Heikkinen, T., & Kvist,T. (2022). Nurses' critical reflections of working in unit practice councils-A qualitative interview study. *Journal of Nursing Management, 30* (1), 252-259. DOI: 10.1111/jonm.13489

Kennedy, E., Kennedy, P., Hernandez, J., Shakoor, K., & Munyan, K. (2022). Understanding redeployment during the COVID-19 pandemic: A qualitative analysis of nurse reported experiences. *SAGE Open Nursing, 8*, 1-10. DOI: 10.1177/23779608221114985

King, R., Taylor, B., Talpur, A., Jackson, C., Manley, K., Ashby, N., tod, A., Ryan T., Wood, E., Senek, M., & Robertson, S. (2021). Factors that optimise the impact of continuing professional development in nursing: A rapid evidence review. *Nurse Education Today, 98.* 104652, 1-15. https://doi.org/10.1016/j.nedt.2020.104652

Labrague, L. (2020). Psychological resilience, coping behaviours and social support among health care workers during the COVID-19 pandemic: A systematic review of quantitative studies. *Journal of Nursing Management, 29* (7), 1893-1905. DOI: 10.1111/jonm.13336

Lasater, K. B., Aiken, L., Sloane, D., French, R., Martin, B., Alexander, M., & McHugh, M. D. (2021). Patient outcomes and cost savings associated with hospital safe nurse staffing legislation: An observational study. *BMJ Open*, *11*: e052899. https://doi.org/10.1136.bmjopen-2021-052899

Lasater, K. B., McHugh, M., Rosenbaum, P. R., Aiken, L., Smith, J., Reiter, J. G., Niknam, B. A., Hill, A. S., Hochman, L. L., Jain, S., & Silber, J. H. (2021). Valuing hospital investments in nursing: Multistate matched-cohort study of surgical patients. British Medical Journal: Quality & Safety, 30(1), 46-55. https://doi.org/ 10.1136/bmjqs-2019-010534

Liesel, D. & Hall, N. (2023). Evaluation of a charge nurse leadership development program. *Nursing Management, 54* (7), 23-30. DOI: 10.1097/01.NUMA.0000538914.53159.FC

Lowe, G. S. (2002). High-quality healthcare workplaces: A vision and action plan. *Hospital Quarterly, 5*(4),49-56. https://doi.org/ 10.12927/hcq...16509

Mabona, J. F., van Rooyen,D., & ten Ham-Baloyi, W. (2022). Best practice recommendations for healthy work environments for nurses: An integrative literature review. *Health SA: Journal of Interdisciplinary Health Sciences, 27*, 1788. DOI: 10.4102/hsag.v27i0.1788

McHugh, M. D., Aiken, L. H., Sloane, D. M., Windsor, C., Douglas, C., &Yates, P. (2021). Effects of nurse-to-patient ratio legislation on nurse staffing and patient mortality, readmissions, and length of stay: A prospective study in a panel of hospitals. *The Lancet, 397*(10228), 1905-1913. https://doi.org/10.1016/S0140-6736(21)00768-6

Macleod, H. (2019). *Humanizing leadership: Reflection fuels, people matter, relationships make the difference.* Friesen Press.

Miambo, M., Silen, C., & McGrath, C. (2021). Lifelong learning and nurses' continuing professional development, a metasynthesis of the literature. *BMC Nursing, 20* (62), 1-13. https://doi.org/10.1186/s12912-021-00579-2

O'Brien-Pallas, L., Thomson, D., Alksnis, C., & Bruce, S. (2001). The economic impact of nurse staffing decisions: Time to turn down another road? *Hospital Quarterly*, *4*(3), 42-50. https://doi.org/ 10.12927/hcq...16795

O'Connor, K. (2017). Addressing floating and patient safety. *Nursing 2017, 47* (2), 57-58. DOI-10.1097/01.NURSE.0000511820.95903.78

Panda, N., Sinyard, R. D., Henrich, N., Cauley, C. E., Hannenberg, A. A., Sonnay, Y., Bitton, A., Brindle, M., & Molina, G. (2021). Redeployment of health care workers in the COVID-19 pandemic: A qualitative study of health system leaders' strategies. Journal of Patient Safety, 17(4), 256–263. https://doi.org/10. 1097/PTS.0000000000000847

Queensland Health. (2023, November 27). *Nurse-to-patient ratios*. https://www.health.qld.gov.au/ocnmo/nursing/nurse-to-patient-ratios

Roberts, A. (2023, October 3). Nurse-patient ratios: These states have these controversial policies in place. *NurseJournal.* https://nursejournal.org/articles/nurse-patient-ratios/

Saville, C., & Griffiths, P. (2021). Ward staffing guided by a patient classification system: A multi-criteria analysis of "fit" in three acute hospitals. *Journal of Nursing Management*, *9*, 2260-2269. https://doi.org/10.1111/jonm.13341

Shaikh, U. (2020, January 29). *Improving Patient Safety and Communication through daily huddles.* Patient Safety Network. https://psnet.ahrq.gov/primer/improving-patient-safety-and-team-communication-through-daily-huddles

Shelford Group. (2023, December 18). *Safer nursing care tool*. Available from https://shelfordgroup.org/safer-nursing-care-tool/

Shirey, M. R. (2015). Enhance your self-awareness to be an authentic leader. *American Nurse Today, 10* (8). https://www.americannursetoday.com/enhance-self-awareness-authentic-leader/

Spetz, J., Chu, L., & Blash, L. (2022). *Forecasts of the Registered Nurse Workforce in California* (p. 2022). https://www.rn.ca.gov/pdfs/forms/forecast2022.pdf

Spiva, L, Davis, S., Case-Wirth, j., Hedenstrom,L., Hogue, V., & Box. M. (202). The effectiveness of charge nurse training on leadership style and resiliency. *Journal of Nursing Administration, 50* (2), 95-103. DOI: 10.1097/NNA.0000000000000848

Tomblin-Murphy, G., Sampalli, T., et al. (2022). *Investing in Canada's Nursing Workforce Post-Pandemic: A Call to Action.* Royal Society of Canada.

Vazquez-Calatayud, M., Errasti-Ibarrondo, B., & Choperena, A. (2021). Nurses' continuing professional development: A systematic literature review. *Nurse Education in Practice, 50,* 102963. https://doi.org/10.1016/j.nepr.2020.102963

Venkatesa Perumal, R. & Singh, M. (2022). Mentorship in nursing in Canada: A scoping review. *Nurse Education in Practice, 65*, 103461. https://doi.org/10.1016/j.nepr.2022.103461

Walden, A., M., Meyer, J. R., Whitaker, B. & Albert, N. M. (2020). Enhancing the caregiver float experience. *Nursing Management, 15* (7), 14-20. DOI-10.1097/01.NUMA.0000669108.28985.67

Wang, A., Devine, C., Hamilton, L., Layton, M. (2023). Do not wait unit it is too late: Using stay interviews to engage and retain nursing staff. *Nursing Leadership, 36* (1), p.46-56. DOI:10.12927/cjnl.2023.27124

Wei. H., Roberts, P., Strickler, J., & Webb Corbett, R. (2019). Nurse leaders' strategies to foster nurse resilience. *Journal of Nursing Management, 27* (4), 681-687. DOI: 10.1111/jonm.12736. Epub 2019 Jan 21.

Wu, A. W., Connors, C., & Everly, G. S. (2020). COVID-19: Peer support and crisis communication strategies to promote institutional resilience. *Annals of Internal Medicine, 172* (12), 822-823. DOI: 10.7326/M20-1236

APPENDICES

Appendix A: Referral of Professional Practice and Workload Issues at KHSC-Connell 10 to an IAC

Jason Hann
Chief Nursing Executive
Kingston Health Sciences Centre

Dear Mr. Hann,

Re: Referral of Professional Practice and Workload Issues at Kingston Health Sciences Centre – Connell 10 Medicine Unit (ONA File # 201803549) to an Independent Assessment Committee (IAC)

The Registered Nurses (RNs) working in the Medicine Unit at Kingston Health Sciences Centre have consistently identified ongoing practice and workload issues as evidenced by the data submitted in more than 340 Professional Responsibility Workload Report Forms (PRWRFs) since 2018.

The RNs have documented that their current workload and practice environment does not allow them to meet the College of Nurses of Ontario (CNO) 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 the Hospital Association Committee meetings by discussing the issues and recommendations documented in our action plan and proposed minutes of settlement. Despite this, a number of the workload and practice issues identified by ONA members remain unresolved, including but not limited to the following:

- Chronic understaffing as a direct result of ongoing violations of the central collective agreement, and failed retention and recruitment strategies.
- Ongoing unstable staff churn and excessive turnover of staffing.
- Unsafe nurse to patient ratios due to an unviable staffing model of care at KHSC.
- Missed and delayed care.
- Charge Nurse's inability to perform required duties including to be a support and expert resource for staff on C10 medicine.
- Inadequate training and available support for staff
- Ineffective communication and lack of leadership.

The Union has grave concerns regarding the potential of 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 Complaint 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 forthcoming.

David McCoy of the Ontario Hospital Association has been contacted to confirm the next IAC Chairperson rotation in accordance with Appendix 2 will be Dr. Claire Mallette. I have confirmed with Dr. Mallette that she is available to Chair this hearing.
Dr. Mallette's contact information is:

Claire Mallette
cmallett@yorku.ca

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, BSc, BScN, MN.
Professional Practice Specialist

C: Bernadette Robinson, Ontario Nurses' Association, Interim Provincial President
Angela Preocanin, ONA, First Vice-President
Annette Saccon, ONA Bargaining Unit President, and Local Coordinator,
Mandy Wilson, ONA Servicing Labour Relations Officer,
Jackie Kehoe-Donaldson, ONA Manager of Professional Practice,
Lorrie Daniels, ONA Manager of Professional Services Learning and Development,
Dr. David Pichora, President and CEO, Kingston Health Sciences Centre
Tyler Hands, Program Director, KHSC
Colton Halligan, Unit Manager, KHSC
Indira Naraine, Director, People Services, KHSC

APPENDIX B: Request to Extend Report Deadline until January 18, 2024.

From: Claire Mallette <cmallett@yorku.ca>
Sent: Monday, July 31, 2023 9:10 AM
To: Haifaa Khadour RN, BSc, BScN, MN (PHC-NP). <HaifaaK@ona.org>; jason.hann@kingstonhsc.ca <jason.hann@KingstonHSC.ca>
Cc: cgabrielli@cogeco.ca; Debra Bournes <debrabournes2014@gmail.com>
Subject: IAC Connell 10 Medicine Unit

Good Morning Haifaa and Jason

I hope you are getting time to enjoy the summer away from the computer.

Cindy Gabrielli, Debra Bournes, and I met on July 17th to discuss the upcoming IAC for the Kingston Health Sciences Centre-Connell 10 Medicine Unit and the information we require for the IAC hearing. I am attaching a document outlining what we discussed and the information we would like included in the Kingston briefing document.

As outlined in the document, could you please confirm October 23, 2023 as the date for all parties to receive the briefing documents. Also, as the IAC is being held in late November and the 45 day time frame to write the report falls over the holiday season, could you confirm that the committee will submit the IAC report on January 18, 2024.
Please do not hesitate to contact me if you have any questions.

All the best,
Claire

Claire Mallette RN, PhD
Director, School of Nursing
York University, Toronto, ON

Haifaa Khadour RN, BSc, BScN, MN (PHC-NP). <HaifaaK@ona.org>
To:Claire Mallette;+2 others
Cc:+2 others

Mon 2023-07-31 10:56 AM

Good morning Claire and IAC Panel,

I trust this message finds you well. I am writing to bring your attention to the guidelines outlined in Appendix 8 of the collective agreement, which state that all relevant documentation, including submissions for the hearing, must be provided to the committee members and the other party at least two weeks before the hearing date. As a result, the submission date for this IAC brief is set for Monday, November 6, 2023.

In the past, it has been customary for ONA to submit the report three weeks in advance, allowing ample time for the panel's comprehensive review. To maintain this precedent,

ONA is committed to delivering the brief on **Monday October 30th, 2023**. Furthermore, the union is requesting data of submissions for supplementary to be **November 10th, 2023**. I kindly request your confirmation on this date.

Considering the holiday season, ONA understands the importance of accommodating everyone's schedule. Therefore, we are in full agreement with the IAC report extension to January 18th, 2024.

Your support in this matter is appreciated, and should you have any further inquiries, please do not hesitate to contact me.

Sincerely

Haifaa Khadour RN, BSc, BScN, MN (PHC-NP).
Professional Practice Specialist
Ontario Nurses' Association

HJ

Hann, Jason <jason.hann@KingstonHSC.ca>

To: Claire Mallette; **+1 other**

Cc: cgabrielli@cogeco.ca; **+1 other**

Mon 2023-07-31 11:55 AM

Start reply with: Wonderful, thank you! | Great, thank you so much! | Sounds great, thank you!

Hello Claire & Haifaa,

Thank you Claire for the document and outline. KHSC will submit the brief by October 23, 2023 and in agreement with the IAC report extension to January 18, 2024.

Sincerely,
Jason

Jason Hann
Executive Vice President Patient Care & Chief Nurse Executive

Appendix C: ONA's Confirmation of the Nomination of the Chair & ONA Representative on the IAC.

April 13, 2023

Dear Dr. Claire Mallette

RE: Organization and Ontario Nurses' Association: Professional Responsibility Complaint – Unit - Independent Assessment Committee – ONA File #

Thank you for accepting the nomination to chair an Independent Assessment Committee (IAC) investigating a complaint at Organization. ONA has informed Mr. David McCoy, Director Labour Relations at the Ontario Hospital Association, of your agreement to Chair this IAC.

I will be providing the Guidelines for the Chairperson of the IAC and a copy of the current Central Hospital Collective Agreement. If you require any other documents please do not hesitate to let me know and I can forward them to you.

The attached letter provides the Association's nominee - name and contact information. The Employer has been requested to share their nominee's information within the timeframes as set out in the Collective Agreement, by **May 3, 2023**. Please set dates with the nominees, who will confirm with their respective parties.

Please be advised the Ontario Nurses Association nominee to the Independent Assessment Committee is:

Cynthia (Cindy) Gabrielli
[redacted]

H: 905[redacted]
C: 905[redacted]
cgabrielli@[redacted]

Sincerely,

ONTARIO NURSES' ASSOCIATION

Haifaa Khadour, RN, BSc, BScN, MN.
Professional Practice Specialist

Cc

Annette Saccon, ONA Bargaining Unit President, and Local Coordinator
Mandy Wilson, ONA Servicing Labour Relations Officer
Jason Hann, Chief Nursing Executive
David McCoy, Director, Labour Relations, OHA

APPENDIX D: Notification of KHSC's Nominee Independent Assessment Committee Connell 10

Hann, Jason <jason.hann@KingstonHSC.ca>

Tue 2023-05-02 6:28 PM

Dear Dr. Mallette,

Dr. Debra Bournes will be Kingston Health Sciences Centre nominee to the Independent Assessment Committee. Dr. Bournes can be contacted at debrabournes

Sincerely,
Jason

Jason Hann
Executive Vice President Patient Care & Chief Nurse Executive
Pronouns: he/him Why I declare my pronouns
Kingston Health Sciences Centre
T: 613.544.3006 C: 613.484.8267
E: Jason.hann@KingstonHSC.ca

KHSC Kingston Health Sciences Centre | (kingstonhsc.ca)

APPENDIX E: Outline of the Steps & Information Needed to Prepare for the IAC Hearing

Discussion notes from July 17, 2023 with Cindy Gabrielli, Debra Bournes, and Claire Mallette in relation to the upcoming IAC for the Kingston Health Sciences Centre-Connell 10 Medicine Unit and the information we would like included in the briefing document.

Please find below what was discussed and next steps:

A. The IAC will be held via Zoom on November 20, 22, & 23, 2023 (agenda to follow). There is no hearing on November 21, to enable each of your teams to review the information presented on November 20, and prepare your responses that will be presented on November 22. Both November 20 and 22 will be full days from approximately 8:30-5:00 pm, and November 23 will be from 8:30 to approximately 1:00 pm.

B. As the IAC is being held at the end of November, part of the 45 days to write the report falls over the holiday season. The IAC will not be writing the report from December 23, 2023 until January 3, 2024. Therefore, the IAC would like to submit the report to both parties on January 18, 2024. Please confirm you agree that because of the holidays, the date for the report will be January 18, 2024

C. We request that the documents you are preparing for the IAC hearing be submitted on October 23, 2023. This time frame provides approximately 3 months to put your briefing documents together and provides adequate time for all of us to review the submitted documents prior to the IAC hearing starting on November 20.

D. The documents and data that should be included in the Kingston submission are listed below. Please submit trended data (graphs) by month (where applicable – we recognize that some data is collected more infrequently – i.e., staff satisfaction etc.) and all versions of requested documents in use for the time period under review – that is 2018-19 through 2019-20, and 2021-2022, 2022-2023, and 2023-2024 YTD:
    1. Staffing model pre (2018-19, 2019-20) and post-pandemic (2021-2022, 2022-2023, 2023-2024 YTD) including:
        a. Description of the staff models implemented during this time frame, including:
            - The rationale for the change
            - How the staffing ratio changed with the new models of care
        b. Nurse-Patient ratio
        c. Budgeted numbers of FTE, PTE RNs and RPNs
        d. # of hours worked by casual RNs, RPNs, PSWs (by month)
        e. Budgeted RN hours per patient day
        f. Budgeted RPN hours per patient day
        g. Budgeted PSW hours per patient day
        h. Actual RN hours per patient day
        i. Actual RPN hours per patient day
        j. Actual PSW hours per patient day
        k. Planned staffing ratio of all healthcare providers for Day, Evening and Night shift
        l. Description of supports and education provided/available to staff while rolling out new models of care

2. Visual layout of the unit and description of how the nurses are assigned to patient rooms

3. Schedule
   a. 6 weeks prior to October 23, 2023 for all healthcare providers
   b. 6 weeks projected after October 23, 2023 for all healthcare providers

4. Job descriptions
   a. RN, RPN, PSW
   b. Charge Nurse job description
   c. Housekeeping, clerical workers on the unit

5. If available, examples of missed or delayed care in the requested timeframes related to understaffing of the unit.

6. Unit capacity rate pre-post pandemic including:
   a. Overcapacity policy for the unit
   b. Budgeted occupancy vs. actual occupancy

7. Years of experience as an RN or RPN on the unit pre and post-pandemic

8. # of vacancies on the Unit (RNs, RPNs, PSWs)

9. Unfilled Leaves of absence (greater that 6 weeks – i.e., include unfilled education leaves, maternity leaves, etc.)

10. Agency Use (agency hours as a % of total worked hours (separately for RNs, RPNs, PSWs)

11. Overtime & Sick time (as a % of total worked hours (separately for RNs, RPNs, PSWs)

12. RN Turnover (% leaving organization and % transferring within the organization)
    a. % by month pre (2018-19, 2019-20) and post-pandemic (2021-2022, 2022-23, 2023-24 YTD)
    b. Reasons for leaving, for those who left the organization

13. Nurses being floated to other areas:
    a. Use of staff floated from other areas (as a % of total worked hours on the unit – separately for RNs, RPNs, PSWs)
    b. # Hours RNs were floated to other units as % of their total worked hours
    c. #times/month RNs are floated to another unit
    d. Units that Connell 10 Medicine Unit nurses are being floated to
    e. Preparation and training of nurses prior to being floated to other units.

14. Staff satisfaction results

15. WSIB Claims: # of workplace injuries on unit/month

16. Policies or programs (implemented or planned) to ensure physical and psychological safety of nurses (or whole team on unit)

17. Leadership Team
    a. Organizational Chart of reporting structure
    b. Description of the leadership team on Connell 10 Medicine Unit
    c. % of time the Nurse Manager is actually on the unit
    d. Job descriptions describing roles and responsibilities
    e. Tenure of leadership team
    f. Descriptions of supportive management and leadership practices, including involvement of nurses in policy and decision making

18. Retention Strategies

19. Recruitment Strategies

20. Onboarding Strategies
    a. Orientation program including:
        - Length
        - Topics and Schedule
        - Number of preceptored shifts
        - Use of NGN program
        - Other
    b. Supports for new staff following the orientation period including
    c. Education and supports mentors/preceptors receive to be effective in their role.

21. Patient Outcomes pre and post-pandemic
    a. Restraint Use
    b. Falls
    c. Delirium
    d. Catheter Associated Urinary Tract Infections
    e. Pain Management
    f. Code Data-i.e. #s of Code Whites called/month
    g. Patient satisfaction results
    h. Medication errors (with and without harm)
    i. Rapid Response Team Calls (if applicable –i.e., use calls to a specialized team from ICU to assess/help with patients who are deteriorating)

Appendix F: IAC Response to Receiving Submissions Prior to the Briefing Note Submissions on October 30, 2023.

From: Claire Mallette
Sent: Friday, August 4, 2023 12:20 PM
To: Haifaa Khadour RN, BSc, BScN, MN (PHC-NP). <HaifaaK@ona.org>; Cynthia Gabrielli <cgabrielli>; Debra Bournes <debrabournes>
Cc: Lorrie Daniels RN, BScN(H), MN (Leadership) <LORRIED@ona.org>; jason.hann@kingstonhsc.ca
Subject: Re: IAC Connell 10 Medicine Unit. ONA'S Acknowledgment to Deadlines for Brief and Supplementary Evidence Submissions

Hi Haifaa and All

Happy Friday before a long weekend!

Thank you for your email. As I stated in my previous email, we will not be reviewing any documents prior to receiving the briefing documents in October from both parties for the IAC hearing. The documents you submitted in your previous email, should be part of your submission as Appendices. It would also be helpful for the IAC, if your team summarizes the outstanding issues that are emerging from these documents in your overview and presentation of the issues.

We ask that your submission on October 30 be as complete as possible identifying the issues with evidences. We ask that any supplemental information before November 8 be kept to information that is new vs. more documents reiterating what has already been stated and supported with evidence in your initial submission; or something that has occurred on the Unit since the submission of the document on October 30, that the IAC needs to be aware of while preparing for the hearing.

After November 8th, we will take requests on a case by case basis to whether more information can be submitted or not by both parties.

Thanks and have a good weekend.
Claire

Claire Mallette RN, PhD

Appendix G: First Class Conferencing Facilitation Confidentiality Agreement

Segan Alexandria Permell <spermell@firstclassfacilitation.ca>
To:Claire Mallette

Thu 2023-11-16 12:30 PM

Hi Claire,

I have read and understand the conditions outlined in the confidentiality statement and agree to all terms and conditions.

Best,
Segan Permell
Web Conference Technician | First Class Conferencing Facilitation
e. spermell@firstclassfacilitation.ca
m. (289)-XXX-XXXX

Appendix H: KHSC Statement of Confidentiality for External Auditor/ /Surveyor/Investigator

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

STATEMENT OF CONFIDENTIALITY FOR EXTERNAL AUDITOR/SURVEYOR/INVESTIGATOR

It is Hospital Policy and law that all Hospital information is confidential. Patient confidentiality is a statutory requirement of the Personal Health Information Protection Act, 2004 (PHIPA). The laws that govern the protection of information will apply, in full, to individuals conducting work at the hospital, including those dealing with offences and penalties.

As an individual conducting work at the Hospital, you may have access to information and material relating to patients, employees, and other individuals of the Hospital, that is of a private and confidential nature.

1. The principles and philosophy of the Hospital will be followed in accordance with the Hospital's rules and standards of conduct. At all times you will respect the privacy and dignity of patients and their families, employees and all associated individuals.

2. You will treat all Hospital records, whether written, verbal or electronically stored, as confidential material and you will protect it to ensure full confidentiality. You will not access records, discuss or use such information unless there is a legitimate purpose to do so as a result of an agreement with your hospital member contact.

Confidentiality is the right of every patient and everyone affiliated with the Hospital. Each of us is expected to respect that right.

I have read and understand the conditions outlined in this statement.

NAME (Please Print)	**WITNESS NAME** (Please Print)
SIGNATURE	**SIGNATURE**
DATE	**DATE**

z:/privacy/forms/03 KHSC Confidentiality statement auditor-surveyor-investigator final June 2018

Appendix I: Request for Additional Information from KHSC

From: Claire Mallette
Sent: Monday, November 13, 2023 8:00 AM
To: Hann, Jason <jason.hann@KingstonHSC.ca>
Cc: Haifaa Khadour RN, BSc, BScN. <HaifaaK@ona.org>; cgabrielli; Debra Bournes <debrabournes>; Lorrie Daniels RN, BScN(H), MN (Leadership) <LORRIED@ona.org>
Subject: In need of more information

Hi Jason,
I hope you had a good weekend.

Thanks so much to you and your team, and the ONA team for putting the submissions together. I can only imagine how much time and work went into them.

Debra, Cindy and I met for a preliminary discussion of the data provided to us in each of the submissions. Based on our discussion we are asking for the following information:

1. **2023-2024 Data YTD**
   Please provide the most up-to-date 2023-2024 data in all the areas you provided in the briefing note including:
   - an update to Tab 6 from your submission in Excel format), an identification of the actual vacancies and whether they are FT, PT, RN or RPN, and any updated data about the progress made in reducing vacancies.
   - Number of unfilled LOAs on C10 (defined as LOAs greater than 6 weeks) on C10 (RN, RPN, PCA separately by month for 2023-2024 YTD)
   - What is the total shortfall (actual vacancies plus unfilled LOAs) of nurses (RN and RPN) and PCAs on C10?

2. **Scheduling/Staffing**
   - A copy of an actual master schedule with identification of who is FT and PT, and whether the nurse is an RN or RPN and the PCAs scheduled for each shift.

3. **Job Description**
   - Operations Manager job description

If you could get this information to us as soon as possible, preferably before the hearing, it would be most appreciated.

Thanks so much,
Claire

Claire Mallette RN, PhD

Appendix J: Final Agendas

Kingston Health Sciences Centre (KHSC) Connell 10 &
Ontario Nurses Association (ONA)
IAC Hearing Draft Agenda
Monday November 20, 2023

Zoom Link: https://firstclassfacilitation-ca.zoom.us/j/66905524895?pwd=TWx0Q29iQVB4U1BSSVRqVTdRRFVUQT09
Meeting ID: 669 0552 4895 Passcode: 8028493502

Time	Item	Participants
08:30-08:45	Welcome and Introductions	C. Mallette (Chair)/All
08:45-08:55	Review of Proceedings of the Day	C. Mallette
8:55-10:00	Watch Virtual Tour of KHSC Connell 10	All
10:00-10:30	Discussion generated from the Video	All
10:30-11:00	Break	All
11:00-12:30	Ontario Nurses' Association Submission Presentation • Presented by: Haifaa Khadour	ONA
12:30-1:15	Lunch Break	
1:15-2:00	Response to questions of clarification from: • Independent Assessment Committee • Kingston Health Science Centre	All
2:00-15:30	Kingston Health Science Centre Submission Presentation • Presented by: KHSC Leadership Team	KHSC
15:30-15:45	Break	
15:45-16:30	Response to questions of clarification from: • Independent Assessment Committee • Ontario Nurses' Association	All
16:30-16:45	Review of Process for Wednesday November 22, 2023	IAC Chair

First Class Conferencing Facilitation: Segan Permell
Email: spermell@firstclassfacilitation.ca

Kingston Health Sciences Centre (KHSC) Connell 10 &
Ontario Nurses Association (ONA)
IAC Hearing Draft Agenda
Wednesday November 22, 2023

Zoom link: https://firstclassfacilitation-ca.zoom.us/j/66199624214?pwd=ZkEzdWxVQ3ZIOFlEMExZVW1ZekpOUT09
Meeting ID: 661 9962 4214 Passcode: 1357752475

Time	Item	Participants
08:30-08:35	Welcome	IAC Chair
08:35-08:45	Review of Proceedings of the Day	IAC Chair
08:45-10:15	Kingston Health Science Centre Response to Ontario Nurses' Association Submission Presented by: KHSC Leadership Team	KHSC
10:15-10:45	Break	All
10:45-11:45	Response to questions from: • Independent Assessment Committee • Ontario Nurses' Association • Discussion	IAC, ONA, and KHSC
11:45-12:45	Lunch Break	All
12:45-14:15	Ontario Nurses' Association Response to Submissions Presented by: Haifaa Khadour	ONA
14:15-14:45	Break	All
14:45-15:45	Response to questions from: • Independent Assessment Committee • Ontario Nurses' Association • Discussion	IAC/KHSC/ONA
15:45-16:00	Review of process for Thursday November 23, 2023	IAC Chair
16:00	Adjournment	IAC Chair

First Class Conferencing Facilitation: Segan Permell
Email: spermell@firstclassfacilitation.ca

Kingston Health Sciences Centre (KHSC) Connell 10 &

Ontario Nurses Association (ONA)
IAC Hearing Draft Agenda
Thursday November 23, 2023

Zoom link: https://firstclassfacilitation-ca.zoom.us/j/64974517373?pwd=UVJ6TlNleStJeHpvWGw1b1h5dkhpZz09
Meeting ID: 649 7451 7373 Passcode: 7145851518

Time	Item	Participants
08:30-8:45	Welcome and Review of Proceedings	IAC Chair
08:45-10:15	Questions to both Parties by the Independent Assessment Committee	IAC
10:15-10:45	Break	All
10:45-12:15	Opportunity for Nurses to make comments	KHSC 10 Connell Nurses
12:15-12:30	Closing Remarks Ontario Nurses Association	ONA
12:30-12:45	Closing Remarks Kingston Health Sciences Centre	KHSC
12:45-13:15	Closing Remarks and Identification of Next Steps by Chairperson and Closure of Hearing	IAC Chair
13:15	Adjournment	IAC Chair

First Class Conferencing Facilitation: Segan Permell
Email: spermell@firstclassfacilitation.ca

Appendix K: ONA's Attendee List for IAC Hearing November 20, 22, & 23, 2023.

ONA Board of Directors:

- Erin Ariss, ONA Provincial President
  - erina@ona.org
- 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
- Andrea Fagan, Professional Practice Specialist
  - andreaf@ona.org
- Kara Northgrave, Professional Practice Specialist
  - karan@ona.org
- Lorrie Daniels, Manager, Manager Member Education
  - 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
- Lori Harreman, ONA Legal Counsel
  - lorih@ona.org

Members of the Local Bargaining Unit - KGH

- Annette Saccon, Bargaining Unit President
  - khscbup@onalocal99.org
- Ellen Mulville, Chair of Hospital Association Committee
  - khschac@onalocal99.org
- Cristine McClennon, Registered Nurse on the C10
  - cristine27@gmail.com
- Bennett Hunter, Registered Nurse on the C10
  - Hunter.Bennett@kingstonhsc.ca
- Alyson Lazier, Registered Nurse on the C10
  - alie_85@hotmail.com

Appendix L: KHSC's Attendee List for IAC Hearing November 20, 22, & 23 2023.

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

KHSC List of Attendees

- Indira Naraine, Director, People Services indira.naraine@kingstonhsc.ca
- Maxwell Crothers, Employee & Labour Relations Advisor maxwell.crothers@kingstonhsc.ca
- Jason Hann, Executive Vice President Patient Care and CNE jason.hann@kingstonhsc.ca
- Thomas Hart, Executive Director Patient Care and Deputy CNE thomas.hart@kingstonhsc.ca
- Tyler Hands, Director Medicine & Neurosciences tyler.hands@kingstonhsc.ca
- Colton Halligan, Medicine Manager colton.halligan@kingstonhsc.ca
- Laura Mitchell, Director Professional Practice laura.mitchell@kingstonhsc.ca
- Kelsi Bailey, Senior Administrative Assistant kelsi.bailey@kingstonhsc.ca
- Joanna Noonan, Director Occ Health, Safety & Wellness joanna.noonan@kingstonhsc.ca
- Renaud Golsse, Director Protection Services renaud.golsse@kingstonhsc.ca
- Jennifer Kasaboski, Clinical Learning Specialist jennifer.kasaboski@kingstonhsc.ca
- Meghan McCourt, Director Patient Flow and Registration meghan.mccourt@kingstonhsc.ca
- Alan Archer, Director Workforce Planning & Utilities alan.archer@kingstonhsc.ca

Appendix M: KHSC's & ONA's Attendee Lists for IAC Hearing November 20, 22, & 23, 2023

KHSC's Attendee Lists for IAC Hearing November 20, 22, & 23, 2023

Name/Email	Title	Nov 20	Nov 22	Nov 23
Alan Archer allan.archer@kingstonhsc.ca	Director Workforce Planning & Utilities			
Kelsi Bailey kelsi.bailey@kingstonhsc.ca	Senior Administrative Assistant	X	X	X
Maxwell Crothers maxwell.crothers@kingstonhsc.ca	Employee & Labour Relations Advisor	X	X	X
Renaud Golsse renaud.golsse@kingstonhsc.ca	Director Protection Services	X	X	X
Colton Halligan colton.halligan@kingstonhsc.ca	Medicine Manager	X	X	X
Tyler Hands tyler.hands@kingstonhsc.ca	Director Medicine & Neurosciences	X	X	X
Jason Hann jason.hann@kinstonhsc.ca	Executive Vice President Patient Care and CNE	X	X	X
Thomas Hart thomas.hart@kingstonhsc.ca	Executive Director Patient Care & Deputy CNE	X	X	X
Jennifer Kasaboski jennifer.kasaboski@kingstonhsc.ca	Clinical Learning Specialist	X		
Meghan McCourt meghan.mccourt@kingstonhsc.ca	Director Patient Flow and Registration			
Indira Naraine indira.naraine@kingstonhsc.ca	People Services	X	X	X
Joanna Noona Joanna.noona@kingston.ca	Director Occ Health, Safety & Wellness		X	X
Laura Mitchell laura.mitchell@kingstonhsc.ca	Director, Professional Practice	X	X	X

ONA's Attendee Lists for IAC Hearing November 20, 22, & 23, 2023

Name/Email	Title	Confidentiality	Nov 20	Nov 22	Nov 23
Erin Aris erina@ona.org	ONA Provincial President				
Lorrie Daniels LORRIED@ona.org	Manager Member Education				
Andrea Fagan andreaf@ona.org	Professional Practice Specialist				
Lori Harreman lorih@ona.org	ONA Legal Counsel	X	X	X	X
Bennett Hunter Hunter.Bennett@kingstonhsc.ca	Registered Nurse on C10	X	X	X	X
Haifaa Khadour HaifaaK@ona.org	Professional Practice Specialist	X	X	X	X
Jackie Kehoe-Donaldson JackieK@ona.org	Manager of Professional Practice Team	X	X	X	X
Alyson Lazier alie_85@hotmail.com	Registered Nurse on C10	X	X	X	X
Cristine McClennon cristine27@gmail.com	Registered Nurse on C10	X	X	X	X
Ellen Mulville khschac@onalocal99.org	Chair of Hospital Association Committee	X	X	X	X
Kara Northgrave karan@ona.org	Manager Member Education	X	X	X	X
Angela Preocanin AngelaP@ona.org	ONA Vice President				
Benjamin Ramirez Jimenez BenjaminRJ@ona.org	Professional Practice Specialist	X	X	X	X
Annette Saccon khscbup@onalocal99.org	Bargaining Unit President	X	X	X	X
DJ Sanderson DJS@ona.org	Executive Lead, Provincial Services				
Mandy Wilson MandyW@ona.org	ONA Labour Relations Officer	X	X	X	X

Appendix N: Connell 10 Unit Map