

**Independent Assessment Committee Report**

**Constituted under Article 8.01 of the**

**Collective Agreement**

**Between**

**Medical Assessment Consultation Unit (MACU)**

**Southlake Regional Health Centre**

**and**

**Ontario Nurses' Association**

**November 14, 2021**

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November 14, 2021

Dear Ms. Richard and Ms. Ferguson,

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 Southlake Regional Health 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 Medical Assessment Consultation Unit (MACU) at Southlake Regional Health Centre.

The members of the Independent Assessment Committee recognize and appreciate, especially during this challenging and unprecedented time due to the COVID-19 Pandemic, the efforts taken by representatives of the Hospital, the Ontario Nurses' Association, and the Registered Nurses to prepare and present information and responses to our questions prior to and during the three-Day hearing, held on September 27, 28, & 29, 2021.

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 in the Medical Assessment Consultation Unit at Southlake Regional Health Centre.

Respectfully Submitted,

A handwritten signature in cursive script that reads "Claire Mallette".

Claire Mallette, RN PhD  
Chairperson, Independent Assessment Committee

A handwritten signature in cursive script that reads "Susan Kwolek".

Susan Kwolek, RN MHSc (Health Admin) CHE  
Nominee for the Hospital

A handwritten signature in cursive script that reads "Cindy Gabrielli".

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

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## **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 RESPONSIBILITY WORKLOAD COMPLAINT**

This section presents the context of practice relating to the Registered Nurses' Professional Responsibility Workload Complaint in the Medical Assessment Consultation Unit (MACU) at Southlake Regional Health Centre (the Hospital); 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 the Association and the Hospital.

### **1.2 Referral to the Independent Assessment Committee**

For approximately the past 2 years, the Medical Assessment Consultation Unit (MACU) RNs have consistently reported their concerns in relation to an increased workload, resulting in decreased quality of care and safety. More than 109 PRWFs from May 30, 2019 to August 22, 2021 have been submitted by MACU nurses. The PRWF's identify the inadequate staffing and appropriate skill mix as the primary and most crucial issues, alongside issues related to patient care and acuity. Multiple Professional Practice and

Hospital Association Committee (HAC) meetings occurred over this time frame with no resolution, and professional responsibility and workload issues continue to be a concern on MACU.

On April 8, 2021, Sandy Paproski, ONA Professional Practice Specialist submitted a letter to Annette Jones, the Chief Nursing Executive (CNE) providing a detailed report of the professional responsibility and workload issues in MACU and advising that these concerns were being forwarded to an IAC for resolution. In the letter, the Association identified, that the current workload and current practice environment does not allow the nurses to meet the College of Nurses of Ontario (CNO) Standards of Practice and Practice Guidelines, and the employer's policies, procedures and vision.

The letter then listed workload and practice issues identified by ONA members that remained unresolved. They are as follows:

1. Failure to have sufficient baseline staffing to accommodate full census.
2. Failure to maintain consistent patient assignment based on skill level/experience, patient acuity and complexity.
3. Insufficient equipment and supplies available for nurses to be able to provide quality safe patient care.
4. Inadequate resources and support available when the MACU is in outbreak or experiencing an increased number of patients requiring infection control precautions.
5. Inadequate support to manage surge capacity.
6. Failure to provide a safe working environment by not providing appropriate staffing when confused, behavioral or violent patients are on the unit.
7. Inadequate communication, education, and training to charge nurse and staff nurses regarding processes on unit, such as admission/discharge protocols, transfer of care protocols, increase workload requests, equipment, and supplies communication etc.

### **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 Southlake Region Health 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 concerns relating to professional practice, patient acuity, fluctuating workloads and fluctuating staffing are resolved in a timely and effective manner. This provision is intended to appropriately address employee concerns relative to their workload issues in the context of their professional responsibility. In particular, the parties encourage nurses to raise any issues that negatively impact their workload or patient care, including but not limited to:

- Gaps in continuity of care;
- Balance of staff mix;
- Access to contingency staff;
- Appropriate number of nursing staff.

In the event that the Hospital assigns a number of patients or a workload to an individual nurse or group of nurses such that they have cause to believe that they are being asked to perform more work than is consistent with proper patient care, they shall:

- (a) i) At the time the workload issue occurs, discuss the issue within the unit/program to develop strategies to meet patient care needs using current resources.
- ii) If necessary, using established lines of communication as identified by the hospital, seek immediate assistance from an individual(s) (who could be within the bargaining unit) who has responsibility for timely resolution of workload issues.
- iii) Failing resolution of the workload issue at the time of occurrence or if the issue is ongoing the nurse(s) will discuss the issue with her or his Manager or designate on the next day that the Manager (or designate) and the nurse are both working or within ten (10) calendar days whichever is sooner.

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

- iv) Complete the ONA/Hospital professional Responsibility Workload Report Form. The manager (or designate) will provide a written response on the *ONA/Hospital Professional Responsibility Workload Report Form* to the nurse(s) within ten (10) calendar days of receipt of the form with a copy to the Bargaining Unit President, Chief Nursing Executive, and the Senior Clinical Leader (if applicable).

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

Hospital Central Agreement – June 7, 2021

- 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 she or he 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 she or he 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.

In accordance with Article 8.01 (xiii) ‘The Assessment Committee shall render its decision, in writing to the parties within forty-five (45) calendar days following completion of its hearing’.

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, the Association and the Hospital 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 Association:**

Cindy Gabrieilli

**For the Hospital:**

Susan Kwolek

**Chairperson:**

Claire Mallette

## 1.4 Proceedings of the Independent Assessment Committee

### 1.4.1 Pre-Hearing

On April 8<sup>th</sup>, 2021, the Hospital received a letter from the Association whereby a Referral of Professional Practice and Workload Issues at Southlake Regional Health Centre Medical Assessment Consultation Unit to an Independent Assessment Committee was made (Appendix 1). On May 7, the Hospital sent a letter to the Association notifying them that the Hospital's nominee for the IAC would be Susan Kwolek (Appendix 2). On May 12, the Association sent an email to the Hospital from Danielle Richard Labour Relations Officer-Professional Practice Specialist notifying them that Claire Mallette would be the Chair of the IAC with Cindy Gabrielli as the Association's nominee (Appendix 3). Danielle Richard replaced Sandy Paproski as the Association's representative on the file.

On June 10, 2021, The IAC members met by Zoom and discussed the following:

- Introductions;
- Overview of the IAC process and timeframes;
- Proposed dates of the IAC; and
- Areas of documentation needed to assist in the IAC's process and deliberations from the Hospital. The information requested included information such as RN turnover and experience, new staff modelling, staff resources, and orientation program. The IAC dates were finalized for September 28, 29 and 30, 2021 which both the Hospital and Association agreed upon

Both the Hospital and Association were given the date of September 7, 2021 to submit their documents to the IAC.

On August 11, 2021, the IAC members met by Zoom to prepare for the Hearing. During the meeting, the Chair was informed by the Hospital's nominee, Susan Kwolek, that the former Chief Nursing Executive (CNE), Annette Jones, had retired and the new CNE is now Elizabeth Ferguson. The decision was made that the IAC Hearing would be conducted virtually due to the pandemic. Cindy Gabrielli requested on behalf of the Association that the IAC Hearing dates be changed to September 27, 28, & 29<sup>th</sup>, since September 30, 2021 is a statutory holiday as the National Day of Truth and Reconciliation. The Hospital agreed to this request.

On August 24, 2021, First Class Conferencing Facilitation was confirmed to coordinate the virtual technology during the IAC Hearing. A confidentiality agreement was received by the facilitator Joseph Jourekian on the same day (Appendix 4).

On September 7, 2021 the Association and Hospital submitted their documents. The Association requested the ability to submit supplementary documents on September 17<sup>th</sup>. The Chair granted permission and gave the Hospital the same opportunity.

The IAC received supplemental documents from both the Hospital and Association on September 17, 2021. The Hospital submitted a Hospital Response Brief and the Presentation package. The Association's supplemental information consisted of more PRW forms, an erratum to the ONA Brief, and information in relation to the MACU RNs and working schedule.

On September 20, 2021 The IAC members reviewed the information from the submitted documents via Zoom and prepared for the IAC Hearing. An email was sent to the Hospital CNE for additional documents (Appendix 5)

The virtual tour of MACU occurred on September 21, 2021 with participants from both the Association and Hospital.

On September 23, 2021, the final agenda (Appendix 6) and attendees (Appendix 7) were sent to the Association and Hospital.

On September 23, 2021 the Chair received an email from Ms. Ferguson the CNE of the Hospital, expressing concern that the Association did not provide presentation materials in their supplemental documents. The Hospital stated, that the "Hospital will be objecting to any further presentation materials that ONA may wish to provide...in the week leading up to the Hearing". The email continued to state that should "ONA be given the opportunity to submit new materials as part of the presentation, the Hospital will seek an opportunity to review the materials in full and gather any necessary responding materials before asking questions of ONA or commencing its presentation...which in all likelihood, would lead to an adjournment and adjustment to the Hearing schedule for that purpose" (Appendix 8).

The IAC met on September 23, 2021 to discuss the Hospital's email and how to proceed. The Chair responded to Ms. Ferguson on September 23, 2021 (Appendix 9). The Chair emphasized that the IAC is committed to following the Collective Agreement in conducting the IAC Hearing. The Chair also highlighted how the IAC believes 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. The Chair pointed out that at no time did the IAC specify what the supplementary documents should include, nor was the presentation requested of either party prior to the IAC Hearing.

In the email to the CNE, the Chair also asked for clarification of the reason why a RPN would be attending all 3 days of the Hearing. The CNE explained that the RPN was participating in the IAC Hearing in the role of a Behavioural Response Nurse that Supports MACU nurses.

On August 24, 2021, Ms. Ferguson thanked the Chair for the clarification (Appendix 10).

### **1.4.2 Hearing**

The Hearing was held virtually via Zoom to comply with the current COVID-19 Pandemic Guidelines and was facilitated by a third party (First Class Conferencing Facilitation). The Hearing convened at 08:30 on September 27, 2021.

The Hearing was held over three days:

Monday September 27, 2021: 8:30-16:00 hours

Tuesday September 28, 2021 8:30-16:30 hours

Wednesday September 29, 2021 8:30-13:15 hours

#### **Hearing Day One: Monday September 27, 2021**

The Chair opened the Hearing at 08:30 with a welcome and a Land Acknowledgement. The Chair then thanked everyone for being present and for their commitment to the IAC process over the next 3 days. Introductions then occurred, with the Chair inviting the IAC members to introduce themselves, followed by introductions of the representatives from the Hospital and Association.

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.*

The IAC Guidelines which were then reviewed are listed below:

1. Adhere to the agenda and timeframes for presentation;
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 MACU, coordinated by the Hospital, was viewed. The tour was led by Stephanie Blair (MACU RN) and Kevin Persaud (Manager MACU). Donna Oliver, (Interim Bargaining Unit President) and Kirsten Tamm (PRW Representative), and Alyson McQueen, Director Medicine Program and Liz Lalingo (Director ED and Mental Health and Interim Director Medicine Program) also participated in the tour.

Following the video, the IAC asked clarification questions related to the medication process, availability of restraints, discharge process, the private rooms that had been converted to semi-private accommodations, equipment availability, and the challenges of accessing hot water.

After a short break, Danielle Richard, Professional Practice Specialist presented on behalf of the Association. The Association's presentation was based on their written pre-Hearing submission and supporting exhibits / explanatory information, as well as a summary of the Professional Responsibility Workload Report Forms (PRWFs) submitted by the Registered Nurses within MACU. During the presentation, the Association reaffirmed their position that the themes of staffing, acuity and complexity, missed or rationed care, violence, infection control, education, orientation, leadership, communication, morale, work

environment, and non-nursing duties and equipment must be addressed for the nurses to meet their CNO Professional Standards and the Hospital's policies, procedures and vision. Following the presentation, the Association responded to clarification questions from the IAC Panel and the Hospital.

After a break for lunch, the Hospital's presentation was given by Elizabeth Ferguson, VP Clinical Transformation Patient Experience and Chief Nursing Executive and Alyson McQueen, Director Medicine Program and Patient Flow and Access. The presentation provided a focus on the issues outlined in the referral to the IAC, an overview of the Hospital and MACU highlighting what is working well and the challenges experienced over the past 2 years. After the presentation, the IAC and Association asked follow up questions.

Prior to adjourning the meeting, the Chair reviewed the process for the next day. The Hearing ended at 16:00 hrs. Following adjournment, the IAC met to review and synthesize the information provided and identify key issues requiring clarification and discussion on the second day of the Hearing.

### **Hearing Day Two: Tuesday September 28, 2021**

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.

Ms. Ferguson provided the Hospital's response to the Association's submission and reaffirmed the position of the Hospital. Following the Hospital's response, discussion ensued with questions being asked by the Association and IAC. Following a break for lunch, Ms. Richards from the Association responded to the Hospital's submission, followed by a discussion and questions by the IAC and the Hospital. The Chair reviewed Day Three's agenda at the end of the day, and the meeting was adjourned at 16:00.

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

### **Hearing Day Three: Wednesday September 29, 2021**

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, except the Behavioural Response Nurse RPN from the Hospital and Jaselyn Espirtu, DJ Sanderson,

and Catherine Hoy from the Association were not present. Athena Brown from the Association attended the meeting for the first time. The IAC panel members asked further questions in order to understand a range of issues and listened to responses from both parties that needed clarification.

After the break the Chair invited registered nurses from MACU 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 perspective to the IAC Hearing.

Ms. Ferguson and Ms. Richard then provided closing remarks on behalf of the Hospital and Association respectively.

The Chair concluded the Hearing by thanking the IAC panel members Cindy Gabrielli, the Association nominee and the Hospital nominee, Susan Kwolek, 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 12:30.

### **1.4.3 Post-Hearing**

The IAC panel members met via Zoom in preparing the Final Report on October 12, 18, November 4<sup>th</sup>, November 11<sup>th</sup> and through emails. All members of the IAC contributed to the final version of the report. The Final report was submitted to the Association and Hospital on November 14, 2021.

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

### **2.1 Information on Southlake Regional Health Centre (SRHC)**

SRHC provides health care to the communities of northern York Region and southern Simcoe County. These regions are some of Ontario's fastest growing and aging populations. As of August 2021, SHRC is funded for 486 beds, and has consistently been

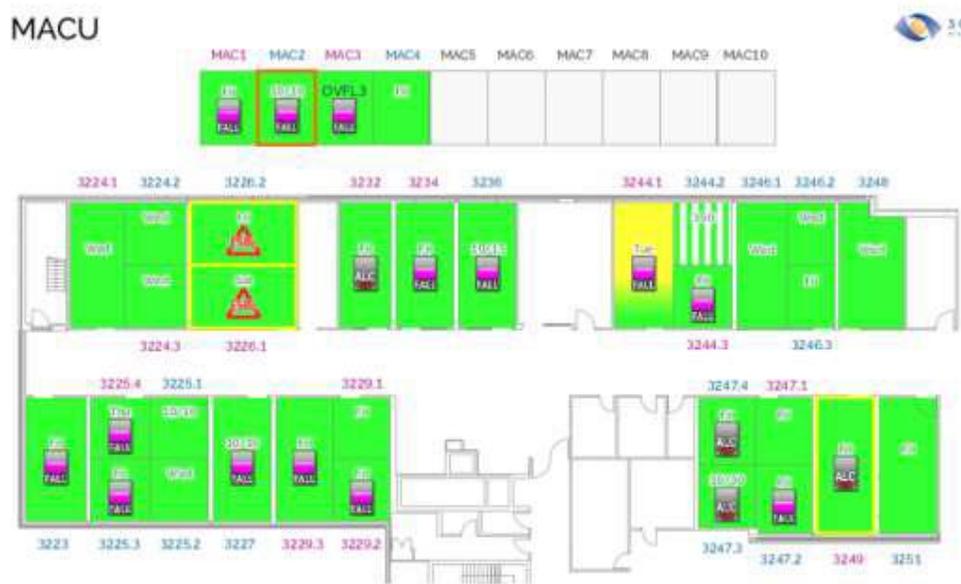
operating and staffing for on average 464 beds. The beds increased to 519 to address surge capacity as a result of the COVID-19 pandemic (MACU IAC Hospital Brief, p. 13).

SRHC offers programs of care for patients who have healthcare needs related to cancer, cardiac, emergency, families and babies, medicine, mental health and surgery. There are also advanced programs in cancer care, cardiac care, cataract surgery, child and adolescent eating disorders, mental health services for children, pediatrics and perinatal care, and thoracic surgery; serving a broader population across the northern GTA and into Simcoe-Muskoka (MACU IAC Hospital Brief, p. 13). In 2020, SRHC employed 1291 Registered Nurses (MACU IAC Hospital Brief, p. 4).

## 2.2 Medical Assessment Consultation Unit

Within the Hospital's Medicine program there are 6 Units and a corporate Virtual Nursing Team. The Medical Assessment Consultation Unit (MACU) is a 34 budgeted bed unit consisting mostly of semi-private rooms with approximately 2 overflow beds. MACU is a general medicine inpatient unit that provides nursing care to acute medicine patients requiring complex care related primarily to cardiac, oncology and thoracic issues. The initial intent of MACU was to relieve pressure from the emergency department; however, on August 1, 2018 the Rapid Assessment Unit (RAU) was introduced to relieve this pressure. MACU also has the potential of being a secure unit. Figure 1 shows the MACU layout since 2015.

Figure 1: MACU layout since 2015



MACU has experienced changes and challenges since 2019. During the period from April, 1 2019 to June, 2021, MACU was over-census 18% of the time by one to two patients. There has also been an unstable leadership team with the introduction of new directors, a new Chief Nursing Executive and 4 managers since 2019.

In February, 2021, a new model of care was introduced at the Hospital and on MACU called the *Team Based Model of Care* with the goal of “transforming independent practice to a collaborative model to improve staff experience, patient experience, patient safety, and to increase the scope of practice by refreshing the skills mix on each unit... and ensure staff were working to full scope, improving their ability to flex resources to meet patient needs, and to elevate the patient experience” (MACU IAC Hospital Brief, p. 29).

With the introduction of the *Team Based Model of Care* there was a change of RN-RPN staffing ratios resulting in the staffing outlined in Table 1 & 2. Table 1 outlines the staffing prior to the implementation of the *Team Based Model of Care* and Table 2 captures the staffing in the *Team Based Model of Care*.

Table 1: MACU Staffing prior to the *Team Based Model of Care*

|                                   | Days  | Nights  |
|-----------------------------------|---|---|
| <b>Charge Nurse</b>               | 1<br>(assigned assignment of<br>2-3 patients) | 1 (assigned an assignment of<br>3-4 patients) |
| <b>Registered Nurse</b>           | 6 + Charge Nurse                              | 6   |
| <b>Registered Practical Nurse</b> | 2   | 0   |
| <b>Patient Service Provider</b>   | Yes   | Yes   |
| <b>Unit Clerk</b>                 | 1   | 0   |
| <b>Patient Flow Navigator</b>     | 2   | 0   |

Table 2: MACU Staffing in the *Team Based Model of Care*

|                                   | Days   | Nights   |
|-----------------------------------|--|--|
| <b>Charge Nurse</b>               | 1<br>(Mon-Fri 8hr, no patient<br>assignment) | 1 with a<br>a patient assignment and<br>charge role) |
| <b>Registered Nurse</b>           | 3 (Sun-Sat, 12 hr. shifts)                   | 2 (Sun-Sat, 12 hr. shifts)                           |
| <b>Registered Practical Nurse</b> | 4 (Sun-Sat, 12 hr. shifts)                   | 4 (Sun-Sat, 12 hr. shifts)                           |
| <b>Patient Service Provider</b>   | 2 (Sun-Sat, 12 hr. shifts)                   | 1 (Sun-Sat, 12 hr. shifts)                           |
| <b>Unit Clerk</b>                 | 1  | 0  |
| <b>Patient Flow Navigator</b>     | 0  | 0  |

As part of the *Team Based Model of Care*, pod (geographic) nursing care was also introduced where the teams worked in 3 pods with 11 to 12 patients in each pod. Figure 2 outlines the staffing for each pod.

Table 3: Staffing Distribution with the Pod System

Assignments are made based on 3 Pod areas – Red, Yellow, and Blue:

| Charge Nurse |                        |                           |                         |
|--------------|------------------------|---------------------------|-------------------------|
|              | Red Pod<br>11 patients | Yellow Pod<br>11 patients | Blue Pod<br>12 patients |
| RN - Days    | 1                      | 1                         | 1                       |
| RPN - Days   | 1                      | 1                         | 2                       |
| PSP - Days   | 2 on days              |                           |                         |
| RN - Nights  | 1                      | 1                         | 0                       |
| RPN - Nights | 1                      | 1                         | 2                       |
| PSP - Nights | 1 on nights            |                           |                         |

Patient care is provided using the 3-Factor Framework (RN and RPN practice: the client, the nurse and the environment).

The Hospital leadership team acknowledged the roll out of the *Team Based Model of Care* did not go well on MACU. Post implementation, due to the lack of education, lack of engagement and no plan to ensure the sustainability of team based care, the nurses reverted to caring for patients in a primary care model. With increasing staff dissatisfaction and an inability to sustain the team-based model, the Collaborative Care Re-Design Project Team was formed in May 2021. Based on learnings from the first roll out, the focus is on stakeholder engagement and participation, as well as a strengthened education and a change management plan to implement a Collaborative Care Model.

In the past two years MACU's RN turnover is greater than the corporate turnover with 16.4% in 2019/2021 and in 2020/2021 being significantly greater at 43.68%. Table 4 shows the turnover rates in comparison to the corporate turnover rate.

Table 4: MACU and Corporate Turnover Rates

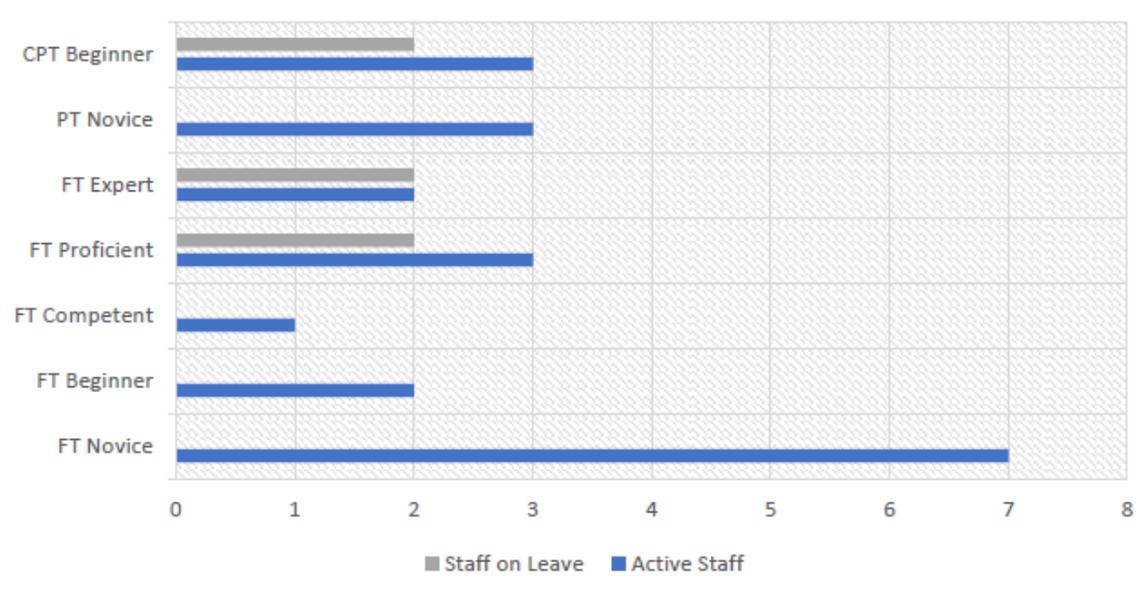
|                         | Fiscal Year 2019-2020 | Fiscal Year 2020-2021 |
|-------------------------|-----------------------|-----------------------|
| Corporate Turnover Rate | 13.76%                | 14.69%                |
| MACU Turnover Rate      | 16.39%                | 43.68%                |

- Notable number of staff new to the area
- Turnover rate includes layoffs that were part of the model of care change in February 2021

In July 2021, Benner's Novice to Expert Model was implemented to assess nursing demographics by education, skills, and experience over time to assist in identifying educational needs, ongoing support and balancing scheduling lines. The assessment was

done on 19 active MACU staff and 6 staff on leave. The results indicated that MACU has a primarily novice demographic (MACU IAC Hospital Brief, p. 16). Table 5 provides the distribution of staff based on Benner’s Novice to Expert Model.

Table 5: MACU Benner Rating for RNs as of July 2021



### 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 (2021) provides a process for both the nurses of the bargaining unit and the administration of the hospital to address workload issues. Article 8 also specifies “patient care is enhanced if concerns related to professional practice, patient acuity, fluctuating workloads and fluctuating staffing are resolved in a timely and effective manner” (p.19). 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 type of issues in writing, enables the Hospital and Association 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 (ONA Collective Agreement, 2021).

Since 2019, with all the changes on MACU, the nurses submitted over 109 PRWFs. Table 6 outlines the number of PRWFs submitted since 2019.

Table 6: MACU PRWFs Submitted since 2019

| MACU PRWFs 2019 | MACU PRWFs 2020 | MACU PRWFs 2021 (to Aug) |
|-----------------|-----------------|--------------------------|
| 67              | 32              | 45                       |

The concerns identified in the PRWFs include:

- Staff skill mix
- Appropriate number of nursing staff
- Ability to staff to baseline
- Access to contingency staff to support sick calls, leave of absences, surge capacity
- Acuity of patients
- Inadequate education of Charge Nurse (post February 2021 Model of Care implementation)
- Broken equipment/lack of supplies
- Staff safety

On January 13, 2020, Southlake and Ontario Nurses' Association (ONA) entered into Minutes of Settlement which were specifically intended to address Professional Responsibility Workload Report Forms (PRWF) that had been submitted by nurses on the Hospital's medical units (including MACU) between 2017 and April 30, 2019. Through those Minutes of Settlement, the Hospital committed to undertake a series of actions relating to staff training and education, standardization of Hospital policies and procedures, equipment and resources, and transparent communication. The parties agreed that any disputes arising under those Minutes of Settlement would ultimately be resolved through the grievance and arbitration process under the Collective Agreement.

Despite this, professional responsibility and workload issues continued on MACU. MACU PRWFs from May 2019 were reviewed at a Hospital Association Committee (HAC) meeting on May 6, 2020 where the Association recommended a sub-HAC meeting to discuss MACU specific issues. Two sub-HAC meetings occurred (May 21 and June 29, 2020), but the issues were not resolved. The Association then proceeded to a formalized Professional Responsibility Complaint in July 2020. Further sub-HAC meetings occurred (July 30, September 23, & October 23, 2020) where recommendations were made to address the issues through an Action Plan. The CNE voiced a commitment to implement changes on MACU, but no perceived changes occurred. In the beginning of 2021, communication between the Hospital and Association broke down. On April 8, 2021 the

Association submitted a letter to the CNE stating that the MACU professional responsibility and workload issues were being forwarded to an IAC for resolution.

### **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:

1. Staffing
2. Leadership
3. Communication
4. Recruitment and Retention
5. Orientation
6. Education
7. Violence
8. Environmental Safety
9. Infection Control
10. Medication Administration
11. Non-nursing Duties and Equipment
12. Professional Responsibility and Workload Process

#### **3.1 STAFFING**

Over the last 20 years there has been a large amount of research examining nurse staffing and the necessary nurse-to-patient ratios for positive outcomes. The Aiken et al. (2002) study, is the seminal study that began this area of research. The findings indicated that in hospitals with higher patient-nurse ratios, there was greater risk of patient mortality, failure to rescue rates, and nurses experiencing burnout and job dissatisfaction. Since then, numerous studies have also found similar results with a relationship between lower registered nursing levels, increased mortality and adverse outcomes.

Griffiths et al. (2016) reviewed the evidence from systematic reviews and 35 primary studies examining staffing and nurse-patient ratios. The findings indicated that when there were higher patient to nurse ratios, there was increased patient mortality, falls, missed care, job dissatisfaction and burnout. A number of studies in the review also identified that a nursing skill mix with a higher proportion of RNs had lower mortality/failure to rescue rates, decreased rates of infection, falls, pressure ulcers and higher patient satisfaction. In a study by Aiken et al. (2014) examining nurses' educational qualifications in relation to patient to nurse ratios, the findings indicated that hospitals had almost 30% lower mortality rates when 60% of the nurses had bachelor's degrees and cared for an average of 6 patients than hospitals with only 30% of the nurses having bachelor's degrees.

In February 2021, a new model of care was introduced on MACU called the *Team Based Model of Care*. The Hospital describes the *Team Based Model of Care* of having the goal of “transforming an independent practice to a collaborative model to improve staff experience, patient experience and safety, and to increase scope of practice by refreshing the skills mix on each unit” (MACU IAC Hospital Brief, p. 29).

As part of the *Team Based Model of Care*, pod nursing care was introduced where the teams worked in 3 geographical pods with 11 to 12 patients in each pod. As a result, the charge nurse had the difficult role of making balanced patient assignments within each pod particularly when the acuity of patients and experience of nurses differed between pods.

In the implementation of the *Team Model of Care* there was also a significant decrease in RNs. On days, the *Pre-Team Model of Care* had 7 RNs with one being the charge nurse who had a patient assignment of 2-3 patients. The *Team Model of Care* had a staffing of 3 RN's and a charge nurse (n=4) without a patient assignment scheduled for 8-hours. When the charge nurse left for the day, one of the 3 RNs had to assume the charge nurse role alongside a patient assignment. On nights, the *Pre-Team Model of Care* had 6 RNS with one being the charge nurse who had an assignment of 3-4 patients. The *Team Model of Care* had 2 RNs and 1 charge nurse (n=3) with a patient assignment on nights. On weekends, the staffing remained the same as during the week, except the charge nurse had a patient assignment (MACU IAC Hospital Brief, p. 14).

In the Hospital MACU IAC Hospital Brief, and presentation, the Hospital acknowledged that the roll out of the *Team Model of Care* “did not go well”, and they have heard the challenges that MACU staff experienced over the past 2 years. In response to these concerns, the leadership team is committed to moving forward with the *Collaborative Care Re-Design* project through engaging with staff to co-develop and implement changes that will ensure a safe working environment (MACU IAC Hospital Brief, p. 37).

One of the changes that the IAC heard during the Hearing, is that the Hospital is implementing an additional RN on days and nights 7 days/week, and a charge nurse on both days and nights working 12 hours vs. only 8 hours on days. This will result in 4 RNs to provide patient care on days and 3 RNs on nights. The charge nurse will not have a patient assignment on days, and it will be up to the team to make the decision on nights whether the charge nurse will have a patient assignment or not.

The IAC acknowledges the increase of one RN on days and nights to provide patient care and increased hours of the charge nurse. However, the Committee recommends that the staffing be increased by one more RN above what the Hospital is implementing, on both days and nights to meet a 60/40 staffing ratio of RNs to RPNs. This would result in nurse-patient ratios of 1 to 4 on days, and 1 to 5 on nights. Canvassing staffing on medical units in 4 GTA large community/teaching hospitals, the IAC identified that they all had 1 to 4

nurse to patient ratio on days and 1 to 5 on nights. This recommendation is also supported by the nurse-patient ratio evidence in that lower patient-nurse ratios have better patient outcomes. This would result in 5 RNs with patient assignments and 1 charge nurse (no patient assignment) on days for a total of 6 RNs, and 4 RNs with patient assignments and 1 charge nurse (no patient assignment) for a total of 5 RNs on nights. A comparison of RN staffing on MACU with the Team Based Model, the proposed Collaborative Care Re-Design Staffing, and the IAC recommendations are listed in Table 7.

Table 7: Summary of Staffing on MACU

|   | <b>Days</b>  | <b>Nights</b>  |
|---|--|--|
| <b>Team Based Model Staffing</b>                      | 3 RNs + Charge Nurse (8 hrs. no patient assignment)    | 2 RNs + Charge Nurse (with a patient assignment )                                      |
| <b>Proposed Collaborative Care Re-Design Staffing</b> | 4 RNs + Charge Nurse (12 hrs.no patient assignment)    | 3 RNs + Charge Nurse (nurses will decide whether it will be with a patient assignment) |
| <b>IAC Staffing Recommendation</b>                    | 5 RNs + 1 Charge Nurse (12 hrs. no patient assignment) | 4 RNs +1 Charge Nurse (no patient assignment)  |

Nurse patient ratios of 1 to 4 on days and 1 to 5 on nights and a charge nurse with no assignment 24/7, will also promote retention and recruitment and support the Hospital's vision of being an employer of choice through enabling staff to provide excellent patient care and be supported in balancing their health and well-being (MACU IAC Hospital Brief, p. 38).

In reviewing both the Hospital and Association briefs, and during the IAC Hearing, the issues of nurse turnover, being continually short staffed, and a primarily novice nurse workforce on MACU was raised and how it was impacting on the quality of nursing care and nurse well-being. Striving for a 70/30 ratio of full time to part time nurses complement would work towards developing stability within the MACU nursing staff, continuity of care, and addressing burnout and decreased job satisfaction. The research literature indicates that increased nurse job satisfaction is closely related to improved work environments, structural empowerment, organizational commitment, professional commitment, patient satisfaction and quality of care (Lu et al., 2019). Offering full time employment would also assist with marketing, recruitment and retention of new nurses within the Hospital. With the hiring of new staff to fill vacancies, the established teams on the master schedule will need to be reassessed to ensure there is a balance of novice and experienced nurses on each team.

In the MACU IAC Hospital Brief Appendices 2, the charge nurse accountabilities are described as working “under the direction of the Clinical Program Manager to coordinate high quality patient and staff experience” (p. 26). Duties related to staffing include directing and modifying patient assignments based on acuity, complexity, geography,

environmental supports and staff experiences and effectively utilizes and coordinates staffing assignments (MACU IAC Hospital Brief Appendices 2). The IAC heard that when there is a change of patient acuity exceeding staff resources or the unit is short staffed, a workload increase request must be submitted, and often times the request is not filled. The IAC recommends that the charge nurse be empowered to call one additional staff member, not on overtime, based on the CNO (2018) 3 Factor Framework and the needs of MACU. Empowerment supports shared team governance, open leadership communication and supportive team relationships and can significantly increase staff morale, productivity, staff retention and patient safety and quality (Linnen & Rowley, 2014).

The Charge Nurse role in the *Team Model of Care* also changed. Prior to the implementation of the new model, there were patient flow navigators who were responsible for arranging the follow up care of people being discharged. In the new model, this role was transferred to the charge nurse who worked alongside the social worker in completing all the necessary tasks related to the person being discharged. During the Hearing, the IAC heard how these tasks would often take up most of the charge nurse's day, leaving little time to fulfill the other charge nurses duties and supporting staff and patients. In the MACU IAC Hospital Brief, the Hospital indicates that a part of the corporate re-education initiative is focusing on the discharge planning process on the units and that the "social workers and charge nurses need role clarity related to discharge planning; and improve communication between both of them (p. 44).

The transition from a staff nurse to a charge nurse, is another area requiring a formalized orientation program that outlines the roles, responsibilities and accountabilities of the charge nurse based on consultation and collaboration of nurses on the unit, especially the nurses who are presently fulfilling the role. The charge nurse works under the direction of the nurse manager to coordinate high quality patient and staff experience and works with the interprofessional team to ensure the day-to-day efficiency of the unit. With the introduction of the new model of care in February 2021 and the elimination of the patient flow navigator role, the charge nurse must now also play an integral role with the social worker in planning and organizing patient discharges. Presently the charge nurse orientation is 1 to 3 buddied shifts. In the Hospital Reply Brief to the IAC, there is a recognition of the need to strengthen the orientation and training for staff nurses to become charge nurses. The Hospital also has developed a Discharge Planning Working Group on MACU, in which they are exploring a stronger process for discharge planning in collaboration with the charge nurse, social workers, clerks, clinical educator and leadership. (p. 26).

## The IAC Recommends:

### 1. Scheduling:

- 1.1 In order to create stability, continuity of care, and address burnout and decreased job satisfaction: The staffing of RNs will be based on a full-time to part-time ratio of 70/30.
- 1.2 Ensure the master schedule has an appropriate number of filled lines, so that when a schedule is posted, the recommended staffing complement is achieved and there are no gaps in the schedule.
- 1.3 A robust pool of part-time and casual nurses will be developed on MACU to fill incidental absences, vacation, and short term leaves.
- 1.4 The teams on the master schedule will be periodically re-assessed to ensure a balance of novice to expert nurses on each team. Any necessary changes to the master schedule to meet this balance will need to follow the collective agreement.

### 2. Patient Assignments:

- 2.1 The Hospital will implement a 60/40 staffing ratio of RNs to RPNs on MACU resulting in the following staffing/day (weekends included):
  - 2.1.1 Days: 5 RNs with patient assignments and 1 Charge Nurse (no patient assignment).
  - 2.1.2 Nights: 4 RNs with patient assignments and 1 Charge Nurse (no patient assignment).
- 2.2 Each nurse is assigned accountability for the total care of a group of patients, with a nurse-patient assignment ratio of 1 to 4 on days and 1 to 5 on nights. This does not preclude the need for team work and collaboration to provide safe, timely and quality care, alongside appropriate consultation for novice staff and RPNs, and enabling nurses to meet CNO standards of practice.
- 2.3 Patient assignments will be made by the Charge Nurse based on the College of Nurses of Ontario (2018) 3 Factor Framework of the nurses' ability to provide safe and ethical care to clients; the patient's complexity,

predictability and risk of negative outcomes; and environmental factors of practice supports, consultation resources and stability and predictability, rather than the previous pod assignment model.

3. Charge Nurse:

3.1 There will be a charge nurse 24/7 with no patient assignment in order to provide support and consultations, escalate workload increases and/or staffing concerns to the Manager and/or CSM.

3.1.1 The charge nurse will be empowered to call in one additional staff member (not on overtime) based on the 3 factor Framework and the needs of MACU.

3.1.2 The charge nurse will be empowered to make the decision to replace a sick call.

3.1.3 The charge nurse will provide the rationale for the staffing adjustment to the manager within 24 hours either verbally or in writing.

3.1.4 The manager will support the decision making of the charge nurse and if discussions need to occur related to the rationale to call in additional staffing, it will be done through a lens of a learning opportunity.

3.1.5 Any additional staffing resulting in overtime requires approval by the manager or CSM.

3.2 The charge nurse positions will be posted as per the Collective Agreement.

3.3 A formalized charge nurse orientation program will be developed and implemented that outlines the roles, responsibilities and accountabilities of the charge nurse based on consultation and collaboration of nurses on the unit, especially the nurse(s) who are presently fulfilling the role.

3.4 The charge nurse will be provided leadership education as part of their professional development in this role.

- 3.5 The permanent charge nurse orientation will consist of 6-12 hour day shifts and 6-12 hour night shifts and/or based on learning needs.
  - 3.6 In the event an orientated charge nurse to MACU is not available (i.e. sick time, vacation, etc.), the nurses will be empowered to decide the most appropriate person to take the charge nurse role. The CSM will be notified and will provide additional support as needed.
  - 3.7 Using Benner's theory of novice to expert, those staff that are considered a proficient or expert nurse on MACU, will be provided the opportunity to receive an orientation of 2-12 hour days and 2-12 hour nights to the charge nurse role to fill in for incidental absences.
4. Discharge Planning:

The IAC panel supports the work already started in establishing a Discharge Working group with the mandate to clearly identify which part of the discharge process will be carried out by each health care professional.

- 4.1 The IAC recommends that this group continues to move forward and must include the social worker, home and community nurse, primary care nurse, charge nurse, physician, pharmacy, occupational and physiotherapists etc..
- 4.2 To begin immediately, discharge rounds will occur twice/week with the social worker as chair to coordinate discharge plans and to identify individual responsibilities and accountabilities of each team member identified.

### **3.2 LEADERSHIP**

Over the past two years the leadership team for MACU has been unstable with the introduction of new directors, managers and a new Chief Nursing Executive. Throughout the 3 day Hearing, the Hospital acknowledged on multiple occasions how challenging and frustrating it has been for the MACU staff over the past 2 years. The new leadership team, stated they were not going to make excuses for the past and voiced a commitment to do things differently in the future. They also emphasized to the staff that they had heard their concerns of wanting to provide a safe and quality practice environment and they wanted to find solutions together. An example of this is that the MACU leadership engaged 30 staff to validate and prioritize the recommendations for MACU in the Collaborative Care Re-

design Project that is a renewed approach focusing on implementation and sustainability of the model of care (MACU ICU Hospital Brief, p. 39).

The CNO Standards (2002) outline how all nurses, regardless of their position, have opportunities for leadership through providing, facilitating and promoting the best possible care/service to the public. One way that the MACU nurses can become engaged and lead in their own practice is the rejuvenation of the MACU Nursing Council. The MACU Nursing Council used to meet regularly, but all meetings have been on hold since 2019. Shared governance and unit councils enable and empower nurses to influence decisions that are related to their practice and work environment. Research has indicated that staff engagement and frontline empowerment positively influences staff morale, productivity, retention, quality of care, and patient outcomes (Linnen & Rowley, 2014; Wessel, 2012). When forming unit councils it is important to ensure membership includes not only experienced nurses on the unit, but newer nurses as well (Ulep, 2018).

The Registered Nurses Association of Ontario (RNAO) Best Practice Guideline Developing and Sustaining Nursing Leadership (2013) identifies five evidence based transformational leadership practices which are fundamental for transforming nurses' work setting into healthy work environments. These practices which apply to all roles and levels of leadership are:

- Building relationships and trust
- Creating an empowering work environment
- Creating a culture that supports knowledge and development and integration
- Leading and sustaining change
- Balancing the complexities of the system, managing competing values and priorities

The IAC panel believes that these practices must be incorporated into the operational, clinical and point of care leadership positions including in the MACU. During the Hearing the IAC heard that the staff has lost trust in the leadership team as a result of being told multiple times that the practice environment would change for the better and nothing occurred. Building trust is imperative in increasing job satisfaction, increased organizational commitment, quality of care and retention (RNAO, 2013). Moving forward, the Hospital will need to deliver on their promises to re-build the trust that was lost over the past years.

Building on emotional intelligence in leaders is also imperative to build trust and a non-authoritarian work environment ((Linnen & Rowley, 2014). Emotional intelligence has been described as having the 4 components of self-awareness, self-management, social awareness and social skills (Cope & Murray, 2017). Emotionally intelligent leaders are self-aware and self-regulate their own emotions to engage staff, resolve conflicts, be

empathetic, and inspire others to be successful (Cope & Murray; Linnen & Rowley). Leaders with high emotional intelligence also recognize they do not have all the answers, and encourage the people they work with to collaboratively find effective solutions. The MACU nursing manager is new to a formal leadership position, and will need support in building a repertoire of leadership styles, developing emotional intelligence and gaining change management knowledge and skills.

The literature also describes the importance of visibility of the leadership team. Being accessible to staff and practicing open consistent communication is important to build trust and staff engagement (Bergstedt & Wei, 2020). Linnen & Rowley (2014) highlight how nurse managers are often overloaded with administrative work that takes them away from engaging with staff and building trust and empowerment. To prevent this from occurring, nurse managers need dedicated time to connect with staff and participate in unit activities.

As part of their commitment to build trust and move forward, the Hospital has engaged with the Huron Studer Group to provide coaching and accelerating services and tools focused on enhancing the skills of clinical managers. Areas of focus will be on enhancing leadership skills and critical leadership competencies, enhance skills in leading and managing change, and improving leadership skills in coaching, providing feedback, performance management and having difficult conversations (MACU IAC Brief Final, p. 37).

The Huron Studer Group helps organizations move with urgency to achieve results and positively impact quality, safety and financial performance through various techniques that increase alignment and accountability, improve employee engagement, the patient experience, and other priority metrics. The Evidence-Based Leadership<sup>SM</sup> framework allows organizations to create a strong foundation to create a high-performance organization; one that is aligned and accountable, providing consistent employee and patient experiences that results in a culture which supports sustained improvements over the long term. One of the strategies Huron Studer encourages organizations to adopt is, *Rounding for Outcomes*. *Rounding for Outcomes* is consistently asking specific questions to those engaged in the process to assess and identify actionable information. The focus of the questions are related to building relationships, identifying what is going well, who is being helpful, what systems or areas could be working better, and what is needed to do their job effectively and efficiently (Huron, 2021). These practices assist staff to feel they have a purpose, are doing meaningful work and they are making a difference.

**The IAC Recommends:**

1. The MACU Manager will:
  - 1.1 Be supported in their professional development in order to be successful in moving forward to implement the necessary changes on MACU.
  - 1.2 Have protected time each day (for example, 7:30-9:30) to be visible on MACU and engage with staff.
  - 1.3 Post when they are not present on the Unit.
  - 1.4 Round with the charge nurse each morning.
  - 1.5 Participate in huddles.
- 2 MACU Unit Council:
  - 2.1 The MACU Unit Council will not replace the need for regular staff meetings.
  - 2.2 Nurses will be paid for time attending Unit Council. If the nurse is scheduled to work, they will be replaced to attend the meeting.
  - 2.3 The manager will be a member of Council, but not as Chair or Co-Chair. Instead the purpose of the manager will be to focus on removing barriers and to support success.
  - 2.4 The manager will immediately put out a call for Chair, Co-Chair and members with a minimum of 6-8 MACU nurses (RNs/RPNs). The Chair and Co-Chair will be selected using a formalized and confidential voting process.
    - 2.4.1 Once formed, the Unit Council will develop Terms of Reference.
    - 2.4.2 The Unit Council will invite other members of the health care team to participate, on an as needed basis.
    - 2.4.3 The Unit Council will meet a minimum of 8 times/year and will develop a work plan for the year.

- 2.4.4 At the end of the year, the Unit Council will review the work plan and evaluate what was accomplished to inform the development of a work plan for the upcoming year.
- 2.4.5 Draft agenda and minutes will be posted two weeks in advance to allow for input from other staff on items to be added to the agenda.

### 3 Senior Leadership Team:

- 3.1 The senior leadership team will develop and implement strategies to increase their visibility with MACU frontline staff.
- 3.2 The senior leadership team will follow up on their commitment to staff during the IAC, for positive change through visible actions improving the MACU workload and work environment issues.
- 3.3 The senior leadership team and manager will utilize the Registered Nurses Best Practice Guideline (2013). *Developing and sustaining nursing leadership best practice guideline* (2<sup>nd</sup> Ed.). [https://rnao.ca/sites/rnao-ca/files/LeadershipBPG\\_Booklet\\_Web\\_1.pdf](https://rnao.ca/sites/rnao-ca/files/LeadershipBPG_Booklet_Web_1.pdf) to assist in identifying ways to build relationships and trust; create an empowering work environment; lead and sustain change; and balance the complexities of the system, while managing competing values and priorities.

## 3.3 COMMUNICATION

The ability to communicate effectively is essential for nurse leaders and building teams. When leader's role model honesty, consistency, respect, compassion, empathy, recognition, inclusiveness and encourage their staff to identify issues in the team through open and honest communication, the components of safety and trust are established (Henderson, 2015). Good communication skills are also associated with better patient outcomes and higher staff satisfaction (Amer, 2013). It is imperative the manager and leadership team engage in conversations and listening to what is important for staff. Nurse leaders should actively listen and practice open transparent communication with their staff, prioritize being visible and accessible and taking a personal interest in them. This type of communication can build trust and improve engagement levels with their teams (Bergstedt & Wei, 2020).

Staff need access to relevant information and resources as appropriate. There are multiple ways of communicating. Examples of channels of communication are staff emails, bulletin boards, team meetings, and face-to face communication (Yeomans & FitzPatrick, 2017).

Methods of communication that increase awareness can be through newsletters, and/or email. Understanding of the communicated messages can be done through face-to face discussions, and involvement of staff can be achieved through team meetings. To foster commitment, staff should be encouraged to participate in problem-solving (Yeomans & Fitzpatrick). Overall, whenever possible, face-to face communication is more engaging and persuasive than emails and other forms of written communication (McShane et al. 2015).

Huddles are another method of communication that can build relationships among team members. Huddles last no more than 15 minutes and are a venue where issues that have occurred in the past 24-hours can be shared; where staff can anticipate issues and plan how to address them; where they can review steps taken to resolve previous issues; and can discuss any additional resources needed. The literature identifies that the use of huddles enables team members to be more open and trusting of each other and fosters openness on how to work with one another more effectively (Billings & Kowalski, 2018).

There have been many changes in the leadership team on the MACU and the hospital over the past few years, beginning with the manager through to the CNE. There have been 4 managers on MACU since 2019 with 3 of them since February, 2021. The present manager started in August, 2021. While the MACU Unit Council used to meet regularly, all meetings have been on hold since 2019. Huddles were also not being implemented. While they have been re-initiated by the new manager in mid-August, 2021, there appears to be no pre-defined times or standard work (structured and consistent process) for the huddles each day. As a result, they are occurring on an ad hoc basis (ONA, IAC Submission, p. 74). Another method of communication was through 5 bulletin boards (Quality Safety Huddle Board, Patient Safety Board, Discharge Info Board, Communication Board, and Education Board) that have not been used. The IAC heard that the manager and leadership team are committed to keeping the bulletin boards up to date with current information.

In the ONA IAC Submission and during the IAC Hearing the role of the clinical support manager (CSM) was discussed in relation to staff requests for increased staffing when patient acuity exceeds the staffing resources or the unit is short staffed. When this occurs, a request for workload increase must be submitted by the nurse manager or charge nurse when appropriate. All the workload requests are reviewed and staffing through the Hospital virtual nursing team (VNT) are distributed based on unit needs. The IAC heard that MACU requests were often not met, with no explanation provided. To foster respect, trust, and mitigate distrust, it is important that there is open communication related to the provision of patient care and other related work activities (RNAO, 2012b). It would appear that there are communication venues already in place. The Southlake Reply Brief document indicates that there are bi-weekly meetings with the CSM and Charge Nurse, end of shift CSM report, implementation of a new CSM report tool on Microsoft Teams, and a weekly Medicine Managers meeting where staffing is reviewed followed by planning (p. 14).

**The IAC Recommends:**

1. Staff Meetings:
  - 1.1 Need to be scheduled immediately, even if they need to be virtual.
  - 1.2 The manager and staff will collectively identify the most appropriate time for staff meetings.
  - 1.3 Staff meetings will be held on a monthly basis
  - 1.4 An agenda will be posted a week in advance to allow for input from staff.
  - 1.5 Minutes of the meeting will be posted a week after the meeting on the Staff Communication Bulletin Board visible to all staff. Staff communication board could be located in the staff room.
2. All Bulletin Boards are kept up to date with timely information
3. The Manager will:
  - 3.1 Round with staff to establish rapport, trust and personal connections and to have an opportunity to give positive feedback and listen to pressing issues expressed by staff.
  - 3.2 Communicate using different and appropriate communication mediums (face to face, emails, bulletin boards etc.).
  - 3.3 In order that the decision making process is transparent, ensure that the decision making for staffing workload increases with the virtual nursing team (VNT) algorithm is shared with staff.
4. Huddles will be led by the charge nurse and the manager will attend.
  - 4.1 A time for daily huddles and standard work (structured and consistent process) will be established and implemented.

5. With the turnover in management, leadership team and staff, there appears to be a lack of clarity in the application of the sick time policy. To ensure a common understanding and implementation of the policy, the IAC recommends re-education of the sick time policy to leadership teams and staff to ensure consistent application.
6. Clinical Supervisor Manager (CSM)
  - 6.1 The CSM will physically attend the unit whenever a request for a workload increase is unmet, explain the rationale for the decision, and discuss and assist the charge nurse in problem solving how to best address the patient care needs.
  - 6.2 The CSM will do rounds to all units either in person or via phone, and will physically attend the unit when requested by the charge nurse.
  - 6.3 The hospital will change the CSM's hours to ensure there is onsite management presence 24 hours/day.
  - 6.4 The Hospital will develop an algorithm to ensure consistency of CSM decision making in addressing workload staffing increases.
  - 6.5 If the CSM is unable to accommodate a staff increase request that impacts patient safety, the CSM will also notify and discuss the safety concern with the on-call manager.

### **3.4 RECRUITMENT AND RETENTION**

The workplace environment is related to the physical and psychological well-being and quality of work life for nurses (Nowrouzi et al., 2016). A healthy workplace is one that is safe, empowering and satisfying (Wei et al., 2018). In a systematic review of nurse work environments, themes of healthy work environments included: factors that impact on nurse outcomes such as psychological health, emotional strain, job satisfaction and retention; nurse workplace interpersonal relationships, job performance and productivity; quality of patient care; safety; and nurse leadership and work environments (Wei et al.). Findings included that nurses' stress levels were directly associated with workload and the number of patients assigned. The findings also indicated that a healthy work environment was significantly positively correlated with job satisfaction and retention.

A positive work environment also influenced retention of new graduate nurses. Significantly higher numbers of new hires resigned from units with work environments that were unhealthy than those units that were healthy. Negative workplace relationships were found to influence nurses' intent to leave, and healthy work environments and nurse leadership were mutually interdependent (Wei et al.).

Another systematic review explored factors influencing retention and recruitment (Marafu et al., 2021). Key factors were related to a number of factors such as professional influences (stress, burnout, high workloads, emotional exhaustion); nursing leadership and management; staffing issues; education and career advancement; organization and work environment issues; support at work; personal factors; demographic issues; and financial and monetary aspects. The findings indicated that organizational culture influences the work environment and nurses' intention to stay or leave their job. Improving the work culture and addressing issues influencing retention and recruitment within the work environment, can lead to improved collaborative relationships between nurses and management, foster retention and recruitment and enhance patient outcomes (Marafu et al.).

The Hospital did an employee pulse survey which included staff experiences. This was a survey of the Medicine Program that was not specific to the MACU. However, when the hospital did a Patient Care Needs Assessment and Environmental Profile on the MACU, a few themes arose. They include; a high level of inexperienced nurses (significant percentage of staff less than three years of nursing experience), often having to orientate additional new staff; high level of anger, job dissatisfaction, and burnout; frequently working short staffed and the charge nurse needing to take an assignment in addition to the charge nurse role. (MACU IAC Hospital Brief, p. 32). All these will impact on staff morale and nursing care. The IAC heard during the Hearing how nurses are stressed, burnt out, turnover is high and staff feel that their voices are not being heard. The Hospital acknowledges there have been numerous challenges on the MACU, and the leadership team are committed to work collaboratively with staff and the Association to address the issues. The Hospital has also begun to implement initiatives to address unresolved workload and practice issues.

With the global nursing shortage, the majority of new hires will be new graduates. The Statistics Canada job vacancies report for the first quarter in 2021, identified that the healthcare and social assistance sector experienced a larger year-over-year increase in job vacancies than all other sectors, with registered nurses and registered psychiatric nurses having over 7,200 vacancies with almost half being vacant for 90 days or more (Statistics Canada, 2021). These novice nurses are entering into a work environment that is overburdened and understaffed resulting in discouraging initial work experiences which can result in high levels of stress, burnout and poor retention (Bakon et al., 2018).

To facilitate and support novice nurses entering into the workplace, transition programs are being developed to encourage the recruitment and retention of new graduates. The Nursing Graduate Guarantee Program (NGG) is a transition program in Ontario designed to support new graduates move into the nursing role within 12 months of registering with CNO. This program provides 20 weeks of funding for each new nurse, with 12 weeks to support their transition to practice independently and 8 weeks of funding to reinvest in professional development of nurses within the organization (Ontario Ministry of Health and Long Term Care, 2021a). The Hospital indicates that a recruitment and retention strategy is being developed and approved and includes utilization of the NGG and Clinical Extern Program.

Preceptorship is imperative in facilitating the novice nurse transition into independent practice (Bakon et al., 2018). Since the preceptor guides the development of the new graduate and provides support within the clinical environment, education on how to successfully implement the preceptor role is necessary. Qualities of a good preceptor include the ability to provide feedback in a meaningful way, assume a teacher role, be a role model, facilitator of learning, and clinical leader (Shinners & Franqueiro, 2015). Conflicts between the preceptor and preceptee have been identified where there is role ambiguity, role conflict and insufficient time to provide the necessary support to the novice nurse (Bakon et al.). In the MACU IAC Hospital Brief, it was identified that the preceptor training program may require strengthening, no current processes exist to identify expert nurses who could be a preceptor, on some units there may not be any expert nurses, and at the present time preceptors are not being paid for the role (p. 46). The Hospital Brief indicates that the Hospital is exploring developing a preceptor program, creating a referral program for expert nurses to become preceptors, and paying a preceptor premium.

Another recruitment strategy is to ensure that nursing students have positive clinical placements as these placement experiences can influence their choice of where to work upon graduation. Research has indicated that students will return to organizations and nursing units where they have had positive experiences and a good learning environment (Rodriguez-Garcia, 2021). This is important to consider not only with nursing students in clinical practicums, but also with student nurse clinical externs within the organization.

Internationally educated nurses (IEN) represent 8.9% of Canada's regulated nursing workforce. With more than 25,000 IEN nurses immigrating to Canada in the last 25 years, they are another source of nurses to aid recruitment. Research examining IEN's in Canada identifies that IENs are not a homogenous group in that they are educated and migrate from different cultures with different nursing educational systems (Covell, et al., 2017). Even though half of the IENs have a bachelors' degree in nursing or greater, they are employed less than those born in Canada (Government of Canada, 2021). IENs are multilingual and multicultural and can apply their knowledge and expertise in providing

culturally safe care (Baumann et al., 2017). Healthcare organizations should consider partnering with universities that bridge training programs for IENs to provide student placements and employment opportunities for this diverse group of nurses. Studies also indicate that mentorship assists IENs adjust to the Canadian healthcare system (Baumann et al., 2017).

### **The IAC Recommends:**

#### 1. Recruitment:

- 1.1 Human resources will examine their hiring processes to ensure barriers to timely recruitment are removed.
- 1.2 The Hospital and Association will take advantage of the New Graduate Guarantee initiative following the Collective Agreement, in recruiting new graduate nurses.
- 1.3 The Hospital will continue to access the Externship Program and provide opportunities for student nurses.
- 1.4 The Hospital and the Association will meet to collaboratively explore how to best implement these initiatives with the goal of attracting as many new graduates as possible and foster positive learning experiences.
- 1.5 The Hospital will explore hiring Internationally Educated Nurses.
- 1.6 As an avenue to recruit new graduate nurses, the Hospital will foster relationships with College and University nursing programs to establish partnerships and increase student placement availability.
- 1.7 The Hospital will develop a robust orientation program tailored to support new nursing hires' learning needs that will continue until the new recruit is competent to independently assume a patient assignment.
- 1.8 The Hospital will develop a preceptor education program that is mandatory for any nurse wanting to be a preceptor for new hires.
- 1.9 Preceptors will be paid the preceptor premium.
- 1.10 Front line staff will be engaged as ambassadors and preceptors for students and new hires.

1.11 Continue participating in nurse job fairs.

2. Retention:

2.1 Create a positive work environment culture in MACU.

2.1.1 In the next 4 to 6 months, the Hospital will provide a structured team building exercise for MACU staff that will include management and all staff on MACU. This will be offered minimally twice to ensure maximum participation and staff will be paid to attend.

2.1.2 The Hospital, leadership team and staff will look for ways to celebrate the success of the MACU team.

2.1.3 Exit interviews will be performed by Human Resources to identify why staff are leaving MACU, and opportunities to retain staff and to address and improve workload issues.

2.1.4 The Hospital, MACU nurse manager, and nursing unit council will identify ways to foster and promote a positive work environment.

2.1.5 The IAC recommends that within the next two months, the Hospital survey MACU staff using a validated staff satisfaction/engagement survey examining changes to culture, staff satisfaction, leadership and their impact on safety and patient care. The staff will be re-surveyed every 6 months to identify any improvements and future opportunities to improve the worklife on MACU.

2.1.6 The Hospital, MACU nurses and the Association will review the results and collaboratively identify additional ways to address the issues and build a positive work environment.

### **3.5 ORIENTATION**

Nursing orientation plays a pivotal role in the competency and retention of newly hired registered nurses. Effective orientation and preceptoring programs promote retention, increased job satisfaction, commitment to the organization and prepares nurses to provide competent, quality patient care (Lalithabai et al., 2021). A well-organized learner specific orientation program needs to focus on developing overall knowledge, competency, experience, relationships, clinical judgement and application skills of nurses in clinical

settings (Lalithabai et al., 2021). Research indicates that poorly implemented orientations are associated with increased turnover, dissatisfaction, lack of confidence, and decreased patient care and safety (Zigmont et al., 2015).

Zigmont et al. (2015) describe an orientation program based on adult learning theory that assesses the nurse's knowledge, competencies, and skills. The orientation plan is tailored to the nurse, based on their knowledge and nursing experience and incorporating their learning needs, and policy and safety guidelines into the plan. The new nurse is then integrated into the clinical setting supported by a consistent preceptor with the maximum amount of learning occurring on the nursing unit with patients. At the beginning of the orientation, the preceptor and new nurse should have a reduced patient assignment to facilitate teaching and learning. The patient care and level of acuity should also be taken into consideration based on the new nurses learning needs and experiences. Zigmont et al. describe the evaluation criteria used to determine when a nurse no longer needs to be on orientation as being based on the nurse demonstrating a safe and competent level of basic skills; prioritizes time and tasks appropriately; critically thinks; ask questions when appropriate; and provides safe patient care.

Preceptors are critical in the orientation process. Selection criteria to whether a person should be a preceptor can include the nurse having an interest in being a preceptor; a determined amount of experience or time in the organization; considered an expert in their practice; and having good communication skills to promote learning and provide feedback (Ward & McComb, 2017). The preceptor should be consistent during the nurse's orientation period. Presently, the Hospital asks nurses to volunteer to be a preceptor. In the previous section on Recruitment and Retention, it was identified in the Hospital IAC Brief the need to strengthen the preceptor program.

Presently, the orientation for new nurses at the Hospital consists of a corporate orientation, general clinical orientation, shared orientation and a unit specific orientation. New nurses are given a self-assessment document to complete, and are provided with 8 12-hour buddied shifts (6 days and 2 nights). During this time the new nurse is expected to complete the orientation checklist. The manager and educator periodically check in with the new nurse to assess how things are going and if the nurse's learning objectives are being met (MACU IAC Hospital Brief, p. 24).

The Hospital Presentation given during the IAC Hearing outlined a more comprehensive orientation program that is under development where the new nurse completes a self-assessment of their general competencies on the last day of the Shared Orientation. When the nurse arrives on their Unit, there will be a specific competency assessment with the manager and educator based on the nurse's self-assessment. A tailored education plan will then be developed and shadowed clinical experiences with a preceptor will begin to address the nurse learning needs (MACU IAC Hearing Presentation, p. 62).

As a result of the global nursing shortage, most of the new hires will be new graduates, and will require the orientation that the Nursing Graduate Guarantee (NGG) can provide through funding from the Ontario Ministry of Health and Long Term Care (2021a). A comprehensive and learner centred orientation will be imperative since there were limited to no clinical experiences during the pandemic and much of the new graduate's clinical practice learning will have been done through virtual simulations. With the anticipated number of novice nurses on the MACU at any given time, and understanding Benner's Model of novice to expert, novice nurses require added guidance and support. This ultimately increases the workload of the nurses on MACU.

**The IAC Recommends:**

1. The IAC strongly recommends the Hospital implement the new clinical (nursing) orientation process as soon as possible to support new nurses in the transition from student nurse to novice nurse.
2. All MACU new nurses will be preceptored by a consistent nurse, understanding there may be incidental absences.
3. For non-Nursing Graduate Guarantee (NGG) nurses on MACU, orientation will be a minimum of 12 preceptored shifts, (6-12 hour day shifts and 6-12 hour evening shifts).
4. The new nurse will be supernumerary during the orientation period.
5. During the orientation period, the preceptor and new nurse will have a reduced patient assignment which will be regularly re-assessed with input from orientee, preceptor and educator.
6. Competency-based assessments using a standardized checklist, will occur with the nurse, preceptor, educator and manager at regular intervals every 2 weeks or at the request of any of those parties to identify learning needs needed to move to independently carrying a patient assignment.
7. Selection criteria will be developed to identify suitable preceptors.
8. The Hospital will offer preceptorship workshops for those interested in being a preceptor.
9. The DETECT program will be part of the MACU orientation process.

### 3.6 EDUCATION

In today's healthcare environments with advancing knowledge and technology, nurses are faced with making decisions and implementing procedures that are new or were previously the responsibility of another healthcare provider (CNO, 2020). All nurses are obligated to have the knowledge, skill and judgement to provide safe and competent care. Nurses in an administrative role "must ensure resources support the delivery of both the initial and ongoing education to support nurses in attaining and maintaining competence" (CNO, 2020, p.6).

Clinical educators play a critical role in supporting nurses and are essential for safe, excellent patient care (Coffey & White, 2019). Clinical educators support nurses, novice nurses and students through role modelling and providing clinical expertise and knowledge on the unit in addressing the learning needs of nurses (Coventry & Russell, 2020). They also act as mentors to nurses in their personal and professional development alongside addressing clinical issues and developing policies and procedures. Clinical educators are essential in supporting nurses integrate their knowledge into practice (Coventry & Russell, 2020).

The Hospital's clinical educator job description outlines that clinical educators "provide leadership, education and clinical expertise in the support, orientation and competency based skill development of hospital staff" (MACU IAC Supplemental Document, p. 1020). Their primary responsibilities involve patient care responsibilities, leadership responsibilities/administration, education/research, and organizational responsibilities. With patient care responsibilities being only one fourth of the responsibilities, it appears that the primary focus is not supporting the nurses on MACU in addressing their learning needs.

On MACU, the clinical educator started in June 2021 with the position being 0.5 FTE on MACU and 0.5 on the Rapid Assessment Unit (RAU). During the Hearing, the IAC learned that the Hospital is considering making the clinical educator role full-time for one year, but this has not yet been confirmed. The Association identified in their submission that many PRWFs commented on the "overwhelming number of new and novice staff working on the unit and how this contributed to increased workload and the need for additional support, direction and supervision by more experienced nurses on MACU (ONA IAC Submission, p. 66-67). In July 2021, Benner's Novice to Expert Model was implemented to assess nursing demographics by education, skills, and experience over time and it was identified that MACU has a primarily novice demographic (MACU IAC Hospital Brief, p. 16).

Coventry and Russell (2020) highlight how the clinical educator role is necessary in providing clinical leadership in guiding the progress of novice nurses in their transition to becoming confident and competent practitioners. With the number of novice nurses on MACU and the anticipated increasing number with new hires, it is imperative these nurses are provided the time and support of a dedicated full time clinical educator.

The Hospital is also engaged in the Ministry of Health Extern Program where nursing students are employed as unregulated health care providers and practice under the direct and/or indirect supervision of registered nursing professions within the organization (Ministry of Health, Ontario, 2021b). It was clear to the IAC that the MACU nurses were unsure of the extern role and whether there was an expectation for the nurses to support, teach, and supervise them. This lack of clarity resulted in confusion and the lack of understanding of the nurse's role with the student nurse externs.

Another area that the clinical educator could focus on is offering the DETECT (deterioration, evaluate, trends, elicit help, communicate, time matters) program to all MACU nurses, regardless of their level of experience. This program focuses on increased knowledge of potential and actual deteriorating health conditions, and assessment skills to recognize and intervene when the person's condition rapidly deteriorates. Nurse's awareness of resources that can be accessed within the Hospital to assist and support best patient outcomes is another focus of the program. The program also increases critical thinking and communication skills (ONA IAC Submission, p. 72).

### **The IAC Recommends:**

1. A dedicated Clinical Educator for MACU full-time for 2-years, starting immediately.
  - 1.1 This position will be re-evaluated at the end of 2 years with input from the educator, staff, and management. The result of the evaluation will be shared with the Association.
  - 1.2 The MACU clinical educator will spend 80% of time on the MACU, working with nurses in supporting their educational needs, orientations, new graduates and novice nurses transition to practice, and assisting in the implementation of the 3 Factor Framework in nursing practice on MACU.
  - 1.3 The educator will provide appropriate education to MACU staff on the student nurse extern's accountabilities and provide support for the MACU staff on how to best to implement this role on MACU.
  - 1.4 A learning needs assessment/checklist will be gathered by the educator of all MACU nurses over the next 4 months.

- 1.5 A competency checklist will be done at the time of hire for new nurses, and will work with the nurse and the preceptor to meet these goals.
  - 1.6 On an annual basis, the MACU educator will survey the staff for their learning needs.
  - 1.7 The MACU educator will plan and offer education days (paid) to address the identified learning needs.
  - 1.8 The MACU educator will provide education for all those nurses who wish to be a preceptor.
  - 1.9 The Hospital will use the remainder of the Nurse Graduate Guarantee funds to support professional development days based on staff identified learning needs.
2. All current staff will have the opportunity to attend the DETECT (deterioration, evaluate, trends, elicit help, communicate, time matters) program. The DETECT program will be offered annually and as needed.

### **3.7 VIOLENCE**

In a national study done by the Canadian Federation of Nurses Federation (2020), 61% of nurses identified over a 12 month period having a serious problem with violence with two-thirds of them reporting they were considering leaving their jobs. Workplace violence has been shown to influence nurses' mental health and can result in physical injury (CNFU, 2020). Assaults where patients become violent is one of the most common forms of workplace violence for nurses (Havaei et al., 2018).

Park et al. (2015) emphasize the importance of assessing work place violence risk factors including organizational factors, work demands and the type of nursing unit. Organizational factors include culture and the psychosocial work environment. Heavy work demands, low staffing levels causing time pressures, high patient acuity and high patient turnover have also been reported to contribute to stressful situations for patients, families and staff.

On MACU, there is a flagging system in place for patients with an increased risk of violence rating based on their violence assessment tool (VAT) score. The flags are placed on the door of the patient's room or on the curtain. It is done upon admission, however it

was not clear of the processes of removal or how changes of the person's risk of violence is implemented and which MACU staff are involved in the process.

The Association's submission indicated that there is a notable disparity between patients identified on the VAT as at risk for violence and the number of staff available to provide appropriate care (ONA IAC Submission Vol 1, p. 52). When a person requires having 1:1 monitoring due to their risk of violence, this results in increased work and stress on the remaining nurses who must then care for additional patients. While the constant observer policy outlines that there must be at all times both audio and unobstructed visual field of the patients on 1:1 monitoring, the PRWF's indicated that there were occasions that the staff providing 1:1 observations were reassigned somewhere else or told to observe more than one patient due to staffing shortages and/or challenges.

There have been times due to the lack of staffing resources on MACU when nurses have been unable to meet the requirement of this policy, evidenced by the documentation in the PRWFs. The nurses also identified that MACU only had one set of restraints that created issues when more than one patient on the unit required restraints at the same time.

The Canadian Nurses Protective Society (2004) states restraints should never be used as a substitute for nursing care and that each situation requires individual ongoing assessment of the person to ensure the implementation of the most reasonable interventions. The Hospital has a comprehensive restraint policy that, highlights that "wherever possible, strategies will be implemented to avoid the use of restraints" and that "restraints should be a temporary or short-term intervention and discontinued as soon as restraint removal can be safely accomplished" (Southlake Additional IAC Hearing Documents, p. 3).

The literature indicates that the focus should be on prevention, alternate approaches, assessment, de-escalation interventions and crisis management (Registered Nurses Association of Ontario [RNAO], 2012a).

The Hospital identified in their brief and presentation that measures are underway to address the issue of violence on MACU. The interventions are focused on implementing a violence assessment and prevention program, Safe Management Group (SMG) training, and behavioural rounds. In the Hospitals Reply Brief, they indicated that all staff are in the process of being trained in violence prevention and potentially aggressive behaviours by educators and the safe management group external consultants. They have also instituted a behavioural RPN who is trained in the gentle persuasion approach, dementia care training, delirium, dementia, depression and behavioural support and is a resource for MACU staff in developing appropriate care plans (MACU IAC Hospital Brief, p. 26). The Hospital has submitted a proposal for additional support for behaviour patients.

In the Hospital's brief, it is also stated that the Code White data indicates there has been a reduced frequency of Code Whites on MACU since the introduction of the behavioural RPN role. During the Hearing, when the IAC asked staff if there is a debriefing after each Code White, it appeared that it did not occur consistently or there was not a formalized format to follow.

**The IAC Recommends:**

1. Patients at Risk of Violence

1.1 All patients who score at risk on the Violence Assessment Tool (VAT) will be reviewed daily by the assigned nurse and charge nurse at the daily huddle and removal and/or changes will be reviewed at the huddle.

1.2 The assigned nurse and charge nurse will have input into the removal and/or changes to the assigned flag to the patient.

1.3 Restraints

1.3.1 Mandatory education using case scenarios will be provided to reinforce the appropriate use of restraints in non-formed MACU patients.

1.3.2 Patients with restraints applied will be reviewed at the daily huddle and their care discussed to ensure least restraint practices.

1.3.3 When a patient is in 5-point restraints, a nurse will be assigned one-to-one.

1.3.4 All patients who are on a Form I and restrained will have both a nurse and security present until the Form I is removed.

1.3.5 The Hospital will review the restraint policies to ensure the least restraint processes are implemented prior to physical restraints

1.3.6 The Hospital will ensure the proper amount of restraints is available to all staff at all times.

2. One-to-one care
  - 2.1 Based on the patient's needs and risk, the appropriate care provider will be assigned for one-to-one observations (i.e. personal care provider, extern, nurse, etc.). Once the appropriate staff member has been assigned, they will not be redeployed.
  - 2.2 As per policy, when a patient is on a one-to-one care, the observer is in audible and visible observance at all times.
  
3. Code White
  - 3.1 Effective immediately, all Code Whites will have a mandatory and formalized debriefing with all those who participated in the code. The debriefing will be led by the manager, or charge nurse, that supports MACU.
  - 3.2 Debriefs will also include discussing emotional aspects which may be affecting the staff as a result of the incident.
  - 3.3 MACU Unit Council will develop a standardized debrief template to be used in Code White debriefings.
  - 3.4 All Code Whites debriefs will be documented and submitted for review by the Joint Health and Safety Committee.
  - 3.5 The Joint Health and Safety Committee will analyze all Code White debriefing data, review the trends, and be empowered to make appropriate corporate recommendations for further education, staff support, and policy changes.
  - 3.6 The Hospital will ensure all staff will be notified immediately to any significant changes in the Code White Policy and on a yearly basis through all avenues of communication (huddle boards, bulletin boards, emails, etc.).
  - 3.7 All current MACU staff must complete their SMG training within the next 6 months. All new MACU staff will receive the training during their orientation.
  - 3.8 All MACU staff will receive a SMG refresher every 2 years or more frequently based on Code White debriefs.
  - 3.9 The IAC supports the need for additional supports for behavioural patients.

### 3.8 ENVIRONMENTAL SAFETY

The physical environment is important as it can greatly influence the health and safety of staff and patients, and productivity (Zborowsky & Bunker-Helimech, 2010). Poorly designed nursing units have been found to contribute to operational inefficiencies, occupational hazards, threaten staff with physical harm, and patient safety (Battisto et al., 2009). Environmental barriers that can contribute to physical workload stressors are poor physical layouts of patient's rooms and increased travel distances between supplies, work areas and patient rooms (Battisto et al.).

In the MACU video and during the Hearing, the IAC heard of rooms on the unit that were initially private rooms. During a patient surge, where the hospital had to address hallway health care, the rooms were converted to semi-private rooms, where one bed is a normal hospital bed and the other is a stretcher. Over time, this temporary solution became permanent, where the private rooms are now semi-private. The nurses described how it is difficult to provide care in these rooms due to the limited space between the two beds and the concern for the patients who must lie on a stretcher throughout their hospital stay. During the Hearing, the Hospital did acknowledge the challenges for both nurses and staff in these rooms, and were considering converting the pantry to a semi-private room, to address this issue. The Hospital also described how they are in the process of creating a second utility room to decrease travel distances between supplies, work areas, and patient rooms.

The IAC also learned from the video that there are challenges in accessing hot water on the Unit and the shower room lock was being opened with a paper clip vs. having a proper locking mechanism. During the discussion following the video, the nurses informed the IAC that they had reported these issues on more than one occasion to management, with no perceived changes occurring. The Hospital did state that due to the age of the building, there were challenges with the plumbing, and they would escalate the hot water issue to be addressed.

The IAC panel members observed during the video that the safe drinking space at the nursing station had been repurposed for a location for discharge charts. Public Health Ontario [PHO], (2012) identifies that staff who consume food or beverages in care areas (client/patient/ resident environment, nursing station, and charting areas) are at increased risk for acquiring serious foodborne gastrointestinal infections. Institutional outbreaks involving staff have been reported, particularly with hepatitis A, cryptosporidiosis and norovirus. (PHO, 2012).

An accreditation standard and required organizational practice (ROP) identifies that there must be a preventative maintenance program for all medical devices, medical equipment and medical technology. Documented preventative maintenance reports, a process to

evaluate the effectiveness of preventative maintenance and a documented process to address incidents related to medical equipment must be in place to satisfy this ROP (Accreditation Canada, 2020). In the fiscal year 2019-2020, the Hospital achieved Exemplary Standing in their Accreditation and met 99.4 percent of the standards. However, staff interviewed by the IAC panel, indicated that they were unaware of preventative maintenance records or a preventative maintenance program and indicated that broken equipment and beds can remain on the floor leaving them uncertain as to the repair status. This is potentially a risk to staff injury as well as to patient safety.

The MACU IAC Hospital Brief describes the Joint Health and Safety Committee (JHSC) consists of management and worker representatives at the Hospital who share a common goal of making the workplace safer and healthier. Workplace safety inspections are conducted by JHSC members to assess the work environment and identify health and safety hazards. The Hospital is also recommending at JHSC, that the manager/delegate perform monthly workplace inspections (p. 27-28).

### **The IAC Recommends**

1. The private rooms that were converted to semi-private be converted back to private rooms immediately.
2. These rooms can only be used as semi-private in extreme circumstances and/or surge for only a limit of 5 days because of the safety and quality of care concerns.
3. Effective immediately, the Hospital will move forward to investigate and rectify the hot water and the shower door lock mechanism issues.
4. The MACU manager and staff will create a safe drinking space away from any areas that may have specimens or blood products present.
5. Ensure there are unit safety inspections on MACU on a monthly basis.
6. Equipment Repairs Process
  - 6.1 The Hospital will develop a clear and transparent process for identifying malfunctioning equipment, removal of said equipment for repair and when equipment is repaired and returned to the unit.
  - 6.2 Equipment in need of repair and/or out for repair are identified on the huddle board.

## 7. Preventative Maintenance

- 7.1 The Hospital will standardize and make transparent to staff the preventative maintenance process.
- 7.2 The Unit Manager and staff will know where the preventative maintenance records are kept and how to access them.

### **3.9 INFECTION CONTROL**

Infection prevention and control is a critical component of patient safety, as health care associated infections are by far the most common complication affecting hospitalized patients. The importance of infection prevention and control and routine practices, as well as additional precautions has most recently been highlighted in the context of the global pandemic. However, it is also increasingly common to have many patients under additional precautions due to community acquired infections and nosocomial or hospital acquired infections.

A Cochrane Database Systematic Review did a rapid qualitative evidence synthesis of 20 relevant studies on barriers and facilitators to healthcare workers' adherence with infection prevention and control guidelines (Houghton et al., 2020). The evidence indicated that, workers identified increased workload and fatigue having to use personal protection equipment (PPE) in caring for patients. Healthcare workers also identified that their responses and utilization of infection prevention and control (IPAC) guidelines was influenced by the level of support they felt they were receiving by the leadership team. Clear communication on IPAC guidelines was imperative and health care workers identified that there was an overall lack of education on how to use PPE. The work place culture also had an influence on the implementation of IPAC guidelines. The implications for practice that should be considered include communication of IPAC guidelines, workload, physical environment, PPE and other supplies availability, training and education, encouraging and ensuring IPAC adherence, and relationships with patients and families (Houghton et al. 2020).

On two occasions, during the COVID 19 pandemic, MACU was identified as the COVID unit. Several meetings of the stakeholders were held to prepare and manage the logistics of converting MACU to a COVID unit. While the manager at the time attended these meetings, there was no staff representation on this working group. However, the manager ensured communication to the staff through huddles and emails.

Staff interviewed by the IAC panel highlighted the following concerns:

- There is a lack of clarity as to the role of the infection control practitioner at the unit level.
- There is a lack of awareness/knowledge of outbreak and pandemic planning.
- There is a concern that the education and training MACU staff receive regarding additional precautions and donning and doffing personal protective equipment does not provide adequate, in the moment support and is not done in person with coaching.
- Patients can remain in isolation for longer than needed due to lack of IPAC support on weekends and holidays.
- There is no visibility of audits and results of audits at the unit level.
- There is a perception that at times there are a significant number of patients who require additional precautions, and this impacts nursing workload.

In order to achieve long-term improvement, the health care setting must make infection prevention an institutional priority and integrate IPAC practices into the organization's safety culture. Improving adherence to infection control practices requires a multifaceted approach that incorporates ongoing education and continuous assessment of both the individual and the work environment. (Public Health Ontario [PHO], 2012), specifically:

- Health care facilities should ensure that appropriate policies and procedures are in place to ensure attendance at training/education in routine practices and additional precautions (including hand hygiene) and that attendance is recorded and reported back to the manager to become a part of the employee's performance review. Evidence based practices and procedures when applied consistently in health care settings can prevent or reduce transmission to providers, clients, residents, patients and visitors.
- Each health care setting should have a policy authorizing any regulated health care professional to initiate the appropriate Additional precautions at the onset of symptoms and maintain precautions until laboratory results are available to confirm or rule out the diagnosis. The person designated as the Infection Control Professional (ICP) for the health care setting: must be informed when Additional precautions are initiated, will verify that the precautions are appropriate to the situation and will be consulted before discontinuation of Additional precautions or according to health care setting policy.
- The Hospital must have a policy that permits discontinuation of additional precautions in consultation with the ICP or designate. The attending physician should be notified when Additional precautions are being discontinued.
- It is important that Additional precautions not be used any longer than necessary and that frequent assessment of the risks of transmission be carried out by ICPs with the goal being the removal of precautions as soon as it is safe to do so.
- During the current coronavirus pandemic, significant emphasis has been placed on the importance of mitigating nosocomial spread of COVID-19. One important consideration involves the appropriate use of effective personal protective equipment (PPE), which

may reduce a healthcare provider's likelihood of becoming infected while simultaneously minimizing exposure to other patients that they care for. It has been demonstrated that inadequate education and training can significantly impact compliance with PPE recommendations. Technique regarding donning and doffing of PPE is crucial to the protection of those who are using it (McCarthy et al., 2020)

- A worker who is required by their employer or by the Regulation for Health Care and Residential Facilities to wear or use any protective clothing, equipment or device shall be instructed and trained in its care, use and limitations before wearing or using it for the first time and at regular intervals thereafter and the worker shall participate in such instruction and training (PHO, 2012). IPAC education should be provided to all staff, especially those providing direct client/patient/resident care, at the initiation of employment as part of their orientation and as ongoing continuing education on a scheduled basis. Lack of adequate training can negatively impact the effective use of PPE and result in poor adherence to infection control precautions and increase the likelihood of contamination.

#### **The IAC Recommends:**

1. The Hospital will regularly review the pandemic and outbreak plans and communicate to all staff at the time of any changes.
2. Outbreak Practices
  - 2.1 The infection control practitioner (ICP) assigned to MACU will provide education, planning, coaching, and support to staff during an outbreak.
  - 2.2 In the event of an outbreak, there will be assigned staff (manager, educator, or an assigned nurse) to provide donning and doffing and bundling of care coaching to ensure appropriate infection control practices are maintained to prevent cross contamination.
  - 2.3 Donning and doffing review should be done in person (not online) yearly and at the beginning of an outbreak.
3. Pandemic Practices
  - 3.1 The Hospital will regularly review the pandemic plan, and review with staff on regular basis.
  - 3.2 Joint Health and Safety Committee will review the pandemic plan on a yearly basis and whenever there are changes to the plan.

4. PPE supplies are reviewed minimally on a daily basis and more frequently in an outbreak/pandemic situation.
5. Staff are aware of how to acquire additional PPE supplies when needed, including N95 masks.
6. Mask fit occurs every 2 years and sooner if requested by the nurse.
7. MACU Infection Control Practitioner
  - 7.1 Will participate in huddles to provide staff with support and to ensure patients are on the appropriate precautions.
  - 7.2 Provide support for the in-charge nurse to be able to remove precautions on the weekend in consultation with the infection control practitioner.

### **3.10 MEDICATION ADMINISTRATION**

The College of Nurses of Ontario (2019) indicates in their practice standards that nurses must collaborate in the development implementation, and evaluation of systems approaches that support safe medication practices within the health care team and should promote and or implement secure and appropriate storage, transportation and disposal of medication. Causes of medication errors include environmental factors, interruptions and distractions, human stress, and miscommunication (Hayes et al., 2015). In an integrative review of characteristics of interruptions during medical administration, nurse colleagues, other staff and self were the most frequently observed sources of interruptions (Schroers, 2018).

The IAC panel members observed on the virtual tour that the automated dispensing cabinet (ADC) as well as the unit dose cart were located in the actual nursing station where noise, interruptions and distraction are plentiful and quite frequent. There is no medication preparation/storage room on this unit. The IAC panel was told that at times there could be a lineup of nurses waiting to access medications at the nursing station. Interruptions slow the process of administration and increase the risk of errors. Nurses and pharmacists dispensing medications are distracted and interrupted as often as every two minutes when providing medication. The risk of medication error increases by 12.7% with each interruption and is doubled when nurses are interrupted four times and tripled when interrupted six times (Institute for Safe Medication Practices [ISMP], 2012). Sources of interruption may be auditory such as telephone calls, patient call bells and talking or visual such as alerts from electronic devices. The PRWFs reported more than 50 instances of missed medications, incorrect or late medication administration

Nurses reported that there are Workstation on Wheels (WOWs) located outside patient rooms and these have bins or drawers for medication storage. WOWs enable nurses to do bedside patient charting and medication administration. However, the IAC heard that not all nurses use the WOWs as they were intended but rather choose to make several trips back and forth to identify medications needed, retrieve the medications from the centralized location in the nursing station and return to administer and document the medication provided. The medication administration process currently adds to nursing workload with numerous back and forths, duplication of effort and workarounds and does not support safe medication administration. When the WOWs are consistently used, nurses can administer medications for their patients from these carts without having to return to the nursing station multiple times and can document the medication process in a timely manner. There is also potentially less distraction at the WOW than at the nursing station. Strategies will need to be developed to address appropriate use of mobile devices while minimizing the risks associated with distractions (ISMP, 2012).

Another way to decrease distractions during medication administration, is to create a no interruption zone away from areas such as the nursing station where talking and interruptions can occur. This zone would be solely for medication administration with automated dispensing cabinets (ADC), drug preparation areas with the necessary supplies, and computer order entry availability (ISMP, 2012). Safe use of technology such as ADC can only be achieved through the adoption of standard practices and processes directly associated with automated dispensing cabinet design and functionality and ideal environmental conditions for the safe use of ADCs (ISMP, 2019). During the Hearing, the IAC heard that the hospital is examining how to create a specific medication preparation area outside of the nursing station.

**The IAC Recommends:**

1. Standardize the process to remove medications from the unit cart and the Accudoses to the WOWs and consider what the role of the unit based pharmacist could be in supporting the process.
2. The MACU Unit Council be empowered to create a standardized medication preparation process with involvement by the unit based pharmacist.
3. The hospital will create a specific medication preparation area that is outside the nursing station and in a location that minimizes distractions and interruptions.

### 3.11 NON-NURSING DUTIES AND EQUIPMENT

Non-Nursing tasks are those tasks performed by nurses below their scope of practice and tasks that do not require nursing knowledge and skill (Grosso et al., 2019). Non-nursing tasks may take nurses away from the bedside and can result in nursing tasks being not done or missed, as well can contribute to decreased job satisfaction. Examples of non-nursing task include clerical work such as answering phones, compiling charts, photocopying forms etc. Non-nursing tasks have been shown through research to contribute to the increase of missed or delayed nursing care and decreased quality of care (Grosso et al.2019). Non-nursing tasks have also contributed to nurses' feelings of burnout, job dissatisfaction, and role conflict (Grosso et al., 2019). In the ONA IAC Submission, it was identified that 26 PRWRFs highlighted that performing non-nursing tasks contributed to delayed or missed care (p. 47).

Non-nursing tasks have increased in the last decade due to cost cutting measures, changes in staff mix, and reductions in nurses and unregulated health care providers (Grosso et al., 2021). Grosso et al., (2021) identify four types of non-nursing functions as administrative-completing forms, compiling charts and/or scheduling appointments; auxiliary-those meant to be performed by unregulated health providers-delivering and retrieving food trays and/or portering; tasks belonging to other allied health care providers-mobilizing patients when physiotherapists are not working; and tasks from the medical profession-making decision about diagnostic procedures when physicians are not available.

The current system for retrieval of equipment is not enabling nurses to have easy access to necessary equipment. Nurses perform workarounds such as determining who actually needs an IV pump when they cannot locate one for use. Although there is a centralized process for inventory and that geographically locates some equipment, staff say it is not kept current and does not prevent them from having to call units or go searching for equipment they need. This takes nursing away from patient care for potentially extended periods of time. Another issue with equipment is a few vital signs machines are wall mounted; others are centralized on the unit. Following IPAC procedures, anytime equipment is shared between rooms and between patients, it must be cleaned by the nurse using the equipment. Nurses spend time cleaning equipment, as well as having to physically locate the tools or equipment they need to do their assessments

Other non-nursing tasks occur when the unit has a patient(s) who is exit seeking, there is an ability to lock down the unit. The IAC panel was told this is not an infrequent occurrence. Nurses are interrupted in their care to open the door for people to access the unit when in lockdown. During the current pandemic and with limits on visitors and

volunteers on the MACU, when a patient is discharged, a nurse accompanies/ transports discharged patients to the lobby. This takes the nurse off the unit for extended periods of time and is work that could be done by others. Family members/friends who provide support to the patient could transport most patients who are being discharged home to the lobby. Other non-nursing staff could perform this task such as a patient family, support person, extern, volunteer, porter etc.

**The IAC Recommends:**

1. Clerical
  - 1.1 Clerical support will work from 08:00 to 20:00 7 days/week.
  - 1.2 Clerical support needs to be replaced when absent.
  - 1.3 The Hospital should consider developing a virtual clerical team to support replacing absences.
- 2 Vital Sign Equipment
  - 2.1 In each patient room, there will be vital sign equipment mounted on the wall and at least 2 mobile units on MACU.
- 3 Standardization of the process to access equipment (i.e. monitors, pumps, specialty beds).
  - 3.1 Review equipment retrieval process, ensure equipment inventory is up-to-date, and make the process transparent to staff.
  - 3.2 Retrieval of equipment not on the unit is a non-nursing duty and will be done by a non-regulated worker.
  - 3.3 The Hospital will consider radio frequency identity chips (RFID) system on pumps, beds, and equipment.
- 4 Buzzer and intercom system when the door is locked.
  - 4.1 The Hospital will install an automated system to open the door that can be accessed at the nursing station.

- 5 Accompanying people leaving the unit on discharge.
  - 5.1 Non-nursing staff will be used to accompany people being discharged to the lobby (i.e. patient support person, porter, extern, volunteer, etc.).
- 6 The hospital will ensure the staff are aware of the process of how to access supplies and/or equipment as necessary.

### **3.12 PROFESSIONAL RESPONSIBILITY WORKLOAD (PRW) PROCESS**

The more than 109 PRWFs submitted by the RN staff on MACU over the past 28 months document significant workload issues related to patient care, patient acuity, fluctuating workloads, fluctuating staffing, and professional practice, all of which affect the perceived ability of RNs to deliver safe, quality patient care. Many of the PRW issues were discussed at several HAC meetings however, other than an assurance to do better and a documented Minutes of Settlement (2020), the majority of issues have been either unresolved or actions committed to being done have not been completed.

Although both parties voiced a commitment to do better at several HAC meetings, there were several other contributing issues influencing the lack of meaningful resolution and collaboration. This includes timing issues and cancelled meetings when hospitals were preoccupied with COVID 19 pandemic issues, as well as a significant turnover in the unit and program leadership.

The impression the IAC panel received from staff and the Association is that there has been little follow-up, little progress on key workload concerns and efforts to resolve issues have been hampered by the lack of attendance of key leaders in the organization, namely the unit manager. The process over the last several years has deteriorated and strained relationships such that productive and collaborative discussion at all levels are no longer occurring.

#### **IAC Recommendations:**

1. Every effort will be made to resolve issues at the unit level with staff and the manager before and after a PRW form is completed.
2. The Hospital and Association will collaboratively work together to resolve workload issues and minimize the perception of a divisive working relationship.

3. The senior leadership team and management will view the PRW process as a way to open communication and be more effective in the problem solving process of addressing the workload issue.
4. Both parties will work together to improve the PRW process with the goal of implementing a collaborative approach to resolve workload issues.
5. Both parties will follow the Collective Agreement Article 8, Professional Responsibility Workload Process.
6. When MACU PRW issues are discussed at HAC and/or sub-HAC, the appropriate people (i.e. manager, CSM, CNE, staff nurses) involved are in attendance when the PRW issues are being discussed.
7. Where an action plan is developed based on the PRW process, both the Association and the Hospital will ensure there is follow up of any outstanding items.
8. HAC meetings are an important avenue for the Hospital and Association to resolve PRW issues, as such, HAC meetings should be rescheduled not cancelled.

#### **PART 4: CONCLUSIONS AND SUMMARY OF RECOMMENDATIONS**

This report contains the Independent Assessment Committee's findings and 12 areas of recommendations regarding the Professional Responsibility and Workload Complaints submitted by registered nurses on the MACU at Southlake Regional Health Centre that impact their ability to provide quality and safe patient care. The process taken through an Independent Assessment Committee 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 Independent Assessment Committee unanimously support all recommendations in the report. The Committee hopes that the recommendations will assist the Hospital and the Association to find mutually agreeable resolutions with regard to nursing workload issues at the Hospital and 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.

## **RECOMMENDATIONS:**

### **I. STAFFING:**

#### 1. Scheduling:

- 1.1 In order to create stability, continuity of care, and address burnout and decreased job satisfaction: The staffing of RNs will be based on a full-time to part-time ratio of 70/30.
- 1.2 Ensure the master schedule has an appropriate number of filled lines, so that when a schedule is posted, the recommended staffing complement is achieved and there are no gaps in the schedule.
- 1.3 A robust pool of part-time and casual nurses will be developed on MACU to fill incidental absences, vacation, and short term leaves.
- 1.4 The teams on the master schedule will be periodically re-assessed to ensure a balance of novice to expert nurses on each team. Any necessary changes to the master schedule to meet this balance will need to follow by the collective agreement.

#### 2. Patient Assignments:

- 2.1 The Hospital will implement a 60/40 staffing ratio of RNs to RPNs on MACU resulting in the following staffing/day (weekends included):
  - 2.1.1 Days: 5 RNs with patient assignments and 1 Charge Nurse (no patient assignment).
  - 2.1.2 Nights: 4 RNs with patient assignments and 1 Charge Nurse (no patient assignment).
- 2.2 Each nurse is assigned accountability for the total care of a group of patients. This will result in a patient assignment ratio of 1 to 4 on days and 1 to 5 on nights. This does not preclude the need for team work and collaboration to provide safe, timely and quality care to support appropriate consultation for novice staff and RPNs and enables nurses to meet CNO standards of practice.

2.3 Patient assignments will be made by the Charge Nurse based on the College of Nurses of Ontario (2018) 3 Factor Framework of the nurses' ability to provide safe and ethical care to clients; the patient's complexity, predictability and risk of negative outcomes; and environmental factors of practice supports, consultation resources and stability and predictability, rather than the previous pod assignment model.

3. Charge Nurse:

3.1 There will be a charge nurse 24/7 with no patient assignment in order to provide support and consultations, escalate concerns, workload increases and/or staffing concerns to the Manager and/or CSM.

3.1.1 The charge nurse will be empowered to call in one additional staff member (not on overtime) based on the 3 factor Framework and the needs of MACU.

3.1.2 The charge nurse will be empowered to make the decision to replace a sick call.

3.1.3 The charge nurse will provide the rationale for the staffing adjustment to the manager within 24 hours either verbally or in writing.

3.1.4 The manager will support the decision making of the charge nurse and if discussions need to occur related to the rationale to call in additional staffing, it will be done through a lens of a learning opportunity.

3.1.5 Any additional staffing resulting in overtime requires approval by the manager or CSM.

3.2 The charge nurse positions will be posted as per the Collective Agreement.

3.3 A formalized charge nurse orientation program will be developed and implemented that outlines the roles, responsibilities and accountabilities of the charge nurse based on consultation and collaboration of nurses on the unit, especially the nurse(s) who are presently fulfilling the role.

3.4 The charge nurse will be provided leadership education as part of their professional development in this role.

- 3.5 The permanent charge nurse orientation will consist of 6-12 hour day shifts and 6-12 hour night shifts and/or based on learning needs.
  - 3.6 In the event an orientated charge nurse to MACU is not available (i.e. sick time, vacation, etc.), the nurses will be empowered to decide the most appropriate person to take the charge nurse role. The CSM will be notified and will provide additional support as needed.
  - 3.7 Using Benner's theory of novice to expert, those staff that are considered a proficient and expert nurse on MACU, will be provided the opportunity to receive an orientation of 2-12 hour days and 2-12 hour nights to the charge nurse role to fill in for incidental absences.
4. Discharge Planning:

The IAC panel supports the work already started in establishing a Discharge working group with the mandate to clearly identify which part of the discharge process will be carried out by each health care professional.

- 4.1 The IAC recommends that this group continues to move forward and must include the social worker, home and community nurse, primary care nurse, charge nurse, physician, pharmacy, occupational and physiotherapists etc..
- 4.2 To begin immediately, discharge rounds will occur twice/week with the social worker as chair to coordinate discharge plans and to identify individual responsibilities and accountabilities of each team member identified.

## **II. LEADERSHIP:**

1. The MACU Manager will:
  - 1.1 Be supported in their professional development in order to be successful in moving forward to implement the necessary changes on MACU.
  - 1.2 Have protected time each day (for example, 7:30-9:30) to be visible on MACU and engage with staff.
  - 1.3 Post when they are not present on the Unit.
  - 1.4 Round with the charge nurse each morning.

- 1.5 Participate in huddles.
2. MACU Unit Council:
    - 2.1 The MACU Unit Council will not replace the need for regular staff meetings.
    - 2.2 Nurses will be paid for time attending Unit Council. If the nurse is scheduled to work, they will be replaced to attend the meeting.
    - 2.3 The manager will be a member of Council, but not as Chair or Co-chair. Instead the purpose of the manager will be to focus on removing barriers and to support success.
    - 2.4 The manager will immediately put out a call for Chair and Co-Chair and members with a minimum of 6-8 MACU nurses (RNs/RPNs). The Chair and Co-Chair will be selected using a formalized and confidential voting process.
      - 2.4.1 Once formed, the Unit Council will develop Terms of Reference.
      - 2.4.2 The Unit Council will invite other members of the health care team to participate on an as needed basis.
      - 2.4.3 The Unit Council will meet a minimum of 8 times/year and will develop a work plan for the year.
      - 2.4.4 At the end of the year, the Unit Council will review the work plan and evaluate what was accomplished to inform the development of a work plan for the upcoming year.
      - 2.4.5 Draft agenda and minutes will be posted two weeks in advance to allow for input from other staff on items to be added to the agenda.
3. Senior Leadership Team:
    - 3.1 The senior leadership team will develop and implement strategies to increase their visibility with MACU frontline staff.
    - 3.2 The senior leadership team will follow up on their commitment to staff during the IAC, for positive change through visible actions improving the MACU workload and work environment issues.

- 3.3 The senior leadership team and manager will utilize the Registered Nurses Best Practice Guideline (2013). *Developing and sustaining nursing leadership best practice guideline* (2<sup>nd</sup> Ed.). [https://rnao.ca/sites/rnao-ca/files/LeadershipBPG\\_Booklet\\_Web\\_1.pdf](https://rnao.ca/sites/rnao-ca/files/LeadershipBPG_Booklet_Web_1.pdf) to assist in identifying ways to build relationships and trust; create an empowering work environment; lead and sustain change; and balance the complexities of the system, while managing competing values and priorities

### III. COMMUNICATION

1. Staff Meetings:
  - 1.1 Need to be scheduled immediately, even if they need to be virtual.
  - 1.2 The manager and staff will collectively identify the most appropriate time for staff meetings.
  - 1.3 Staff meetings will be held on a monthly basis
  - 1.4 An agenda will be posted a week in advance to allow for input from staff.
  - 1.5 Minutes of the meeting will be posted a week after the meeting on the Staff Communication Bulletin Board visible to all staff. Staff communication board could be located in the staff room.
2. All Bulletin Boards are kept up to date with timely information.
3. The Manager will:
  - 3.1 Round with staff to establish rapport, trust and personal connections and to have an opportunity to give positive feedback and listen to pressing issues expressed by staff.
  - 3.2 Communicate using different and appropriate communication mediums (face to face, emails, bulletin boards etc.).
  - 3.3 In order that the decision making process is transparent, ensure that the decision making for staffing workload increases with the virtual nursing team (VNT) algorithm is shared with staff.

4. Huddles will be led by the charge nurse and the manager will attend.
  - 4.1 A time for daily huddles and standard work (structured and consistent process) will be established and implemented.
5. With the turnover in management, leadership team and staff, there appears to be a lack of clarity in the application of the sick time policy. To ensure a common understanding and implementation of the policy, the IAC recommends re-education of the sick time policy to leadership teams and staff to ensure consistent application.
6. Clinical Supervisor Manager (CSM)
  - 6.1 The CSM will physically attend the unit whenever a request for a workload increase is unmet, explain the rationale for the decision, and discuss and assist the charge nurse in problem solving how to best address the patient care needs.
  - 6.2 The CSM will do rounds to all units either in person or via phone, and will physically attend the unit when requested by the charge nurse.
  - 6.3 The hospital will change the CSM's hours to ensure there is onsite management presence 24 hours/day.
  - 6.4 The Hospital will develop an algorithm to ensure consistency of CSM decision making in addressing workload staffing increases.
  - 6.5 If the CSM is unable to accommodate a staff increase request that impacts patient safety, the CSM will also notify and discuss the safety concern with the on-call manager.

#### **IV. RECRUITMENT AND RETENTION**

1. Recruitment:
  - 1.1 Human resources will examine their hiring processes to ensure barriers to timely recruitment are removed.
  - 1.2 The Hospital and Association will take advantage of the New Graduate Guarantee initiative following the Collective Agreement, in recruiting new graduate nurses.

- 1.3 The Hospital will continue to access the Externship Program and provide opportunities for student nurses.
  - 1.4 The Hospital and the Association will meet to collaboratively explore how to best implement these initiatives with the goal of attracting as many new graduates as possible and foster positive learning experiences.
  - 1.5 The Hospital will explore hiring Internationally Educated Nurses.
  - 1.6 As an avenue to recruit new graduate nurses, the Hospital will foster relationships with College and University nursing programs to establish partnerships and increase student placement availability as an avenue to recruit new graduate nurses.
  - 1.7 The Hospital will develop a robust orientation program tailored to support new nursing hires' learning needs that will continue until the new recruit is competent to independently assume a patient assignment.
  - 1.8 The Hospital will develop a preceptor education program that is mandatory for any nurse wanting to be a preceptor for new hires.
  - 1.9 Preceptors will be paid the preceptor premium.
  - 1.10 Front line staff will be engaged as ambassadors and preceptors for students and new hires.
  - 1.11 Continue participating in nurse job fairs.
2. Retention:
- 2.1 Create a positive work environment culture in MACU.
    - 2.1.1 In the next 4 to 6 months, the Hospital will provide a structured team building exercise for MACU staff that will include management and all staff on MACU. This will be offered minimally twice to ensure maximum participation and staff will be paid to attend.
    - 2.1.2 The Hospital, leadership team and staff will look for ways to celebrate the successes of the MACU team.

- 2.1.3 Exit interviews will be performed by Human Resources to identify why staff are leaving MACU, and opportunities to retain staff and to address and improve workload issues.
- 2.1.4 The Hospital, MACU nurse manager, and nursing unit council will identify ways to foster and promote a positive work environment.
- 2.1.5 The IAC recommends that within the next two months, the Hospital survey MACU staff using a validated staff satisfaction/engagement survey examining changes to culture, staff satisfaction, leadership and their impact on safety and patient care. The staff will be re-surveyed every 6 months to identify any improvements and future opportunities to improve the worklife on MACU.
- 2.1.6 The Hospital, MACU nurses and the Association will review the results and collaboratively identify additional ways to address the issues and build a positive work environment.

## **V. ORIENTATION:**

1. The IAC strongly recommends the Hospital implement the new clinical (nursing) orientation process as soon as possible to support new nurses in the transition from student nurse to novice nurse.
2. All MACU new nurses will be preceptored by a consistent nurse, understanding there may be incidental absences.
3. For non-Nursing Graduate Guarantee (NGG) nurses on MACU, orientation will be a minimum of 12 preceptored shifts, (6-12 hour day shifts and 6-12 hour evening shifts).
4. The new nurse will be supernumerary during the orientation period.
5. During the orientation period, the preceptor and new nurse will have a reduced patient assignment which will be regularly re-assessed with input from orientee, preceptor and educator.
6. Competency-based assessments using a standardized checklist, will occur with the nurse, preceptor, educator and manager at regular intervals every 2 weeks or at the request of any of those parties to identify learning needs needed to move to independently carrying a patient assignment.

7. Selection criteria will be developed to identify suitable preceptors.
8. The Hospital will offer preceptorship workshops for those interested in being a preceptor.
9. The DETECT program will be part of the MACU orientation process

## **VI. EDUCATION:**

1. A dedicated Clinical Educator for MACU full-time for 2-years, starting immediately.
  - 1.1 This position will be re-evaluated at the end of 2 years with input from the educator, staff, and management. The result of the evaluation will be shared with the Association.
  - 1.2 The MACU clinical educator will spend 80% of time on the MACU, working with nurses in supporting their educational needs, orientations, new graduates and novice nurses transition to practice, and assisting in the implementation of the 3 Factor Framework in nursing practice on MACU.
  - 1.3 The educator will provide appropriate education to MACU staff on the extern's accountabilities and provide support for the MACU staff on how to best to implement this role on MACU.
  - 1.4 A learning needs assessment/checklist will be gathered by the educator of all MACU nurses over the next 4 months.
  - 1.5 A competency checklist will be done at the time of hire for new nurses, and the educator will work with the nurse and the preceptor to meet these goals.
  - 1.6 On an annual basis, the MACU educator will survey the staff for their learning needs.
  - 1.7 The MACU educator will plan and offer education days (paid) to address the identified learning needs.
  - 1.8 The MACU educator will provide education for all those nurses who wish to be a preceptor.

- 1.9 The Hospital will use the remainder of the Nurse Graduate Guarantee funds to support professional development days based on staff identified learning needs.
2. All current staff will have the opportunity to attend the DETECT (deterioration, evaluate, trends, elicit help, communicate, time matters) program. The DETECT program will be offered annually and as needed.

## **VII. VIOLENCE:**

### **1. Patients at Risk of Violence**

- 1.1 All patients who score at risk on the Violence Assessment Tool (VAT) will be reviewed daily by the assigned nurse and charge nurse at the daily huddle and removal and/or changes will be reviewed at the huddle.
- 1.2 The assigned nurse and charge nurse will have input into the removal and/or changes to the assigned flag to the patient.
- 1.3 Restraints
  - 1.3.1 Mandatory education using case scenarios will be provided to reinforce the appropriate use of restraints in non-formed MACU patients.
  - 1.3.2 Patients with restraints applied will be reviewed at the daily huddle and their care discussed to ensure least restraint practices.
  - 1.3.3 When a patient is in 5-point restraints, a nurse will be assigned one-to-one.
  - 1.3.4 All patients who are on a Form I and restrained will have both a nurse and security present until the Form I is removed.
  - 1.3.5 The Hospital will review the restraint policies to ensure the least restraint processes are implemented prior to physical restraints.
  - 1.3.6 The Hospital will ensure the proper amount of restraints is available to all staff at all times.

## 2. One-to-one care

- 2.1 Based on the patient's needs and risk, the appropriate care provider will be assigned for one-to-one observations (i.e. personal care provider, extern, nurse, etc.). Once the appropriate staff member has been assigned, they will not be redeployed.
- 2.2 As per policy, when a patient is on a one-to-one care, the observer is in audible and visible observance at all times.

## 3. Code White

- 3.1 Effective immediately, all Code Whites will have a mandatory and formalized debriefings with all those who participated in the code. The debriefing will be led by the manager, or charge nurse, that supports MACU.
- 3.2 Debriefs will also include discussing emotional aspects which may be affecting the staff as a result of the incident.
- 3.3 MACU Unit Council will develop a standardized debrief template to be used in Code White debriefings.
- 3.4 All Code Whites debriefs will be documented and submitted for review by the Joint Health and Safety Committee.
- 3.5 The Joint Health and Safety Committee will analyze all Code White debriefing data, review the trends, and be empowered to make appropriate corporate recommendations for further education, staff support, and policy changes.
- 3.6 The Hospital will ensure all staff will be notified immediately to any significant changes in the Code White Policy and on a yearly basis through all avenues of communication (huddle boards, bulletin boards, emails, etc.).
- 3.7 All current MACU staff must complete their SMG training within the next 6 months. All new MACU staff will receive the training during their orientation.
- 3.8 All MACU staff will receive a SMG refresher every 2 years or more frequently based on Code White debriefs.
- 3.9 The IAC supports the need for additional supports for behavioural patients.

## **VIII. ENVIRONMENTAL SAFETY:**

1. The private rooms that were converted to semi-private be converted back to private rooms immediately.
2. These rooms can only be used as semi-private in extreme circumstances and/or surge for only a limit of 5 days because of the safety and quality of care concerns.
3. Effective immediately the Hospital will move forward to investigate and rectify the hot water and the shower door lock mechanism issues.
4. The MACU manager and staff will create a safe drinking space away from any areas that may have specimens or blood products present.
5. Ensure there are unit safety inspections on MACU on a monthly basis.
6. Equipment Repairs Process
  - 6.1 The Hospital will develop a clear and transparent process for identifying malfunctioning equipment, removal of said equipment for repair and when equipment is repaired and returned to the unit.
  - 6.2 Equipment in need of repair and/or out for repair are identified on the huddle board.
7. Preventative Maintenance
  - 7.1 The Hospital will standardize and make transparent to staff the preventative maintenance process.
  - 7.2 The Unit Manager and staff will know where the preventative maintenance records are kept and how to access them.

## **IX. INFECTION CONTROL**

1. The Hospital will regularly review the pandemic and outbreak plans and communicate to all staff at the time of any changes.

## 2. Outbreak Practices

- 2.1 The infection control practitioner (ICP) assigned to MACU will provide education, planning, coaching, and support to staff during an outbreak.
- 2.2 In the event of an outbreak, there will be assigned staff (manager, educator, or an assigned nurse) to provide donning and doffing and bundling of care coaching to ensure appropriate infection control practices are maintained to prevent cross contamination.
- 2.3 Donning and doffing review should be done in person (not online) yearly and at the beginning of an outbreak.

## 3. Pandemic Practices

- 3.1 The Hospital will regularly review the pandemic plan, and review with staff on regular basis.
  - 3.2 Joint Health and Safety Committee will review the pandemic plan on a yearly basis and whenever there are changes to the plan.
4. PPE supplies are reviewed minimally on a daily basis and more frequently in an outbreak/pandemic situation.
  5. Staff are aware of how to acquire additional PPE supplies when needed, including N95 masks.
  6. Mask fit occurs every 2 years and sooner if requested by the nurse.
  7. MACU Infection Control Practitioner
    - 7.1 Will participate in huddles to provide staff with support and to ensure patients are on the appropriate precautions
    - 7.2 Provide support for the in-charge nurse to be able to remove precautions on the weekend in consultation with an infection control practitioner.

## **X. MEDICATION ADMINISTRATION:**

1. Standardize the process to remove medications from the unit cart and the Accudoses to the WOWs and consider what the role of the unit based pharmacist could be in supporting the process.

2. The MACU Unit Council be empowered to create a standardized medication preparation process with involvement by the unit based pharmacist.
3. The hospital will create a specific medication preparation area that is outside the nursing station and in a location that minimizes distractions and interruptions.

## **XI. NON-NURSING DUTIES AND EQUIPMENT:**

1. Clerical
  - 1.1 Clerical support will work from 08:00 to 20:00 7 days/week.
  - 1.2 Clerical support needs to be replaced when absent.
  - 1.3 The Hospital should consider developing a virtual clerical team to support replacing absences.
- 2 Vital Sign Equipment
  - 2.1 In each patient room, there will be vital sign equipment mounted on the wall and at least 2 mobile units on MACU.
- 3 Standardization of the process to access equipment (i.e. monitors, pumps, specialty beds).
  - 3.1 Review equipment retrieval process, ensure equipment inventory is up-to-date, and make the process transparent to staff.
  - 3.2 Retrieval of equipment not on the unit is a non-nursing duty and will be done by a non-regulated worker.
  - 3.3 The Hospital will consider radio frequency identity chips (RFID) system on pumps, beds, and equipment.
- 4 Buzzer and intercom system when the door is locked.
  - 4.1 The Hospital will install an automated system to open the door that can be accessed at the nursing station.

- 5 Accompanying people leaving the unit on discharge.
  - 5.1 Non-nursing staff will be used to accompany people being discharged to the lobby (i.e. patient support person, porter, extern, volunteer, etc.).
- 6 The hospital will ensure the staff are aware of the process of how to access supplies and/or equipment as necessary.

## **XII. PROFESSIONAL RESPONSIBILITY AND WORKLOAD (PRW) PROCESS:**

1. Every effort will be made to resolve issues at the unit level with staff and the manager before and after a PRW form is completed.
2. The Hospital and Association will collaboratively work together to resolve workload issues and minimize the perception of a divisive working relationship.
3. The senior leadership team and management will view the PRW process as a way to open communication and be more effective in the problem solving process of addressing the workload issue.
4. Both parties will work together to improve the PRW process with the goal of implementing a collaborative approach to resolve workload issues.
5. Both parties will follow the Collective Agreement Article 8, Professional Responsibility Workload Process.
6. When MACU PRW issues are discussed at HAC and/or sub-HAC, the appropriate people (i.e. manager, CSM, CNE, staff nurses) involved are in attendance when the PRW issues are being discussed.
7. Where an action plan is developed based on the PRW process, both the Association and the Hospital will ensure there is follow up of any outstanding items.
8. HAC meetings are an important avenue for the Hospital and Association to resolve PRW issues, as such, HAC meetings should be rescheduled not cancelled.

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## **APPENDICES**

## Appendix 1: Referral of Professional Practice and Workload Issues at SRHC MACU to the IAC



### Ontario Nurses' Association

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

April 8, 2021

#### SENT BY EMAIL

Annette Jones  
Vice President, Patient Experience and Chief Nursing Officer  
596 Davis Drive  
Newmarket, ON L3Y 2P9

Dear Annette,

**Re: Referral of Professional Practice and Workload Issues at Southlake Regional Health Centre Medical Assessment Consultation Unit to an Independent Assessment Committee (IAC) – ONA Case # 202006333**

This letter is in follow up to our discussions regarding the ongoing and escalating issues being reported to the Hospital and the Union by the Registered Nurses (RNs) from the Medical Assessment Consultation Unit (MACU) and is in accordance with Article 8.01(a) v) of the Hospital/Ontario Nurses' Association (ONA) collective agreement.

The RNs working in the Medical Assessment Consultation Unit at Southlake Regional Health Centre have consistently identified ongoing practice and workload issues as evidenced by the data submitted on over 91 Professional Responsibility Workload Report Forms (PRWRFs) since May 2019

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, the employer's policies and procedures, and vision. 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(s). Despite this, a number of the workload and practice issues identified by ONA members remain unresolved including but not limited to:

- 1) Failure to have sufficient baseline staffing to accommodate full census.
- 2) Failure to maintain consistent patient assignment based on skill level/experience, patient acuity and complexity.
- 3) Insufficient equipment and supplies available for nurses to be able to provide quality safe patient care.
- 4) Inadequate resources and support available when unit in outbreak or experiencing an increase number of patients requiring infection control precautions.

Provincial Office: Toronto  
Regional Offices: Ottawa • Hamilton • Kingston • London  
Orillia • Sudbury • Thunder Bay • Timmins • Windsor

## Appendix 1 cont'd: Referral of Professional Practice and Workload Issues at SRHC MACU to the IAC

Annette Jones April 8, 2021

Page 2

Professional Practice and Workload Issues at Southlake Regional Health Centre (MACU)

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- 5) Inadequate support to manage surge capacity.
- 6) Failure to provide safe working environment by not providing appropriate staffing when confused, behavioral or violent patients on unit.
- 7) Inadequate communication, education, and training to charge nurse and staff nurses regarding processes on unit, such as admission/discharge protocols. Transfer of care protocols, increase workload requests, equipment, and supplies communication etc.

The Union is extremely concerned with regards to 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 and Workload Issues is vital to enable the RNs to deliver safe, competent, and ethical patient care. Accordingly, the Union is forwarding the complaint to an Independent Assessment Committee (IAC) as per Article 8 of the Collective Agreement.

A Chairperson will be invited from the list in Appendix 2, pending confirmation from the Ontario Hospital Association. Please provide written confirmation concerning the name, mailing address, home or cell and office phone numbers, fax number and e-mail address of your nominee. The union will provide the name and contact information of our nominee in a subsequent communication.

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



Sandy Paproski  
ONA Professional Practice Specialist

- C: Annette Smith, Local Coordinator  
 Jill Moore, Bargaining Unit President  
 Todd Davis, ONA Servicing Labour Relations Officer  
 Susan Delisle Gosse, ONA Manager, Professional Practice  
 Krystal Arden, President and CEO, Southlake Regional Health Centre  
 Annette Jones, Chief Nursing Executive, Southlake Regional Health Centre  
 Vickie McKenna, ONA President  
 Cathryn Hoy, ONA Vice-President  
 DJ Sanderson, ONA Regional VP

## Appendix 2: Letter from SHRC to the Association



596 Davis Drive  
Newmarket, ON L3Y 2P9  
T: 905-895-4521  
TTY: 905-952-3062  
southlake.ca

May 7, 2021

**VIA EMAIL**

Ms. Sandy Paproski  
Professional Practice Specialist  
Ontario Nurses' Association  
85 Grenville Street, Suite 400  
Toronto, ON M5S 3A2

**Re: Referral of Professional Practice and Workload Issues at Southlake Regional Health Centre Medical Assessment Consultation Unit to an Independent Assessment Committee (IAC) – ONA Case # 202006333**

Dear Ms. Paproski,

Thank you for your letter dated April 8, 2021 notifying that the union is forwarding the Professional Responsibility Complaint in the Medical Assessment Consultation Unit to an IAC.

As per your request please consider this our written confirmation of the Hospital's Nominee for the IAC as follows:

Susan Kwolek  
416-573-9706  
[Suskwolek@gmail.com](mailto:Suskwolek@gmail.com)

Should you have any further questions or require any further information, please feel free to contact me at (905) 895-4521 extension 2146.

Sincerely,

Annette Jones  
Vice President Patient Experience and Chief Nursing Officer  
Adjunct Lecturer, University of Toronto  
Southlake Regional Health Centre  
596 Davis Drive, Newmarket, ON L3Y 2P9

Copy to:  
Erin Silverman, SRHC Manager, Labour Relations  
Lucie Walker, SRHC Director, Human Resources  
Chris Cecchini, SRHC Vice President, Human Resources  
Betty Perkins, Manager, Medical Assessment Consultation Unit  
Liz Lalingo, SRHC Director, Emergency and Mental Health Program  
Barbara Steed, SRHC Executive Vice-President  
Arden Krystal, SRHC President and Chief Executive Officer

Sue Kwolek, SRHC Independent Assessment Committee Nominee  
Jill Moore, ONA Local Coordinator and Bargaining Unit President  
Vickie McKenna, ONA President  
Cathryn Hoy, ONA Vice-President  
DJ Sanderson, ONA Regional VP  
Susan Delisle Gosse, ONA Manager, Professional Practice  
Annette Smith, Local Coordinator  
Todd Davis, ONA Servicing Labour Relations Officer

## Appendix 3: Letter from the Association to the SRHC



### Ontario Nurses' Association

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

May 12, 2021

#### **SENT VIA EMAIL**

Annette Jones  
Vice President Patient Experience and Chief Nursing Officer  
Southlake Regional Health Centre  
596 Davis Drive  
Newmarket, ON L3Y 2P9

Dear Ms. Jones,

**Re: Referral of Professional Practice and Workload Issues at Southlake Regional Health Centre Medical Assessment Consultation Unit to an Independent Assessment Committee (IAC) – ONA Case # 202006333**

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Thank you for your letter dated May 7, 2021 notifying that the union and written confirmation of Susan Kwolek as the Hospital's Nominee for the IAC.

Please be advised in accordance with the Hospital/Ontario Nurses' Association (ONA) collective agreement, Claire Mallette has accepted the nomination to Chair the Independent Assessment Committee (IAC). This has occurred in consultation with Mr. David McCoy, Director, Labour Relations, Ontario Hospital Association (OHA). Claire's contact information is as follows:

Claire Mallette RN, PhD  
Associate Professor (Tenured)  
School of Nursing, York University  
354, Health, Nursing & Environmental Bldg.  
4700 Keele St., Toronto, ON M3J 1P3  
cmallett@yorku.ca  
Phone: (416) 736-2100 ext. 44541  
Phone (cell): (289) 439-2771

Please be advised that the Ontario Nurses' Association nominee to the Independent Assessment Committee is Cindy Gabrielli.

Cindy's contact information is as follows:

Cindy Gabrielli, RN (EC), BScN, MSN  
6285 McMicking St.  
Niagara Falls, ON L2J 1W7

Provincial Office: Toronto  
Regional Offices: Ottawa - Hamilton - Kingston - London  
Orillia • Sudbury • Thunder Bay • Timmins • Windsor

## Appendix 3 cont'd: Letter from the Association to the SRHC

Annette Jones/Letter dated May 12, 2021  
Re: IAC Chair and ONA Nominee

2

Phone (cell): 905-329-3597  
Phone (home): 905-357-6276  
Email: cgabrielli@cogeco.ca

The parties have collaborated and attempted to attain resolutions to address some of the practice and workload issues in the MACU. 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



Danielle Richard RN BScN  
ONA Professional Practice Specialist

C: Annette Smith, Local Coordinator  
Jill Moore, ONA Bargaining Unit President  
Todd Davis ONA Servicing LRO  
Susan Delisle Gosse ONA Manager, Professional Practice  
Arden Krystal, SRHC President and Chief Executive Officer  
Lucie Walker, SRHC Director, Human Resources  
Claire Mallette, Chair Independent Assessment Committee  
Cindy Gabrielli, ONA Independent Assessment Committee Nominee  
Sue Kwolek, SRHC Independent Assessment Committee Nominee

## Appendix 4: First Class Facilitation Confidentiality Agreement

**Tuesday, August 24, 2021**

Confidentiality Agreement:

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

Joseph Jourekian

\_\_\_\_\_  
Name (print)

*Joseph Jourekian*

\_\_\_\_\_  
Signature

2021/08/24

\_\_\_\_\_  
Date

## Appendix 5: Email to the CNE for More Information on September 20, 2021

**From:** Claire Mallette

**Sent:** September 20, 2021 3:05 PM

**To:** Elizabeth Ferguson <EFerguson@southlakeregional.org>

**Cc:** Danielle Richard <DanielleR@ona.org>; cgabrielli@cogeco.ca <cgabrielli@cogeco.ca>; Susan Kwolek <suskwolek@gmail.com>

**Subject:** IAC Hearing documents

Hi Liz

The IAC met today to review both sets of documents and discuss all the information provided. Thanks to both you and Danielle for getting them put together. During our discussion we identified the following documents that would be helpful for the IAC to have prior to the Hearing next week. The documents we would like to review are as follows:

- Restraint Policy
- Code White Policy
- 1-1 care of the patient Policy
- Sick time replacement process or policy
- The actual MACU assignment sheets for a 6-week timeframe.
- MACU's sick time and overtime data
- Social Worker job description

Many thanks

Claire

## Appendix 6: Final Agenda of the IAC Hearing

Independent Assessment Committee Hearing  
Ontario Nurses' Association & Southlake Regional Health Centre/Medical Assessment Consultation Unit (MACU)

### Southlake Regional Health Centre Medical Assessment Consultation Centre (SRHC/MACU) & Ontario Nurses Association (ONA) IAC Hearing Final Agenda Monday September 27, 2021

Zoom Link: <https://firstclassfacilitation-ca.zoom.us/j/67535272478?pwd=dTdObzVlaIn2ODFMc1dVUmZWWIBJZz09>

| Time        | Item   | Participants            |
|-------------|--|-------------------------|
| 08:30-08:45 | Welcome and Introductions  | C. Mallette (Chair)/All |
| 08:45-08:55 | Review of Proceedings by Chairperson   | C. Mallette             |
| 8:55-10:00  | Watch Virtual Tour of SRHC/MACU  | All                     |
| 10:00-10:30 | Break  | All                     |
| 10:30-11:00 | Discussion generated from the Video  | All                     |
| 11:00-12:30 | Ontario Nurses' Association Submission Presentation<br>Danielle Richard<br><br>Response to questions of clarification from: <ul style="list-style-type: none"> <li>• Independent Assessment Committee</li> <li>• Southlake Regional Health Centre</li> </ul> | ONA, IAC, SRHC          |
| 12:30-1:30  | Lunch Break  | All                     |
| 1:30-15:00  | SRHC Submission Presentation-Elizabeth Ferguson & Alyson McQueen<br><br>Response to questions of clarification from: <ul style="list-style-type: none"> <li>• Independent Assessment Committee</li> <li>• Ontario Nurses' Association</li> </ul>             | SRHC, IAC, ONA          |
| 15:00-15:30 | Break  | All                     |
| 15:30-16:00 | Review of Process for Tuesday September 28, 2021   | IAC Chair               |
| 16:00       | Adjournment  | IAC Chair               |

First Class Conferencing Facilitation:

Joseph Jourekian, Email: [jjourekian@firstclassfacilitation.ca](mailto:jjourekian@firstclassfacilitation.ca)

## Appendix 6 cont'd.: Final Agenda of the IAC Hearing

Independent Assessment Committee Hearing

Ontario Nurses' Association & Southlake Regional Health Centre/Medical Assessment Consultation Unit (MACU)

### Southlake Regional Health Centre Medical Assessment Consultation Centre (SRHC/MACU) & Ontario Nurses Association (ONA) IAC Hearing

#### Final Agenda

Tuesday September 28, 2021

Zoom link: <https://firstclassfacilitation->

[ca.zoom.us/j/65509635128?pwd=WFgrbG5UdUk5bGxXZWg4MFBBrb2xIQ09](https://ca.zoom.us/j/65509635128?pwd=WFgrbG5UdUk5bGxXZWg4MFBBrb2xIQ09)

| 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 | Southlake Regional Health Centre Response to Ontario Nurses' Association Submission   | SRHC               |
| 10:15-10:45 | Break   | All                |
| 10:45-11:45 | Response to questions from: <ul style="list-style-type: none"> <li>Independent Assessment Committee</li> <li>Ontario Nurses' Association</li> <li>Discussion</li> </ul> | IAC, ONA, and SRHC |
| 11:45-12:45 | Lunch Break   | All                |
| 12:45-14:15 | Ontario Nurses' Association Response to Southlake Regional Health Centre Submissions  | ONA                |
| 14:15-14:45 | Break   | All                |
| 14:45-15:45 | Response to questions from: <ul style="list-style-type: none"> <li>Independent Assessment Committee</li> <li>Ontario Nurses' Association</li> <li>Discussion</li> </ul> | IAC/SRHC/ONA       |
| 15:45-16:00 | Review of process for Wednesday September 29, 2021  | IAC Chair          |
| 16:00       | Adjournment   | IAC Chair          |

First Class Conferencing Facilitation:

Joseph Jourekian, Email: [jjourekian@firstclassfacilitation.ca](mailto:jjourekian@firstclassfacilitation.ca)

## Appendix 6 cont'd.: Final Agenda of the IAC Hearing

Independent Assessment Committee Hearing  
Ontario Nurses' Association & Southlake Regional Health Centre/Medical Assessment Consultation Unit (MACU)

**Southlake Regional Health Centre Medical Assessment Consultation Centre (SRHC/MACU)  
& Ontario Nurses Association (ONA) IAC Hearing  
Final Agenda  
Wednesday September 29, 2021**

**Zoom link:** <https://firstclassfacilitation-ca.zoom.us/j/68726949042?pwd=azl3NThqUkRBQjMwS2RyOTJKaWZFdz09>

| 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, ONA and SRHC |
| 10:15-10:45 | Break  | All               |
| 10:45-12:00 | Opportunity for MACU Nurses to make comments   | MACU Nurses       |
| 12:00-12:15 | Closing Remarks ONA  | ONA               |
| 12:15-12:30 | Closing Remarks Southlake  |                   |
| 12:30-1:00  | Closing Remarks and Identification of Next Steps by Chairperson and Closure of Hearing | IAC Chair         |
| 12:30       | Adjournment  | IAC Chair         |

**First Class Conferencing Facilitation:**  
Joseph Jourekian, Email: [jjourekian@firstclassfacilitation.ca](mailto:jjourekian@firstclassfacilitation.ca)

## Appendix 7: IAC SHRC Attendees

### Southlake IAC Attendees

| Name  | Sept 27 | Sept 28 | Sep 29 |
|---|---------|---------|--------|
| Barb Steed, EVP Clinical Programs   | X       | X       | X      |
| Liz Ferguson, VP Clinical Transformation & CNE  | X       | X       | X      |
| Alyson McQueen, Director Medicine Program   | X       | X       | X      |
| Liz <u>Lalingo</u> , Director ED and Mental Health (Interim Director Medicine Program)          | X       | X       | X      |
| Kevin <u>Persaud</u> , Manager MACU   | X       | X       | X      |
| Izabela <u>Smolik</u> , Interim Director Quality, Prof Practice, Pt Experience and Pt Relations | X       | X       | X      |
| Chris <u>Cecchini</u> , VP Employee Experience and CHRO   | X       | X       | X      |
| Tanya <u>Mais</u> , Employee Labour Relations Consultant  | X       | X       | X      |
| Andrew <u>Zabrovsky</u> , Hicks Morley legal  | X       | X       | X      |
| Grant Nuttall, Hick Morley legal  | X       | X       | X      |
| Meredith Weber, RPN MACU  | X       | X       |        |

## Appendix 7 cont'd.: IAC ONA Attendees

### ONA Southlake Regional Health Centre MACU IAC Attendees

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| Name                      | Position  | Sept 27 | Sept 28 | Sept 29 |
|---------------------------|---|---------|---------|---------|
| Danielle Richard          | RN PPS ONA                                      | X       | X       | X       |
| Lorrie Daniels            | RN PPS ONA                                      | X       | X       | X       |
| Kathrine Armenta          | RN PPS ONA                                      | X       | X       | X       |
| Benjamin Ramirez- Jimenez | RN PPS ONA                                      | X       | X       | X       |
| Sandy Paproski            | RN PPS ONA                                      | X       | X       | X       |
| Donna Oliver              | SRHC RN<br>Interim Bargaining<br>Unit President | X       | X       | X       |
| Todd Davis                | SLRO ONA  | X       | X       | X       |
| Kirsten Tamm              | SRHC RN PRW<br>Representative                   | X       | X       | X       |
| Stephanie Blair           | SRHC MACU RN                                    | X       | X       | X       |
| Amanda Rivard             | SRHC MACU RN                                    | X       | X       | X       |
| Alyxa D'andrade           | SRHC MACU RN                                    | X       | X       | X       |
| Jaselyn Espiritu          | SRHC MACU RN                                    | X       | X       |         |
| Susan Delisle Gosse       | RN, PP Manager                                  | X       | X       | X       |
| DJ Sanderson              | RN VP Region 3<br>ONA BOD                       | X       | X       |         |
| Cathryn Hoy               | RN ONA 1 <sup>st</sup> VP                       | X       | X       |         |
| Athena Brown              | Manager, PST                                    |         |         | X       |
| Alison Dover              | ONA Litigator                                   | X       | X       | X       |
| Raji Grewal               | ONA Seconded<br>SLRO                            | X       | X       | X       |
| Andrea Cashman            | RN PPS ONA                                      | X       | X       | X       |

□

## **Appendix 8: Email from the CNE to the Chair in regards to supplemental documentation, September 23, 2021**

**From:** Elizabeth Ferguson <EFerguson@southlakeregional.org>  
**Sent:** September 23, 2021 11:18 AM  
**To:** Claire Mallett <cmallett@yorku.ca>; Susan Kwolek <suskwolek@gmail.com>  
**Subject:** RE: request for clarification

Hello Claire and Susan,

I am writing to follow up on the issue we have addressed below concerning the parties' submissions for the IAC hearing next week. As you are aware, Appendix 8 to the Collective Agreement sets out the IAC guidelines, and provides that all relevant documents, including submissions to be put forward at the hearing, are to be delivered to the Committee and the other party no less than two weeks before the hearing. Additional documentation may be submitted only on approval from the Chair.

In this matter, the Chair had previously set a deadline of September 7th, 2021 for the parties to exchange briefs and documents, which both parties complied with. ONA then requested an opportunity to provide further submissions, and both parties were given until September 17th, 2021 to do so. The Hospital provided the Board and ONA with all of its materials for the hearing, including our submissions/presentation for the hearing, by this deadline, as required by the Collective Agreement. ONA did not provide its presentation materials. To the Hospital's knowledge, ONA has not requested an extension of the September 17<sup>th</sup> deadline, or for a further opportunity to submit documentation or submissions to the Board for our hearing next week, as would be required by the Collective Agreement.

In these circumstances, the Hospital will be objecting to any further presentation materials that ONA may wish to utilize next week, as those materials were not submitted by the deadline set by the Chair. This is a matter of fairness and adherence to the requirements of the Collective Agreement. Should the IAC Panel and the Chair disagree, and should ONA be given the opportunity to submit new materials as part of its presentation next week, the Hospital will be seeking an opportunity to review those materials in full and to gather any necessary responding materials before asking questions of ONA or commencing its presentation. We will likely be seeking an adjournment and an adjustment to the hearing schedule for that purpose.

Sincerely,  
Liz

## **Appendix 9: Email from the Chair to the CNE in Regards to Supplemental Documentation, September 23, 2021**

**From:** Claire Mallette <cmallett@yorku.ca>  
**Sent:** Thursday, September 23, 2021 9:36 PM  
**To:** Elizabeth Ferguson <EFerguson@southlakeregional.org>; Susan Kwolek <suskwolek@gmail.com>  
**Cc:** cgabrielli@cogeco.ca  
**Subject:** Re: request for clarification

Dear Liz

Thank you for your email.

The IAC met to discuss your email and are committed to following the Collective Agreement and conduct the IAC Hearing next week. We are moving forward with the belief 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.

Both parties were asked to submit their briefing documents and additional documents that we requested by September 7, 2021, which you both provided. You were also both treated equally in being given extensions for submissions of supplementary documents that the two parties chose to provide. At no time, did the IAC specify what the supplementary documents should consist of, nor was a presentation requested of either party prior to the IAC hearing.

During the IAC Hearing next week, both ONA and Southlake are to present the information from their submissions on the first day (Sept 27). On day two, both parties will have the opportunity to respond to the presentations and ask questions.

Thank you for submitting your Attendee List. Could you please help the IAC understand the role of Meredith Webster, RPN MACU in the IAC Hearing? In reviewing all of Southlake's documents, there was no indication of issues related to RN-RPN relationship, nor was it identified in the ONA documents. As the IAC is focusing on the RN role, and the RPNs are not part of ONA, we would like to know Ms. Webster's role in the IAC Hearing.

With thanks,  
Claire

## Appendix 10: Email Response from CNE to the Chairs Email September 24, 2021

**From:** Elizabeth Ferguson <EFerguson@southlakeregional.org>  
**Sent:** September 24, 2021 12:15 PM  
**To:** Claire Mallette <cmallett@yorku.ca>; Susan Kwolek <suskwolek@gmail.com>  
**Cc:** cgabrielli@cogeco.ca <cgabrielli@cogeco.ca>  
**Subject:** RE: request for clarification

Hello Claire,  
Thank you for clarifying. Our concern stemmed from your comment:

*ONA has not sent their presentation in their preliminary documents. I anticipate we will only see it on Monday when they do their presentation. We can ask for a copy after they have done their presentation.*

Meredith Weber is our Behavioral Response Nurse that supports MACU and has been invited as an expert resource to support the concerns raised by ONA cited as Issue #4: Violence. Meredith will not be speaking to RN/RPN relationships. Hopefully that answers your question.

Regards,  
Liz