

Independent Assessment Committee Report
Constituted under Article 8.01 of the
Collective Agreement
Between
St. Mary's General Hospital Emergency Department
and
Ontario Nurses' Association

July 16, 2021

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July 16, 2021

Dear Ms. Daniels and Ms. Faulkner,

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 St. Mary's General Hospital 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 Emergency Department at St. Mary's General Hospital.

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 June 1-3, 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 Committee has made seventy-nine (79) recommendations in eleven (11) areas regarding issues that impact the workload of Registered Nurses.

The members of the Independent Assessment Committee unanimously support all recommendations in this Report. The Committee hopes the recommendations will assist the Hospital and the Association, to work together, to find mutually agreeable resolutions with regard to nursing workload issues in the Emergency Department at St. Mary's General Hospital.

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

Yours sincerely,



Ella Ferris RN, MBA
Chairperson, Independent Assessment Committee



Jayne Menard, RN, BSN, MHS, CHE
Nominee for the Hospital



Cindy Gabrielli, RNEC, BScN, MSN
Nominee for the Association

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PART 1: INTRODUCTION

1.1 ORGANIZATION OF THE INDEPENDENT ASSESSMENT COMMITTEE REPORT

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

PART 1 INTRODUCTION

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

PART 2 PRESENTATION OF THE PROFESSIONAL RESPONSIBILITY WORKLOAD COMPLAINT

This section presents the context of practice relating to the Registered Nurses' Professional Workload Complaint in the Emergency Department (ED) at St. Mary's General Hospital (the Hospital); summarizes the relevant history leading to the referral of the Professional Workload Complaint to the IAC; and reviews the presentations by the Ontario Nurses' Association (the Association), and the Hospital at the Hearing.

PART 2 DISCUSSION, ANALYSIS AND RECOMMENDATIONS

PART 4 CONCLUSION AND SUMMARY OF RECOMMENDATIONS

PART 5 APPENDICES

Supporting data, including the Submissions and Exhibits of the Ontario Nurses' Association and St. Mary's General Hospital are on file with both parties.

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

The nurses in the ED at the Hospital started to report their concerns related to professional responsibility and workload issues in May 2018. In January 2019 and throughout 2019, an increasing number of PRWRs were being completed and by May 2021 a total of 219 PRWRs had been completed and signed by ED nurses, with no resolution by management.

The Association states in their Brief that "two hundred and nineteen Professional Responsibility Workload Report Forms have been submitted. Noteworthy is the fact that, managements responses repeatedly state that the RN staff have not engaged in the problem-solving process at page 4 of the PRWR form, indicating this step was not followed in at least 42 PRWR responses. Further comments recommending areas that staff should consider in their problem-solving (82) times or the suggestion that problem-solving, and critical thinking are strongly recommended (at least a dozen times). The remainder of the management responses, reiterate the shift details and census, or describes why management were unable to fill a vacancy, sick leave, or long-term absences etc. Responsibility for resolution is shifted to the staff with direction to

problem-solve, when it is management that has the responsibility for operational decision-making, quality of care and patient safety.”¹

The Hospital's position as stated in their Brief, is that the nurses are not following the Collective Agreement when completing the PRWRF. “Where nurses believe that workload issues are preventing them from meeting patient care standards, the most important thing is to address those issues in a timely manner so that patient care standards can be met. There have been cases where Workload Forms are completed and submitted even when the Resource Nurse or ED Management are available and have not been consulted or given opportunity to reallocate resources within the ED.”²

In summary, the nurses documentation on the PRWRFs reflects the following concerns and issues related to insufficient baseline staffing, lack of replacement staff, excessive wait times for patient assessment and care, delays and backlogs at Triage, inability to apply the College of Nurses (CNO) Three Factor Framework to assist Registered Practical Nurses (RPNs), as required, due to the RNs own heavy workload assignments, delays in transfer to bed for admitted patients, insufficient education related to orientation and mentorship, and lack of essential equipment and supplies.

In a letter dated December 18, 2020, Ms. Lorrie Daniels, Professional Practice Specialist, ONA, advised Ms. Leisa Faulkner, Vice President, Patient Services and Chief Nursing Executive (Acting) that despite the Hospital and the Association regularly meeting until July 2020, prior to discussions breaking down, and a six month opportunity for the Hospital to resolve the issues, there remains a lack of effective communication and leadership support to indicate that the concerns expressed by the ED Nurses remain unresolved. Therefore, the matter will proceed to an IAC with Ella Ferris as Chair and Cindy Gabrielli as ONA's Nominee.

“The RNs in the Emergency Department have documented that the current practice, patient care and workload environment does not allow them to meet the College of Nurses of Ontario (CNO) standards; and they believe they are being asked to perform more work than is consistent with proper patient care. Effective supports have not been provided to respond to patient acuity and volumes, fluctuating workloads, fluctuating staffing and professional practice issues.”³

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 St. Mary's General Hospital (Expiry June 7, 2021) as stated below:⁴

¹ ONA Submission, Volume 1-Brief, p. 16, May 11, 2021

² SMGH Submission, Brief p. 16, May 10, 2021

³ Letter from Association to St. Mary's General Hospital, December 18, 2020

⁴ Hospital ONA Central Collective Agreement, Expiry June 7, 2021

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.

- 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.

The IAC's jurisdiction thus relates to whether Registered Nurses are being requested and/or required to assume more work than is consistent with the provision of proper patient care. Workload is influenced by both direct factors (e.g., nurse-patient ratio, patient acuity/complexity of care requirements, patient volume) and indirect factors (e.g., roles and responsibilities of other care providers, physical environment of practice, standards of practice, and systems of care). The IAC is responsible for examining factors impacting workload and for making recommendations to address workload issues. Concerns outside of workload are beyond the jurisdiction of the IAC.

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

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

The members of the Independent Assessment Committee were:

Chairperson: Ella Ferris

For the Association: Cindy Gabrielli

For St. Mary's General Hospital: Jayne Menard

1.4 Proceedings of the Independent Assessment Committee

1.4.1 Pre-Hearing

On December 18, 2020, the Association notified the Hospital, in a letter, that the Association was forwarding the Professional Responsibility Complaint to an Independent Assessment Committee (IAC).

⁵ Arbitration Hearing Brantford General Hospital and Ontario Nurses' Association, Paula Knopf p. 6 October 6, 1996

The Association also advised that Ella Ferris had accepted the nomination to Chair the IAC and that the Association's Nominee, was Cindy Gabrielli. (Appendix 1).

On February 9, 2021 – IAC members Cindy Gabrielli (ONA Nominee) and Ella Ferris (IAC Chair) had an introductory telephone meeting.

On February 11, 2021, The Chair of the IAC wrote to the Hospital to advise "that since the Hospital had failed to provide the name and contact information of the Hospital Nominee for the IAC, in accordance with the ONA-Hospital Collective Agreement article 8.01 (a) xii, the Hearing will proceed on the following dates of Tuesday June 1st, Wednesday June 2nd and Thursday June 3rd, 2021."⁶ (Appendix 2)

On February 18, 2021, legal counsel for the Hospital advised the IAC Chair that Ms. Leisa Faulkner, Vice President of Patient Services and Chief Nursing Executive was not able to attend, the dates indicated in the Chair's February 11, 2021 letter, due to another pre-scheduled matter which could not be rescheduled. The Hospital was requesting that the IAC Hearing matter be rescheduled. Counsel also advised that the Hospital would send confirmation of the Hospital's Nominee as soon as possible. (Appendix 3)

On February 19, 2021, the Chair responded to counsel's letter stating that she understood that the Hospital was not available on June 1, 2, & 3, 2021 due to previous commitments. Further, the Chair requested that the Hospital name their Nominee as soon as possible so that the IAC Chair could work with all parties to confirm a mutually agreeable date. (Appendix 4)

The same day, February 19, 2021, the IAC Chair received a letter from the Association advising that "Article 8.01 of the ONA-Hospital Collective Agreement was amended in the last round of central bargaining to address situations where one party fails to meet its obligations with respect to the IAC process, with respect to establishing the membership of an Independent Assessment Committee (IAC)."⁷ Further, the Association advised that since the Hospital has failed to meet the required timeline to appoint a nominee to the IAC, within the 30-day requirement, decisions already made cannot be undone. Therefore, the Hearing ought to proceed and start on June 1, 2021. The Association acknowledged in their letter that SMGH can appoint a Nominee today or any day until the IAC Hearing begins on June 1, 2021. (Appendix 5)

On February 23, 2021 – IAC Members Cindy Gabrielli and Ella Ferris had a telephone meeting to discuss the IAC Data Request to St. Mary's General Hospital

On March 1, 2021, The IAC Chair responded to the Association's February 19, 2021 letter, copying the Hospital's legal counsel, stating, "You have expressed concern that in failing to appoint the Hospital IAC nominee, St. Mary's General Hospital (SMGH) has failed to comply with the requirements of Article 8.01 and that allowing the Hospital to alter the ability of the IAC to proceed, as planned, results in undermining the change outlined during the last round of Hospital-ONA bargaining."⁸ The Chair advised in this letter that she would advise the Hospital that the Hearing will proceed as scheduled on June 1, 2, & 3, 2021. (Appendix 6)

On March 4, 2021, the IAC Chair wrote to the Hospital legal counsel advising that the IAC Hearing would proceed on June 1, 2, & 3, 2021. In this letter the Chair also requested that the Hospital send a list of

⁶ Letter from IAC Chair to SMGH, February 11, 2021

⁷ Letter from ONA to IAC Chair, February 19, 2021

⁸ Letter from IAC Chair to ONA, March 1, 2021

documents by May 4, 2021, to assist the IAC in conducting its work including our analysis, deliberations, and recommendations. The IAC Chair also requested that the Hospital appoint their Nominee as soon as possible in order that the IAC could plan the next steps in preparing for the IAC Hearing. (Appendix 7)

On March 11, 2021, the IAC Chair received a letter from the Hospital's legal counsel advising that Jayne Menard had been appointed as the Hospital IAC nominee. (Appendix 8)

On March 18, 2021, IAC Members Jayne Menard (Hospital Nominee) and Chair, Ella Ferris held an Introductory Zoom Meeting to discuss the current status and progress to date on the SMGHED-ONA file. Post Zoom Meeting the Chair provided the Hospital Nominee with all relevant documentation to date.

On March 22, 2021, the IAC Chair received an email notification from the Hospital's legal counsel's office that the Hospital would be available for the IAC Hearing scheduled for June 1, 2, & 3, 2021. (Appendix 9)

On March 25, 2021, in a letter to the Hospital's legal counsel, the IAC Chair acknowledged receipt of the March 22, 2021 email confirming the Hospital's attendance at the Hearing on June 1, 2, & 3, 2021. The IAC Chair also requested that the Hospital submit their Brief Submission to the IAC, electronically, no later than May 10, 2021. The IAC Chair advised that in accordance with the IAC Guidelines, ONA's Brief would be shared with the Hospital and the Hospital's Brief shared with ONA and both submissions shared with members of the IAC, in compliance with the role of the IAC Chairperson. (Appendix 10)

On April 6, 2021, The IAC met via Zoom Meeting and discussed the following:

- Introductions
- Overview of SMGHED – ONA Process to date and the IAC Hearing scheduled for June 1, 2, & 3, 2021
- Data Request to the Hospital due on May 4, 2021

On May 1, 2021, the IAC Chair was notified by letter that the Hospital was working diligently on the documentation due on May 4, 2021, however, the Hospital IT system had not been functioning properly since April 22, 2021, greatly hampering the Hospital's ability to gather the documentation. Further, if the Hospital IT system could not be fixed the Hospital advised that they may not be able to meet the May 4, 2021 deadline, however, the Hospital advised that they would send all documentation that had been gathered as of May 4, 2021. (Appendix 11)

On May 2, 2021, the IAC Chair sent an acknowledgement letter in response to the concerns regarding possible delay in receiving the IAC data request due on May 4, 2021. Further, the Chair advised the Hospital that the Brief due on May 10, 2021, is unique and distinct from the data request due on May 4, 2021. (Appendix 12)

On May 4, 2021, the IAC received all data as per our request dated March 4, 2021.

On May 10, 2021, The Hospital Brief Submission was received and shared with ONA and the IAC members.

On May 10, 2021, The ONA Brief submission was delayed briefly due to technical issues, however, was received on May 11, 2021 at 0200 hours. The IAC Chair shared ONA's Submission with the Hospital and the IAC on May 11, 2021.

On May 20, 2021, the IAC met via Zoom Meeting to discuss:

- The Agenda for each day of the Three-Day Hearing
- Analysis of the Hospital Data Request (Document Production) submission received May 4, 2021
- Outstanding questions and/or concerns requiring clarification

On May 24, 2021, Legal counsel for the Hospital sent the Association a letter requesting that ONA provide the data source for a list of statements in the ONA Brief Submission. (Appendix 13)

On May 25, 2021, the IAC Chair sent an email to legal counsel for the Hospital to advise that ONA would provide references at the Hearing. (Appendix 14)

On May 26, 2021, the IAC met via Zoom Meeting to discuss:

- Analysis of Hospital Brief Submission
- Analysis of ONA Brief Submission
- Process for the Hearing to be facilitated by a third party

On May 27, 2021, the final Agenda for Hearings to be held June 1, 2, & 3, 2021, were sent via email to the Hospital, ONA, and IAC members. (Appendix 15)

On June 1, 2021, in the evening on the first day of the IAC Hearing, ONA provided, via email, a response to the Hospital's request for the data sources in ONA's Brief Submission. (Appendix 16)

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. The Hearing convened at 0830 on June 1, 2021.

The Hearing was held over three days:

Tuesday June 1, 2021: 0830 - 1615 hours

Wednesday June 2, 2021: 0830 - 1630 hours

Thursday June 3, 2021: 0900 – 1400 hours

Participants and observers on the respective Hearing dates are listed in (Appendix 17). The Hospital participants remained the same over all three days; the Association observers and participants changed daily due to schedules as reflected in Appendix 17.

Hearing Day One: Tuesday June 1, 2021

The Chair opened the Hearing at 0830 with a welcome and thanked everyone for their commitment to the IAC process and for setting aside three days to attend the Hearing. She thanked the Hospital for their thorough response to the IAC's Data Request and the Hospital and ONA for their detailed Brief Submissions. The Chair also stated that the IAC hopes that all attendees can participate fully in all aspects of the Hearing; however, the IAC does understand that these are unusual and unprecedented

times and that if some attendees were called out unexpectedly, on an urgent matter due to COVID, that the Committee would, with respect, understand and accept this urgent absence.

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

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

The Ground Rules were communicated as follows:

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

The next item on the Agenda was the viewing of a Virtual Tour Video of the Hospital's Emergency Department, previously produced by the Hospital and lead by Ms. Wendy James, Program Manager Emergency Department and Erin Ariss, RN in the Emergency Department, and the President ONA, Local 55. The IAC Panel and the Association asked questions related to the Virtual Tour which were answered by Ms. James and Ms. Ariss.

After a break, Ms. Lorrie Daniels, Professional Practice Specialist, presented on behalf of the Association. The Association's presentation was based on their written Pre-Hearing Brief submission and the supporting Exhibits as well as a summary of the 219 Professional Responsibility Workload Report Forms (PRWRFs), from May 2018 to May 2021 submitted by the Registered Nurses in the Emergency Department. During the presentation, the Association reaffirmed their position that the themes of staffing levels/skill mix, missed, incorrect or rationed care, inadequate education, shortage of equipment, violence and safety concerns, inadequate and inappropriate management communication and responses to the issues raised leading to a toxic work environment and low morale among the nurses. The Association highlighted that these issues continue to occur, without appropriate management action, despite the nurses continued documentation of their workload concerns and their inability to meet the College of Nurses of Ontario (CNO) standards.

ONA responded to clarification questions from the IAC Panel and the Hospital.

After a lunch break, Ms. Leisa Faulkner, Vice President, Patient Services and Chief Nursing Executive, presented on behalf of the Hospital. The Hospital presentation was based on their Pre-Hearing Brief

Submission and their Document Productions (Data Request) Submission. The presentation summarized some key facts about the Hospital, including quality and performance metrics including pay for performance and pay for results metrics, staffing models in the Emergency Department and staffing resources available to assist the nurses. Regarding the PRWRFs the Hospital indicated that they have recorded 165 versus ONA's count of 219. The Hospital reported a 26% decrease in Emergency visits from 2017/18 to 2020/21. Ms. Faulkner discussed the Education/Quality Orientation/Mentorship Approach and Educational supports including the Educator's role. The Hospital acknowledged the leadership turnover in Program Manager, Assistant Manager and Educator roles throughout the last three years; however, the current Manager has been in her role since December 2018. The Hospital expressed concern about the impact on leadership morale and supports a third-party culture assessment of the ED. The Hospital also acknowledged that they recognize that violence prevention is a priority and Senior Management has secured funding and approved the next steps in the implementation of a GPS Wireless Security Alarm System.

"The Hospital believes that the Parties have now addressed the issues related to the Emergency Department and to have either implemented or are implementing the resources and procedures necessary to provide workload consistent with proper patient care requirements using current resources".⁹

After a short break, the IAC Panel and the Association asked clarification questions. During this session, the Association was able to confirm that the discrepancy in the number of PRWRFs is because ONA's reporting period was May 2018 to May 2021 while the Hospital reporting period was only from January 2019 to January 15, 2021. ONA was presenting on three years of PRWRFs while the Hospital was counting only two years of PRWRFs.

Before adjourning, the IAC Chair provided an overview of the Agenda for Day Two and advised that the Hearing on Day Three would adjourn at 1300 hours rather than at noon as previously scheduled. The Chair adjourned the Hearing at 1615 hours.

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

Hearing Day Two: Wednesday June 2, 2021

The IAC Chair opened the Hearing at 0830 hours welcoming everyone back and reviewed the Ground Rules as there were new ONA participants. New ONA attendees introduced themselves. All Hospital participants were the same as the previous day.

Ms. Faulkner provided the Hospital's response to the Association's submission and reaffirmed the position of the Hospital. The Hospital participants responded to questions from the IAC Panel and the Association. After a lunch break, Ms. Daniels provided the Association's response to the Hospital's submission and responded to questions from the IAC Panel and the Hospital. The IAC Panel and participants from both parties participated appropriately in the discussions following the presentations.

⁹ SMGH Brief, Executive Summary, p. 3, May 10, 2021

The IAC Chair thanked everyone for their participation and reviewed the process for Day Three of the Hearing and adjourned the meeting at 1630 hours.

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

Thursday June 3, 2021

The IAC Chair opened the Hearing at 0900 hours, reviewed the Ground Rules and welcomed everyone to the third and final Hearing Day. New ONA participants were present and were invited to introduce themselves. All the participants for the Hospital were the same as on the previous days.

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

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

Ms. Daniels and Ms. Faulkner were invited to provide closing remarks on behalf of the Association and the Hospital, respectively.

The IAC Chair concluded the Hearing by thanking Cindy Gabrielli, the Association Nominee and Jayne Menard, the Hospital Nominee; as well as thanking all the participants for their commitment to the Hearing process and for their active and open discussions during the proceedings. The IAC Chair also communicated the hope that the opportunity for open and transparent discussion during the Hearing and the recommendations in the final IAC Report will enable both parties to move forward together to seek resolution of the outstanding issues. The Chair advised that the IAC Report will be distributed by July 18, 2021, to be in compliance with the 45-day requirement as outlined in the Collective Agreement.

The IAC Chair closed the Hearing at 1400 hours.

1.4.3 Post-Hearing

At the close of the Hearing, the IAC met via Zoom and had extensive discussion about themes related to issues identified and determined priority areas requiring recommendations; We met via Zoom on June 19, 2021, to discuss the first draft of the IAC Report and any required edits. We met via Zoom, on July 5, 2021, to discuss, make revisions and share comments on the second draft of the Report. We reviewed draft three of the Report via email and recirculated draft four of the Report on July 14, 2021, for final comments. All members of the IAC contributed to the final version of the IAC Report. The Final Report was submitted to the Association and the Hospital on Friday, July 16, 2021.

PART 2: PRESENTATION OF THE PROFESSIONAL RESPONSIBILITY WORKLOAD COMPLAINT

2.1 Information on St. Mary's General Hospital

St. Mary's General Hospital is an acute-care facility within the Waterloo Wellington Local Health Integration Network (WWLHIN). The WWLHIN serves approximately 775,000 residents in Waterloo Region, Wellington County, and the southern part of Grey County.¹⁰

"St. Mary's General Hospital is funded for 147 beds and has been consistently staffing and operating an average of 192 with an increase in capacity to surge up to 200 beds during COVID-19 Pandemic response planning. The Hospital has nearly 2000 physicians, staff and volunteers providing excellent, compassionate care to hundreds of thousands of patients and families every year".¹¹ It is the second-largest acute care hospital in the St. Joseph's Health System.

St. Mary's has five areas of clinical focus as follows:

- Cardiac Care (Regional Cardiac Centre)
- Respiriology Care (Level 1 Thoracic Surgery Centre)
- Outpatient Day Surgery
- General Medicine
- 24/7 Emergency Services

There are approximately 600 Registered Nurses at the Hospital, and they are represented by the ONA and are bound by the Hospital ONA Central Collective Agreement and the Local Agreement.

"St. Mary's patient demographic is changing, with a growing senior's community over the age of 75, and a population that is demonstrating greater cardiac care needs, with increasing complexity. The cardiac care needs have evolved significantly, and the patients' ages and demographics make those needs much more complicated. The Waterloo Region, including Kitchener has the 8th highest proportion of immigrants which is the third highest outside the Greater Toronto Area. Research indicates that certain immigration categories, such as refugees, are more often affected than others with certain chronic conditions and disabilities."¹²

2.2 Emergency Department Physical Layout¹³ and Current Staffing for Each Area

St. Mary's Emergency Department is a full-service department, open 24 hours a day, 7 days a week with an average of 150 people seen and treated daily. The Emergency Department was renovated in 2004, to the current space adding 29 stretcher locations and 3 resuscitation rooms, as well as the Ambulatory Care Area with 9 care spaces, and an updated waiting room.

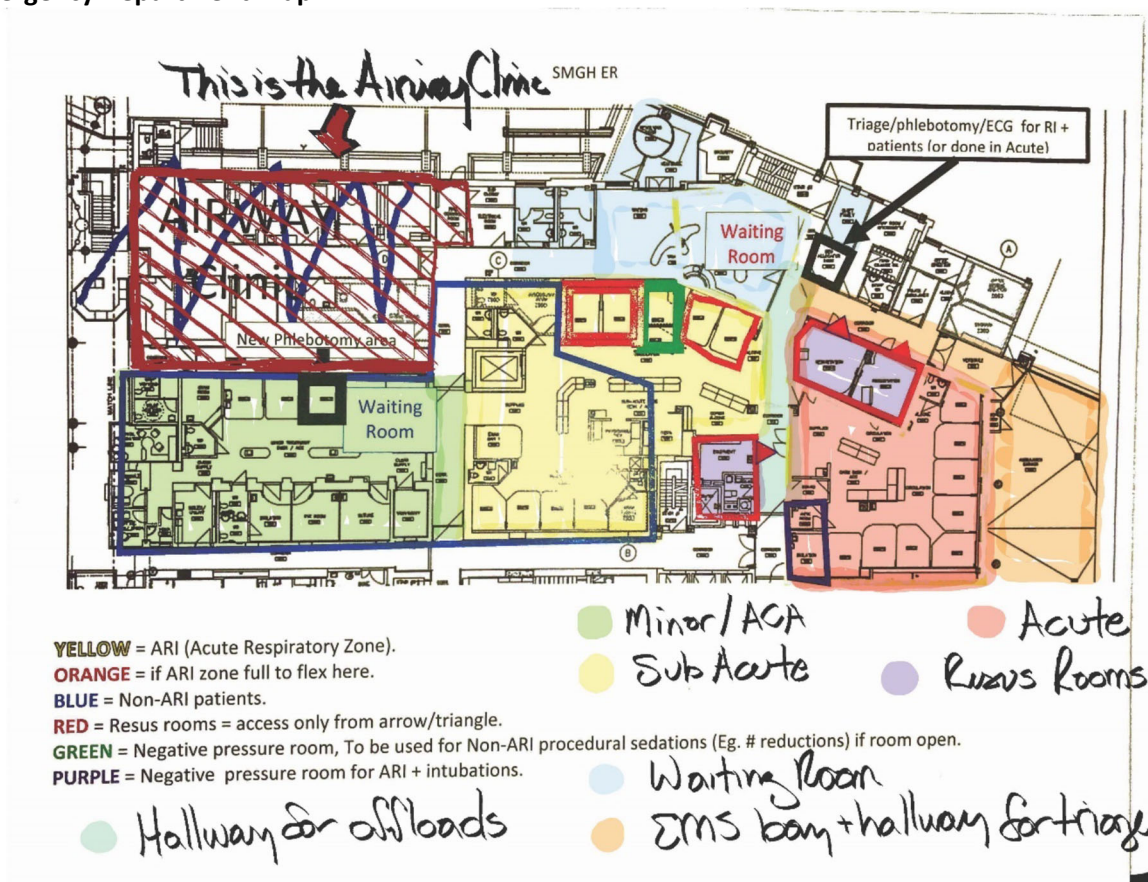
¹⁰ ONA Submission, Volume 1-Brief, p. 4, May 11, 2021, Population and Immigration
https://www.regionofwaterloo.ca/en/regional-government/resources/Reports-Plans-Data/Public-Health-and-Emergency-Services/WR_ImmigrationProfile_2019.pdf

¹¹ SMGH Submission, Brief, p. 9, May 10, 2021

¹² ONA Submission, Volume 1-Brief, p. 4, May 11, 2021, <https://www.smgh.ca/st-marys-needs-third-cardiac-catheterization-suite-for-safe-and-timely-response-to-growing-demand-for-life-saving-services/Youtube/DrMcNamara>

¹³ ONA Submission, Volume 1-Brief, SMGH Submission, Brief and Virtual Tour (Hearing), June 1, 2021

Emergency Department Map



"The Emergency Department is divided into various designated care areas, as highlight in differing colours in the above map. The legend provides an explanation of the layout as identified by the different coloured areas."¹⁴

Triage

The Triage area is in the middle of the blue waiting room area. It is the semicircle marking directly above the dark green (negative pressure room) outlined in subacute. It is surrounded by the waiting area, also highlighted in blue. The purpose of Triage is to gather enough information to make a clinical judgment for priority of care; it is a sorting process performed by a qualified RN to rapidly assess patients upon their arrival to the ED. Triage is performed according to Canadian Triage and Acuity Scales (CTAS). CTAS is a provincially mandated system used by all Emergency Departments in Ontario. The triage RN utilizes a standardized set of guidelines – the CTAS – to assess severity of presenting issue(s) by considering presenting complaint and any modifiers such as vital signs or comorbidities. An electronic triage assessment tool, eCTAS, is used to input patient information gathered during the triage process. The patient is accordingly assigned a triage category or score.

The Hospital has two triage assessment areas. The first located in the hallway that connects the ambulance garage with the ED and also serves as an entrance to the Hospital for patients arriving by ambulance. The second triage area is located at the main ED entrance and is comprised of two triage

¹⁴ ONA Submission, Volume 1-Brief, p. 7, May 11, 2021

stations, a registration area, and the main waiting room. The Security Office is located just inside the door, in the entrance foyer; and a screener station was added by the entry door inside the Department in March of 2020 as part of the COVID-19 pandemic response strategy.

There is one RN assigned to triage 24/7 who is responsible to triage all ambulatory incoming patients as well as to oversee and observe all patients in the waiting area, to maintain CTAS guidelines for reassessment of all patients under their care. The Resource Nurse or a delegate is assigned to triage the ambulance patients.

The area outlined in bold black in the upper right area of the map, adjacent to the EMS hallways and labelled with a black arrow and just to the left of the 'Waiting Room' sign indicated with a title in red font, is the ECG and Lab room.

"After completing the triage process, the Triage Nurse prints and applies an armband on the patient and will initiate applicable Medical Directives based on the patient's presenting complaint. Patients are prioritized for physician assessment primarily by urgency as indicated by triage score and then by time of arrival. Triage Nurses are in frequent communication with other members of the team, for example when a patient needs to be seen more urgently. If space is not readily available, patients wait in the waiting room and should be reassessed by the Triage Nurse according to CTAS guidelines until they can flow to the appropriate area/zone in the Department. Additionally, patients are instructed to alert the Triage Nurse if their condition changes as recommended in the Canadian Triage and Acuity Scale Education Manual for patients in the waiting room. Patients are assigned to an appropriate location for access to treatment within the Department. When a patient presents who requires emergency or urgent intervention, or their condition deteriorates before triage is complete or being assigned a bed, they are placed in any available space for treatment until an alternate option is available. The Triage Nurse can use the overhead paging system when immediate help is required and/or advises the Resource Nurse.

Patients arriving by ambulance are directed to the assigned bed and registration is performed by a Communication Clerk. If no bed is immediately available, the patient and paramedic crew are put on offload delay until a space can be created or is available, or, depending on individual patient factors, can wait in the waiting room. Nurses assigned to Triage have specific additional education, orientation, and/or experience."¹⁵

Acute Care (AC) Area

The coral identifies the Acute Care (AC) area. The Acute Care area (AC) is comprised of 12 patient care spaces, including three resuscitation (resus) rooms (outlined in red), 8 curtained bays, and one negative pressure room. All beds are monitored. Two of the resus rooms are directly accessible from both the connecting hallway from the ambulance garage and have doors directly connecting to the AC area from the other end of the room (i.e., two doors to the rooms); and the third resus room is a few meters away. All resus rooms have sliding opaque glass doors, resus 3 has a second, smaller door that connects it from the hallway between AC and the Subacute area. Three RNs are assigned to AC 24/7.

Pre-COVID-19 pandemic (before March 26, 2020)

¹⁵ SMGH Submission, Document Production (Data Request), pgs. 12-13, May 4, 2021

This area is designated for unstable, critically ill patients (CTAS 1-3) and includes 3 resuscitation rooms (outlined in red). These are Resus 1, Fractures/lacerations (frac/lac) and Resus 3 which are used for CTAS 1 and sometimes CTAS 2 patients, difficult fractures, and suturing. Prior to COVID this was the area where patients with the most acute care needs were assigned. In response to COVID-19, Resus 1 and Resus 2 were retrofitted with hoarding and negative pressure systems so that they could be used to cohort patients presenting with symptoms consistent with acute respiratory illness. Resus 3 houses the Broselow cart that contains pediatric resuscitation equipment and supplies and is the room of choice for high acuity pediatric patients.

The pale orange area is where EMS brings patients in from the ambulance bay. The Resource RN triages the patient in the second red triangle arrow, off the resus room in that hallway. The EMS then moves around the corner to the light green hallway with the patient. There can be up to four stretchers in the offload area at one time. One RN is assigned from 1100 to 2300 hours to provide care in this area. The offload RN is funded by the Region of Waterloo Paramedics Services.

"Patients with higher acuity illness are assigned to the AC area.

- CTAS Level 1 patients are at immediate risk of deterioration and require immediate, aggressive interventions. Examples of patients requiring resuscitation include but are not limited to vital signs absent (VSA), cardiac arrest, respiratory arrest, major trauma (shock), severe respiratory distress, and altered level of consciousness or unconscious.
- CTAS Level 2 patients are considered emergent, presenting with conditions that are a potential threat to life, limb or function, requiring rapid medical intervention by physician or medical directive because they are at risk for rapid deterioration. Examples include but are not limited to moderate respiratory distress, hypertension, altered level of consciousness, and chest pain.
- CTAS Level 3 patients are considered urgent, presenting with conditions that could potentially progress to a serious problem requiring emergency intervention. Vital signs are usually normal or at the upper and lower ends of the normal range. Examples include but are not limited to mild respiratory distress, hypertension with no symptoms, moderate abdominal pain, nausea/vomiting (mild dehydration). These patients have a clear potential for deterioration.

COVID-19 pandemic response (since March 26, 2020)

In response to the COVID-19 pandemic, flow through the ED was adjusted to create an area to cohort patients presenting with symptoms consistent with acute respiratory illness (ARI)/COVID-19. ED staff, Infection Prevention and Control, and Health and Safety were engaged in developing the Pandemic Response Plan. Resus rooms 1 and 2 were retrofitted with hoarding and negative pressure systems. The air handling system in Resus 3 was adjusted to create relative negative pressure. All three resus rooms had anterooms created using hoarding. The hoarding was refreshed as needed throughout the first and second pandemic waves and was replaced in April 2021. Resus rooms can be used for any patient, regardless of whether they meet the case definition for ARI/COVID-19. An additional crash cart with resuscitation drugs (similar to resus 1) was purchased and added to resus 2; an airway cart was added by Respiratory Therapy.

All patients assigned to AC require droplet/contact precautions. The result of the cohorting is that acuity of patients in the area vary on a continual basis depending on the patients presenting who meet the case definition for ARI/COVID-19, and AC may not have the highest acuity patients as was the norm pre-COVID-19.”¹⁶

NOTE: The nurses have expressed concern that one of the retrofitted rooms does not meet the requirement of a negative pressure room as the door does not close properly to create the required seal.

Subacute Care (SAC) Area

The pale-yellow area is designated the Subacute Care Area (SAC). Subacute is a 12-bay area with cardiac monitoring capabilities at each bay and includes a negative pressure room and 4 hallway beds (EMS Offload). The goal is to empty the unconventional hallway beds before 2300 as the offload nurse responsible for those patients is scheduled until 2300 hours. If these beds are not empty the nurses assigned to SAC take on this assignment in addition to their SAC assignment. CTAS Level 2,3,4, & 5 patients can be assigned at anytime to SAC if the decision has been made to close the Ambulatory Care Area. Generally, these are patients who are unwell and not independently mobile. This area is for admitted patients or more acute patients awaiting further investigations. Subacute is staffed with three nurses, either three RNs or two RNs and one RPN 24/7.

Pre-COVID-19 pandemic (before March 26, 2020)

In general, patients assessed to be a lower acuity/more stable CTAS Level 2 or 3 or a higher acuity CTAS Level 4 could be assigned to SAC.

COVID-19 pandemic response (since March 26, 2020)

All CTAS Level 2 and Level 3, and potentially higher acuity Level 4, who do not meet case definition for ARI/COVID-19 are assigned to SAC. The result is a potential increased acuity compared to pre-COVID-19 norm in SAC.

Ambulatory Care Area (ACA) or Minor Treatment (MT)

The pale green Ambulatory Care Area (ACA) or Minor Treatment (MT) as it is also called, has 9 patient care spaces, consisting of three rooms and six stretchers and is intended for patients who are independently mobile, requiring interventions that are in keeping with “treat and street”. One stretcher is a specialized gynecological stretcher; another room has a slit lamp for eye exams. There is also a waiting room where patients wait to be seen and can await test results. These patients waiting are the responsibility of the one nurse assigned to ACA. It is expected that physician assessments of CTAS Level 4 or Level 5 are generally assigned here. This area however can hold upwards of 15 to 40 patients. One nurse, either an RN or an RPN is assigned daily, but only from 0700 hours to 0200 hours.

“Patients assigned to the ACA area are typically CTAS level 4 or 5

¹⁶ SMGH Submission, Document Production (Data Request), pgs. 13-15, May 4, 2021

- CTAS level 4 patients are considered less urgent and have conditions that relate to patient age, distress, or potential for deterioration that would benefit from intervention or reassurance within one to two hours. Examples of level 4 patients include but are not limited to chronic confusion, ear ache, minor trauma, urinary tract infection symptoms, or moderate pain.
- CTAS level 5 patients are considered non-urgent and have conditions that may be acute but non-urgent as well as conditions which may be part of a chronic problem with or without deterioration. The investigation or interventions for some of these illnesses or injuries could be delayed or even referred to other areas of the health care system such as a primary care practitioner. Examples of level 5 patients include but are not limited to minor trauma, sore throat, or medication requests. Nurse Practitioners also work in the ACA area to assess and initiate interventions on appropriate patients.”¹⁷

“The Emergency Department (ED) is a dynamic care environment in which the team is required to make accurate and timely assessments for patients presenting with a broad spectrum of symptoms and injuries. The nature of ED Nursing is unpredictable and episodic. This has been identified in past IACs involving EDs.”¹⁸

The Emergency Nurses Association states, “The scope of emergency nursing practice involves assessment, analysis, nursing diagnosis, outcome identification, planning, implementation of interventions, and evaluation of human responses to perceived actual or potential sudden, urgent, physical or psychological problems that are primarily episodic or acute and which occur in a variety of settings. These may require minimal care to life-support measures; patient, family, and other significant education; appropriate referral and discharge planning; and knowledge of legal implications. Emergency nursing practice includes the provision of care that ranges from birth, death, injury prevention, women’s health, and life and limb-saving measures.”¹⁹

The Emergency Nurses of Ontario states, “As a primary care practitioner, the Emergency Nurse is a visible community resource both in terms of health care delivery and health teaching. Emergency Nursing is the nursing care of a constantly changing variety of clients, who present with health problems which are undiagnosed from both a nursing and medical perspective. The environment is unique in terms of the fluctuating volume of clients, the variety of health problems and the dynamic nature of client activity, and the unscheduled and unpredictable manner in which clients arrive.”²⁰

2.3 Major Changes Impacting the ED Since September 2019

“Cerner Implementation at SMGH

SMGH changed health information system platform and implemented Cerner Health Information System beginning November 3, 2019; the Go-Live period and support model continued until December 15, 2019. In order to provide staff at elbow support, the organization employed a team approach for superusers and all levels of leadership. The ED Manager, Assistant Manager, and interim educator

¹⁷ SMGH Submission, Document Production (Data Request), p. 17, May 4, 2021

¹⁸ SMGH Submission, Brief, p. 10, May 10, 2021.

¹⁹ Emergency Nurses Association (ENA) Emergency Nursing Scope of Practice www.ena.org

²⁰ Emergency Nurses Association of Ontario (ENAO) What is Emergency Nursing www.enaon.ca

worked 12-hour rotating shifts to provide 24/7 coverage, at the same time allowing for a reduced schedule for other hospital activities and functions that were not considered essential.

Technology

Installation of two additional wall mounted cardiac monitors in SA in October 2019 so that each bed space has a stationary monitor. Two portable or "roving" monitors were also received at the same time, increasing the number of portable monitors to three. The roving monitors have Wi-Fi capability, allowing cardiac rhythms to be pulled to the central station in AC and SA. All monitors can perform 12-lead ECGs. There was a software upgrade for monitors (ST Review) in November 2019.

FT RN Scheduling

On September 30, 2019, staff were informed individually for those impacted, and then the entire group, regarding issue with the continental lines on the schedule at the time. Specifically, RNs working those lines were missing a shift every six weeks for full time hours. It was also noted at the time that the two day/two night lines were unevenly distributed. On October 30, 2019, the full time (FT) new line selection process was started. The first schedule with new line selection for FT was posted in January 2020.

Department maintenance and repairs

Minor maintenance and repair projects often require short term adjustments to patient flow in the ED. These occurrences are timed and planned to minimize impact on departmental functions, and are communicated with the team through posted signage, email, and verbally. The project that had the most impact on ED was X-raying and coring the concrete slab that sits above ED in order for construction and installation to continue on the new Heart Rhythm suite. This required that the subacute and ambulatory care areas of the ED be closed and empty of people. A collaborative approach was taken to create a robust plan to run ED out of the Acute Care Area and Airway Clinic, and with Endoscopy set up as a SA-type area for patients who needed longer for their assessment. ED Leadership and staff, Health and Safety (H & S), Engineering, Pharmacy, Infection Prevention and Control (IPAC), and Managers for areas being used were all involved in the planning.

Pandemic response

On March 11, 2020, the World Health Organization declared a COVID-19 Pandemic. In response to the pandemic, usual ED patient flow was adjusted to incorporate infection prevention and control measures into departmental operations. ED staff, IPAC, H & S, Engineering and ED Leadership were involved in the planning." The Hospital, like all Hospitals in Ontario had to create and adapt Pandemic Plans through the first wave, the interwave, recovery, and second wave."²¹

The IAC understands that all of the above changes have put a major strain on the Hospital's management team and on all staff resources while managing the usual day to day patient care requirements. However, in the Hospital setting, safe, quality patient care must always be the first priority. The IAC believes that effective leadership of the front-line nurses is always critical to the delivery of safe, quality patient care, and especially during times of rapid change such as implementing new electronic documentation systems and responding to unprecedented health care demands such as COVID-19. Nursing leadership must find a balance between implementing and managing essential corporate priorities and responding to internal and external conditions, while at the same time, providing supportive, transformational leadership and maintaining safe, quality patient care.

²¹ SMGH Submission, Document Production (Data Request), pgs. 42-44, May 4, 2021

2.4 Patient Volumes ²²

PATIENT INFORMATION FOR THE EMERGENCY DEPARTMENT (ITEM 1)

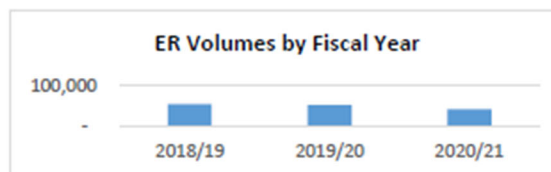
Patient Demographic data is instrumental in emergency department management and resource planning.

A) Volumes

Emergency Department visits have decreased by 23% from 2018/19 to 2020/21. When comparing all three (3) fiscal years' visits by weekday, Monday shows as the highest number of visits for each fiscal year. Saturday shows the lowest number of visits for each fiscal year. When comparing all three (3) fiscal years visits by hour of the day, 11:00 a.m. shows as the highest peak.

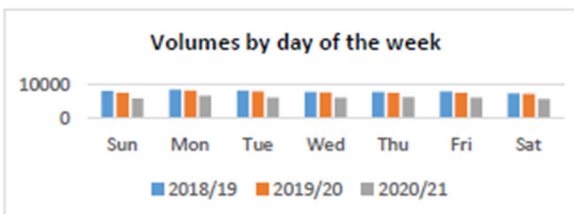
Volumes by Fiscal Year

	2018/19	2019/20	2020/21
Volume	54,833	52,919	42,433

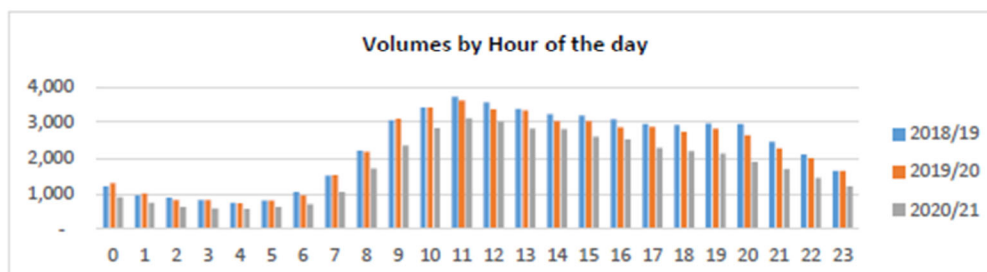


Volumes by day of the week

	2018/19	2019/20	2020/21
Sun	7910	7464	5811
Mon	8363	8170	6604
Tue	8095	7854	6100
Wed	7732	7541	6096
Thu	7666	7361	6132
Fri	7810	7359	5990
Sat	7257	7170	5700



(Refer to Appendix 1 to view 'Volumes by Hour' data)



²² SMGH Submission, Document Production (Data Request), P. 2, May 4, 2021

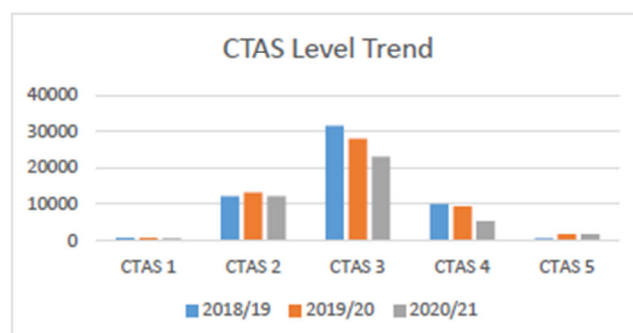
2.5 Distribution by Canadian Triage and Acuity Scale (CTAS) ²³

B) Distribution by CTAS level

The Canadian Triage and Acuity Scale (CTAS) is a tool that enables Emergency Departments (ED) to: prioritize patient care and access requirements, examine patient flow and care processes, complement other workload, case mix, and resource requirement measures. CTAS supports ED nurses and physicians to triage patients according to acuity, risk, and care needs based on their presenting signs and symptoms, ensure that the sickest and highest risk patients are seen first when ED capacity has been exceeded and reassess patients when required to wait for a treatment space. ED Leadership regularly reviews and analyzes ED patient visits based on volume, acuity and by CEDIS presenting complaint. This review aids in the ongoing development of an operational plan to ensure resources are available/scheduled at peak times as informed by trending.

With the decrease in ED yearly volume as demonstrated in A) CTAS volumes correspondingly have decreased. CTAS Levels 1-4 have had a noticeable decrease year over year however CTAS 5 volumes have increased. CTAS 5 are the less acute/Non urgent population. A review of data also demonstrates that Monday has the highest presentation of all CTAS which corresponds with volume.

	2018/19	2019/20	2020/21
CTAS 1	684	697	481
CTAS 2	12,175	13,235	12,132
CTAS 3	31,436	27,977	22,966
CTAS 4	10,012	9,382	5,202
CTAS 5	526	1,628	1,652



²³ SMGH Submission, Document Production (Data Request), p. 3, May 4, 2021

As illustrated in the Patient Volumes chart above, the Hospital provided good information related to patient volumes year over year from 2018/19 to 2020/21, including the number of visits each day of the week and each hour of the day. Volumes each day are fairly consistent, with an increase on Mondays and Tuesdays. Volumes by hour of the day indicate that patient visits from midnight to approximately 0700 hours are less, and the volumes start to increase at 0800/0900 hours and steadily increase into the evening before starting to decrease again at 2100 hours. There was a decrease in patient volumes in 2020/21, at the Hospital. This was a trend seen in all hospitals across Ontario, due to COVID-19.

The second chart, Distribution by Canadian Triage and Acuity Scale (CTAS), identifies the trend over three years related to the number of CTAS level patients from 1 to 5. Chart two shows the CTAS trends since 2018/19 which shows a decrease in CTAS 1 to 4 and an increase in CTAS 5.

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

"The Professional Responsibility and Workload (PRW) process was developed to assist Registered Nurses (RNs) through the difficult and often stressful process of raising and resolving issues related to professional practice, patient acuity, fluctuating workloads, and fluctuating staffing, and resolving these concerns in a timely and effective manner."²⁴ The PRW process is meant to promote safe and best possible patient care and also to protect the ONA member who may identify that patients and staff may be at risk because of improper staffing, skill mix, practice, and workload issues.

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

The Collective Agreement specifies the process for documenting these issues in writing on the PRWRF, and thus implementing a process that facilitates employers to work with ONA and its members to mutually resolve issues in the best interest of safe, ethical, and proper patient care.

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

²⁴ ONA Submission, Volume 1 - Brief and PRWRF Tracking Report, p. 9, May 11, 2021

"The College of Nurses of Ontario practice standards outline the expectations for nurses that contribute to public protection. They inform nurses of their accountabilities and the public of what to expect of nurses. The standards apply to all nurses regardless of their role, job description or area of practice."²⁵

The nurses in the ED at the Hospital started to report their concerns related to professional responsibility and workload issues in May 2018. In January 2019 and throughout 2019, an increasing number of PRWRs were being completed and by May 2021 a total of 219 PRWRs had been completed and signed by ED nurses, with no resolution by management.

The Association states in their Brief that "two hundred and nineteen Professional Responsibility Workload Report Forms have been submitted. Noteworthy is the fact that, managements responses repeatedly state that the RN staff have not engaged in the problem-solving process at page 4 of the PRWR form, indicating this step was not followed in at least 42 PRWR responses. Further comments recommending areas that staff should consider in their problem-solving (82) times or the suggestion that problem-solving, and critical thinking are strongly recommended (at least a dozen times). The remainder of the management responses, reiterate the shift details and census, or describes why management were unable to fill a vacancy, sick leave, or long-term absences etc. Responsibility for resolution is shifted to the staff with direction to problem-solve, when it is management that has the responsibility for operational decision-making, quality of care and patient safety."²⁶

The Association's position as stated in their Brief, is that "This request for a review of professional practice, patient acuity, fluctuating workload and fluctuating staffing arises out of article 8 of the current Collective Agreement between the parties; and the College of Nurse (CNO) accountability for Registered Nurses (RNs) to report practice concerns to their employer so that the employer can attempt to resolve the concerns, (CNO: Professional Practice Standards, Revised 2002).²⁷ At the Hearing, the Association communicated that there is no requirement for a nurse to advise management that they will be completing a PRWR.

Missed care was a patient safety concern reported multiple times by the ED nurses on the PRWRs over the three-year period.

Missed Care Source: PRWRs as per ONA's Hearing Presentation June 1, 2021²⁸

- Unable to provide Care in a timely manner – 194 times
- Unable to document in a timely manner – 55 times
- Unable to Assess and/or Reassess in a timely manner – 83 times
- Unable to move a patient to an inpatient bed – 121 times
- Missed Orders - 8 times
- Medication – 7 times
- Laboratory Values – 21 times
- Physician Orders – 26 times
- Assessment of Vital Signs – 3 times
- Supporting Novice Learners – 149 times

²⁵ College of Nurses of Ontario, <https://www.cno.org/en/learn-about-standards-guidlelines/standards-and-guidelines/>

²⁶ ONA Submission, Volume 1-Brief, p. 16, May 11, 2021

²⁷ ONA Submission, Volume 1 – Brief, p. 10, May 11, 2021

²⁸ Missed Care Source, ONA Hearing Presentation, June 1, 2021

The Hospital's position as stated in their Brief, is that the nurses are not following the Collective Agreement when completing the PRWRF. "Where nurses believe that workload issues are preventing them from meeting patient care standards, the most important thing is to address those issues in a timely manner so that patient care standards can be met. There have been cases where Workload Forms are completed and submitted even when the Resource Nurse or ED Management are available and have not been consulted or given opportunity to reallocate resources within the ED."²⁹

Further the Hospital stated in its Brief Submission, "The Hospital believes that the Parties have now addressed the issues related to the Emergency Department and to have either implemented or are implementing the resources and procedures necessary to provide workload consistent with proper patient care requirements using current resources".³⁰

In summary, the nurses documentation on the PRWRFs reflects the following concerns and issues related to insufficient baseline staffing, lack of replacement staff, excessive wait times for patient assessment and care, delays and backlogs at Triage, inability to apply the College of Nurses (CNO) Three Factor Framework to assist Registered Practical Nurses (RPNs), as required, due to the RNs own heavy workload assignments, and delays in transfer to bed for admitted patients, insufficient education related to orientation and mentorship and lack of essential equipment and supplies.

The Hospital Association Committee (HAC) meetings are a good forum for the parties to engage in discussion of issues, including workload, and to seek common resolutions. The Association and the Hospital were meeting monthly through 2018, 2019 and until February 2020, when meetings were put on hold due to COVID-19. Since early 2019, the Hospital and the Association agreed to utilize one day a month to deal with HAC and grievances. The Chief Nursing Executive and the Directors attended the HAC portion to discuss workload before the grievance meeting. The meetings were deemed nonproductive by the Association as no progress toward resolution on matters related to staffing, workload, and equipment were achieved. The Hospital expressed the view that the base staffing in the ED was adequate and that concerns of missed care could be managed effectively through increased teamwork.

The Bargaining Unit President and Service Labour Relations Officer (SLRO) attended five HAC meetings to discuss the workload and practice issues being raised by RNs in the ED, on January 11, February 8, March 8, April 12, and June 14, 2019. Failing resolution of the identified issues at these meetings, the ONA Professional Practice Specialist (ONA PPS) became involved. The first meeting with the ONA PPS was held on September 17, 2019 and a subsequent meeting on October 23, 2019. At the October meeting the Hospital stated that they were not available to meet until January 2020, due to Hospital-wide priority of implementing the PRISM Computer documentation project.³¹

Meetings began again in January 2020, however, after ten meetings held over eighteen months, with no action toward resolution, communication broke down after the last meeting held on July 16, 2020. The Hospital provided a copy of the "St. Mary's General Hospital (SMGH) – Emergency Department (ER) Items to Resolve Workload Issues" including Workload (patient safety/staffing levels, lack of role clarity, inappropriate reassignment of ER staff), Environment (insufficient resources to support clients placed in Offload), Education (lack of coaching and mentoring), Communication (lack of leadership and support),

²⁹ SMGH Submission, Brief p. 16, May 10, 2021

³⁰ SMGH Brief, Executive Summary, p. 3, May 10, 2021

³¹ ONA Submission, Volume 1 – Brief, pgs. 12-16, May 11, 2021

Staff morale, Equipment (lack of adequate and up to date equipment), Public Safety/Professional Regulation (Professional and Practice Standards), which indicated that no agreement had been made on the items of concern.³²

Part 3: DISCUSSION, ANALYSIS AND RECOMMENDATIONS

3.1 Hospital Admissions “No Bed Admit” Patients Held in the Emergency Department

The Hospital ED is open 24/7 and emergency visits occur on a regular basis. The admission rate, through the ED, in 2020/2021 was 11.8%. This rate of admission is an increase from 10.1% in 2018/19 and 10.4% in 2019/20.³³

Once a decision to admit has been made there are many factors that affect time to bed, including Hospital occupancy levels, inpatient bed availability, organizational patient flow and discharge practices. The table below outlines the average number of hours from decision to admit to time patient left the ED.

2018/19	2019/20	2020/21
26.3 hours	26.2 hours	20.4 hours

In 2020/21 the average length of stay in the ED, after decision to admit, was 20.4 hours. Emergency departments do not function like inpatient units, and it is challenging for nurses to provide the appropriate level of care for admitted patients in the ED environment. Patients remain on a stretcher for several hours. They may not be able to walk about freely and maintain effective mobilization. Washroom facilities are shared by several patients and the busy ED activity makes it difficult for patients to rest. Nurses who are expected to respond to a constant flow of emergency patients, with unpredictable care needs, are expected to manage the routine orders and care of the admitted patient. Understandably, the COVID-19 Pandemic has made things more challenging for admitted ED patients and the nurses who care for them.

Admitted patients in the ED create back up patient flow within the Department. Emergency patients are waiting in the main waiting room or the ACA waiting area as there are no available stretchers for incoming ED patients awaiting assessment by the physician or nurse practitioner. The Pandemic has made this more difficult due to the safety requirements to follow isolation/public health guidelines. With the onset of the Pandemic, the admission to the ED had fallen in-line with the decreased patient volumes, however, no bed admits remains a challenge, as documented in many PRWRFs. The chart below illustrates the number of patients admitted with no bed available, by month, over the last three years.³⁴

Number of Admits No Beds at Midnight (Hospital Census)												
Year	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
2018/19	241	202	261	233	180	175	255	155	193	237	182	255
2019/20	192	199	220	160	146	247	235	272	297	364	364	178
2020/21	72	148	154	145	169	111	122	164	132	160	203	229

³² SMGH Submission, Brief, Tab 1, pgs. 1-38, May 10, 2021

³³ SMGH Submission, Document Production (Data Request), p. 6, May 4, 2021

³⁴ SMGH Submission, Document Production (Data Request), p. 7, May 4, 2021

"Too many seriously ill patients have to wait more than three hours to see an emergency doctor. And too many admitted patients have to wait more than a day lying on a stretcher in an emergency department cubicle, or in a hallway, waiting for an inpatient bed to become available. Many would say even one patient is too many to be waiting in a hallway for so long.

Whatever the cause, waits in emergency for an inpatient bed are major contributors to the emergency department overcrowding that can affect the care of all patients. The consequences can include poor quality of care, increased morbidity and mortality, and increased risk of errors by overworked and overstressed medical and (*nursing*) staff.

As well, because they usually have to occupy a bed in emergency while they wait, sometimes for many hours, admitted patients may impede access to emergency beds, doctors, nurses and other resources for other patients still waiting for care. A lack of available inpatient beds for patients from emergency may be linked to many possible factors. For example, a hospital may simply not have enough beds to meet the needs of the growing community it is serving; inefficient inpatient bed management may lead to patients not moving in and out of hospital wards as quickly as possible; or inefficient housekeeping practices may mean inpatient beds are not readied for the next patient quickly enough."³⁵

The IAC understands that not all admissions wait in the ED for several hours, however, an average wait of 20.4 hours means that some patients are waiting longer than 20.4 hours while some are waiting less. It was clear on the workload forms and during the Hearing that the workload of nurses in the ED is significantly and negatively impacted by the presence of no bed admit patients held in the ED. Further, the nurses expressed concern with their inability to provide safe, quality care to the admitted patients while responding in a timely and effective manner to the care needs of incoming ED patients.

The IAC is aware the Hospital has a detailed surge policy for the entire Hospital. It was stated at the Hearing and provided in the Hospital's submission that there is a bed management program and staff with the responsibility to manage patient flow. It was also noted that, at times, when the ED nurses called for assistance, the Clinical on Call was able to help facilitate patient flow, although there were many times when patient movement from the ED was not possible despite efforts made.

The Hospital submission highlighted that there is a Flow Committee, however, the IAC did not receive or hear any evidence of recommendations, or any actions taken by the Hospital to develop an active bed management policy, to mitigate the impact on patients and nurses when there is a high volume of no bed admits in the ED. An effective strategy to make patient flow everyone's responsibility is a constant requirement, and every effort must be made to manage all inpatient beds to coordinate and match ED admissions. Those responsible for bed management must facilitate timely transfer from the ED to inpatient beds and must be working with inpatient units to ensure timely discharges. "A strategy to actively manage hospital beds has been associated with decreased ED LOS and fewer hours on ambulance diversion."³⁶

³⁵ Health Quality Ontario, Under Pressure: Emergency department performance in Ontario, 2016

³⁶ Barrett L, Ford S, Ward-Smith P, et al. A bed management strategy for overcrowding in the emergency department. *Nursing Economic\$*. 2012; pgs. 82-85, Volume30, Issue 2

The IAC Recommends:

1. Starting immediately, the resource nurse attend and participate in the daily bed flow meetings to report on the number of patients waiting in ED for a bed and any potential admissions.
2. Staff continue to page 'nurse required' when in a crisis for short-term patient care support.
3. The Hospital develop a policy, within three months, that would allow for the assignment of a medical nurse to the ED to care for admitted medical patients when there are five (5) medical no bed admissions and no anticipated beds for the next twelve (12) hours. The Resource Nurse to determine when it is necessary to activate this policy based on workload in the ED and the Department's ability to provide safe, quality care to other Emergency patients.
4. The Hospital develop a policy, within three months, that would allow for the assignment of a critical care nurse to the ED, from the admitting ICU, to care for the patient if there is no ICU bed available. The Resource Nurse to determine when it is necessary to activate this policy based on the workload in the ED and the Department's ability to provide safe, quality patient care to other Emergency patients.
5. The policy developed states the Resource Nurse has the authority to call in an ED RN, without consultation with the Clinical on Call as follows:
 - a. when a medical nurse or ICU nurse is not available;
 - b. if an RN is not available a RPN to be called in;
 - c. if no ED nurse available call the Clinical on Call to facilitate a nurse reassignment from within the Hospital.

This Policy to be evaluated in six months with input from Management, the Association, and the Resource Nurses.

6. The Hospital review the current status of the Flow Committee including Terms of Reference and mandate and within three (3) months develop a best practice bed management policy with a corporate commitment to make ED admit no bed patients a priority.

3.2 Human Resources Planning and Registered Nurse Staffing

3.2.1 Data Related to Number of RNs working in 24 Hours at Comparator Hospitals

On Day Two of the Hearing the Hospital presented Data from an informal process, they conducted, to understand staffing models at Hospital comparators with the following results:

"St. Mary's General Hospital – 57,000 visits

- RN/RPN Days 8 RN's 1 RPN
- RN/RPN Nights 7 RN 1 RPN
- RN swing shifts - RN 09–21, 11-23, 14–02
- Lab Support - 1030-2200
- Porters – Days -2, Nights-2, 1400-0200 - 1

Guelph General Hospital – 62,000 visits

- RN/RPN - Days 9 RN's 1 RPN
- RN/RPN - Nights 7 RN 1 RPN
- RN swing shifts - RN 09–21, 10-22, 18–06
- RPN Swing Shift – 0830-2030, 11-23
- Lab Support - 10-18
- Attendant – stocks supplies, assists in portering

Cambridge Memorial Hospital – 52,000 visits

- RN – Days/ Nights – 8
- RN Swing shifts – 09-21, 11-23 x 2
- No dedicated lab support

Grand River Hospital 67,000 visits

- RN/RPN - Days 11 RN's 2 RPN
- RN/RPN - Nights 11 RN 1 RPN
- RN swing shifts - RN 0930–2130, 11-23 x 2
- Lab Support - 24/7 Porter 1000-2200

Highlights

- Staffing aligned with partners when looking at volumes. It is important to note these volumes are approximate.
- SMGH has increased lab support and porter support compared to Guelph and Cambridge.³⁷

Although the Hospital states that their staffing complement aligned with that of their chosen comparators, the IAC observed, based on the data provided that all hospitals have more nurses, in a 24 hour period, than SMGH as follows:

Guelph General Hospital

- 1 additional RN on days
- 2 RPN swing shifts

Cambridge Memorial Hospital

- 1 additional RN on nights

Grand River Hospital

- 3 additional RNs on days
- 1 additional RPN on days
- 4 additional RNs on nights

The Association also provided information related to hospital comparators looking at hours of care per patient visit as shown in the chart below.³⁸ “At St. Mary's General Hospital in a 24 hour period there are an average 1.6 nursing hours per patient per visit. St. Mary's daily baseline staffing based on 12 hour tours, is 8 RNs on Days and 7 RNs on Nights and 3 “Swing” shifts. St. Mary's provincial comparators based on the above notes criteria volumes, CTAS distribution and Cath Lab status, included University

³⁷ SMGH Power Point Presentation, Hearing Day Two, Slides 15-17, June 2, 2021

³⁸ ONA Submission, Supplemental Information, p. 145, May 25, 2021

Health Network – Toronto General Site who are staffed with 13 RNs on both Day and Night shifts as well as 3 “Swing” shifts. Windsor Regional is the second hospital comparator which ONA was able to secure staffing data for both the Metropolitan and the Quellerie Sites and their staffing at the Met Campus is 11 RNs on Day and Night shifts with 3 “Swing” shifts, and at the Quellerie Campus is 13 RNs on Days and 12 RNs on Nights, with 2 “Swing” shifts.”³⁹

In each comparison, St. Mary's General Hospital staff is well below the comparator hospitals with higher volumes over 5 years than all the comparators, except UHN-TGH in 2019, based on Ontario Health reported ED volumes and CTAS distribution.

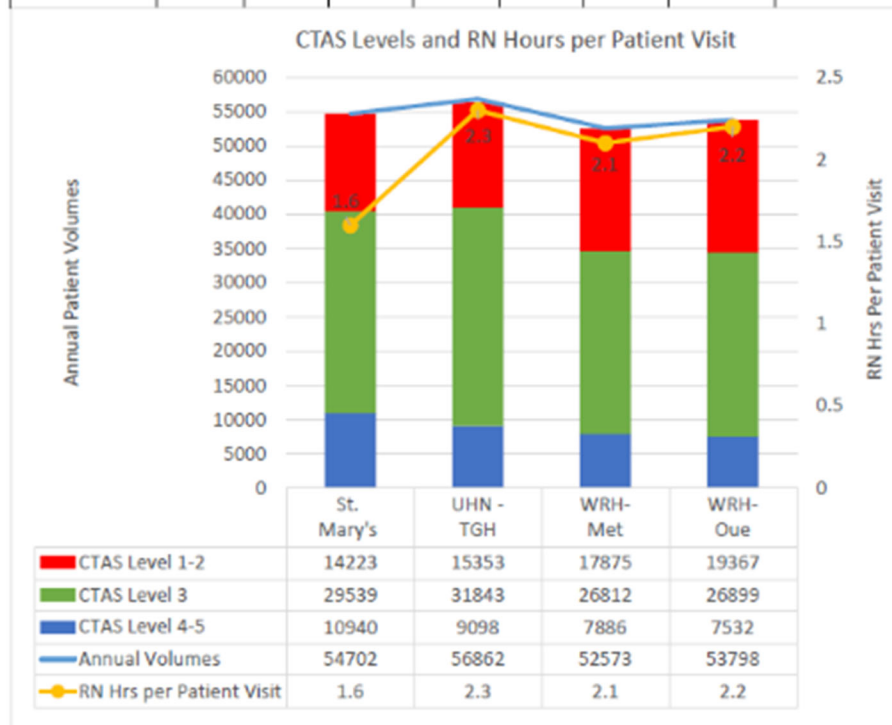
During the Hearing, the Hospital stated that they did not believe that the hospital comparators selected by the Association were comparable hospitals, in particular the Toronto General Hospital Site at University Health Network (TGH-UHN). The IAC observed that excluding TGH-UHN, did not alter the fact that all other comparator hospitals have more nursing staff in a 24 hour period and they all provided more RN hours of care, per Emergency patient visit, than at SMGH. The IAC believes that the best comparator may be Grand River Hospital (GRH) as this hospital serves the same geographic patient population and provides primary, secondary, and tertiary levels of care. Grand River Hospital provides 24/7 Emergency Department care, and areas of clinical services are Critical Care, Medicine, Renal, Stroke, General Surgery and it is a Regional Cancer Centre. SMGH provides 24/7 Emergency Department care and is a Regional Cardiac Centre, Respiriology Care Centre including Level 1 Thoracic Surgery and has a focus on Medicine and Outpatient Day Surgery. Both SMGH and GRH provide clinical programs that rely heavily on a highly functioning, efficient ED staffed with skilled and knowledgeable health care professionals, which includes Registered Nurses who are the first line of care for each Emergency patient.

³⁹ ONA Submission, Supplemental Information, p. 146, May 25, 2021

Hospital Comparators of Similar Volumes, Acuity and Like Patient Populations

(ie. Each Comparator Site has a Cardiac Cath Lab)

Hospital	Total Annual ED Visits	CTAS 1 (% of total visits)	CTAS 2 (% of total visits)	CTAS 3 (% of total visits)	CTAS 4 (% of total visits)	CTAS 5 (% of total visits)	# Visits per 24 Hrs	Total Nursing Hours per Patient Visit
St. Mary's General Hospital	54702	1	25	54	18	2	150	1.6
Toronto General Hospital	56862	1	26	56	15	1	156	2.3
Windsor Metropolitan Site	52573	1	33	51	11	4	144	2.1
Windsor Ouellette Site	53798	1.4	35	49	12	2.3	147	2.2



3.2.2 Staffing Related Information

St. Mary's Emergency Department (ED) is staffed with both Registered Nurses (RNs) and Registered Practical Nurses (RPNs). The RN and RPN staffing Model of Care is based on a daily baseline of 8 RNs and 1 RPN on the day shift and 7 RNs and 1 RPN on the night shift. There are also 3 RN swing shifts, a 0900 to 2100 hours RN Float, an 1100 to 2300 hours EMS Offload RN which is funded through Ministry Pay for Performance (P4R) and the Region of Waterloo Paramedic Services, and a 1400 to 0200 hours RN Float. In addition, there are 3 Nurse Practitioners (NPs), 1 shared with Thoracic Surgical Program, with a Respiriology Specialty and works between the ED and the Airway clinic. Two full-time NPs are scheduled in the Minor Treatment (MT) or Ambulatory Care Area (ACA), one scheduled daily for 12 hours. The NPs role is conducting assessments, consultation, and health teaching; the role does not include direct nursing care interventions. NPs do not have access or permissions to document nursing care

interventions in the Cerner electronic documentation system. There are also two Geriatric Emergency Medicine (GEM) nurses working in the ED with one scheduled from 0700 to 1900 daily. The nursing team is supported by Attendants and Communication Clerks.

As outlined above the Hospital and the Association disagree on the appropriate staffing to provide safe, quality patient care in the ED. The Hospital stated clearly in the Pre-Hearing submissions to the IAC and at the Hearing that the ED has adequate staff to provide safe, quality care. The Association in its Pre-Hearing submission to the IAC and in its presentations at the Hearing are clear that more RNs are needed in the ED to provide safe, quality patient care. ONA's recommendation is the addition of 4 RNs on day shift and 4 RNs on night shift, bringing the day RN complement to 12 RNs and the night RN complement to 11 RNs. ONA recommends that the three swing shifts remain unchanged.

The goal within the ED is a primary model of care, however, assignment of patients from triage is based on available space and geographic area regardless of the category of nurse assigned to that space. This leads to high acuity patients frequently being designated to care spaces being managed by an RPN, without ability to appropriately assess and consider assignments.

After careful consideration and review of all the staffing related information received, in particular the comparator data, and the information documented in the 219 PRWRFs, the IAC determined that there is an urgent need to address the concerns and frustration of the nurses due to the fluctuating staffing complement and fluctuating patient volumes and patient acuity. The IAC believes these gaps in care negatively impact patient care and demonstrate that the current staffing complement is inadequate for the ED nurses to meet safe, quality standards of care, as they are being asked to perform more work than is consistent with proper care.

The IAC believes that safe, quality patient care can only be achieved in a more stable and predictable work environment with a focus on a quality practice setting. As described by both statements cited previously from the Emergency Nurses Association (ENA) and Emergency Nursing Association of Ontario (ENAO), the Emergency Nurse works in an environment that is constantly changing minute to minute. Patients present with a range of undiagnosed symptoms and the nursing team available must be prepared to quickly assess and provide safe, quality care to patients requiring minimal care to those requiring acute life-saving care.

This study by MacPhee et al. (2017) had relevance as the IAC reviewed the 219 PRWRFs and was considered in our staffing recommendations. The study used the Holden et al. human factors framework to conceptualize workload and examine the impact on patient and nurse outcomes. In this study, unit-level workload factors included nurse reported patient-RN ratios, patient acuity, and patient dependency; job-level workload factors included nurses' perceptions of heavy workload, nursing tasks left undone and compromised professionals standards due to workload; and task-level workload factors included the frequency of interruptions to workflow. The authors found heavy workload at all three levels was associated with adverse patient outcomes, such as patient falls and urinary tract infections, and negative nurse outcomes, such as job satisfaction and emotional exhaustion.

"A significant finding from our study was that the strongest predictor of both nurse outcomes (i.e., emotional exhaustion and job satisfaction) was compromised professional nursing standards due to workload."⁴⁰

Nursing is a caring profession built upon nurse-patient relationships. When nursing is reduced to "task and time" mechanistic approaches to care delivery, nurses suffer from emotional and moral distress. Compromised nursing standards are a source of emotional distress and moral distress, with deeper ethical roots. "...moral distress occurs when the internal environment of nurses—their values and perceived obligations—are incompatible with the needs and prevailing views of the external work environment."⁴¹ "Outcomes from emotional and moral distress include emotional exhaustion/burnout, job dissatisfaction and eventual exit from the profession. Epstein and Delgado recommended that administrators engage nurses in discussions around values conflicts, while Pendry advocated for informal team discussions and formal ethics committees."⁴²

Due to the unpredictable nature of nursing care requirements in the ED and the consistent concerns the IAC heard from the nurses, in both the PRWRFs and the presentations made on Day Three of the Hearings, expressing their inability to provide safe, quality care and to meet the CNO standards; the IAC believes that the current ED staffing, at the Hospital, is inadequate to meet the clinical care requirements of patients coming to the ED. The ED must be staffed to safely care for the highest volume of patients with the highest acuity care needs and not be staffed based on data and statistics that look at average caseloads and average CTAS levels only. While this does mean that the Department may, at times, appear to be overstaffed, this is the cost of running a highly effective ED where all patients, at all times, can feel confident that there will be a trained nurse ready to care for them and to ensure safe, quality care always. On those shifts when patient volumes are such that nurses do not have a full patient assignment, this is the time that the RNs can do their on-line education and required skills upgrading or review new policies and procedures or posted communications from management.

3.2.3 Full Time Equivalents

The ED has 48.7 budgeted full-time RN equivalents (FTEs) in 2020/21, however, the Hospital reports that the actual expenditures for the past four years has been 47.5 FTEs, 50.6 FTEs, 50.5 FTEs, 50.4 FTEs as indicated in the table below.⁴³

Of note the actual expenses include overtime hours as well as orientation shifts which means some of the paid hours are non-productive hours as it relates to actual nursing care hours provided.

⁴⁰ MacPhee, M., Dahinten S. V, and Havael, F., The Impact of Nursing Perceived Nurse Workloads on Patient and Nurse Outcomes. Administrative Sciences, Volume 7, Issue 1.

⁴¹ Epstein, E.G.; Delgado, S. Understanding and addressing morale distress, Online J. Issues, Nurs. 2010, 15. [Google Scholar] [CrossRef]

⁴² MacPhee, M., Dahinten S. V, and Havael, F., The Impact of Nursing Perceived Nurse Workloads on Patient and Nurse Outcomes. Administrative Sciences, Volume 7, Issue 1.

⁴³ SMGH Document Production Submission (Data Request), p. 45, May 4, 2021

FULL TIME EQUIVALENTS (FTEs)					
Class	Year	Year	Year	Year	Year
	2017/18 Actual	2018/19 Actual	2019/20 Actual	2020/21 Actual	20/21 Budget
Nurse Practitioner	2.6	2.7	2.7	2.6	2.5
Nurse Manager	1.0	0.6	1.5	1.8	2.0
RN	47.5	50.6	50.5	50.4	48.7
RPN	4.8	4.6	4.7	4.7	4.4
Unregulated	29.6	31.0	29.7	29.5	29.0
Purchased Service	0.1	0.2	0.1	0.0	
Grand Total	85.6	89.6	89.2	89.0	86.6

3.2.4 Headcount

As of May 4, 2021, when the data request was sent by the Hospital to the IAC there were 33 full time (FT) RNs positions, 30 part time (PT) RN positions and 8 casual part time (CPT) RN positions. Based on this information, the current RN FT complement is 46.5% of the total headcount 71 and the complement of PT/CPT is 53.5%. There were 6 RNs on leave of absences (LOA) (5 maternity leaves (MLOA) and one LOA). Five of these leaves were filled with temporary full time (TFT) positions and one is under recruitment. There were 5 PT RNs on LOA (4 MLOA).⁴⁴

Class	Headcount	Headcount	Headcount	Headcount
	Year	Year	Year	Year
	2017/18	2018/19	2019/20	2020/21
Nurse Manager	1	1	2	2
NP	6	5	8	8
RN	69	75	75	71
RPN	8	6	8	9
Porter	14	14	14	15
Unregulated	25	19	22	22
Grand Total	123	120	129	134

"The Ontario Government has pledged to increase the percentage of registered nurses working full-time in Ontario: It's specific commitment is to create a nursing workforce in which 70% of all RNs in Ontario work full-time."⁴⁵ "Secure 70 Per Cent Full-Time Employment for all Nurses Evidence shows that workforce stability, with higher proportions of full-time RN staff, is significantly associated with lower mortality rates, continuity of care and continuity of caregiver, and improved patient behaviours. Conversely, excessive use of part-time and casual employment for RNs has been associated with decreased morale, an unstable workforce where nurses move to other jurisdictions to find full-time work, disengagement among nurses, and lack of continuity of care for patients. RNAO has long campaigned for 70 per cent full-time employment for all nurses. Full-time RNs increased from a low of 50 per cent in 1998 to 65.4 percent in 2009 (65.6 per cent if nurse practitioners are included). This is

⁴⁴ SMGH Document Production Submission (Data Request), p. 46, May 4, 2021

⁴⁵ The 70% Solution: A Progress Report on Increasing Full-time employment for Ontario RNs, RNAO, June 2005

dramatic progress that has resulted in better retention, better quality of patient care, and more people wanting to enter the profession. There is no question that 70 per cent full-time employment for nurses is an achievable target. Certainly, it has been achieved in the US, where the latest federal survey data show that 70.1 per cent of RNs are full-time. RNAO's 2005 survey, The 70 Per Cent Solution, found that the strongest progress in full-time RN employment took place in the hospital sector."⁴⁶

The Government of Ontario has continued its commitment to ensure full time work for Registered Nurses. "The Nursing Graduate Guarantee (NGG) Program is designed to support Registered Nurses and Registered Practical Nurses who are within 12 months of registering with the College of Nurses of Ontario (CNO) by providing them with a full-time employment opportunity. The (NGG) uses the [\(NGG\) Online Portal](#) to link new nurses and employers. Funding is provided to create transition to practice opportunities for new nurses who will lead to full-time employment. The Ministry will provide 20 weeks of funding for each new nurse approved to participate in the (NGG). This includes 12 weeks of funding for the nurse's transition to practice period and 8 weeks of funding to reinvest in existing frontline nurses and their professional development."⁴⁷

When assessing the complement of full time, part time and casual RNs required, it is important that management consider the many factors affecting a nurse's choice to work part time or casual, such as addressing work-life balance, flexibility in scheduling to meet family or other obligations such as academic pursuits or seeking a more supportive work environment. However, it is essential that the number of full time RN positions is adequate to maintain a stable and consistent staffing complement to ensure that scheduling needs can be met if safe, quality care is to be provided at all times.

The IAC Recommends:

1. The ED increase its full time RN complement to a minimum of 70%. This will reduce the need to schedule part time or casual part time nurses above their part time commitment, on a regular basis, to fill the base schedule. This will provide a pool of available staff to fill in short-term and long-term vacancies and will also result in a cost savings as the need for overtime will decrease.
2. The Hospital and Program Manager review and consider accessing the Government Funded Nursing Graduate Guarantee (NGG) Program to assist with recruitment of full time nurses with adequate funding to effectively orientate and transition to the ED practice environment.

3.2.5 Sick Time and Overtime

There has been a significant increase in both sick time and overtime in the last four years for a total FTE complement of 7.2 RN FTEs in 2020/21. In 2017/18 there was 1.9 FTEs in sick time and current year 2020/21 it is up to 3.1 FTEs. An increase of 1.2 FTEs or 63%. This is a total 6,045 paid sick hours or an average of 183 hours per nurse representing 15.3 (12 hour) shifts or 22.9 (8 hour) shifts given that there are 33 FT RNs. In 2017/18 overtime was 1.5 FTEs and in 2020/2021 it is 4.1 FTEs. An increase of 2.6 FTEs or 173%. The Hospital states that there is recognition of the correlation between sick time and overtime and the impact on staff. To that end the Hospital has hired more part time nurses in an effort

⁴⁶ Creating Vibrant Communities: RNAO's Challenge to Ontario's Political Parties, 2011 Provincial Election, Technical Background, January 2010, p.47

⁴⁷ https://.health.gov.on.ca/en/pro/programs/hhrsd/nursing/early_career.aspx

to have staff available to backfill short-term and long-term vacancies. The Hospital is trying to focus on a wellness strategy and has hired an Injury Management Specialist, a Disability Management Specialist, and a Health and Wellness Specialist. "On February 19, 2021, a 45 min wellness session on stress and burnout was facilitated with the ED staff."⁴⁸ Although staff engagement, in the session, was noted to be positive, it was not clear how many nurses participated and if they could leave the clinical environment to attend this session. Further, an analysis as to what is causing this increase in sick time and overtime is required so that the issue can be understood and resolved.

Davey et al. (2009) carried out a systematic review of the explanatory factors of staff absenteeism in health-care facilities in which they identified eight categories of variables, namely: the attendance expected of health-care workers; attitudes to work; intentions to either leave or stay; stress or burnout; the characteristics of management practices; human resources management practices; the demographic behaviours of health-care workers; and work characteristics. The study identified Implications for nursing management: Work environment factors that increase nurses' job satisfaction and reduce burnout and job stress need to be considered in managing staff nurse absenteeism.⁴⁹

Account Type		FTEs	FTEs	FTEs	FTEs
FTE Type	Class	Year	Year	Year	Year
Overtime		2017/18	2018/2019	2019/20	2020/21
	NP	0.0	0.0	0.0	0.0
	Manager	0.0	0.0	0.0	0.1
	RN	1.5	1.9	2.5	4.1
	RPN	0.0	0.0	0.1	0.1
	Unregulated	0.7	1.7	1.5	1.3
Overtime total		2.2	3.6	4.1	5.6
Sick	NP	0.1	0.0	0.1	
	Manager	0.0	0.0	0.1	0.0
	RN	1.9	1.6	2.4	3.1
	RPN				0.0
	Unregulated	0.8	0.8	1.4	1.4
Sick Total		2.8	2.4	3.9	4.5
Grand Total		5.0	6.0	8.0	10.1

The IAC Recommends:

1. The Program Manager work with the Health and Wellness team to hold nurse specific wellness sessions that focus on issues relevant to nurses in the ED.
2. The Program Manager assess the contributing factors to the high sick time and develop a plan to reduce sick time to the 2018/19 level of 1.6 FTE within two years, by September 2023. That will represent 3,120 total paid sick hours, equivalent to 94.6 paid sick hours or 7.9 (12 hour) shifts or 11.8 (8 hour) shifts, per nurse assuming 33 full time nurses.

⁴⁸ SMGH Submission, Document Production (Data Request), p. 47, May 4, 2021

⁴⁹ Davey M.M., Cummings G., Newburn-Cook C.V. & Lo E.A., Predictors of nurse absenteeism in hospitals: a systematic review, Journal of Nursing Journal of Nursing Management, April 2009, Volume 17, issue3, Pgs. 312-30

3. The Program Manager assess the contributing factors to the overtime shifts and develop a plan with a goal to eliminate overtime shifts as a cost reduction strategy and to minimize the need for nurses to work excessive hours by September 2022. This will reduce the stress of nurses feeling that they need to go to work, when called for overtime, to support their colleagues who will work short staffed if they say no to the overtime shift.

3.2.6 Staff Turnover

The Hospital's Perspective

In 2020/21 the ED posted 69 positions. Of the 69 postings the following reasons for the vacancy are:

- 10 represent leaves of absences
- 56 represent a true vacancy (termination, resignation, or retirement)
- 3 represent additional FTEs (1 regular part time; 2 temporary full time)

Appendix 32 in SMGH data submission indicates the RN turnover for 2018 at 12%, 2019 at 9%, 2020 at 15%, and as of March 31, 2021, a three month rate of 8%.⁵⁰ The Hospital stated that all turnover were resignations except for one termination. The Hospital's perspective is that the resignations were to pursue full-time positions elsewhere or resulted from changes in circumstances (for example relocation or completion of higher education). Some of those departed employees returned to SMGH when opportunity arose. The Hospital turnover report captures only the RNs that left the Hospital, not those transferring to part time or casual part time in the ED or those transferring to another department within the Hospital.

The Association's Perspective

ONA's overview of staff turnover presents a different view as it captures any change in an RNs status within the Hospital, as well as those leaving the Hospital. ONA's position is that the staff turnover for RNs in the ED is extremely high and unsustainable and that nurses are leaving the ED because of the heavy workload, unsafe practice environment, and lack of action on behalf of management to address staff concerns. They report that within the last two years 22 of 28 full time nurses have left the ED, either resigning or transferring out, representing 79% turnover rate. Of the 9 leaving the FT ED positions 6 moved to another unit within the Hospital. ONA states that these nurses would come back to the ED if staffing and workload improved. Five RNs transferred from PT to casual PT within the ED.

The IAC believes that regardless of which turnover data we reviewed the turnover rate is high enough to be of concern. While there are many reasons that nurses may leave their jobs such as retirement, to pursue education or another career, or choosing to work in another organization, it is commonly accepted that a high turnover rate can occur when nurses feel unappreciated, dealing with short staffing which leads to heavy workload, and concern about the inability to provide safe, quality care. Whatever the reasons that an RN leaves their position there is an impact on the Hospital both from a quality and financial perspective. Losing an experienced nurse from the ED who is replaced by a novice nurse means that it could be a minimum of two years before that nurse is competent to replace the lost skills, knowledge, and experience of the exiting nurse. This will negatively impact the quality of care, especially

⁵⁰ SMGH Submission, Document Production (Data Request), p. 1100, May 4, 2021

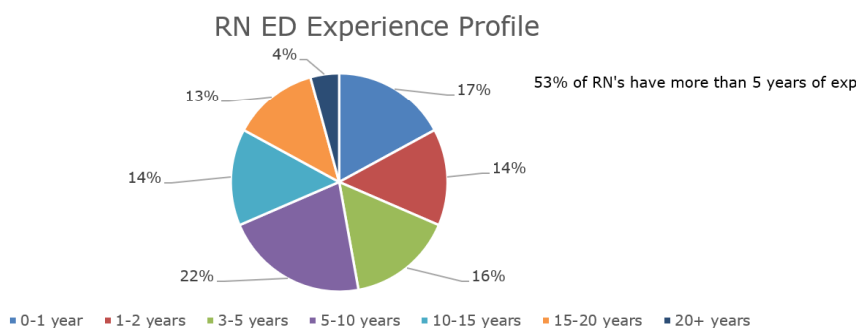
if this novice nurse is one of many to be orientated into a complex under-staffed Department. From a financial position it is very costly to recruit and train a new nurse, especially in a specialty area such as the Emergency Department. The ED requires a stable workforce to consistently deliver safe, quality care and a high turnover compromises the Department's ability to maintain a stable workforce.

The staff turnover in the ED has altered the ED work experience available within the nursing team as illustrated in the chart below.⁵¹ While the chart shows that 52% of nurses have over five (5) years of ED nursing experience, it also illustrates that 31% have less than two (2) years experience and 17% have less than one (1) year experience. Having almost 20% of novice nurses, with one (1) year or less of ED experience, places additional workload pressures and stress on experienced nurses in a busy ED. The experienced nurses may not always be available to support and teach, at the same time as they are carrying a heavy patient assignment, leading to frustration and morale distress. Orientation, education and mentoring of new hires and ongoing professional development is essential for developing a high functioning team of ED nurses. Education recommendations will be addressed in a later section under Education.

RN ED Experience Profile

	0-1 year	1-2 years	3-5 years	5-10 years	10-15	15-20	20+ years
Total RNs	12 (17%)	10 (14%)	11 (16%)	15 (21%)	10 (14%)	9 (13%)	3 (4%)

N = 70 RNs – 2 TFT only, no permanent position) = 68 plus 3 vacancies = 71



⁵¹ SMGH Hearing Presentation Day 1, June 1. 2021

The IAC Recommends:

1. The Program Manager closely monitor the staff turnover to understand what is driving the high turnover in the ED. Once factors have been identified the Program Manager will create a corrective action plan with a goal to reduce turnover rate to 5% by December 2022 and to 3% by July 2023.
2. Every nurse leaving the ED have the opportunity for an exit interview, electronically, if possible, and in person if requested. The exit interview process to be conducted by the Human Resources Department.
3. All nursing leadership from the Chief Nursing Executive, to the Director, to the Program Manager, and to the Assistant Manager will commit to creating a nursing culture which values the nurses and their unique contribution to safe, quality patient care and that leads to nurse's job satisfaction which will support a commitment to stay in their positions.

3.2.7 Recruitment and Retention

One of the factors affecting the workload challenges of the RNs in the ED is the fact that the Department is chronically under-staffed. Whenever there is a full time vacancy due to a resignation or a long-term leave, the part time and casual part time nurses are assigned to fill these schedule lines. This results in the inability to cover short-term vacancies due to sick leave or other unplanned vacancies which has increased the number of shifts nurses are working without a full complement of staff. This adds to the workload of those working the short staffed shift and this has been a contributing factor to the increased PRWRFs.

Historically, the Hospital was able to hire experienced RNs to work in the ED, however, in the current environment all hospitals are challenged to hire sufficient experienced RNs to meet their staffing needs. This is a reality that may be with the healthcare system in Ontario, well into the future. This has resulted in the need to fill vacancies with inexperienced ED nurses. Occasionally new recruits have some medical and/or surgical experience, however, it is more likely that new graduates, with no clinical experience beyond their student days, are available in the recruitment pool.

Despite this challenging reality, the ED Program Manager is responsible to ensure the adequate number of skilled and competent RNs to provide safe, quality care for all patients presenting at the ED. If not addressed in a timely and effective manner, the current issues with nurse shortages and increased workload will lead to more RN sick time, overtime, and turnover. This in turn will lead to the recruitment of novice nurses who will be asked to fulfil duties beyond their skill levels before they are fully orientated and competent. As outlined in many of the PRWRFs this places pressure on experienced nurses, taking them away from their patient assignments and creating a stressful work environment, as they feel that they cannot provide safe, quality care consistent with the CNO standards of practice.

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

"Retaining nurses within the healthcare system is a challenge for hospital administrators. Understanding factors important to nurse retention is essential. Clinical and managerial competence, engagement with their employees, and presence on the unit are key to retaining a satisfied nursing workforce."⁵²

The IAC did not see any evidence of a recruitment and retention strategy. The only references to recruitment were noted in many of management's responses to PRWRFs which indicated that the manager was consistently recruiting to fill vacancies created by permanent vacancies, planned due to MLOAs, and unplanned due to sick time or other short-term vacancies. The IAC believes that this is a key area for improvement.

The IAC Recommends:

1. The Program Manager, with the Human Resources Department, develop a comprehensive nursing recruitment and retention strategy for the ED with a goal to fill long term vacancies prior to the person taking leave and to decrease staff turnover to 5% by December 2022 and to 3% by July 2023.
2. The Program Manager and Assistant Manager develop a schedule to ensure that one of them is available in the ED, on a daily basis, to consult with the Resource Nurse to assess the patient care requirements and to support short term staffing needs for the next 24 hours. On Friday, the consultation to include assessing any known staffing gaps throughout the weekend.
3. The Program Manager assess the key areas of nurse dissatisfaction within the ED and develop a corrective action plan, which is to be informed through staff input, to address these issues by March 2022.
4. The Program Manager and Educator develop an onboarding evaluation program for every new RN hire that involves a one-on-one discussion at three (3) months, six (6) months and one year. The discussion to include, but not limited to the following topics:
 - a) performance and achievements to date;
 - b) what is working well from an education, orientation, and integration perspective;
 - c) any areas of concern; and,
 - d) any opportunities for improvement.

3.2.8 Staffing Requirements Specific to Each Area of the Emergency Department

After careful review and consideration of the data presented by both parties, Pre-Hearing and at the Hearing, as well as drawing on the experiences of the IAC members, and the evidence cited in this Report, related to staffing and the factors that impact the RNs workload, the IAC is recommending the addition of five (5) RNs, in a 24 hour period, to the base staffing. This will result in eleven (11) Registered Nurses on the day shift and nine (9) Registered Nurses on the night shift, maintaining the three (3) Swing shifts.

⁵² Bugajski, Andrew, Lengerich, Alex, Marchese, Matthew, Hall, Brittany, Yackzan, Susan, Davies, Claire, Brockopp, Dorothy, The Importance of Factors Related to Nurse Retention Using the Baptist Health Nurse Retention Questionnaire Part 2; The Journal of Nursing Administration, June 2017, Volume 47, Issue 6, 302-312

The IAC Recommends:

1. An increase in five (5) RN positions, in the ED, for each 24 hour period for a total of eleven (11) RNs on days and nine (9) RNs on nights. The three (3) swing shifts to be maintained. Postings for all additional RNs recommended, as outlined below, for Triage, Acute/Subacute Care Area and Ambulatory Care Area, to be posted, as soon as possible, but no later than three months from the date of this Report, July 16, 2021.

Triage

The current staffing at Triage is 1 RN 24/7. There were several reported concerns documented on the PRWRFs stating that the Triage nurse was not able to meet the CTAS guidelines for initial assessment nor was he/she able to monitor and reassess the patients in the waiting room in compliance with the CTAS guidelines and to re-categorize patient's acuity levels, as necessary. The Hospital reports a 20% decrease in patient volumes in 2020 which is consistent with hospitals across Ontario, however, the Hospital response on some of the recent PRWRF indicates that volumes are starting to increase to pre-COVID-19 levels. It is important to note that even with decreased volumes nurses did not experience less workload. The strain of working in the challenging and unprecedented situation due to COVID-19 did impact nursing workload. Since March 2020 the ED nurses had to take every precaution to keep themselves safe and to keep patients safe. Every patient entering the ED was a potential COVID-19 patient. The nurses met all Infection and Prevention Control Guidelines, working in personal protective equipment and donning and doffing essential protective gear throughout their busy shifts. The impact of this added stress, to an already stressful environment, must be considered despite a decrease in actual patient volumes.

Many PRWRF reports identify a range from between one hour to greater than two hours, for a patient to receive an initial triage assessment by an RN. As the Regional Cardiac Care Centre, which in 2017 was reported to be one of three top-performing hospitals in Canada for cardiac care, multiple PRWRFs identify patients sitting in the waiting room, with chest pain for more than one to three hours. In 19 PRWRFs staff identified patients with chest pain waiting in the waiting room for 40 minutes to three hours, and at least four identified patients waiting for 30-40 minutes for an initial Electrocardiogram (ECG). In January 2021, the Cardiac Care Centre expanded the Cardiac Catheterization Lab service to include an Electrophysiology Lab which performs ablations.

The Hospitals Strategic Plan Vision 2026 states "a commitment to grow specialized services and expand the reach of Cardiac and Chest services, to meet the needs of our growing and diverse communities. with outcomes on par with the best in Ontario and Canada."⁵³ Cardiac services have grown 55% since 2005 and the Hospital is committing to grow an additional 43% by 2033/34. The commitment to grow Cardiac, Respiriology and Thoracic Surgery Level 1 services requires alignment of resources across all departments that will be impacted by the growth in these Tertiary programs. The Hospital's Priority 1, Expand Equitable Access to High Quality, Empowered Care⁵⁴, can only be achieved with the right number of skilled health care professionals. This includes the right number of skilled and knowledgeable RNs in the ED. The Hospital will need to secure additional, adequate government funding if the strategic

⁵³ SMGH Strategic Plan 2021-2026

⁵⁴ SMGH Strategic Plan 2021-2026

priorities are to be achieved. This funding should be allocated across all services and departments that contribute to safe, quality patient care in these expanded services, including the ED.

2. A second Triage RN be assigned 24/7 to ensure timely assessment of all patients coming to the ED and to meet the CTAS reassessment requirement of patients in the waiting room.
3. The Vice President Patient Services and Chief Nursing Executive review all new funding allocation for expanded Cardiac, Thoracic, Respiriology, and Cancer services and advocate for additional budget to ensure that the ED can be staffed adequately to respond to the patients that will access these specialized services through the ED.

Acute Care

The Acute Care area has 9 stretchers and 3 Resuscitation Rooms with 3 RNs assigned 24/7. The Acute Care area sees the sickest patients coming to the ED receiving CTAS 1, 2, and 3 patients. The CTAS 1 patients require 1:1 or greater nursing care for immediate resuscitation and stabilization and receive care in the Resuscitation Room. CTAS 2 and 3 patients require intensive workups and interventions to diagnose and treat their symptoms. RNs reported on 85 PRWRFs issues involving a lack of adequate staff to safely manage the patient care needs due to high patient acuity.

Subacute Care

The Subacute area has 12 patient spaces, plus 4 hallway stretchers. Moderately acute patients are generally seen here, however, due to COVID-19 CTAS level 2 and 3 patients can be seen in Subacute. All bays have a cardiac monitor. Most patients have higher acuity care needs requiring RN level of care. Subacute is staffed by 3 RNs or 2 RNs and 1 RPN. From 1100 to 2300 hours the offload nurse cares for the 4 hallway patients, however, when the offload nurse leaves, any remaining patients in the hallway are cared for by the Subacute area nurses.

The IAC Recommends:

4. An additional RN be assigned to float between Acute Care and Subacute Care 24/7.

Ambulatory Care

The Ambulatory Care Area (ACA) or Minor Treatment has 9 patient care spaces with an 8 chair waiting room. The goal is to assess CTAS level 4 and 5 in ACA, however, there has been an increase of higher acuity patients being seen in ACA since the requirement to designate the Acute Care as the ARI/COVID area. Further, "RNs have reported on 30 PRWRFs issues of high patient volumes with 1 RN or frequently 1 RPN, patient census of 14 to 24, as well as high patient acuity, lack of ability to isolate, patients on Form 1 and being assigned so many patients that the nurses are unable to see and assess them all."⁵⁵ The ACA is usually staffed with one RPN, and occasionally with one RN. During COVID-19 CTAS level 2 and 3 patients are seen in ACA. These patients are often sicker with a high probability for rapid deterioration and can be beyond the scope of RPN practice. Having a RN/RPN dyad assigned to ACA will ensure a collaborative model of care that will meet patient care needs.

⁵⁵ ONA Submission, Brief Volume 1, p. 37, May 11, 2021

The IAC Recommends:

5. An RN be assigned to the Ambulatory Care Area in addition to the RPN.
6. The Program Manager monitor utilization of the ACA, both volumes and acuity of patients, over a two month period to determine if the ACA should remain open 24/7.
7. If the ACA is to remain open 24/7 staff with an RN and a RPN 24/7.

3.2.9 Resource Nurse

"The Resource Nurse is a front line leader who supports high quality patient care, is responsible for the day-to-day operation of the Emergency Department, coordinates flow of the Emergency Department, and manages resources in collaboration with the Emergency Department Manager.

The Resource Nurse will be an active participant in the department activities and act as a clinical resource to staff in the Emergency Department. They will assist in implementing and directing patient care, and facilitate achievement of department goals and objectives."⁵⁶

The Resource Nurse role carries broad and expansive responsibilities to plan, direct and coordinate patient care, to assign duties to team members consistent with the members knowledge, skill and scope of practice, to provide leadership and support to staff, mentor and role model for staff members, work collaboratively with Bed Management to promote flow within the facility, and collaborate with the Clinical on Call/Administrator on Call to facilitate patient flow.

Based on the information documented in the PRWRFs, the IAC believes that the current assignment of the Resource Nurse does not align with the responsibilities listed in the Job Description. Rather, it appears that the Resource Nurse is pulled in many directions, at times taking a patient assignment or triaging at the Ambulance Triage area. The result is the important roles and responsibilities of the Resource Nurse to plan, direct and coordinate care, and to meet the other responsibilities as noted above, are not effectively carried out on a day-to-day basis.

The Resource Nurse role as described in the Role Description, if implemented as planned, could go a long way in supporting the Department to function more efficiently and effectively and the role as intended would add valuable mentorship to the newly hired nurses.

The IAC Recommends:

1. The Program Manager and Assistant Manager roles and responsibilities should be communicated to all ED staff.

⁵⁶ SMGH Submission, Document Production (Data Request), Emergency Department Resource Nurse Role Description, Appendix 6 p. 120, May 4, 2021

2. The Resource Nurse should be supported in their role by the Program Manager and Assistant Manager, on a daily basis.
3. The Resource Nurse role does not take a patient assignment, cover for breaks, cover Ambulance Triage or any other duties that take them away from their key responsibilities of ensuring safe, quality patient care, supporting staff, managing patient flow and efficient and effective running of the day-to-day operations. The Resource Nurse will use his/her professional discretion to intervene and provide patient care, as appropriate, to ensure safe, quality care for all patients within the ED.

3.3 Skill Mix Registered Nurses and Registered Practical Nurses

Appropriate staffing in the ED is dependent on having nurses with the right skill, experience, and education to provide safe, quality patient care. Staffing and skill mix involve several factors.

- 1) Patient/family needs,
- 2) The environment in which care occurs,
- 3) Knowledge/expertise of the nurses. (HHR, demonstration project, April 2009 RN/RPN utilization toolkit project)⁵⁷

RPNs were introduced in SMGH ED in 2016. Since that time, they have worked in minor treatment (now named Ambulatory Care Area (ACA)), and the Subacute Areas of the ED. The Hospital revised the RPN Job Description, roles and responsibility document, to integrate the College of Nurses of Ontario, Three-Factor Framework for RN and RPN in the ED. The Hospital supports maximizing the scope of practice of the RPN. There must also be consideration of the regulatory requirements associated with scope of practice, education, training and mentoring that may be required.

The College of Nurses states both the RN and RPN study from the same body of knowledge, RN's study for a longer time period. This provides the RN with a greater knowledge foundation in clinical practice, decision making, critical thinking, leadership, research utilization and resource management. Therefore, the level of autonomous practice between the RN and RPN is different.

The Three-Factor Framework encompasses three factors which include the client, the nurse, and the environment. It is these factors which need to be considered with the assignment of a patient population to ensure a match of the nurse's skills with the client needs, as well as the need for consultation and collaboration among care providers.

The first factor is the client which include complexity, predictability and risk of negative outcomes. Therefore, the less complex, more predictable, and low risk for negative outcomes, less need for consult or transfer of care by the RPN. The second factor is the nurse, and this includes leadership, decision-making and critical thinking skills. The third fact is the environment, which includes practice supports, consultation resources and the stability/predictability of the environment. Therefore, the more stable

⁵⁷ Government of Ontario, Ministry of Health and Long Term Care, Nursing Secretariat, Health Human Resources Project RN/RPN Toolkit, 2009

the environment the more autonomous the practice of the RPN. All three factors are to be considered when assigning the RPN.⁵⁸

Each nurse is responsible for their own level of competency and must know when it is time to transfer care. Patients in the ED, prior to physician assessment, do not have a diagnosis and therefore there is an unknown to all patients arriving in the ED. The Hospital's ED, like all ED's is very busy and chaotic, and therefore the environment in of itself is unstable.

The Association expressed concern about one nurse being assigned to ACA in their Pre-Hearing Submission and reiterated this concern at the Hearing. "At times, as many as 15 to 40 patients can be situated in this area, waiting to be seen, and almost exclusively with only ever one nurse, an RN or more often, an RPN."⁵⁹

In Sub-Acute, the RPN has his/her own assignment of patients which can include CTAS level 2 & 3 patients, who can be unpredictable, and unstable based on triage category.

CTAS level 1 to 3 patients are more complex. The patient's condition/care are less likely to be easily identifiable and stable, therefore more unpredictable. RPN's can recognize changes to a patient condition whereas the RN can anticipate changes (CNO). Since CTAS level 1 to 3 patients are more acute the RN is able to anticipate for potential changes based on their knowledge base.

The Hospital in its own roles and responsibilities of the RPN state "providing care for patients who are stable and less complex with a predictable outcome".⁶⁰

The IAC supports the continued role of the RPN in the ED functioning to full scope of practice, however, the environment in a busy ED creates some challenges and these need to be carefully considered in patient assignments.

The IAC Recommends:

1. An RN be assigned in the Ambulatory Care Area in addition to the RPN (*as recommended above*)
2. The Hospital conduct an evaluation of the RN/RPN Model of Care in the ED. Evaluation to be done by an external expert on RN/RPN Model of Care implementation in an Emergency Department.

3.4 Education

The IAC reviewed documents that were submitted by the Hospital and the Association and listened to issues presented during the Hearing related to absence of the Educator, as she was seconded to a large organization wide project. Both parties recognized that this left gaps in educational support during this period for new hires and novice nursing staff during increased patient volumes and high acuity. The IAC

⁵⁸ College of Nurse of Ontario, Practice Guideline, RN&RPN Practice: The Client, the Nurse, and the Environment, Revised 2018

⁵⁹ ONA Submission, Brief, Volume 1, p 38, May 11, 2021

⁶⁰ SMGH Submission, Document Production (Data Request) RPN ED, Job Description, p. 121, May 4, 2021

recognizes that the consistent presence of the Educator in the ED is important in order to build a good working relationship with the staff, so that they feel safe and supported in their learning development. During the Hearing, the Hospital leadership noted that 80% of the Educator's time is devoted to the ED and 20% is devoted to corporate education. The IAC supports this division of time to meet the needs of the Department. The IAC believes that the Educator needs to be actively involved in clinical practice which focuses on identifying learning opportunities for staff.

The IAC supports in house education and believes it is pertinent to maintaining the standards of care in the highly specialized ED. One of the roles of the Nurse Educator is to teach best practices related to emergency nursing in real time, as well as scheduled in-services. The Nurse Educator role focuses on ensuring that nurses have the skills and training to succeed in the unpredictable environment of a busy ED. This means that a coordinated educational plan that assesses the needs of all the nursing staff is developed to target opportunities to meet the learning needs of novice nurses, as well as those nurses who have identified learning gaps and all nurses to maintain ongoing learning and professional development. The IAC were impressed by the Emergency Department Education Planning Group that was initiated by the Hospital and the nursing staff and believe that it is an innovative working group that should be utilized to advance the development of learning and professional development requirements within the Department. The IAC also notes that intensive specialty training programs can be outsourced to ensure more comprehensive learning objectives are met in a focused learning environment.

A comprehensive orientation curriculum for new staff, especially novice nursing staff is imperative to the success and retention of newly hired RNs. The IAC thought the educational requirements for staff applying to work in the ED were adequate and agreed the newly developed orientation program offered by the Hospital looks very good; however, felt that only twelve shifts with a preceptor left novice nurses feeling unprepared to meet the requirements of their job. This was highlighted in the Professional Responsibility Workload Reports and in the minutes of the Hospital Association Committee.⁶¹ The role of the preceptor was discussed during the Hearing and the lack of a dedicated preceptor for an orientee was noted. The IAC recognizes a dedicated preceptor can be a challenge due to sick time, vacation, out of hospital transfers and the needs of the Department but believes a consistent preceptor supports an orientee, in their development, by building upon the skills and patient care encounters that they manage together. The Core Competencies for the Emergency Nurse checklist in the Hospital, submission that was developed by the Emergency Nurses Association of Ontario (ENAO), is an excellent tool to identify and monitor the learning needs and competencies of emergency room nursing staff and the IAC supports the use of this tool.

The ENA's position statement recommends that "emergency department leadership ensures that RNs receive appropriate education and demonstrate the knowledge application and situational awareness required to successfully function in the role of triage nurse according to professional and accreditation standards."⁶² Further, NENA recommends a minimum of two years recent acute care emergency nursing practice, demonstrated competence in emergency nursing practice, displayed acquisition of advanced assessment, interviewing and interpersonal skills and training in current CTAS (Canadian Triage and Acuity Scale).⁶³

⁶¹ONA submission vol.11 –PRC Feb.27, 20. Handwritten notes p.13

⁶² [triagequalificationscompetency \(ena.org\)](https://www.ena.org/triagequalificationscompetency)

⁶³ [Standards-of-ED-Nursing-Practice-2018.pdf \(nena.ca\)](https://www.nena.ca/Standards-of-ED-Nursing-Practice-2018.pdf)

The Emergency Department Education Planning group discussed the qualifications for Triage certification at the Hospital and came to the agreement that two years emergency room experience, successful completion of the Triage course and other pertinent courses listed in the minutes are recommended to qualify to work in Triage.⁶⁴

The IAC Recommends:

1. Orientation of novice nurses to be increased to 36 shifts, immediately, and reassessed by the orientee, preceptor and Nurse Educator at 18 shifts to assess effectiveness of knowledge transfer. Orientation may continue with the option to increase autonomy by varying levels or may be transitioned to complete autonomy and discontinued based upon past experience, knowledge and other factors.
2. Staff be encouraged to become preceptors and a list of available preceptors be maintained by the educator.
3. Preceptors be given information and education on the role of a preceptor.
4. One Preceptor will be assigned for an orientee's full orientation program.
5. The Educator to devote 80% of time in the ED providing education to the ED staff.
6. The Hospital provide the fees for the Pediatric Emergency Assessment, Recognition and Stabilization (PEARS) course. This may be done using a staggered approach as courses become available with recertification required every two years.
7. Using Benner's Stages of Clinical Competence, the Nurse educator will meet with each staff member over the next six months to determine their level of Clinical Competence using the Emergency Nurses of Ontario Competency Checklist (Revised April 2019). The competency list to be updated by each RN as skills are developed and reviewed annually with the educator.
8. The Triage Nurse will have two years of emergency room experience, complete the Triage Course, and demonstrate situational awareness before being assigned to Triage.
9. The ED Educational Working Group continue its work on assessing current state and informing future state related to:
 - a) Current recruitment credentials and education requirements;
 - b) Orientation and Onboarding Program;
 - c) Continuing Education.

3.5 Equipment

"The Hospital agrees that access to up-to-date equipment is critical for providing high-quality care for patients. It is committed to adding equipment where it is warranted." The Hospital states in their

⁶⁴ SMGH Brief Submission – Tab 8, Emergency Department Education Planning Group, Oct.2019, pgs. 1661-1667, May 11, 2021

submission that it has made many purchases of equipment in the past three years, in response to ONA's concerns, staff suggestion/request, huddle tickets or work-related improvements. "St. Mary's considers this issue to be resolved."⁶⁵

The Association indicates in their submission that the issue of supplies and equipment remains outstanding as reported in the PRWRFs at least 80 times. Although the Hospital has purchased one arrest cart there is still an identified need by the Association that another arrest cart is needed so that one arrest cart is available in each area of the ED. Another supply concern is the need for Maternal, Pediatric and Neonatal supplies as well as mounted Blood Pressure in Acute Care for infection control purposes."⁶⁶

The IAC believes very strongly that it is essential that nurses have the appropriate supplies and equipment in working order, ready and available, to provide safe, quality care at all times. One minute could potentially result in a negative outcome for a patient. The IAC read on many PRWRFs and in the HAC Meeting Minutes, as well as heard during the Hearing, that supplies and equipment are not always available in the ED when needed by the nurses, to provide vital care. Some equipment is not working or items, including medications are expired or simply not available. Several workload forms documented not enough IV pumps and having to look for them across the Hospital. Searching for equipment or running to another area to get an item, in a busy department, increases the workload of the nurses and ultimately affects the care they deliver.

The IAC Recommends:

1. The Hospital purchase, immediately, a crash cart which will be situated in the ACA.
2. The Hospital ensure, immediately, that each crash cart has a working Zoll defibrillator.
3. The Hospital assess the non-clinical positions in the ED to determine an appropriate role to take on the responsibility to monitor and to check equipment and supplies and maintain regular stock quotas. Equipment and supplies to be replaced before expiry.
4. The Hospital work with the Biomedical team to develop a proactive Biomedical equipment process to perform preventative maintenance and to ensure that all equipment is in working order or is replaced in a timely manner.
5. A Registered Nurse be assigned, on the daily work assignment, to check the crash carts and the Braslow cart daily and following each use.
6. All Registered Nurses who notice that a piece of equipment is not working or notice that supplies are expired will proactively address this and ensure that the matter is resolved by reporting to the appropriate person or if possible, replacing the item.
7. All ED staff when transferring a patient to an inpatient bed will ask the receiving unit to provide an IV pump for every pump that will be left on the receiving unit.

⁶⁵ SMGH Submission, Brief p. 29/30, May 10, 2021

⁶⁶ ONA Submission, Volume 1 – Brief, p. 59, May 11, 2021

3.6 Workplace Violence and Security

Health care workers, particularly nurses, regularly face violent physical, sexual and verbal abuse from patients and their families/visitors.⁶⁷ The prevalence of violence in the healthcare setting has been reported to be greater than in any other occupational setting, such as police departments and prison systems. Research has found that nurses in emergency departments (ED) are noted to be in the highest risk group for a violent patient encounter.⁶⁸ Security expert, Alan Butler states that "Unlike any other care area in the hospital, the situational unknowns faced by ED care providers are especially impactful. This is due to a number of factors, such as the following:

- Care providers know little about the patient's condition, medical history or mental status when they arrive.
- Patients often arrive fully clothed, sometimes with bags of property that could include any number of items meant to cause bodily harm to themselves or to others.
- Patients may be the victim or the aggressor in a violent act.
- Patients often arrive with family and friends who may help or hinder the care of the patient.
- Many patients have behavioral health issues that can affect the provider's ability to address other immediate medical needs.
- Patients with behavioural health issues may need to stay in the ED for extended periods of time while a more appropriate care option is located.

Because of these environmental and patient variables, health care providers must manage the ED, and the associated safety risks to staff, patients and visitors, differently than any other care environment in the hospital."⁶⁹ The Occupational Health and Safety Act, 2009, Bill 168 (46) outlines the obligation that employers have to protect workers from violence.⁷⁰ "The employer must assess the risks of workplace violence on a regular basis. Violence may arise from a number of predisposing factors such as the nature of the workplace, the type of work, and the conditions of work."⁷¹ Furthermore, the employer must also reassess the risks as often as is necessary to ensure that related policies, programs, and resources continue to meet the needs in protecting workers from workplace violence.⁷²

"An effective approach to reduce physical assaults and threats in the ED must be based on a comprehensive intervention strategy. Implementing any necessary environmental changes, developing policies and procedures, and offering education and training are the three fundamental interventions benefitting all staff members, no matter their role."⁷³

⁶⁷Brophy, J.T, Keith, M.M, Hurley, M. Assaulted and unheard: violence against healthcare staff. *Scientific Solutions* 2017; 0 (0) 1-26.

⁶⁸Gillespie GL, Gates DM, Miller M, Howard PK. Emergency department workers' perceptions of security officers' effectiveness during violent events. *Work*. 2012; 42(1):21–27. [PubMed] [Google Scholar]

⁶⁹Butler, Alan. Health Facilities Management Facilities: crafting a customized approach to help better manage the unique challenges facing healthcare. Es August 2019 <https://www.hfmmagazine.com/articles/370>

⁷⁰[Occupational Health and Safety Act, R.S.O. 1990, c. O.1 \(ontario.ca\)](#)

⁷¹Gillespie GL, Gates DM, Miller M, Howard PK. Emergency department workers' perceptions of security officers' effectiveness during violent events. *Work*. 2012; 42(1):21–27. [PubMed] [Google Scholar]

⁷²Occupation Health and Safety Act PART III.0.1 Violence and Harassment

⁷³ Butler, Alan. Health Facilities Management Facilities: crafting a customized approach to help better manage the unique challenges facing healthcare. Es August 2019 <https://www.hfmmagazine.com/articles/370>

Security professionals are called upon by staff when it comes to protecting patients, visitors and staff in aggressive or violent situations. Security presence and visibility provides a message to staff and patients that the organization prioritizes a safe care environment for everyone.

The IAC recognizes that the Hospital leadership has planning underway for many of the components required to provide a safe work environment. The groundwork has been done for a GPS staff alarm system. A security office is located at the entrance to the Emergency Department and a guard is available for assistance when required. A Code Silver Policy has been developed but not implemented.

Both the Hospital and the Association highlighted in their Submissions and during the Hearing that keeping staff safe from verbal and physical abuse and violence is a priority. The Association documented in their Brief that: "At least 20 PRWRFs have reported issues of RN harm and need for increased security support, related to a multitude of factors, including extended wait times, overcrowding, stress and anxiety related to the current pandemic, the opioid crisis leading to a change in patient population and an increased number of patients on Form 1 Mental Health Crisis."⁷⁴ During the Hearing the IAC heard from the Association and from the nursing staff about concerns related to safety and the increased risk of violence in the ED, as they shared their lived experiences. The Hospital also addressed staff safety and reported on 24 violent staff incidents over the past three years. All incidents had been reviewed by the Joint Occupational Health and Safety Committee (JOHSC), including security reports to mitigate risk.⁷⁵ Further, the Hospital committed to 24/7 security guard presence in the ED.

Given the level of potential or actual violent events that have occurred, the IAC acknowledges the importance of a work environment that provides the resources necessary to ensure staff safety.

The IAC Recommends:

1. The Hospital ensure security officer presence in the ED 24/7, effective immediately.
2. Security guard will round hourly in the ED. The security guard to be located in an area that is visible to patients and staff.
3. Security guards will be level three trained and will intervene as needed to protect staff and patients.
4. The Hospital conduct an annual Risk Assessment of the Emergency Department with an ED staff member and a member of the Joint Occupational Health and Safety Committee (JOHSC). Risks will be identified and reported to the leadership team and to the JOHSC and a corrective action plan, with timelines, will be developed and implemented.
5. The Hospital develop an education and training plan for the ED and security staff on de-escalation strategies and nonviolent interventions from a recognized program such as Non-violent Crisis Intervention or Trauma-Informed De-escalation Education for Safety and Self-Protection (TIDES). The plan to be fully implemented by September 2022.

⁷⁴ ONA Submission, Volume 1 – Brief, p. 63. May 11, 2021

⁷⁵ SMGH Slide Presentation at Hearing, June 1, 2021

6. The Code Silver Policy be implemented with staff training and a plan for mock Code Silvers by November 30, 2021.
7. The GPS staff alarm system be implemented by September 2022.

3.7 Safety/Housekeeping

Although violence has been identified as the foremost safety concern of health care workers, there are other safety issues facing ED staff daily. The frequency and diversity of patient encounters exposes staff and patients to a multitude of viruses and pathogens. Contaminated surfaces and equipment contribute to the transmission of microorganisms and to the burden of health care-associated infections. Effective infection control policies can mitigate the risk of exposure to staff and patients. The physical environment plays an important role in the ability of hospitals to successfully manage environmental risks.

Housekeeping staff, who are trained and knowledgeable in best practices and whose main function is the cleaning of the department, are the most effective method of ensuring the highest standards of environmental cleaning is maintained. Ensuring a safe, clean and hygienic environment and minimizing microbial contamination of surfaces, items and equipment within the health care environment is increasingly recognized as an essential approach to reducing the risk of health care-associated infections for all patients, visitors and staff within health care settings.⁷⁶ "Reducing the risk of transmission of infection from the health care environment requires the cooperation of all staff in the health care setting. It also requires an appropriately staffed, trained, educated and supervised environmental services program."⁷⁷ Efforts to reduce the risk of transmission of microorganisms from the environment requires the cleaning and disinfection of all surfaces and items in the health care setting on a regular basis. The best practices for cleanliness in health care settings have been developed and revised by the Provincial Infectious Diseases Advisory Committee (PIDAC).⁷⁸

Health care settings are complex environments where the provision of care to large numbers of patients results in the contamination of surfaces and equipment with harmful microorganisms. Regularly scheduled and episodic cleaning practices which provides effective cleaning and disinfection of surfaces, items and equipment is an essential activity that protects patients, staff and visitors from infection. The IAC believes that because of the increased risks and consequences of infection transmission in this setting, the best practice approach requires highly skilled housekeeping services. In the ED, at the Hospital the Attendant provides a number of services that include cleaning, washing floors, cardiopulmonary resuscitation, and portering of patients to Diagnostic Imaging.⁷⁹ The IAC understands the principles of the multi-task role of the Attendant; however, we believe the importance of maintaining a safe environment for staff and patients must be a top priority.

⁷⁶Ontario Agency for Health Protection and Promotion (Public Health Ontario), Provincial Infectious Diseases Advisory Committee. Best practices for environmental cleaning for prevention and control of infections in all health care settings. 3rd ed. Toronto, ON: Queen's Printer for Ontario; 2018

⁷⁷Ontario Agency for Health Protection and Promotion (Public Health Ontario), Provincial Infectious Diseases Advisory Committee. Best practices for environmental cleaning for prevention and control of infections in all health care settings. 3rd ed. Toronto, ON: Queen's Printer for Ontario; 2018

⁷⁸Ontario Agency for Health Protection and Promotion (Public Health Ontario), Provincial Infectious Diseases Advisory Committee. Best practices for environmental cleaning for prevention and control of infections in all health care settings. 3rd ed. Toronto, ON: Queen's Printer for Ontario; 2018

⁷⁹ SMGH Submission, Document Production (Data Request), May 4, 2021

The IAC viewed the Department Tour Video and noted the close proximity of the chairs in the main waiting room of the ED. During the Pandemic outbreak of the past year and a half, many hospitals have been faced with managing a busy ED waiting room while still providing segregated waiting room chairs for their patients. Plexiglas dividers have been the solution used by many organizations to provide added protection in waiting rooms where there is close proximity of patients to one another.

The IAC Recommends:

1. The Hospital implement a plan to assign dedicated housekeeping staff to maintain the physical environment of the Emergency Department including the waiting rooms by October 2021.
2. The Hospital purchase and install Plexiglas dividers/partitions between the chairs in both waiting areas by October 2021.
3. The Hospital develop and administer a Post COVID survey to the Emergency Department staff and physicians with questions related to lessons learned, what went well, and opportunities for improvement. The results to be shared with staff and physicians. Relevant ideas and suggestions will be implemented immediately, if appropriate, or added to future pandemic plans for the Emergency Department.

3.8 Morale and Toxic Work Environment

The Association perspective is that "Staff feel demeaned and undermined by leadership, often experiencing distress regarding their lack of ability to deliver safe, quality patient care, and ensure client safety while managing overwhelming numbers of interventions. Staff report feelings of moral distress and ethical dilemmas. Staff have identified issues of inadequate resources, insufficient RNs to fill the schedule. Weekly emails identifying "Leftover Needs" show there are as many as 25 or more uncovered shifts on the schedule in need of an RN."⁸⁰

"The Hospital agrees that we are mutually accountable for a psychologically safe environment so that all employees are supported to perform optimally. In January 2020, the Hospital shared with the Association that it has reviewed options to have a culture audit done in the Emergency Department after the implementation of PRISM go-live."⁸¹ When COVID-19 happened this plan was not able to move forward. The Hospital stated at the Hearing, that they remain committed to conduct a Culture Survey in the ED.

The RNAO healthy work environments (HWE) best practice guidelines (BPG) are designed to support health-care organizations in creating and sustaining positive work environments. "A healthy work environment for nurses is complex and multidimensional, comprised of numerous components and relationships among the components. A comprehensive model is needed to guide the development, implementation and evaluation of a systematic approach to enhancing the work environment of nurses. Healthy work environments for nurses are defined as practice settings that maximize the health and well-being of the nurse, quality patient/client outcomes, organizational performance and societal outcomes."⁸²

⁸⁰ ONA Submission, Volume 1- Brief, p 74, May 11, 2021

⁸¹ SMGH Submission, Brief, Tab 1, p. 29

⁸² Registered Nurses of Ontario (RNAO), Best Practice Guideline: Workplace Health, Safety & Wellbeing of the Nurse, p. 14, 2008

A quality practice setting is the responsibility of both the employer and the nurse. It is a shared responsibility which will support nurses in providing safe effective and ethical care. A nurse in an administrative role demonstrates the Accountability Standard by, advocating for a quality practice setting that supports nurses' ability to provide safe, effective and ethical care.⁸³

A quality practice setting will provide resources, including appropriate staffing to support nurses to establish a therapeutic relationship with their patients. Promote positive collegial/interprofessional relations by role modeling and promoting an organizational culture of respect.⁸⁴

It was evident in the Pre-Hearing submissions and throughout the Hearing that the morale and the culture at the Hospital's ED is a major concern to the Hospital, the Association and the Registered Nurses. The RNs in the ED feel that their issues are not being heard and are not considered valid by management. The responses from the Hospital to the PRWRFs do not appear to address the root of the issue or try to determine the root cause for the documentation. Throughout the Hearing the nurses expressed the feeling of a 'toxic environment'. These persistent unresolved issues between management and the nurses have contributed to an all time low morale and has resulted in some nurses leaving the ED or transferring to part time to avoid working in this unhealthy work environment.

The nurses have brought their concerns to the Hospital several times at HAC since May 2018, expressing that they feel a lack of support from management and are frustrated that management has taken no action to address their expressed concerns. The Hospital did suggest in January 2020 that they were looking into an external organization to come in and do a culture assessment in the ED. Due to PRISM/Cerner electronic documentation go-live and then COVID-19 the Hospital has not pursued this culture assessment.

The Hospital has provided Mental Health & Wellness Initiatives which is Pandemic focused and wellness sessions were held with the ED staff. The Hospital did express, at the Hearing, its intent to move forward on a plan to conduct a culture assessment in the ED. The Association would also like to see a ED culture assessment completed. By making a healthy work environment a priority it is possible to create a work environment that values the unique contribution, skill, knowledge, and experience of the ED nurses. This will set the nurses up for success and result in an environment where patients receive safe, quality care in a quality practice setting. If management looks after the needs of the nurses and provides the appropriate education and resources, the nurses will be capable of meeting patient care needs and the Hospital will achieve its vision "Inspiring Excellence. Healthier Together."

The IAC Recommends:

1. The Hospital and the Association agree to a process for a third party culture assessment of the ED and that the Hospital proceed to book this within the next three (3) months.
2. The Hospital conduct a valid quality of work life staff survey for the nurses in the ED with questions specific to all aspects of the environment. These would include but not limited to the work environment, safety, leadership, and quality of patient care.
3. The Hospital and the Association review the results of the quality of work life survey and together with the nurses identify themes requiring improvement and develop a corrective

⁸³ College of Nurses of Ontario, Practice Standard: Professional Standard, Revised 2002

⁸⁴ College of Nurses of Ontario, Practice Standard: Therapeutic-Nurse-Client Relationship, Revised 2006

action plan with specific outcome measures and timelines. *(NOTE: if the Hospital can ask for nurse specific results from the last Quality of Life staff survey done for Accreditation, this may serve as a starting point to identify opportunities for improvement).*

4. The Hospital and the Association review the RAO Best Practice Guideline: Workplace Health, Safety, & Wellbeing of the Nurse and implement those recommendations that both parties agree will be appropriate to improve nurse and management morale in the ED.
5. The Hospital develop an evaluation process to monitor and measure the impact of implementing changes within the Department that affect the nurses work life, scheduling, or practice environment. This can be done through surveys and focus groups.
6. The Hospital continue its Mental Health and Wellness initiatives and expand the focus beyond the Pandemic.
7. The Program Manager work with the Health and Wellness team and the ED nurses to implement the ED wellness program focused on burnout and stress, presently in a draft form.
8. The Unit Based Council (UBC) continue to meet monthly and to develop Terms of Reference. Agendas to be developed with input from all staff. All minutes to be posted for all staff within a week of the meeting. Management to be invited as required.

3.9 Leadership and Communication

"The Vice President/Chief Nursing Executive (CNE) is responsible for maintaining clinical and patient-care standards, ensuring that patient safety and access to the right care is maintained. The CNE reports to the Chief Executive Officer (CEO) and the hospital's Board of Directors.

The Director, Surgical Services and Emergency Department reports directly to the CNE, and provides senior leadership direction to the ED, functioning as an operational and communication link between the department and senior team to ensure alignment with organizational priorities. The Director provides guidance and leadership support to the ED Program Manager.

The ED Program Manager reports directly to the Director and is accountable for the functioning of the department, including program planning to ensure appropriate systems and resources are in place to support timely and appropriate patient flow. The ED Manager collaborates with the Director in designing, implementing, monitoring, revising, and managing patient care, and department processes and procedures designed to facilitate efficient and effect operation of the program.

The Assistant Program Manager reports to the ED Program Manager, working collaboratively in the overall functioning of the ED program. The Assistant Program Manager is more directly involved in the daily operations of the department in consultation with the Program Manager, and works with the ED Educator on the professional growth and development of department staff to promote continual improvement in clinical practice and quality patient care.

During the Accreditation Canada Survey, it was noted under clinical leadership, that the organization has a strong team in the ED."⁸⁵

There have been many changes in leadership positions in ED in the last three years. Since 2018 there has been three managers, three assistant managers and four educators in permanent, temporary, or interim roles. The current manager has been in her position since December 2018 and recently the Hospital has hired a permanent Assistant Manager and a permanent Educator to the ED.

On many occasions the Program Manager's response to the PRWRF was interpreted as dismissive and derogatory in tone suggesting to the RNs "problem-solving in the moment is strongly encouraged."⁸⁶ The nurses felt that this type of response was condescending and implied that the nurses are not using every possible resource appropriately to improve the workload situations. Registered Nurses are accountable to use their judgement in challenging patient care situations and it seemed evident that the Resource Nurse, in the majority of PRWRF, called for additional resources appropriately and on many occasions called the Clinical on Call, often with no support to resolve the issue at hand.

It appears that there is inability of management and staff to effectively communicate with one another in a collaborative and collegial manner to meet common goals and resolve issues at the unit level. Stable leadership creates an opportunity for a new beginning, with a focus on transformational leadership, to build trusting relationships between management and the RNs working in the ED.

The Hospital states in its submission, "St. Mary's is committed to developing a strong, collaborative working relationship between ED Management and staff in the ED. St. Mary's has taken great efforts to develop a Code of Conduct and Respectful Workplace Policy which reinforces these principles."⁸⁷

The Hospital agrees with the Association that ED management's communication should be effective, clear, and transparent. The Hospital believes that this is currently the case. The Program Manager has made attempts in the past several months to improve communication with nurses through email, staff meetings and unit huddles and has re-established the Unit Based Council.

During the Hearing the Hospital listed the following actions that they believe demonstrates their commitment to improved communication:⁸⁸

- Daily status exchange with the Resource Nurses and the Manager/Assistant Manager
- Department huddles two to three times a week
- ED Quality and Operations Meeting
- Unit Based Council Monthly Meetings (last held May 4, 2021)
- Resource Team Meetings alternate Mondays (held March 6th and April 27th)
- ED/Diagnostic Imaging Process Mapping for all modules completed
- ED/3E Transfer of Accountability (TOA) ED Inpatient Working Group

These are all good communication and nurse engagement strategies; however, at this time it is important that management understand the core issues driving staff dissatisfaction and to make efforts

⁸⁵ SMGH Submission Document Production (Data Request), p. 23, May 4, 2021

⁸⁶ ONA Submission, Brief, Volume 1, p. 68, May 11, 2021

⁸⁷ SMGH Submission, Brief, p. 28, May 10, 2021

⁸⁸ Hospital Slide Presentation, Hearing June 1, 2021

to mend the broken relationship. Until the concerns, expressed by the nurses, related to disrespectful and demeaning communication and the lack of responses to nurses' patient safety and workload issues, are addressed in a more personal open and transparent manner, these more formal communication strategies do not appear to be improving the situation.

The IAC is concerned with the breakdown in communication between management and the nurses. An area of major concern relates to how this communication breakdown has negatively impacted the dialogue required to address the nurses concerns with workload related to high patient acuity and inadequate staff, which has resulted in their inability to consistently meet their CNO practice standards. The IAC observed that there is a vastly different perspective, between the Hospital and the Association, related to the ability of the RNs in the ED to meet their professional practice standards.

The Hospital states, "It is not clear to the Hospital why nurses feel they are unable to meet CNO Standards and Guidelines."⁸⁹

The Association states. "The request for a review of professional practice, patient acuity, fluctuating workloads, and fluctuating staffing arises out of article 8 of the current Collective Agreement between ONA and the Participating Hospitals."⁹⁰ "RNs in the SMGH ED have regularly and consistently reported professional practice concerns to the management, up to and including the Chief Nursing Executive. Nursing workload, in particular, as it relates to acuity and complexity and the fluctuating workload of the patient population in the Emergency Department has a significant impact and can lead to negative patient outcomes."⁹¹

Emergency nurses work within a team based model of care and if patients seeking care in the ED are to receive the highest quality standard of care, the ED nurses must be supported to enable them to contribute their skills, knowledge and judgement in a manner that significantly contributes to the best quality outcome possible for each and every patient. The IAC believes that the Hospital nursing leadership has the same goal, that of ensuring each patient coming to the ED receives safe, quality care. The Nursing leadership team has the responsibility and capability to make this a reality.

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

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

- Identifying goals that reflect CNO mission and values and facilitate the advancement of professional practice
- Provide feedback and support to staff about nursing issues at the individual and organizational level
- Involving nursing staff in decisions that affect their practice

The CNO standards articulate how a nurse in a formal leadership position can support nurses, in the practice environment, to meet their professional standards.⁹²

⁸⁹ SMGH Submission, Brief, p. 30, May 10, 2021

⁹⁰ ONA Submission, Volume 1 - Brief p. 10, May 11, 2021

⁹¹ ONA Submission, Volume 1 – Brief, p. 18, May 11, 2021

⁹² College of Nurses of Ontario Practice Standards - Professional Practice Standards, p. 10, 2002

The Hospital informed the IAC that they will be implementing the LEADS in a Caring Environment Framework which "is a leadership capabilities framework representing an innovative and integrated investment in the future of health leadership in Canada. It provides a comprehensive approach to leadership development for the Canadian health sector, including leadership within the whole-system, within the health organizations, and within individual leaders."⁹³ There are five competencies related to the LEADS framework: Lead Self, Engage Others, Achieve Results, Develop Coalitions, and Systems Transformation and there is evidence that this is a leadership development approach that advances leadership competencies.

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

This Best Practice Guideline identifies and describes:

- leadership practices that result in healthy outcomes for patients/clients, organizations and systems;
- system resources that support effective leadership practices;
- organizational culture, values and resources that support effective leadership practices;
- personal resources that support effective leadership practices; and
- anticipated outcomes of effective nursing leadership.⁹⁴

The five practices of transformational leaders:

1. Building relationships and trust is a critical leadership practice, the foundation on which the other practices rest. Relationships include those formed between individual nurses, on teams and in internal and external partnerships.
2. Creating an empowering work environment depends on respectful, trusting relationships among people in a work setting. An empowered work environment has access to information, support, resources, and opportunities to learn and grow, in a setting that supports professional autonomy and strong networks of collegial support.
3. Creating a culture that supports knowledge development and integration involves fostering both the development and dissemination of new knowledge and instilling a continuous-inquiry approach to practice, where knowledge is used to continuously improve clinical and organizational processes and outcomes.
4. Leading and sustaining change involves the active and participative implementation of change, resulting in improved clinical and organizational processes and outcomes.

⁹³ Canadian College of Health Leaders, Professional and Leadership Development, <https://leadsCanada.net/site/framework>

⁹⁴ RNAO Healthy Work Environment: International Affairs and Best Practice Guideline Developing and Sustaining Nursing Leadership, Second Edition, 2013 p. 13

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

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

- valuing nurses' critical role in providing patient/client care;
- supplying sufficient and appropriate human and financial resources;
- providing necessary information and decision support; and
- creating a culture and climate conducive to effective, efficient nursing care.⁹⁵

The IAC Recommends:

1. All nursing leadership, including the Chief Nursing Executive, Clinical Director, Program Manager, Assistant Manager and Educator, increase their visibility in the ED to understand the daily stresses of the RNs and to support their work and decision making.
2. Nursing Leadership review the RNAO International Affairs and Best Practice Guideline (BPG): Developing and Sustaining Nursing Leadership, Second Edition (2013) and determine practices outlined in the BPG that could be adopted to develop nursing leaders at all levels of the organization from the bedside to the boardroom.
3. Nursing leadership engage positively in the Professional Responsibility Process to create a positive culture, to establish collaboration, problem-solving and open and effective communication, at all times, to achieve mutually agreeable resolutions as issues arise.
4. Program Manager to have daily "huddles" with RNs to ask about their day and if there is anything that can be done to assist them to do their job better.
5. Management and staff to work together collaboratively to develop a new and positive work environment based on mutual respect and trust. After the culture survey is complete, engage an external facilitator to assist in identifying the roles that each person needs to play in working towards the achievement of common goals.
6. Management implement regular staff meetings with nursing input into the agenda. Schedule these at a time when staff can attend. Meeting minutes to be documented, printed, and posted on the unit bulletin board.
7. Management and staff agree to adhere to the Code of Conduct Policy and all organizational policies.

In addition to the above recommendations, the IAC believes that there is a unique opportunity for management and the ED nurses to commit to a new, open and transparent communication style by demonstrating a renewed commitment to using the HAC as a forum for open dialogue

⁹⁵ RNAO Healthy Work Environment: International Affairs and Best Practice Guideline Developing and Sustaining Nursing Leadership, Second Edition, 2013 p. 17

aimed at addressing and resolving issues and concerns that are impacting nursing workload and safe, quality patient care.

3.10 Professional Responsibility Workload (PRW) Process and Report Forms

"The Professional Responsibility and Workload (PRW) process was developed to assist Registered Nurses (RNs) through difficult and often stressful processes of raising and resolving issues related to professional practice, patient acuity, fluctuating workloads, and fluctuating staffing and resolving these concerns in a timely manner."⁹⁶ The PRW process is meant to promote safe and best possible patient care and also to protect the ONA member who may identify that patients and staff may be at risk. The purpose of the Professional Responsibility Workload Report Form (PRWRF), as outlined in the Collective Agreement, is for nurses to document these concerns in writing and to submit the PRWRF to management. Nurses in the ED at St Mary's have met their obligation related to concerns and have documented these issues as is their professional responsibility. It is only the nurse(s) who can determine, based on their own assessment, whether he/she is providing safe, quality patient care. It is this assessment in which each nurse will determine whether a PRWRF will be completed. Once received management is to respond and seek resolution to the identified issue(s).

The Hospital's position as stated in their Brief, is that the nurses are not following the Collective Agreement when completing the PRWRF. "Where nurses believe that workload issues are preventing them from meeting patient care standards, the most important thing is to address those issues in a timely manner so that patient care standards can be met. There have been cases where Workload Forms are completed and submitted even when the Resource Nurse or ED Management are available and have not been consulted or given opportunity to reallocate resources within the ED."⁹⁷

The Association's position as stated in their Brief, is that "This request for a review of professional practice, patient acuity, fluctuating workload and fluctuating staffing arises out of article 8 of the current Collective Agreement between the parties; and the College of Nurse (CNO) accountability for Registered Nurses (RNs) to report practice concerns to their employer so that the employer can attempt to resolve the concerns, (CNO: Professional Practice Standards, Revised 2002).⁹⁸ At the Hearing, the Association communicated that there is no requirement for a nurse to advise management that they will be completing a PRWRF.

Given that the ED nurses have completed 219 PRWRFs, over the past three years, without resolution between the nurses, the Association, and the Hospital, it is the opinion of the IAC that the PRW process, as intended, is not being utilized to facilitate discussion and promote problem solving between the parties.

Article 8:01 provides a process in which staff nurses, as well as administration, are to address workload issues. Article 8 specifies "at the time the workload occurs, discuss this issue within the unit/program to develop strategies to meet care needs using current resources". It further states "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." The Collective Agreement further states, "Failing resolution 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

⁹⁶ ONA Submission, Volume 1 – Brief, p. 9, May 11, 2021

⁹⁷ SMGH Submission, Brief p. 16, May 10, 2021

⁹⁸ ONA Submission, Volume 1 – Brief, p. 10, May 11, 2021

next day that the manager and the nurse are both working or within (10) calendar days, whichever is sooner.”⁹⁹

The IAC Recommends:

1. The Hospital and the local Association work together to improve the Professional Responsibility Workload (PRW) process with the goal of implementing a collaborative approach to resolving workload concerns. This will include commitment on both sides to follow the steps in the collective agreement including timelines established in this process.
2. RNs in the ED continue to document their concerns on the Professional Responsibility Workload Report Form, in alignment with the Collective Agreement.
3. RNs in the ED make an effort to communicate their patient care concerns, to the Program Manager and/or the Assistant Program Manager, when available, and to the Clinical on Call evening, nights, and weekends to give management the opportunity to resolve the matter and facilitate decisions that will support safe, quality patient care.
4. Management review and respond to the PRWRF in writing as per the Collective Agreement and engage in dialogue with the nurse(s) about the complaint with the goal to resolve the immediate issue and move toward a long-term resolution, if required.
5. The Hospital engage the Association with planning for the implementation of an electronic PRWRF process. Once parties agree, move forward with the implementation within six months.
 - a. The process for submission of the form would be for the nurse(s) to complete the PRWRF and submit electronically to the manager.
 - b. The manager to respond within 10 days as per the Collective Agreement.
 - c. The manager to use the 10-day window to discuss the workload complaint with the nurse(s) involved, with an ONA representative present, if desired, to understand the concerns and to seek resolution.
 - d. Unresolved complaints will be presented at the Hospital Association Meeting as per the Collective Agreement with the intent to identify themes and work together on resolutions.
 - e. The Program Manager provide the Chief Nursing Executive (CNE) with a Workload Grievance Summary Report, every two weeks for the next six months, to include the number of PRWRFs completed, the workload issue documented, and any developing themes of concern. The CNE to support the Program Manager to develop corrective action plans and to support the manager and the nurses to resolve issues in a timely and effective manner.

⁹⁹ Hospital ONA Collective Agreement, Expiry June 7, 2021

3.11 Hospital Association Committee

6.03 Hospital-Association Committee¹⁰⁰

- (a) There shall be a Hospital-Association Committee comprised of representatives of the Hospital, one of whom shall be the Chief Nursing Executive or nursing designate and of the Union, one of whom shall be the Bargaining Unit President or designate. The number of representatives is set out in the Appendix of Local Provisions and the membership of the Committee may be expanded by mutual agreement.
- (c) The purpose of the Committee includes:
 - i) Promoting and providing effective and meaningful communication of information and ideas, including but not limited to workload measurement tools and the promotion of best practices. Such communication may include discussion of nursing workload measurement and patient acuity systems. The Hospital will provide, upon request, information on workload measurement systems applicable to nursing currently used by the Hospital, and evaluations completed by the Hospital of such systems.
 - ii) Reviewing professional responsibility complaints with a view to identifying trends and sharing organizational successes and solutions, making joint recommendations on matters of concern including the quality and quantity of nursing care and discussing the development and implementation of quality initiatives;
 - iii) Making joint recommendations to the Chief Nursing Executive; on matters of concern regarding recurring workload issues including the development of staffing guidelines, the use of agency nurses and use of overtime;
 - iv) Dealing with complaints referred to it in accordance with the provisions of Article 8, Professional Responsibility;
 - v) Discussing and reviewing matters relating to orientation and in-service programs;
 - vi) Promote the creation of full-time positions for nurses, and discuss the effect of such changes on the employment status of the nurses.

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

¹⁰⁰ Hospital ONA Collective Agreement, Expiry June 7, 2021

The IAC Recommends:

1. The HAC meetings be re-established on a renewed basis with the intent to follow the process and intent outlined in Article 6.03 of the Collective Agreement.
2. All parties in attendance at the HAC, treat one another in a professional, respectful manner and through dialogue seek to find common solutions to identified concerns.
3. The following format for HAC be adopted.
 - a. Meetings to be Chaired on an alternating basis by ONA and the Hospital
 - b. Minutes continue to be taken by ONA and the Hospital, alternating on a monthly basis and circulated within one week to all members of the Committee
 - c. The Agenda be circulated 10 days prior to the meeting to give all parties ample opportunity to add any issues/items required by either party
 - d. The CNE/Directors continue to attend meetings when related to workload
 - e. When agreement on an issue(s) is achieved, the agreement be put in writing, reviewed, and signed by all parties to ensure that all agree and sign off on joint decisions.
 - f. That a separate meeting be called to deal with workload concerns that are escalating in a particular unit so that trends can be identified, and corrective action put in place in a timely and effective manner.

4.1 CONCLUSION AND SUMMARY OF RECOMMENDATIONS:

After completing a thorough review and analysis of the Pre-Hearing documentation received from both parties and the presentations at the Hearing held on June 1, 2, & 3, 2021, the IAC has made seventy-nine (79) recommendations in the following eleven (11) areas:

**I Hospital Admissions "No Bed Admit" Patients Held in the Emergency Department:
Six (6) Recommendations**

1. Starting immediately, the resource nurse attend and participate in the daily bed flow meetings to report on the number of patients waiting in ED for a bed and any potential admissions.
2. Staff continue to page 'nurse required' when in a crisis for short-term patient care support.
3. The Hospital develop a policy, within three months, that would allow for the assignment of a medical nurse to the ED to care for admitted medical patients when there are five (5) medical no bed admissions and no anticipated beds for the next twelve (12) hours. The Resource Nurse to determine when it is necessary to activate this policy based on workload in the ED and the Departments ability to provide safe, quality care to other Emergency patients.
4. The Hospital develop a policy, within three months, that would allow for the assignment of a critical care nurse to the ED, from the admitting ICU, to care for the patient if there is no ICU bed available. The Resource Nurse to determine when it is necessary to activate this policy based on the workload in the ED and the Departments ability to provide safe, quality patient care to other Emergency patients.

5. The policy developed states the Resource Nurse has the authority to call in an ED RN, without consultation with the Clinical on Call:
 - a. when a medical nurse or ICU nurse is not available;
 - b. if an RN is not available a RPN to be called in;
 - c. if no ED nurse available call the Clinical on Call to facilitate a nurse reassignment from within the Hospital.

This Policy to be evaluated in six months with input from Management, the Association, and the Resource Nurses.

6. The Hospital review the current status of the Flow Committee including terms of reference and mandate and within three (3) months develop a best practice bed management policy with a corporate commitment to make ED admit no bed patients a priority.

II Human Resources Planning and Registered Nurses Staffing: Twenty-Two (22) Recommendations

Full Time Equivalents and Headcount: Two (2)

1. The ED increase its full time RN complement to a minimum of 70%. This will reduce the need to schedule part time or casual part time nurses above their part time commitment, on a regular basis, to fill the base schedule. This will provide a pool of available staff to fill in short-term and long-term vacancies and will also result in a cost savings as the need for overtime will decrease.
2. The Hospital and Program Manager review and consider accessing the Government Funded Nursing Graduate Guarantee (NGG) Program to assist with recruitment of full time nurses with adequate funding to effectively orientate and transition to the ED practice environment.

Sick Time and Overtime: Three (3)

1. The Program Manager work with the Health and Wellness team to hold a nurse specific wellness session to focus on issues relevant to nurses in the ED.
2. The Program Manager assess the contributing factors to the high sick time and develop a plan to reduce sick time to the 2018/19 level of 1.6 FTE within two years, by September 2023. That will represent 3,120 total paid sick hours, equivalent to 94.6 paid sick hours or 7.9 (12 hour) shifts or 11.8 (8 hour) shifts, per nurse assuming 33 full time nurses.
3. The Program Manager assess the contributing factors to the overtime shifts and develop a plan with a goal to eliminate overtime shifts as a cost reduction strategy and to minimize the need for nurses to work excessive hours by September 2022. This will reduce the stress of nurses feeling that they need to go to work, when called for overtime, to support their colleagues who will work short staffed if they say no to the overtime shift.

Staff Turnover: Three (3)

1. The Program Manager closely monitor the staff turnover to understand what is driving the high turnover in the ED. Once factors have been identified the Program Manager will create a

corrective action plan with a goal to reduce turnover rate to 5% by December 2022 and to 3% by July 2023.

2. Every nurse leaving the ED have the opportunity for an exit interview, electronically, if possible, and in person if requested. The exit interview process to be conducted by the Human Resources Department.
3. All nursing leadership from the Chief Nursing Executive to the Director, to the Program Manager, and to the Assistant Manager will commit to creating a nursing culture which values the nurses and their unique contribution to safe, quality patient care and that leads to staff satisfaction that supports a commitment to stay in their positions.

Recruitment and Retention: Four (4)

1. The Program Manager, with the Human Resources Department, develop a comprehensive nursing recruitment and retention strategy for the ED with a goal to fill long term vacancies prior to the person taking leave and to decrease staff turnover to 5% by December 2022 and to 3% by July 2023.
2. The Program Manager and Assistant Manager develop a schedule to ensure that one of them is available in the ED, on a daily basis, to consult with the Resource Nurse to assess the patient care requirements and to support short term staffing needs for the next 24 hours. On Friday, the consultation to include assessing any known staffing gaps throughout the weekend.
3. The Program Manager assess the key areas of nurse dissatisfaction within the ED and develop a corrective action plan, which is to be informed through staff input, to address these issues by March 2022.
4. The Program Manager and Educator develop an onboarding evaluation program for every new RN hire that involves a one-on-one discussion at three (3) months, six (6) months and one year. The discussion to include, but not limited to the following topics:
 - a) performance and achievements to date;
 - b) what is working well from an education, orientation, and integration perspective;
 - c) any areas of concern; and,
 - d) any opportunities for improvement.

Staffing Requirements Specific to Each Area in the Emergency Department: Seven (7)

1. An increase in five (5) RN positions, in the ED, for each 24 hour period for a total of eleven (11) RNs on days and nine (9) RNs on nights. The three (3) swing shifts to be maintained. Postings for all additional RNs recommended, as outlined below, for Triage, Acute/Subacute Care Area and Ambulatory Care Area, to be posted, as soon as possible, but no later than three months from the date of this Report, July 16, 2021.

Triage Area

2. A second Triage RN be assigned 24/7 to ensure timely assessment of all patients coming to the ED and to meet the CTAS reassessment requirement of patients in the waiting room.

3. The Vice President Patient Services and Chief Nursing Executive review all new funding allocation for expanded Cardiac, Thoracic, Respiriology, and Cancer services and advocate for additional budget to ensure that the ED can be staffed adequately to respond to the patients that will access these specialized services through the ED.

Acute Care and Subacute Care Area

4. An additional RN be assigned to float between Acute Care and Subacute Care 24/7.

Ambulatory Care Area

5. An RN be assigned in the Ambulatory Care Area in addition to the RPN.
6. The Program Manager monitor utilization of the ACA, both volumes and acuity of patients, over a two month period to determine if the ACA should remain open 24/7.
7. If the ACA is to remain open 24/7 staff with an RN and RPN 24/7.

Resource Nurse: Three (3)

1. The Program Manager and Assistant Manager roles and responsibilities should be communicated to all ED staff.
2. The Resource Nurse should be supported in their role by the Program Manager and Assistant Manager, on a daily basis.
3. The Resource Nurse role does not take a patient assignment, cover for breaks, cover Ambulance Triage or any other duties that take them away from their key responsibilities of ensuring safe, quality patient care, supporting staff, managing patient flow and efficient and effective running of the day-to-day operations. The Resource Nurse will use his/her professional discretion to intervene and provide patient care, as appropriate, to ensure safe, quality care for all patients within the ED.

III Skill Mix Registered Nurses and Registered Practical Nurses: 2 (Two) Recommendations

1. An RN be assigned in the Ambulatory Care Area in addition to the RPN (as recommended above)
2. The Hospital conduct an evaluation of the RN/RPN Model of Care in the ED. Evaluation to be done by an external expert on RN/RPN Model of Care implementation in an Emergency Department.

IV Education: Nine (9) Recommendations

1. Orientation of novice nurses to be increased to 36 shifts, immediately, and reassessed by the orientee, preceptor and Nurse Educator at 18 shifts to assess effectiveness of knowledge transfer. Orientation may continue with the option to increase autonomy by

varying levels or may be transitioned to complete autonomy and discontinued based upon past experience, knowledge and other factors.

2. Staff be encouraged to become preceptors and a list of available preceptors be maintained by the educator.
3. Preceptors be given information and education on the role of a preceptor.
4. One Preceptor will be assigned for an orientee's full orientation program.
5. The Educator to devote 80% of time in the ED providing education to the ED staff.
6. The Hospital provide the fees for the Pediatric Emergency Assessment, Recognition and Stabilization (PEARS) course. This may be done using a staggered approach as courses become available with recertification required every two years.
7. Using Benner's Stages of Clinical Competence, the Nurse educator will meet with each staff member over the next six months to determine their level of Clinical Competence using the Emergency Nurses of Ontario Competency Checklist (Revised April 2019). The competency list to be updated by each RN as skills are developed and reviewed annually with the educator.
8. The Triage Nurse will have two years of emergency room experience, complete the Triage Course, and demonstrate situational awareness before being assigned to Triage.
9. The ED Educational Working Group continue its work on assessing current state and informing future state related to:
 - a) Current recruitment credentials and education requirements;
 - b) Orientation and Onboarding Program;
 - c) Continuing Education.

V Equipment: Seven (7) Recommendations

1. The Hospital purchase, immediately, a crash cart which will be situated in the ACA.
2. The Hospital ensure, immediately, that each crash cart has a working Zoll defibrillator.
3. The Hospital assess the non-clinical positions in the ED to determine an appropriate role to take on the responsibility to monitor and to check equipment and supplies and maintain regular stock quotas. Equipment and supplies to be replaced before expiry.
4. The Hospital work with the Biomedical team to develop a proactive Biomedical equipment process to perform preventative maintenance and to ensure that all equipment is in working order or is replaced in a timely manner.
5. A Registered Nurse be assigned, on the daily work assignment, to check the crash carts and the Braslow cart daily and following each use.

6. All Registered Nurses who notice that a piece of equipment is not working or notice that supplies are expired will proactively address this and ensure that the matter is resolved by reporting to the appropriate person or if possible, replacing the item.
7. All ED staff when transferring a patient to an inpatient bed will ask the receiving unit to provide an IV pump for every pump that will be left on the receiving unit.

VI Workplace Violence in the Emergency Department: Seven (7) Recommendations

1. The Hospital ensure security officer presence in the ED 24/7, effective immediately.
2. Security guard will round hourly in the ED. The security guard to be located in an area that is visible to patients and staff.
3. Security guards will be level three trained and will intervene as needed to protect staff and patients.
4. The Hospital conduct an annual Risk Assessment of the Emergency Department with an ED staff member and a member of the Joint Occupational Health and Safety Committee (JOHSC). Risks will be identified and reported to the leadership team and to the JOHSC and a corrective action plan, with timelines, will be developed and implemented.
5. The Hospital develop an education and training plan for the ED and security staff on de-escalation strategies and nonviolent interventions from a recognized program such as Non-violent Crisis Intervention or Trauma-Informed De-escalation Education for Safety and Self-Protection (TIDES). The plan to be fully implemented by September 2022.
6. The Code Silver Policy be implemented with staff training and a plan for mock Code Silvers by November 30, 2021.
7. The GPS staff alarm system be implemented by September 2022.

VII Safety/Housekeeping: Three (3) Recommendations

1. The Hospital implement a plan to assign dedicated housekeeping staff to maintain the physical environment of the Emergency Department including the waiting rooms by October 2021.
2. The Hospital purchase and install Plexiglas dividers/partitions between the chairs in both waiting areas by October 2021.
3. The Hospital develop and administer a Post COVID survey to the Emergency Department staff and physicians with questions related to lessons learned, what went well, and opportunities for improvement. The results to be shared with staff and physicians. Relevant ideas and suggestions will be implemented immediately, if appropriate, or added to future pandemic plans for the Emergency Department.

VIII Morale and Toxic Work Environment: Eight (8) Recommendations

1. The Hospital and the Association agree to a process for a third party culture assessment of the ED and that the Hospital proceed to book this within the next three (3) months.
2. The Hospital conduct a valid quality of work life staff survey for the nurses in the ED with questions specific to all aspects of the environment. These would include but not limited to the work environment, safety, leadership, and quality of patient care.
3. The Hospital and the Association review the results of the quality of work life survey and together with the nurses identify themes requiring improvement and develop a corrective action plan with specific outcome measures and timelines. *(NOTE: if the Hospital can ask for nurse specific results from the last Quality of Life staff survey done for Accreditation, this may serve as a starting point to identify opportunities for improvement).*
4. The Hospital and the Association review the RNAO Best Practice Guideline: Workplace Health, Safety, & Wellbeing of the Nurse and implement those recommendations that both parties agree will be appropriate to improve nurse and management morale in the ED.
5. The Hospital develop an evaluation process to monitor and measure the impact of implementing changes within the Department that affect the nurses work life, scheduling, or practice environment. This can be done through surveys and focus groups.
6. The Hospital continue its Mental Health and Wellness initiatives and expand the focus beyond the Pandemic.
7. The Program Manager work with the Health and Wellness team and the ED nurses to implement the ED wellness program focused on burnout and stress, presently in a draft form.
8. The Unit Based Council (UBC) continue to meet monthly and to develop Terms of Reference. Agendas to be developed with input from all staff. All minutes to be posted for all staff within a week of the meeting. Management to be invited as required.

IX Leadership and Communication: Seven (7) Recommendations

1. All nursing leadership, including the Chief Nursing Executive, Clinical Director, Program Manager, Assistant Manager and Educator, increase their visibility in the ED to understand the daily stresses of the RNs and to support their work and decision making.
2. Nursing Leadership review the RNAO International Affairs and Best Practice Guideline (BPG): Developing and Sustaining Nursing Leadership, Second Edition (2013) and determine practices outlined in the BPG that could be adopted to develop nursing leaders at all levels of the organization from the bedside to the boardroom.

3. Nursing leadership engage positively in the Professional Responsibility Process to create a positive culture, to establish collaboration, problem-solving and open and effective communication, at all times, to achieve mutually agreeable resolutions as issues arise.
4. Program Manager to have daily "huddles" with RNs to ask about their day and if there is anything that can be done to assist them to do their job better.
5. Management and staff to work together collaboratively to develop a new and positive work environment based on mutual respect and trust. After the culture survey is complete, engage an external facilitator to assist in identifying the roles that each person needs to play in working towards the achievement of common goals.
6. Management implement regular staff meetings with nursing input into the agenda. Schedule these at a time when staff can attend. Meeting minutes to be documented, printed, and posted on the unit bulletin board.
7. Management and staff agree to adhere to the Code of Conduct Policy and all organizational policies.

In addition to the above recommendations, the IAC believes that there is a unique opportunity for management and the ED nurses to commit to a new, open and transparent communication style by demonstrating a renewed commitment to using the HAC as a forum for open dialogue aimed at addressing and resolving issues and concerns that are impacting nursing workload and safe, quality patient care.

X Professional Responsibility Workload: Five (5) Recommendations

1. The Hospital and the local Association work together to improve the Professional Responsibility Workload (PRW) process with the goal of implementing a collaborative approach to resolving workload concerns. This will include commitment on both sides to follow the steps in the collective agreement including timelines established in this process.
2. RNs in the ED continue to document their concerns on the Professional Responsibility Workload Report Form, in alignment with the Collective Agreement.
3. RNs in the ED make an effort to communicate their patient care concerns, to the Program Manager and/or the Assistant Program Manager, when available, and to the Clinical on Call evening, nights, and weekends to give management the opportunity to resolve the matter and facilitate decisions that will support safe, quality patient care.
4. Management review and respond to the PRWRF in writing as per the Collective Agreement and engage in dialogue with the nurse(s) about the complaint with the goal to resolve the immediate issue and move toward a long-term resolution, if required.
5. The Hospital engage the Association with planning for the implementation of an electronic PRWRF process. Once parties agree, move forward with the implementation within six months.

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

XI Hospital Association Committee (HAC): Three (3) Recommendations

1. The HAC meetings be re-established on a renewed basis with the intent to follow the process and intent outlined in Article 6.03 of the Collective Agreement.
2. All parties in attendance at the HAC, treat one another in a professional, respectful manner and through dialogue seek to find common solutions to identified concerns.
3. The following format for HAC be adopted.
 - a. Meetings to be Chaired on an alternating basis by ONA and the Hospital;
 - b. Minutes continue to be taken by ONA and the Hospital, alternating on a monthly basis and circulated within one week to all members of the Committee;
 - c. The Agenda be circulated 10 days prior to the meeting to give all parties ample opportunity to add any issues/items required by either party;
 - d. The CNE/Directors continue to attend meetings when related to workload;
 - e. When agreement on an issue(s) is achieved, the agreement be put in writing, reviewed, and signed by all parties to ensure that all agree and sign off on joint decisions;
 - f. That a separate meeting be called to deal with workload concerns that are escalating in a particular unit so that trends can be identified, and corrective action put in place in a timely and effective manner.

The members of the IAC unanimously support all recommendations in this Report. The IAC hopes that the recommendations and this process will assist the Hospital and the Association to find mutually agreeable resolutions to workload concerns and to create a quality practice environment in the Emergency Department at St. Mary's General Hospital.

Appendix 1

Letter from ONA to SMGH December 18, 2020



Ontario Nurses' Association

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

December 18, 2020

SENT VIA EMAIL

Leisa Faulkner
Vice President, Patient Services & Chief Nursing Executive (Acting)
St Mary's General Hospital
911 Queen's Blvd
Kitchener, ON
N2M 1B2

Dear Leisa,

This letter is in follow up to our discussions at the PRC/Hospital Association meeting on July 16, 2020 regarding professional practice and workload issues in the Emergency Department at St. Mary's General Hospital (SMGH) and is in accordance with Article 8.01(a) v) of the Hospital/Ontario Nurses' Association (ONA) collective agreement.

The Registered Nurses (RNs) working in the Emergency Department at St. Mary's General Hospital have consistently identified serious practice and workload concerns, as evidenced by the data submitted on one hundred and sixty-eight Professional Responsibility Workload Report Forms (PRWRFs) since January 2019 to today's date.

The RNs working in the Emergency Department have documented that the current practice, patient care and workload environment does not allow them to meet College of Nurses of Ontario (CNO) standards; and they believe they are being asked to perform more work than is consistent with proper patient care. Effective supports have not been provided to respond to patient acuity and volumes, fluctuating workloads, fluctuating staffing and professional practice issues.

The parties met regularly until July 2020, prior to discussions breaking down. ONA extended timelines to provide management with the opportunity to develop strategies and take actions to resolve the practice concerns and workload issues. Despite this, the employer has been unable to propose or agree to sufficient measures to resolve the very serious practice and workload concerns identified by ONA members. As discussed at the last meeting, actions to date have not sufficiently resolved the workload and practice concerns, and have had little impact on nursing workload, patient safety and standards of care. In accordance with the ONA/Hospital Central Collective Agreement, the Union is seeking resolution of the concerns on behalf of our members and the patients that they care for, and remains very concerned regarding the potential for catastrophic negative patient outcomes.

Unresolved issues in the Emergency Department include inadequate baseline Registered Nurse staffing to manage the volume and acuity of patients, and support safe and timely triaging of patients. Further issues include scope of practice concerns for RPN practice, with RPNs being placed in situations to practice beyond their scope of practice, as well as a lack of adequate

Leisa Faulkner/Letter dated December 18, 2020
SMGH Emergency Department/Advancing to IAC

equipment, and training and mentorship supports. There is a lack of and ineffective communication and leadership support, including demeaning and derogatory comments from management and a general overall lack of support for staff.

Timely and effective resolution of the Professional Responsibility Complaint is vital to enable Emergency Department RNs to deliver safe, competent and ethical patient care. Accordingly, the Union is forwarding the complaint to an Independent Assessment Committee, per Article 8 of the collective agreement. Should the parties resolve the issues prior to the IAC hearing, the request for an IAC hearing will be withdrawn.

Please be advised in accordance with the Hospital/Ontario Nurses' Association (ONA) collective agreement, Elle Ferris 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).

Ella's contact information is:

Ella Ferris
66 Lyall Avenue
Toronto, ON M4E 1W3
Phone: (647)290-8547
Email: ella.ferris@outlook.com

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

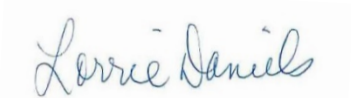
Cindy's contact information is:

Cindy Gabrielli, RN (EC), BScN, MSN
6285 McMicking St.
Niagara Falls, ON L2J 1W7
Phone (cell): 905-329-3597
Phone (home): 905-357-6276
Email cgabrielli@cogeco.ca

Please provide the name and contact information for your nominee to the Chairperson, Ella Ferris and copy the Union, in accordance with the timeframes set out in the Collective Agreement by January 17, 2021.

Yours truly,

ONTARIO NURSES' ASSOCIATION



Lorrie Daniels, RN, BScN (H)
Professional Practice Specialist

Leisa Faulkner/Letter dated December 18, 2020
SMGH Emergency Department/Advancing to IAC

C: Lee Fairclough, President, SMGH
 Stephanie Pearsall, Program Director, Surgical Services and Emergency, SMGH
 Wendy James, Manager Emergency Department, SMGH
 Sherri Ferguson, Vice President, Quality, People and Performance, SMGH
 Dr. Peter Potts, Chief of Staff, SMGH
 Dr. Jason Green, common Chief, GRH/SMGH Emergency Medicine
 David McCoy, Director, Labour Relations, OHA
 Erin Ariss, ONA Bargaining Unit President, SMGH
 Brenda Pugh, Local Coordinator, ONA Local 55
 Sherri Ludlow, Labour Relations Officer (Servicing), ONA
 Susan Delisle Gosse, Professional Practice Manager, ONA
 Matthew Stout, WDST Manager, ONA

Appendix 2

Letter Chair of IAC to SMGH February 11, 2021

February 11, 2021

SENT VIA EMAIL

Leisa Faulkner
Vice President, Patient Services and Chief Nursing Executive (Acting)
St. Mary's General Hospital
911 Queen's Blvd.
Kitchener, ON
N2M 1B2

Dear Leisa Faulkner,

This letter is in follow up to the letter sent to you, dated December 18, 2020, from Lorrie Daniels, Professional Practice Specialist, Ontario Nurses' Association (ONA), related to Article 8.01 (a) v) of the Hospital Ontario Nurses Association (ONA) Collective Agreement. In this letter you were asked to provide the name and contact information of the Hospital's nominee.

As of today February 9, 2021, you have failed to provide the name and contact information of your nominee to the Independent Assessment Committee (IAC). Therefore, as Chair of the IAC, I am writing to advise, that in accordance with the Hospital ONA Collective Agreement Article 8.01 (a) xii the IAC will proceed, and the IAC Hearing will take place on the following dates, Tuesday June 1st, Wednesday June 2nd and Thursday June 3rd, 2021.

Cindy Gabrielli, ONA Nominee and I are available these dates and look forward to confirming the next steps with you and the Hospital, in order that we can find a resolution to ensure safe, competent, and ethical care in the Emergency Department at St. Mary's General Hospital.

Please advise on the name of your nominee, if appointed prior to the commencement of the Independent Assessment Hearing dates.

Thank you for your consideration.

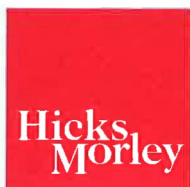
Yours truly,



Ella Ferris, RN, MBA
Chair Independent Assessment Committee

Appendix 3

Letter from SMGH Legal Counsel to IAC Chair February 18, 2021



Hicks Morley Hamilton Stewart Storie LLP
150 Caroline St. S., Suite 404
Waterloo, ON N2L 0A5
Tel: 519.746.0411 Fax: 519.746.4037

KATHRYN L. MEEHAN
kathryn-meehan@hicksmorley.com
Direct: 519.883.3120

Toronto
Waterloo
London
Kingston
Ottawa

File No. 590-246
February 18, 2021

Sent By Email: (ella.ferris@outlook.com)
STRICTLY PRIVILEGED & CONFIDENTIAL

Ella Ferris
Chair Independent Assessment Committee

Dear Ms. Ferris:

Re: Independent Assessment Committee Hearing - Emergency Department

We have been retained by St. Mary's General Hospital in the above noted matter.

We are in receipt of your correspondence to Ms Leisa Faulkner, Vice President, Patient Services and Chief Nursing Executive, indicating scheduled dates for the IAC Hearing of June 1, 2 and 3, 2021. Unfortunately Ms. Faulkner is not able to attend those dates due to another pre-scheduled matter which cannot be re-scheduled, so we are requesting that the IAC hearing matter be rescheduled for a date that she may attend.

I am also not available on June 1, 2021. I am scheduled to attend an arbitration hearing regarding an ONA grievance for St. Mary's General Hospital.

We can also advise that the Hospital is in the process of finalizing who will be the Hospital's Nominee and we anticipate being able to advise of that individual's name next week. Therefore, we would ask that the Hospital Nominee's availability also be taken into account in finding mutually agreeable dates. We will send separate correspondence confirming who will be the Hospital's Nominee as soon as possible.

Thank you kindly.

Yours very truly,

A handwritten signature in black ink, appearing to read "KLM", followed by a long horizontal flourish.

Kathryn L. Meehan

KLM/jt
13511001_1.docx

Appendix 4

Letter from IAC Chair to SMGH February 19, 2021

Ella Ferris
Ella.ferris@outlook.com

February 19, 2021

SENT VIA EMAIL

Kathryn L. Meehan
Hicks Morley Hamilton Stewart Storie LLP
150 Caroline St. South, Suite 404
Waterloo ON N2L 0A5

Re: Independent Assessment Committee Hearing Emergency Department St. Mary's General Hospital

Dear Ms. Meehan,


Thank you for your letter dated February 18, 2021. I understand that the Hospital is not available to attend the proposed Independent Assessment Hearing (IAC) dates of June 1, 2, 3, 2021 due to previous commitments. Further, you advised that the Hospital is in the process of finalizing the Hospital's nominee.

I look forward to hearing the name of the individual selected as the Hospital's IAC Nominee at your earliest convenience. At that time, I will work with the Hospital and the IAC members to finalize mutually agreeable dates for the IAC Hearing to proceed.

I have copied Lorrie Daniels, Ontario Nurses' Association Professional Practice Specialist and Cindy Gabrielli, Ontario Nurses' Association (IAC) Nominee and respectfully request that you copy these parties in all future correspondence in this matter.

Thank you for your consideration.

Yours truly,



Ella Ferris, RN, MBA
Chair Independent Assessment Committee

Copy: Lorrie Daniels, ONA Professional Practice Specialist
Cindy Gabrielli, ONA IAC Nominee

Appendix 5

Letter from ONA to IAC Chair February 19, 2021

February 19, 2021

Chair Ferris
66 Lyall Avenue
Toronto, ON M4E 1W3

Dear Ella,

Thank you for copying me on your correspondence today to Kathryn Meehan, as well as forwarding to me Kathryn's correspondence dated February 18, 2021. As you may be aware, Article 8.01 of the ONA-Hospital collective agreement was amended in the last round of central bargaining to address situations where one party fails to meet its obligations with respect to the IAC process, with respect to establishing the membership of an Independent Assessment Committee (IAC).

In particular, I note that ONA and St. Mary's General Hospital (SMGH) were given notice to proceed to an IAC proceeding on December 18, 2020. Following from that date, Article 8.01(a)(xii) required each party to appoint a nominee to the IAC no later than 30 days, being January 17, 2021. ONA appointed Cindy Gabrielli in our letter dated December 18, 2020; and as Kathryn Meehan's correspondence of February 18, 2021 acknowledged, SMGH still has not appointed its nominee to the IAC to date.

Since SMGH has failed to meet this timeline, it is ONA's position that SMGH has no ability to reject any process decision that the IAC members have decided in the absence of a SMGH nominee. As the second paragraph of Article 8.01(a)(xii) makes clear, the failure of either party to the collective agreement to appoint a nominee in the required time frame does not affect the fact that "the process will proceed" in the absence of that party's nominee. I, of course, acknowledge that SMGH can appoint a nominee to the IAC today or any day until the IAC hearing begins on June 1, 2021. However, the late appointment of the SMGH nominee to the IAC should not allow that nominee to override anything that the IAC had decided to do in accordance with the collective agreement up to that late date of appointment. To put it in colloquial terms, "the horse is out of the barn" and decisions already made cannot be undone; to allow SMGH to change decisions that it could have had input into but did not due to the failure of SMGH to appoint its nominee to the IAC would undermine the collective agreement change made by the addition of the phrase "the process will proceed" in Article 8.01(a) in the last round of Hospital-ONA bargaining.

On a related note, I have consulted with the ONA bargaining unit, and there is no grievance scheduled for arbitration on June 1, 2021 of which they are aware. If Ms. Meehan could clarify which grievance she believes has been scheduled for a hearing on June 1, 2021, I will share that

information with the bargaining unit.

Yours Truly,

ONTARIO NURSES' ASSOCIATION



Lorrie Daniels
ONA Professional Practice Specialist

C: Kathryn Meehan, Employer Counsel
Cindy Gabrielli, ONA Nominee
Erin Ariss, RN, Local 55 Bargaining Unit President
Sherri Ludlow, ONA Labour Relations Officer (Servicing)

Appendix 6

Letter from IAC Chair to ONA March 1, 2021

Ella Ferris
Chair, SMGH Independent Assessment Committee
Ella.Ferris@outlook.com

Lorrie Daniels
ONA Professional Practice Specialist
Ontario Nurses Association
85 Grenville Street, Suite 400,
Toronto, Ontario M5S 3A2

SENT VIA EMAIL

March 1, 2021

Dear Lorrie,

Thank you for your letter dated February 19, 2021 clarifying ONA's position related to the changes in article 8.01 in the last ONA-Hospital Collective Agreement. I understand that the phrase "the process will proceed" was added to article 8.01 (a) to address situations where one party fails to meet its obligations with respect to establishing the members of an Independent Assessment Committee (IAC).

You have expressed concern that in failing to appoint the Hospital IAC Nominee, St. Mary's General Hospital (SMGH) has failed to comply with the requirements of article 8.01 and that allowing the Hospital to alter the ability of the IAC to proceed, as planned, results in undermining the change outlined during the last round of Hospital-ONA bargaining.

To address the concerns outlined in your letter, I will be sending Kathryn Meehan, Employer's Counsel, a letter advising that the SMGH IAC will proceed on June 1, 2, 3, 2021. I will also request a list of documents with information from SMGH that will assist the IAC members to conduct the work of the IAC. Further, I will advise that I look forward to working with the Hospital IAC Nominee as soon as their Nominee is selected.

I trust that this approach will suffice to address ONA's expressed concerns.

Thank you.

Sincerely,



Ella Ferris RN, MBA
Chair, Independent Assessment Committee SMGH

Copy: Kathryn Meehan, Employer Counsel
Cindy Gabrielli, ONA Nominee
Erin Ariss RN, Local 55 Bargaining Unit President
Sherry Ludlow, ONA Labour Relations Officer (Servicing)

Appendix 7

Letter from IAC Chair to SMGH March 4, 2021

Ella Ferris
Ella.ferris@outlook.com

March 4, 2021

SENT VIA EMAIL

Kathryn L. Meehan
Hicks Morley Hamilton Stewart Storie LLP
150 Caroline St. South, Suite 404
Waterloo ON N2L 0A5

Re: Independent Assessment Committee Hearing Emergency Department St. Mary's General Hospital

Dear Ms. Meehan,

I am writing in follow-up to your letter to me dated February 18, 2021 as well as the letter from Lorrie Daniels, ONA Professional Practice Specialist to me dated February 19, 2021 related to the St. Mary's General Hospital (SMGH) Independent Assessment Committee (IAC).

As the Chair of the SMGH-IAC I wish to advise the Hospital that the IAC Hearing will be proceeding as scheduled on June 1,2,3, 2021 for several reasons. First, to date the hospital has not provided any alternative dates for the SMGH-IAC. Secondly, the hospital has not provided the name of a Hospital IAC Nominee. And thirdly, in response to the concerns related to Article 8.01 of the Hospital-ONA collective agreement, as outlined in the ONA letter dated February 19, 2021 to which you were copied.

Further, I have attached a document outlining a list of documents requested from SMGH, no later than May 4, 2021. This information, with the relevant documents is required to assist the IAC to conduct our work, including our analysis, deliberations, and recommendations.

To move forward and to find a mutually agreeable approach for the SMGH-IAC, I look forward to a response from the Hospital as soon as possible regarding the appointment of their IAC Nominee and to plan the next steps for the IAC Hearing.

It is my goal to achieve a successful IAC review and Final Report for the Hospital and ONA. As soon as the Hospital's IAC Nominee is selected, I will work with that individual, ONA's IAC Nominee and all relevant parties in the best interest of ONA and the Hospital to complete the IAC.

Thank you for your consideration.

Yours truly,



Ella Ferris, RN, MBA
Chair Independent Assessment Committee

Copy: Leisa Faulkner, Vice President, Patient Services and Chief Nursing Executive (Acting), SMGH
Lorrie Daniels, ONA Professional Practice Specialist
Cindy Gabrielli, ONA IAC Nominee

Independent Assessment Committee for St. Mary's General Hospital

Data Request on March 4, 2021 with request for information no later than May 4, 2021

1) Patient Information for the Emergency Department (ED) for the past three fiscal years April 1, 2018 to March 31, 2019; April 1, 2019 to March 31, 2020; and April 1, 2020 to March 31, 2021

- a) Volumes by year, day of the week and by hour of the day
- b) Distribution by CTAS level; by year, day of the week, and hour of the day
- c) Ambulance volumes and offload times by year, day of the week, date, and hour of day
- d) Time to initial assessment by nurse and by doctor
- e) Admission by CTAS level including admission rate
- f) Number of admits with no beds by hour of the day
- g) Time to admission after decision to admit
- h) ED length of stay by day of the week

2) Unit Organization/Functioning

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

3) Staffing Data for fiscal 2018-2019, 2019-2020, 2020-2021 (April 1st to March 31st)

- a) Budgeted Full-time Equivalents (FTEs) for all staff categories in the ED
- b) Total paid hours in FTE's for full-time (FT), part-time (PT), casual, agency RNs YTD
- c) Number of FT, PT, and casual RNs (i.e., headcount)
- d) Number of RN and RPN positions in the current fiscal year 2020-2021

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

4) Budget and Performance Indicators for the past three fiscal years 2018-2019, 2019-2020, 2020-2021 (April 1st to March 31st)

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

5) Quality of Care Performance Indicators

- a) Patient Satisfaction Results in ED for the past three years
- b) Staff and Physician Satisfaction Results for the past two time periods collected
- c) Number and type of critical incidence in the ED for the past three years
- d) Number and type of staff injury in ED for the past three years
- e) Number of Medication incidents in the past three years
- f) Number of patient falls in the past three years
- g) Results of triage audits for the past three years
- h) Program Quality Committee Minutes and/or Department or Program Meetings related to staffing and change processes for the past three years
- i) Reports on any other indicators being utilized to monitor and evaluate efficiency, effectiveness, and quality care in the ED during the past three years

6) Hospital Association Committee (HAC) Agendas and Minutes from 2018, 2019, 2020, 2021 and any other Agendas and Minutes of meetings regarding workload complaints in the ED

7) ED Staff Meeting Minutes for 2018, 2019, 2020 and 2021

Appendix 8

Letter from SMGH to IAC Chair March 11, 2021



Hicks Morley Hamilton Stewart Storie LLP
150 Caroline St. S., Suite 404
Waterloo, ON N2L 0A5
Tel: 519.746.0411 Fax: 519.746.4037

KATHRYN L. MEEHAN
kathryn-meehan@hicksmorley.com
Direct: 519.883.3120

Toronto
Waterloo
London
Kingston
Ottawa

File No. 590-246

March 11, 2021

Sent By Email: (ella.ferris@outlook.com)
STRICTLY PRIVILEGED & CONFIDENTIAL

Ella Ferris
Chair Independent Assessment Committee

Dear Ms. Ferris:

Re: Independent Assessment Committee Hearing - Emergency Department

We write to inform you that the Hospital's IAC nominee in the above-referenced matter is Ms. Jayne Menard. Our nominee's contact information is as follows:

- Telephone: 519-421-4218
- Email: jmenard@wqh.on.ca

Yours very truly,

A handwritten signature in blue ink, appearing to read "KLM", with a long horizontal flourish extending to the right.

Kathryn L. Meehan

KLM/jt
13656872_1.docx

c.c.: Lorrie Daniels, ONA Professional Practice Specialist, via email
Cindy Gabrielli, ONA IAC Nominee, via email

Appendix 9

Email from SMGH to IAC Chair March 22, 2021

FW: St. Mary's General Hospital and Independent Assessment Committee - Hearing



Ella Ferris <ella.ferris@outlook.com>

2021-06-12 4:32 PM

To: Ella Ferris

Sent from [Mail](#) for Windows 10

From: [Johana Toriumi](#)

Sent: March 22, 2021 9:42 AM

To: ella.ferris@outlook.com

Cc: [Kathryn L. Meehan](#); LORRIED@ona.org; cgabrielli@cogeco.ca

Subject: St. Mary's General Hospital and Independent Assessment Committee - Hearing

Dear Ms. Ella Ferris,

Please be informed that the Hospital will be in attendance on June 1, 2 and 3, 2021.

Many thanks.

Johana Toriumi

Legal Assistant to [Kathryn L. Meehan](#)

johana-toriumi@hicksmorley.com

t: 519.883.3109

Hicks Morley Hamilton Stewart Storie LLP

150 Caroline St. S., Suite 404, Waterloo, ON N2L 0A5

[Website](#) | [Twitter](#) | [LinkedIn](#)

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Appendix 10

Letter from IAC Chair to SMGH March 25, 2021

Ella Ferris
Ella.ferris@outlook.com

March 25, 2021

SENT VIA EMAIL

Kathryn L. Meehan
Hicks Morley Hamilton Stewart Storie LLP
150 Caroline St. South, Suite 404
Waterloo ON N2L 0A5

Re: St. Mary's General Hospital (SMGH) Brief to the Independent Assessment Committee (IAC)

Dear Ms. Meehan,

As the Chair of the Independent Assessment Committee, SMGH-IAC I am writing to acknowledge receipt of the email, dated March 22, 2021 from Johana Toriumi, confirming the Hospital's attendance at the SMGH-IAC Hearing scheduled for June 1, 2, and 3, 2021. Now that all parties agree with the IAC Hearing dates, I am writing to request that the Hospital submit their Brief to me, electronically, no later than May 10, 2021.

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

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

Please note that although item number 4 above states that the Brief is to be sent via courier, I am requesting that it be sent electronically to ensure timely distribution to all parties. On receipt of both the Hospital's and the Union's Briefs on May 10, 2021, I will distribute the briefs to each party simultaneously, as well as to members of the IAC Committee, in compliance with my responsibility as Chairperson.

Thank you for your attention to this request.

Yours truly,



Ella Ferris, RN, MBA
Chair Independent Assessment Committee

Copy: Leisa Faulkner, Vice President, Patient Services and Chief Nursing Executive (Acting), SMGH
Lorrie Daniels, ONA Professional Practice Specialist
Cindy Gabrielli, ONA IAC Nominee
Jayne Menard, SMGH IAC Nominee

Appendix 11

Letter from SMGH to IAC Chair May 1, 2021



Hicks Morley Hamilton Stewart Storie LLP
150 Caroline St. S., Suite 404
Waterloo, ON N2L 0A5
Tel: 519.746.0411 Fax: 519.746.4037

KATHRYN L. MEEHAN
kathryn-meehan@hicksmorley.com
Direct: 519.883.3120

Toronto
Waterloo
London
Kingston
Ottawa

File No. 590-246
May 1, 2021

Sent By Email: (ella.ferris@outlook.com)
STRICTLY PRIVILEGED & CONFIDENTIAL

Ella Ferris
Chair Independent Assessment Committee

Dear Ms. Ferris:

**Re: Independent Assessment Committee Hearing - Emergency Department
St. Mary's General Hospital**

I am writing to advise that St. Mary's General Hospital has been working diligently to collect all of the documentation requested in your March 4, 2021 letter. Unfortunately, the Hospital's IT system has not been functioning properly since Thursday, April 22, 2021. This has resulted in the Hospital's administration not having access to files, which has greatly hampered the Hospital's ability to gather the documentation.

I have been advised that the IT team is continuing to work to fix the problem and as such it is our hope that the Hospital will be able to provide all of the documentation in accordance with the May 4, 2021 deadline. Nonetheless, I wished to advise you in advance of this potential obstacle. If the IT team is not able to resolve the system problems in time, we will provide you with all of the documentation that the Hospital has gathered thus far (which is extensive) on May 4, 2021 so that the panel and ONA may begin to review it. We will also flag in the document brief any information that is missing from the March 4, 2021 list and will provide such information at the earliest possible time.

I trust this is satisfactory. Please do not hesitate to contact me if you have any questions.

Yours very truly,

A handwritten signature in blue ink, appearing to be "KLM", written over a light blue horizontal line.

Kathryn L. Meehan

KLM/jt
13957403_1.docx

- c.c.: 1. Jayne Menard, Hospital's Nominee, via email: jmenard@wgh.on.ca;
2. Lorrie Daniels, ONA Professional Practice Specialist,
via email: LORRIED@ona.org; and
3. Cindy Gabrielli, ONA IAC Nominee, via email: cgabrielli@cogeco.ca

Appendix 12

Letter from IAC Chair to SMGH May 2, 2021

Ella Ferris
Ella.ferris@outlook.com

May 2, 2021

SENT VIA EMAIL

Kathryn L. Meehan
Hicks Morley Hamilton Stewart Storie LLP
150 Caroline St. South, Suite 404
Waterloo ON N2L 0A5

Re: St. Mary's General Hospital (SMGH) March 4, 2021 Documentation Request for the Independent Assessment Committee Review

Dear Ms. Meehan,

Thank you for your letter of May 1, 2021 advising of the Hospital's IT system failure that may cause a delay in the Hospital's ability to send all the documents requested, by the IAC, in my letter dated March 4, 2021.

The IAC will appreciate receiving any documents that are ready on May 4, 2021 and as you suggest the remaining documents, as soon as possible. This will allow our review to proceed as necessary to prepare for the IAC Hearing scheduled on June 1,2, and 3, 2021.

Please note that the Hospital's Brief requested in my letter dated March 25,2021 is different and distinct from the list of documents requested in my letter dated March 4, 2021. The Hospital's Brief is due on May 10, 2021. On receipt of both the Hospital's and the Union's Briefs, via email, I will distribute the briefs to each party simultaneously, as well as to members of the IAC Committee, in compliance with my responsibility as Chairperson.

Thank you very much.

Yours truly,



Ella Ferris, RN, MBA
Chair Independent Assessment Committee

Copy: Leisa Faulkner, Vice President, Patient Services and Chief Nursing Executive (Acting), SMGH
Lorrie Daniels, ONA Professional Practice Specialist
Cindy Gabrielli, ONA IAC Nominee
Jayne Menard, SMGH IAC Nominee

Appendix 13

Letter from SMGH to IAC Chair May 24, 2021



Hicks Morley Hamilton Stewart Storie LLP
150 Caroline St. S., Suite 404
Waterloo, ON N2L 0A5
Tel: 519.746.0411 Fax: 519.746.4037

KATHRYN L. MEEHAN
kathryn-meehan@hicksmorley.com
Direct: 519.883.3120

Toronto
Waterloo
London
Kingston
Ottawa

File No. 590-246
May 24, 2021

Sent By Email: (ella.ferris@outlook.com)
STRICTLY PRIVILEGED & CONFIDENTIAL

Ella Ferris
Chair Independent Assessment Committee

Dear Ms. Ferris:

**Re: Independent Assessment Committee Hearing - Emergency Department
St. Mary's General Hospital**

We have reviewed the ONA Brief Submissions and we have some clarification questions with respect to sources of information. We respectfully request that ONA provide source data for the following statements from the ONA Brief Submissions:

1. Population data/immigrant data- source (p. 4)
2. Population demonstrating greater cardiac care needs with increasing complexity (p. 4)-source
3. Door to triage time—quantify “extremely delayed” as suggested by work load forms (p. 5) range from 1 hour to greater than 2 hours (volume related to this issue?) - how often does this occur and how much of a delay?
4. Source for the statement that the cardiac care centre being expanded to include Electrophysiology for ablations has contributed to high staff turnover, decreased morale and burnout.
5. Reference to long waits for triage, increased patient acuity, complexity and volumes, patients waiting in waiting room, often 60-75 patients in the ED—source of information (pp. 12, 25)
6. Increasing paediatric patient volumes -source (pp.13, 29)
7. Concerns re: violence and staff safety were raised-source of concerns - source (p. 13)

8. Statement-conditions resulting in missed care, gaps in care and rationed care, negative patient outcomes, delays in assessing and intervening with chest pain and increased errors - source (p. 16)
9. Statement-ongoing strain has decreased job satisfaction, increased stress and burn out, loss of staff - source (p. 16)
10. Patient volumes data-source (p. 19)
11. Patient volume and acuity data-source (p. 21)
12. Graph (p. 23) - source and time period
13. Graph (p. 24) - source
14. Data indicating a 265% increase in acuity of patients assessed in SMGH ED — source (p. 25)
15. Two charts—STEMI comparison—source (p. 26)
16. Paragraph on Thoracic patients, comment on the patient type, intervention needed and acuity of the patients—source-(p. 29)
17. Statement—ED holds in AC can be 36 hours or longer -- source (p.31)
18. (pp 32, 33) all of the data referenced re: novice, FT, PT and turnover—source
19. (p. 36) statement on patient outcomes in sub acute last paragraph---are there patient examples associated with these claims and source?
20. Patient holds in the ED avg 8.2 per day and 986 patients have waited for space – source (p. 44)
21. CTAS level data (p.48) - source
22. Reference to significant number of workload forms in which working with novice staff was cited (p. 53): What is ONA's definition of novice staff? The Hospital is seeking clarification of how ONA is defining who is a novice nurse i.e. Years of experience as a nurse, years of experience as an emergency nurse or a proven framework such as Benner's novice to expert framework?

Yours very truly,



Kathryn L. Meehan

KLM/jt

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- c.c.: 1. Jayne Menard, Hospital's Nominee, via email: jmenard@wgh.on.ca;
2. Lorrie Daniels, ONA Professional Practice Specialist,
via email: LORRIED@ona.org; and
3. Cindy Gabrielli, ONA IAC Nominee, via email: cgabrielli@cogeco.ca

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Appendix 14

Email from IAC Chair to SMGH May 25, 2021

From: Kathryn L. Meehan
Sent: May 26, 2021 9:42 AM
To: Ella Ferris; Lorrie Daniels; Leisa Faulkner; Jayne Menard; cgabrielli@cogeco.ca
Cc: Johana Toriumi
Subject: RE: Correspondence to Chair - Request for Source Data SMGH re IAC

Thank you Ms Ferris.



Kathryn L. Meehan ("she/her")
kathryn-meehan@hicksmorley.com
t: 519.883.3120 | m: 226.338.5036
[Website Bio](#) | [LinkedIn Profile](#)

Hicks Morley Hamilton Stewart Storie LLP
150 Caroline St. S., Suite 404, Waterloo, ON N2L 0A5
[Website](#) | [Twitter](#) | [LinkedIn](#)

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From: Ella Ferris <ella.ferris@outlook.com>
Sent: May 25, 2021 4:56 PM
To: Kathryn L. Meehan <Kathryn-Meehan@hicksmorley.com>; Lorrie Daniels <LORRIED@ona.org>; Leisa Faulkner <lfaulkner@smgh.ca>; Jayne Menard <jmenard@wgh.on.ca>; cgabrielli@cogeco.ca
Cc: Johana Toriumi <Johana-Toriumi@hicksmorley.com>
Subject: RE: Correspondence to Chair - Request for Source Data SMGH re IAC

Dear Ms. Meehan,
I am writing to advise that ONA will provide the information that you request at the Hearing.
Thank you.
Regards,
Ella Ferris
Chair SMGHED-ONA IAC Hearing

Sent from [Mail](#) for Windows 10

From: [Kathryn L. Meehan](#)
Sent: May 24, 2021 10:11 PM
To: [Ella Ferris](#); [Lorrie Daniels](#); [Leisa Faulkner](#); [Jayne Menard](#); cgabrielli@cogeco.ca
Cc: [Johana Toriumi](#)
Subject: Correspondence to Chair - Request for Source Data SMGH re IAC

Hello Ms. Ferris,

Please see attached correspondence.

Kind regards,
Kathryn



Kathryn L. Meehan ("she/her")
kathryn-meehan@hicksmorley.com
t: 519.883.3120 | m: 226.338.5036
[Website Bio](#) | [LinkedIn Profile](#)

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Appendix 15

Hearing Agendas: June 1, 2, and 3, 2021

St. Mary's General Hospital Emergency Department (SMGHED) – Ontario Nurses' Association (ONA) Independent Assessment Committee (IAC) Hearing

**Agenda Final
Tuesday June 1, 2021
Zoom Meeting**

Time	Item	Participants
0830-0845	Welcome and Introductions	E. Ferris/All
0845-0855	Review of Proceedings by Chairperson	E. Ferris IAC Chair
0855-1000	Watch Virtual Tour of SMGH Emergency Department	All
1000-1015	Break	All
1015-1200	Ontario Nurses' Association Submission Presentation ONA Response to clarification questions from: <ul style="list-style-type: none">• Independent Assessment Committee• St. Mary's General Hospital	IAC, ONA, and SMGH
1200-1300	Lunch Break	All
1300-1430	St. Mary's General Hospital Submission Presentation	IAC, SMGH, ONA
1430-1440	Break	All
1440-1455	SMGH Response to clarification questions from: <ul style="list-style-type: none">• Independent Assessment Committee• Ontario Nurses' Association	IAC, SMGH, ONA
1455-1515	Review of Process for Wednesday June 2, 2021	IAC Chair
1515	Adjournment	IAC Chair

St. Mary's General Hospital Emergency Department (SMGHED) – Ontario Nurses' Association (ONA) Independent Assessment Committee (IAC) Hearing

Agenda Final (Revised May 27, 2021)

Wednesday June 2, 2021

Zoom Meeting

Time	Item	Participants
0830-0835	Welcome	E. Ferris/IAC Chair
0835-0845	Review of Proceedings by Chairperson	IAC Chair
0845-1045	St. Mary's General Hospital Response to Ontario Nurses' Association Submission	IAC, SMHG, ONA
1045-1100	Break	All
1100-1200	SMGH Response to questions from: <ul style="list-style-type: none">• Independent Assessment Committee• Ontario Nurses' Association• Discussion	IAC, SMGH, ONA
1200-1300	Lunch Break	All
1300-1500	Ontario Nurses' Association Response to St. Mary's General Hospital Submission	IAC, SMGH, ONA
1500-1515	Break	All
1515-1615	ONA Response to questions from: <ul style="list-style-type: none">• Independent Assessment Committee• St. Mary's General Hospital• Discussion	IAC, SMGH, ONA
1615-1630	Review of Process for Thursday June 3, 2021	IAC Chair
1630	Adjournment	IAC Chair

**St. Mary's General Hospital Emergency Department (SMGHED) – Ontario
Nurses' Association (ONA) Independent Assessment Committee (IAC) Hearing**

**Agenda Final
Thursday June 3, 2021
Zoom Meeting**

Time	Item	Participants
0900-0915	Welcome and Review of Proceedings	IAC Chair
0915-1045	Questions to both Parties by the Independent Assessment Committee	IAC, ONA and SMGH
1045-1100	Break	
1100-1145	Opportunity for ED Nurses to make comments	ED Nurses
1145-1200	Closing Remarks and Identification of Next Steps by Chairperson and Closure of Hearing	IAC Chair
1200	Adjournment	IAC Chair

Appendix 16

Email response from ONA re data sources for ONA's Brief Submission June 1, 2021

From: Lorrie Daniels
Sent: June 1, 2021 11:03 PM
To: Ella Ferris; cgabrielli@cogeco.ca; Jayne Menard; Kathryn L. Meehan; Leisa Faulkner
Subject: 20210601_Clarification Questions_ONA Response

Hello
Please find attached ONAs response to the Hospitals questions,
Thank-you

Lorrie

Lorrie Daniels, RN, BScN(H), MN (Leadership),
Professional Practice Specialist
Ontario Nurses Association
55 Head Street, Suite 306
Dundas, Ontario, L9H 3H8
Tel: 905-628-0850 ext. 5028
1-800-387-5580
Fax: 905-628-2557 or 1-866-928-3496
Email: lorried@ona.org
Website: www.ona.org

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Response to Counsel and Hospital Data Source Questions

1. Population and immigration https://www.regionofwaterloo.ca/en/regional-government/resources/Reports-Plans--Data/Public-Health-and-Emergency-Services/WR_ImmigrationProfile_2019.pdf
2. <https://www.smgh.ca/st-marys-needs-third-cardiac-catheterization-suite-for-safe-and-timely-response-to-growing-demand-for-life-saving-services/?hlite=%27youtube%27%2C%27Dr.%27%2C%27Brian%27%2C%27McNamara%27>
3. ONA/Hospital PRWRFs
4. ONA/Hospital PRWRFs
5. ONA/Hospital PRWRFs
6. ONA/Hospital PRWRFs
7. ONA RN Members - ONA/Hospital PRWRFs
8. ONA/Hospital PRWRFs
9. ONA/Hospital PRWRFs
10. The HAY Report ONA Exhibit 36
11. Region of Waterloo Planning, Development and Legislative Service April 14, 2020
12. Graph source: ONA aggregation and analysis of patient visits per 24 hour (Ontario Health data) and nursing hours per 24-hour period (internal data) used to calculate nursing hours per patient visit. 2019 used as base- last year without disruptions of pandemic. ONA Provincial Member Survey conducted by PPS of ED Staffing and Annual ED Visits for Selected Comparator Sites May 2021
13. Access to Care-Ontario Health – Annual ED Visits for St. Mary's General Hospital by CTAS level for the period covering Apr 1, 2008 to December 31, 2014 Received May 2021.
14. Region of Waterloo Planning, Development and Legislative Service April 14, 2020
15. CorHealth Ontario quarterly reporting data for Waterloo Wellington LHIN 2018- present
16. ONA RN Members - ONA/Hospital PRWRFs
17. ONA/Hospital PRWRFs
18. ONA/Hospital PRWRFs, ONA Seniority List December 30, 2020
19. ENA, 2017 & ONA/Hospital PRWRFs
20. ONA/Hospital PRWRFs
21. ONA/Hospital PRWRFs
22. Patricia Benner Theoretical Framework Novice to Expert, 1984.

Appendix 17

List of Participants and Observers for Hearing Dates June 1, 2, & 3, 2021

Final ONA Attendees List for SMGH ED Independent Assessment Committee

Hearing Participants and Observers June 1, 2, & 3, 2021

June 1, 2021	June 2, 2021	June 3, 2021	Position
Lorrie Daniels	Lorrie Daniels	Lorrie Daniels	RN, Professional Practice Specialist, ONA
Danielle Richard	Danielle Richard	Danielle Richard	RN, Professional Practice Specialist, ONA
Andrea Fagan	Andrea Fagan	Andrea Fagan	RN, Professional Practice Specialist, ONA
Michelle Gibeau	Michelle Gibeau	Michelle Gibeau	RN, Professional Practice Specialist, ONA
Sandy Paproski	Sandy Paproski	Sandy Paproski	RN, Professional Practice Specialist, ONA
Erin Ariss	Erin Ariss	Erin Ariss	RN, ED SMGH, President Bargaining Unit
Sherri Ludlow	Sherri Ludlow	Sherri Ludlow	RN, Labour Relations Officer
Deanna Dowsett	Deanna Dowsett	Deanna Dowsett	RN, ED SMGH
Lawson Sherwood	Lawson Sherwood	Lawson Sherwood	RN, ED SMGH
Tina Klassen,	Tina Klassen	Tina Klassen	RN, ED, SMGH
Jessica Graff	Jessica Graff	Jessica Graff	Rn, ED SMGH
Susan Delisle Gosse	Susan Delisle Gosse	Susan Delisle Gosse	RN, Professional Practice Manager, ONA
Angela Preocanin,	Angela Preocanin	Angela Preocanin	RN, VP Region 4, ONA Board of Directors
Brianna Pfeffer,		Brianna Pfeffer	RN, ONA Observer
Rob Dobrucki,	Rob Dobrucki	Rob Dobrucki	ONA Litigator
Heather Roberts	Heather Roberts	Heather Roberts	RN, ONA Seconded SLRO
Helle Little	Helle Little	Helle Little	RN, ONA Health & Safety Specialist
Alison Brown	Alison Brown	Alison Brown	RN, ED SMGH ONA Member Observer
	Laura Lee	Laura Lee	RN, ED SMGH ONA Member Observer
	Lois Millar	Lois Millar	RN, ED SMGH ONA Member Observer
	Matthew Stout		Manager, Labour Relations West District Service Team
	Danika McIntosh		RN, ED SMGH ONA Member Observer
	Patrick Stephenson		RN, ED SMGH ONA Member Observer
	Athena Brown		Manager, Provincial Services Team
		Vicki McKenna	RN, ONA Provincial President
		Cathryn Hoy	RN, ONA First Vice President

St. Mary's General Hospital Emergency Department – Ontario Nurses' Association

Independent Assessment Committee Hearing June 1, 2, & 3, 2021

Participants for St. Mary's General Hospital

Kathryn Meehan, Counsel for the Hospital

Leisa Faulkner, VP Patient Services and Chief Nursing Executive

Stephanie Pearsall, Director, Perioperative Services and Emergency Department

Kathleen Demers, Director, Chest, Medicine, and Professional Practice

Wendy James, Program Manager Emergency Department

Sherri Ferguson, VP Quality, People and Performance

Ibrahim Ahmed, Manager of Financial Planning and Decision Support