

Independent Assessment Committee Report

**Constituted under Article 8.01 of the
Collective Agreement**

between

**Guelph General Hospital
and**

Ontario Nurses' Association

May 30, 2021

Independent Assessment Committee

Guelph General Hospital and The Ontario Nurses' Association

Melissa Skinner
VP Patient Services
Chief Nursing Executive
Guelph General Hospital

Lorrie Daniels
Professional Practice Specialist
Ontario Nurses' Association

The members of the Independent Assessment Committee Panel respectfully submit the attached Report with findings and recommendations regarding the Professional Development Complaint presented by the Registered Nurses working on the Special Care Nursery of the Guelph General Hospital (GGH).

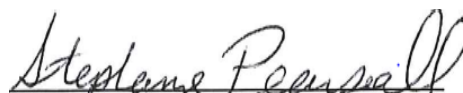
The Professional Responsibility Complaint was presented to the Independent Assessment Committee, in accordance with Article 8.01 of the Collective Agreement between the Guelph General Hospital and the Ontario Nurses' Association, at a Hearing held April 27-29, 2021.

The Independent Assessment Committee Panel recognizes and appreciates especially during this unprecedented time with the COVID-19 Pandemic, the time, energy and thoughtfulness provided by representatives of the Guelph General Hospital, the Ontario Nurses' Association and the Registered Nurses working on Special Care Nursery to prepare and present information regarding the Professional Responsibility Complaint, and to respond to the Panel's questions. The attached Report contains unanimously supported recommendations which we hope will assist all parties to continue to work together, within the context of a quality practice environment that supports professional practice, to provide proper patient care to the patients residing on the Special Care Nursery.

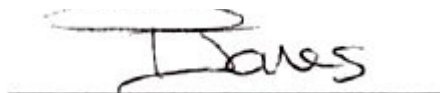
Respectfully submitted on May 30th, 2021.



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



Stephanie Pearsall, BScN, MHS
Guelph General Hospital Nominee



Pauline Jones, RN, BScN, MN
Ontario Nurses' Association Nominee

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SECTION 1

INTRODUCTION

1.1 Organization of the Independent Assessment Committee Report

The Independent Assessment Committee (IAC) Report is presented in five (5) sections.

Section I reviews the IAC's jurisdiction as outlined in the Collective Agreement between the Guelph General Hospital ('the Hospital') and the Ontario Nurses' Association ('the Association'), reviews the process of referral of the Professional Responsibility Complaint ('the PRC') to the IAC, and presents the Pre-Hearing, Hearing and Post-Hearing processes.

Section II presents the IAC's understanding of the PRC, including the development of the PRC, referral of the PRC to the IAC, and activities undertaken between the IAC referral and IAC Hearing, and presents the IAC's understanding of the Association's and Hospital's perspectives regarding the PRC issues.

Section III presents the IAC Panel's analysis and discussion of the issues relating to the Professional Responsibility Complaint (PRC).

Section IV presents the IAC Panel's conclusions and recommendations.

Section V contains the Appendices referenced throughout the IAC Report.

1.2 Jurisdiction of the Independent Assessment Committee

ARTICLE 8 – PROFESSIONAL RESPONSIBILITY

(Article 8.01 applies to employees covered by an Ontario College under the *Regulated Health Professions Act* only.)¹

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

¹ ONA Collective Agreement (Expiry June 7, 2021)

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.

NOTE: It is understood and agreed that the provisions of Article 3 have application to conduct pursuant to this provision.²

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

The Registered Nurses (RNs) working in the Special Care Nursery at GGH have consistently identified ongoing practice and workload concerns as evidenced by the data submitted on numerous Professional Responsibility Workload Report Forms (PRWRFs) in 2019-2021 as evidenced by the ONA submission dated October 8, 2021 and received by the IAC Chairperson January 16, 2021.

Documentation reflects that the practice, patient care and workload environment does not allow Special Care Nursery (SCN) staff to meet College of Nurses of Ontario (CNO) standards; and the nurses in Special Care Nursery believe they are being asked to perform more work than is consistent with proper patient care. The staff believe the employer is not providing effective supports and resources to respond to patient acuity and volumes, fluctuating workloads and unit activity, fluctuating staffing and professional practice issues.

These underlying workload issues and practice concerns have been identified and documented since September 2018 by submitting Professional Responsibility Workload Report Forms (PRWRF) to report their concerns of increased patient acuity and patient census. ONA referred this file to an Independent Assessment Committee (IAC) hearing on December 18, 2020.³

This correspondence identified Donna Rothwell as the Chair of the IAC as per the ONA/Hospital Central Agreement list of Committee Chairs. ONA forwarded this correspondence to the Chair, naming ONA's nominee, Pauline Jones, RN, BScN, MN.⁴

Guelph General Hospital (GGH) responded to ONA's correspondence indicating their disagreement with the Union's representation of the facts and requested a report for ONA to support the issues proceeding

² ONA Collective Agreement (Expiry June 7, 2021)

³ ONA Submission Volume II Exhibit 27

⁴ ONA Submission Volume II Exhibit 28

to the proposed IAC. Documentation was provided by ONA to GGH which included the July 22, 2020 Action Plan working document and the October 8, 2020 letter identifying escalating issues and outstanding concerns on January 20, 2021.⁵ GGH named their nominee for the IAC, Stephanie Pearsall, BScN, MHS on February 7, 2021.⁶

1.4 Proceedings of the Independent Assessment Committee

1.4.1 Pre-Hearing

1.4.1.1 Nominee Selection

In accordance with Article 8.01 (a) (viii), the Association and the Hospital identified their Nominees to the IAC. The IAC Chairperson received notification of the Association's Nominee, Pauline Jones, on January 14, 2021 (*Appendix 2*) and the Hospital's Nominee, Stephanie Pearsall, on January 16, 2021. (*Appendix 3*).

1.4.1.2 IAC Introductory Teleconference

The IAC Chairperson contacted the Nominees on February 2, 2021 and provided copies of correspondence related to IAC Guidelines and Nominee Role, ONA's correspondence related to GGH SCN to the GGH CNE and GGH SCN Action Plan (dated October 8, 2020), and GGH List of Items requested for the upcoming IAC for the Nominees to review.

On February 10, 2021 both the Association and GGH received a draft agenda for the IAC hearing scheduled for April 27th, 28th and 29th, 2021 and correspondence from the IAC Chairperson and both nominees were copied on this correspondence.

Several email exchanges occurred prior to the IAC Panel's introductory teleconference held on March 16, 2021. The Chairperson reviewed the jurisdiction of the IAC within the Collective Agreement, discussed the role of the Nominees and Chairperson, reviewed the three phases of the IAC process, and discussed logistics associated with scheduling the Hearing and the process for review of the Hearing Briefs.

It was then decided that the IAC Panel members would meet on Tuesday April 6, 2021 following receipt of the Association's and GGH's submissions to discuss any issues or concerns. The meeting occurred with the IAC Chairperson and the Nominees. It was decided following our April 6, 2021 meeting the IAC Committee Chair and Nominees would meet again on Tuesday April 13, 2021. Based upon this meeting a series of additional questions were identified and developed for GGH to respond to. (*Appendix 4*). Please see section 1.4.1.3 for further meeting dates and purposes of the meetings.

⁵ ONA Submission Volume II Exhibits 29 and 30

⁶ ONA Submission Volume II Exhibit 31

1.4.1.3 Hearing Confirmation and Hearing Brief Distribution

The date for the Hearing was confirmed on February 7, 2021. The location was simultaneously discussed given the current COVID-19 Pandemic and the need to ensure both parties were meeting their obligation to protect key stakeholders in this process.

Both parties discussed the pros and cons of holding the IAC in person and through a virtual platform. The IAC Chairperson explored hosting the IAC at a local venue in Guelph, Ontario however, due to the Pandemic it was realized that this could not occur given the limited capacity the venue could hold as well as meeting the needs of both the Association and GGH's responsibilities of meeting the Pandemic requirements such as social distancing and gathering of groups.

It was mutually decided by the Association and GGH, that the IAC scheduled for April 27th, 28th and 29th, 2021 be held virtually. The Chairperson secured a third party to support the virtual meeting held between the IAC Chairperson, Nominees, the Association and GGH.

The IAC Chairperson wrote to the Hospital and the Association on February 9, 2021 respectively to confirm the date of the Hearing and to provide the draft Hearing Agenda. Respecting the principle of full disclosure and to streamline the process of the Hearing by enabling the IAC to become familiar with the issues in advance, the IAC requested the Hospital and the Association to submit a Hearing Brief to the Chairperson by Thursday April 1, 2021.

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

- Association Brief received on April 1, 2021 and distributed to the IAC Panel and the Hospital on April 2, 2021;
- Hospital Brief received April 1, 2021 and distributed to the IAC Panel and the Association on April 2;
- Further questions were identified by the IAC Panel and correspondence was sent out on April 15, 2021 with the intent to have the responses returned April 22, 2021.
- Monday April 19, 2021 Melissa Skinner, VP CNE GGH and Lorrie Daniels ONA Professional Practice Specialist for ONA and the IAC Chairperson held a meeting to discuss the COVID-19 Pandemic situation and its potential impact on the IAC hearing. It was decided to modify the agenda (Appendix 5) so that we could start the sessions earlier and simultaneously be flexible in the event emergent issues arose and those participating needed to respond to.
- IAC Panel held another call to review materials and respond to any questions in preparation for the IAC hearing
- Responses were received on April 22, 2021 from GGH and was sent electronically to the Association, the ONA nominee and the GGH nominee. (Appendix 4)
- April 25, 2021 IAC Panel met again to review the responses of the GGH submission to generate questions for the upcoming sessions at the IAC Hearing.

1.4.1.4 IAC Panel Pre-Hearing Meetings

The IAC Panel held Pre-Hearing meetings as outlined above to review the anticipated process of the Hearing, Hearing Briefs and identified key issues for exploration at the Hearing.

1.4.1.5 COVID-19 Pandemic Planning

- The Association, Hospital and IAC Chairperson met to address the current situation and its potential impact on the IAC hearing. It was decided to modify the agenda (Appendix 5) so that we could start the sessions earlier and simultaneously be flexible in the event emergent issues arose and those participating needed to respond to.

1.4.1.6 GGH SCN Tour: Tuesday April 27th, 2021

On the morning of Tuesday April 27th, 2021 the IAC Panel observed a Site Tour of GGH SCN previously developed and uploaded to You Tube via Zoom at 0900 hrs. In addition to the IAC Panel, the following individuals attended the Site Tour:

On behalf of the GGH:

- Melissa Skinner, VP & CNE
- Geoff Wood, Director of HR
- Kim Towes, Sr. Director of Patient Services
- Karen Suk-Patrick, VP of HR

On behalf of the Association:

- Lorrie Daniels, ONA Professional Practice Specialist
- Danielle Richard RN, ONA PPS
- Andrea Fagan, RN ONA PPS
- Jennifer Dorling, RN GGH Bargaining Unit President
- Sarah Clarke, RN GGH
- Karen Horsfall RN GGH
- Cindy Kranendonk, RN GGH
- Amy Tettman, RN GGH
- Susan Desisle Gosse ONA, PP Manager
- Angela Preocanin ONA Region 4 VP
- Kathryn Hoy ONA VP
- Kaitlin Carr GGH SCN RN
- Haifaa Khadour RN ONA

The Tour was conducted by Sarah Clarke RN, SCN and Kim Towes Senior Clinical Director. It included a comprehensive review of the GGH SCN.

The Tour provided an opportunity to understand the complexity of the diverse patient population being cared for on GGH SCN, the practice environment, care provision, medication administration processes, inter and intraprofessional communication and the geographical configuration of GGH SCN.

1.4.2 IAC Hearing

1.4.2.1 IAC Hearing Schedule

The Hearing convened via Zoom for all participants at 0945 hours. The Hearing was held over three days as follows utilizing Zoom due to the current COVID-19 Pandemic guidelines:

April 27th, 2021: 0945 – 13:30 hours

April 28th, 2021: 08:30 – 12:50 hours

April 29th, 2021 : 08:30 – 12:05 hours

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

1.4.2.2 Hearing Day 1: April 27th, 2021

The IAC Chairperson opened the Hearing at 1000 hours. Following introduction of the three IAC Panel members and round-table introduction of the Hospital and Association participants, the IAC Chairperson reviewed the following:

- Recognizing and thanking all of the participants for their ongoing care and commitment to patients and families during our COVID-19 Pandemic
- the Hearing process, including anticipated flow and organization of each day;
- the jurisdictional scope of the IAC, including the purpose of the IAC and the nature of its non-binding recommendations;
- the role of Hearing participants, to promote clarity of understanding of the issues from their perspective; and
- the ‘ground rules’, to facilitate a respectful, collaborative, constructive and non-adversarial environment to promote discussion and professional dialogue.

The Association’s presentation to the IAC Panel and the Hospital was presented by Lorrie Daniels, ONA Professional Practice Specialist. The presentation included an overview of Article 8.01, CNO Professional Standards, a historical overview, concerns identified by ONA members on GGH SCN and ONA’s nine (9) recommendations.

Following the presentation, the Association responded to questions of clarity related to the Association’s presentation from the Hospital and the IAC Panel members.

A break was held between the Association and Hospital presentations.

The Hospital presentation began at 1150 hours and was presented by Melissa Skinner, GGH VP and CNE. An overview of the GGH SCN and Leadership team, Program Goals and services, the current challenges, what is working well, improvement initiatives, and next steps.

Following the presentation, the Hospital responded to questions of clarity related to the Hospital’s presentation from the Association and the IAC Panel members.

The IAC Chairperson adjourned the Hearing at 1330 hours.

1.4.2.3 Hearing Day 2: April 28th, 2021

The IAC Chairperson opened the Hearing at 0830 hours.

Melissa Skinner supported by members of the Hospital IAC Hearing team, provided the Hospital's response to the ONA Hearing Submission. Following a break, Lorrie Daniels supported by members of the Association IAC Hearing team, provided the Association's response to the Hospital Hearing Submission.

Both the Hospital and the Association teams participated in active discussion.

The Chairperson adjourned the Hearing at 1250 hours.

1.4.2.4 IAC Panel Intra-Hearing Meeting

The IAC Panel met during the afternoon and evening of April 28, 2021 and the morning of April 29, 2021. The intent was to review and synthesize the data collected during the Hospital tour of GGH SCN and the wealth of information presented through the written submissions, supporting documents, presentations and discussion during the Hearing, to identify key questions to lead and engage in meaningful dialogue for the purposes of Hearing discussions on Thursday April 29th, 2021

1.4.2.5 Hearing Day 3: April 29th, 2021

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

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

All Hearing participants in attendance were provided the opportunity to address the IAC Panel and actively participate in the discussions.

Melissa Skinner, VP and CNE on behalf of the Hospital, and Lorrie Daniels, Professional Practice Specialist on behalf of the Association, provided final comments following the Question and Answer session.

The IAC Chairperson's closing comments referenced the following key points:

- Acknowledged the tremendous time and effort by both the Hospital and Association that was undertaken for the IAC Hearing and the excellent submissions and presentations to inform the IAC Panel and both parties of the issues in the Special Care Nursery especially during this unprecedented time with COVID-19 Pandemic.
- Thanked the staff who were in attendance and, also acknowledged their active participation in the IAC Hearing and their willingness to bring forward important issues related to quality and safe patient care
- Thanked all those in attendance for their openness, honesty and willingness to share their personal stories, thoughts, patient experiences and concerns related to workload, professional responsibilities and accountabilities

- Respecting the “ground rules” throughout the IAC hearing
- Reconfirmed that the IAC process is intended to provide an independent objective external perspective to aid in the resolution of outstanding issues, and that although the recommendations are non-binding, it is hoped that they will provide a foundation from which both parties can move forward constructively; and
- Confirmed that the IAC Report would be submitted within forty-five (45) calendar day timeframe as stipulated in Article 8.01 (a) (viii) of the Collective Agreement.
- I hope everyone who participated in this process will reflect on discussions held these past two and one half days to understand the importance of how we can move forward in a positive, professional and collegial manner to bring about the required changes in the best interest of quality, ethical and safe patient care
- I also want to thank the IAC Panel – Pauline and Stephanie for your contributions, knowledge and expertise as we have collaborated over the past several weeks and as we move forward with the development of the key recommendations for the IAC Report

1.4.3 Post-Hearing

1.4.3.1 IAC Report Development

The initial draft of the IAC report was circulated on April 30, 2021 to the Nominees to provide more detail of the proposed recommendations in preparation for an IAC Panel teleconference to be held on Sunday May 2, 2021. The purpose of this call was to discuss the overall framework of the IAC report and recommendations.

Following the hearing the IAC Panel met to discuss key themes and issues. Based on these themes the IAC Panel developed initial recommendations in preparation for the development of the second draft of the IAC report.

The IAC conducted a teleconference on May 2, 9, 16, 23 and the 30th to review the second, third, fourth, fifth and final draft of the IAC report.

1.4.3.2 IAC Report Submission

The IAC Report was submitted to the Association and the Hospital by email, in PDF format, on May 30, 2021.

SECTION II

PRESENTATION OF THE PROFESSIONAL RESPONSIBILITY COMPLAINT (PRC)

2.1 Development of the Professional Responsibility Complaint (PRC)

2.1.1 Events Prior to Referral of the Professional Development Complaint (PRC)

Guelph General Hospital falls within the Waterloo Wellington Local Health Integration Network (WWLHIN), The WWLHIN serves approximately 775,000 residents in Waterloo Region, Wellington County, the City of Guelph, and the southern part of Grey County.

This covers approximately 4,800 square kilometers, stretching from Proton Station in the north to Ayr in the south, Clifford at the most westerly point and Erin to the east. It also encompasses the major urban centers of Waterloo, Kitchener, Cambridge, and Guelph. 90% of their geography is rural, and 90% of the population lives in urban areas. ⁷

The Maternal Child Program at Guelph General Hospital includes the Family Birthing Unit, the Special Care Nursery (SCN) and the Paediatric Unit. GGH sees approximately 1700 births annually, of which approximately 20 percent require care in the Special Care Nursery.

GGH SCN Designation: Level II A

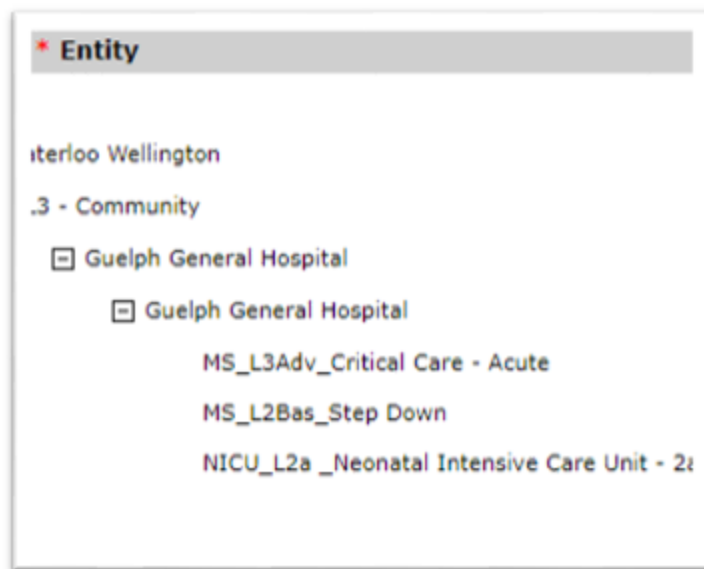
Based upon clarification sought by posed questions to GGH regarding their SCN designation on April 15, 2021, the following information was provided.

GGH is designated as a Level IIa Neonatal Intensive Care Unit according to the Provincial Council for Maternal Child Health (PCMCH).

In confirmation of that designation, our CCIS profile below lists GGHs Adult Critical Care status as a Level 3 ICU, Level 2B Critical Care – Step Down and Level 2a Neonatal Intensive care Unit (see below). In appendix 3 is an example of reports provided by CCIS with our designation identified in the top left. These reports are posted in the SCN. ⁸

⁷ ONA Submission Volume 1

⁸ GGH Response to Additional Questions April 15, 2021.



Accessed from CCIS on April 9th, 2021 by S. Hall

The unit baseline staffing is two (2) Registered Nurses (RNs) per shift, twelve-hour tours, seven days per week. SCN RNs have specialized skills, knowledge and experience in the care of babies with intensive care needs. The SCN census is variable, as is common in maternal child nursing areas. The average census is six babies; however, the census can escalate to 12 and fall to 2 or 3 for brief periods. Patient acuity, however, has been escalating significantly over the past five to ten years and as a result staff have continuously added higher level nursing skills and interventions to their toolboxes, to take on more acute and complex neonatal care needs.

SCN Model of Care

The Special Care Nursery employs seven full-time RNs, plus one RN who works a shared full-time position between the Special Care Nursery and Paediatrics, six part-time RNs, and two casual part-time RNs. The RNs in this unit have been reporting professional practice and workload issues for more than two years and escalating their concerns to nursing leadership without resolution.

Currently, the Special Care Nursery is a ten-pod open bay set up, with the ability to surge to 12 beds, although staffing and equipment become a challenge in these situations. There are plans in place for an upcoming renovation, to change the unit to single patient/family rooms in the future. The renovation has been delayed/on hold and an expected start or completion date is unclear.

The fundraising campaign for the Special Care Nursery renovation has identified the need to expand the unit to meet up to date standards, infection control practices and precautions, and due to the growth and expanding population of young families. The need for expansion will address several aspects of care for the neonatal population at Guelph General, care needs that are essential now and into the future, including adequate numbers of trained staff to deliver the care.

All Registered Nurses are held accountable by the College of Nurses (CNO) to advocate on behalf of their clients; to provide, facilitate and promote the best possible care. The nurses in SCN at GGH have met these standards by diligently documenting and reporting their nursing care and practice concerns on Professional Responsibility Workload Report Forms (PRWRFs) to the administrative nurses; the Clinical Director (manager), Senior Director and Chief Nursing Executive (CNE) since September 2018.

Staff have identified issues of insufficient baseline staffing, a lack of resources for replacement staffing and issues related to a single nurse frequently being left alone in SCN. This occurs on occasions when staffing of a second RN cannot be achieved, however most commonly it occurs when one of the two RNs must leave the SCN to attend a high-risk delivery, assist with an IV insertion on Paediatrics, or to respond to a Code Pink, often requiring the second RN in that circumstance, among other issues.

Further issues and concerns raised by the Registered Nurses in the Special Care Nursery include: a lack of adequate supports for education, insufficient or improperly functioning equipment; a lack of supportive and effective leadership; the lack of proactive planning and staffing for known activities within the program; and an ever-declining staff morale and burnout in a toxic work environment.⁹

The World Health Organization (WHO) released a report entitled, “State of the World’s Nursing -2020 Investing in Education, Jobs and Leadership”¹⁰ speaks to the importance of our global nursing issues and the relevance and importance of jobs, leadership and education in our nursing profession.

Professional Responsibility and Workload Process

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

The PRW process was designed not only to promote the safety and best possible care of patients, but also for the protection of the Ontario Nurses’ Association (ONA) members who may identify that patients and staff are at risk because of improper staffing, skill mix, practice and workload issues. The collective agreement specifies the process for documenting these issues in writing on the Professional Responsibility Workload Report Form (PRWRF), and thus implementing a process that facilitates employers to work with ONA and its members in order to mutually resolve issues in the best interest of safe, ethical and proper patient care.

The College of Nurses of Ontario (CNO) has Standards of Practice that registrants are expected to meet in order to provide safe, ethical and quality patient care within their scope of practice.

RNs have a professional obligation to ensure nursing practices are carried out according to the CNO Standards of Practice. If nurses cannot meet these standards it is up to individual nurses to report these concerns to the employer and attempt to resolve the issues. The employer, on the other hand, has an obligation to respond to the reported concerns, and to provide a quality practice environment that facilitates and permits nurses to meet CNO standards. The Professional Responsibility Clause is

⁹ ONA Submission Volume 1

¹⁰ World Health Organization (2020) <https://www.who.int/publications/i/item/9789240003279>

designed to assist both frontline and administrative RNs in meeting their professional obligation to the CNO and to enhance and promote safe, quality patient care.

The Professional Responsibility Workload Report Form is a documentation tool to identify and demonstrate ongoing trends, barriers to the provision of safe, competent and ethical care and any contributing workplace problems; and provides a process and forum for RNs to make recommendations to the employer to address the issues. The PRWRF promotes a problem-solving approach by means of facilitating discussion with, and requiring a written response from, the Manager. Once the employer has been made aware of the Professional Responsibility and Workload Issue(s), it is the administrative nurses' accountability to their own CNO Standards to advocate for and pursue resolution.¹¹

2.1.2 Events Following Referral of the Professional Responsibility Complaint

Professional Responsibility and Workload Issues at Guelph General Hospital¹²

The Special Care Nursery RN staff began raising professional responsibility and workload issues in the SCN in September 2018 by submitting PRWRFs to report their concerns of increased census and patient acuity. The SCN nurses reported their concerns for safe quality patient care to nursing leadership, the Clinical Director (Manager), Senior Director and Chief Nursing Executive (CNE). Responses from management either failed to include any actions or solutions to address the issues raised, or no responses at all were provided.

In addition to staffing issues, other issues identified in the Action Plan to address the PRW Issues and discussed at Sub-HAC meetings with the employer are:

- a lack of supports including lack of a dedicated Charge RN and a dedicated Unit Clerk;
- a lack of policies and training regarding increasing skill requirements i.e. updated CPAP, Rapid Sequence Intubation and more;
- RNs frequently required off the unit, leaving one RN alone for extended periods of time, creating an unsafe situation;
- poor leadership;
- poor morale; and
- equipment issues.

Lack of resolution of these issues has led to further decrease morale and a high level of burnout among SCN staff. There is also an increasing level of discontent and conflict with staff from the other areas who are being pulled from their areas and reassigned to SCN.

Initial meetings at the Hospital Association Committee (HAC) took place in February and March 2019 prior to an ONA Professional Practice Specialist becoming involved. Overall, eight meetings with the HAC or sub-HAC took place between February 2019 and July 2020. Extension of timelines to attempt resolution were mutually agreed to, until dialogue broke down in July 2020. No resolution to any of the identified issues has been achieved to date.

The Hospital-Association Committee (HAC) at Guelph General Hospital is scheduled to meet bi-monthly and at times more often, as necessary, in accordance with Articles 6.03 and 8.01. From the Union's

¹¹ ONA Submission Volume 1

¹² ONA Submission Volume 1

perspective, the process for the HAC at GGH is broken and non-productive. One hour of the HAC meeting is dedicated to discussing workload issues, to propose solutions or ideas, after which, the remainder of the meeting addresses human resource issues outside of the PRWRF issues. Meetings are scheduled bimonthly; however, it is difficult to get managers to attend and the meetings are often not solution focused. Specifically, there are no clear terms of reference, and issues raised by the Union are often discussed but solutions are not reached; instead, discussion is deferred to the next meeting.

In particular, the Special Care Nursery (SCN) issues were first raised at the HAC meeting on February 14, 2019, without resolution. The ONA SLRO attended this HAC meeting. The hospital identified strategies of daily huddles and benchmarking as work underway, as well as revealing fiscal issues as a concern. At that time, solutions suggested by the Hospital and captured in the SLRO meeting notes included a focus on team building, initiating a check-in on SCN by the Family Birthing Unit (FBU) Charge RN, reassessment of unit clerk supports, and it's noted that some staff within the program were cross trained.¹³

Special Care Nursery workload issues were again discussed at a March 28, 2019 HAC meeting, which was attended by the Bargaining Unit President; the SLRO was not present for this meeting. Strategies discussed at the meeting included initiating a plan to cross train other staff from the Paediatric Unit and the FBU, to provide access to potential in-house resources in times of surge as well as to support break coverage (Exhibit 6). Further, a review of possible unit clerk resources within the hospital to support SCN was to be undertaken by leadership, along with the assignment of a unit attendant, once per week on Thursdays, to be responsible for the ordering of supplies.

The next meeting to discuss the workload and practice issues for the RN staff in Special Care Nursery occurred on October 4, 2019, with the involvement of ONA's Professional Practice Specialist, Action Plan and PPS Notes. A change in PPS assignment occurred in November 2019 when the file was assumed by PPS, Lorrie Daniels and the next meeting occurred on December 6, 2019.

Starting in October 2019 and for all subsequent sub-HAC PRC meetings, an Action Plan outlining the issues was utilized and exchanged between the parties. The Action Plan described areas of concern associated with the issues raised by the nurses, as well as specific recommendations put forward by ONA on behalf of the members, to resolve the outstanding issues.

Specifically identified at the December 6, 2019 meeting were issues of staffing, skill mix, patient volumes, acuity and complexity and the RNs' inability to meet their College of Nurses Professional and other regulatory standards. Also included were issues related to equipment and supplies, including issues of lack of supplies, IV poles and pumps and improperly functioning monitors that are unable to maintain calibration of neonatal settings, a lack of support staff including lack of a unit clerk, and a lack of support by a Charge Nurse, action plan, PPS sub-HAC meeting notes, and images of the different monitors demonstrating adult versus newborn monitors.¹⁴

A subsequent sub-HAC PRW meeting occurred January 24, 2020, where additional issues were added to the Action Plan (Exhibit 12) to address added concerns being brought forward through the PRWRFs related to communication, morale and staff burnout (Notes: Exhibit 13). The outbreak of the Covid-19 global pandemic led to meetings being postponed. Meetings resumed via GGH's WebEx technology, in Spring 2020, occurring on June 4 and July 22, 2020.

¹³ ONA Submission Volume 1

¹⁴ ONA Submission Volume 1

Relations began to erode prior to and following the meeting on June 4, 2020, when the issue of staff intimidation and targeting concerns were raised by ONA in the action plan (Exhibit 14) and meeting discussion (Exhibit 15). The Employer provided the updated action midway through the meeting (Exhibit 16). The issues of escalating mistrust were compounded, when the Vice President of Human Resources, who had attended meetings in the past, however was not identified as an attendee during the introductions and unbeknownst to the ONA team, his presence became aware, unannounced after almost an hour into the meeting. Pre and post meeting email discussions ensued (Exhibits 17,18, 19 & 20).

On July 22, 2020, dialogue and relations became unproductive, when the Hospital announced a plan to merge the staffs of Special Care Nursery and Paediatrics, as their solution to the lack of baseline staffing in the Special Care Nursery. Action plan (Exhibit 21) and ONA meeting notes (Exhibit 22). The Union identified barriers the solution posed in achieving resolution to the identified issues, most significantly the insufficient baseline RN staffing in SCN. The two units are also located geographically distant, at opposing ends of the same level of the hospital. The paediatric unit baseline staff is also two RNs per shift; thus, reassigning an RN from paediatrics to support SCN leaves one nurse alone on paediatrics.

The proposed solution fails to address the underlying root cause of the issues in SCN, being a lack of adequate baseline staffing to manage the escalating acuity and complexity of the neonatal patient population. The lack of supports, such as a dedicated Charge Nurse and a dedicated unit clerk also remain outstanding with the proposed merger solution; and the cost and time required to educate and train all staff in both areas, especially given the immediate need for supports in the SCN leaves several questions related to this action. The Hospital had determined their next steps and were unwilling to discuss further, mutually agreeable solutions, leaving the Union to pursue next steps.

On October 6, 2020, the PPS, Bargaining Unit President and SLRO met with members of the Special Care Nursery to review the status of actions being taken by leadership regarding the training and merger of Paediatric staff and SCN staff, to review the most current PRWRFs submitted by staff, and to discuss the issues and management's responses and any actions or resolutions identified in those responses, meeting notes.

At that time, five new PRWRFs submitted between August 22 and October 3, 2020 identified continuing and escalating issues of increased patient acuity and census, acute admissions, babies needing isolation precautions and situations of unsafe care. No manager responses were provided to staff regarding the issues identified in these PRWRFs. At this time concerns began to surface regarding the clinical director's lack of response and lack of intervention, related to escalating animosity between staff of SCN and FBU.

The SCN staff were frequently calling the FBU to ask for 'help' with feedings and break relief, as instructed to do by management at previous sub-HAC meetings and in discussions at the 'walls,' as the morning huddles are referred to.

The Union sent a letter to CNE, Melissa Skinner, on October 8, 2020 outlining the recent concerns that were brought forward and requesting immediate intervention be taken to address the issues and ensure a safe quality environment for staff and the patients in Special Care Nursery. The Union identified their interest in resuming discussions should the Hospital have new strategies or solutions to propose, and willingness to come together to discuss such proposals and actions, in order to achieve resolution of the issues.

On November 12, 2020, when no actionable response had been received from the employer, the Union invited the employer to consider the option of mediation to achieve resolution as an alternative to advancing to an Independent Assessment Committee (IAC) to review of the issues. The Hospital declined the Union's invitation to participate in Mediation.

The Union's letter advancing the issues to an IAC was forwarded to Melissa Skinner, CNE on December 18, 2020. The letter identified Donna Rothwell would act as Chair to the Independent Assessment Committee, as per the ONA/Hospital Central Collective Agreement, list of Committee Chairs. The Union further forwarded their letter to the Chair, naming their nominee, Pauline Jones, RN BScN, MN

The Hospital's response letter on January 16, 2021 indicated their disagreement with the Union's representation of the facts and requested a report from ONA to support the issues proceeding to the IAC. Documentation, which had been previously provided, including the July 22, 2020 Action Plan working document and the October 8, 2020 letter outlining escalating issues and outstanding concerns, was forwarded to the Hospital on January 20, 2021. The Hospital named their nominee, Stephanie Pearsall to the IAC panel on February 7, 2021.

Sixty-seven (67) Professional Responsibility Workload Report Forms have been submitted. Noteworthy is the fact that, of the 67 PRWRFs, less than 50% have been responded to by the manager. Registered nurses in SCN report situations of insufficient baseline staffing, high and unsafe patient to nurse ratios, lack of appropriately trained special care nursery RN resources, and a lack of staff to fill vacancies or provide coverage during times of surge. These conditions are resulting in skill mix issues, gaps in care, often missed or rationed care, and a lack of time to support parents and care providers.

Often, a staff member who has had minimal orientation is reassigned to SCN from other areas such as Paediatrics or Family Birthing Unit, and at times an RPN is sent from Postpartum to assist. These staff are unable to provide the full range of care needs for patients. This further increases the workload of the SCN RN, as many patient care interventions must be delayed until the SCN qualified RN can perform them. As well, the SCN RN may be required to enter data into the patient's chart as the staff reassigned to support do not have access to the ISP documentation system, which can result in missed documentation.

At times, reassigned staff are required to act as the second nurse required to staff the SCN and are left alone in the SCN when, the SCN trained RN is required to leave to attend a high-risk case in Labour and Delivery. SCN staff are frequently pulled off the unit to attend high-risk deliveries, Code Pink or start intravenous on paediatrics, leaving a single SCN RN or the reassigned staff alone in the unit. Often reassigned staff lack the required skills, including NRP and other training to manage an independent patient assignment due to the acuity and complexity of the patient population.

In July 2020, during the Covid-19 pandemic and the continued burden of the staffing crisis, the leadership announced their plan to merge the staffs of the Special Care Nursery and Paediatrics units, as a solution to address staffing issues. The Hospital identified they would develop a plan to provide a fulsome orientation and cross training to all full-time and part-time staff in each area, such that all RN staff would be trained to work in both Special Care Nursery and on Paediatrics areas, fully skilled and competent. The two units are geographically separated by two lengthy hallways, fire doors and around a stairwell.

The ongoing strain and burden of managing very high workloads, along with a slowly and poorly designed plan for cross training and orientation, has led to increased stress, and burnout among staff.

and the overall morale of the unit staff is dreadful. The outstanding practice and workload issues of insufficient staffing, high patient acuity, unmet care needs due to lack of resources, a lack of educational opportunities and recertification for staff, ongoing concerns for patient and staff safety along with the lack of effective nursing leadership and effective communication, has resulted in staff burnout and poor morale and has created a toxic workplace environment. The hospital has failed to resolve any of the issues raised by the Registered Nurses in the SCN since the onset of the submission of their PRWRFs.

A Letter of Complaint was finally submitted by the Union to the Independent Assessment Committee (IAC) Chairperson on December 18, 2020. As indicated in the Union's Letter of Complaint, ONA respectfully requests that the IAC assess the nursing practice and workload concerns put before them from the perspective of being able to provide safe, ethical, competent, and professional quality patient care in a quality practice setting according to relevant professional and specialty standards, and supporting research and literature, including the following College of Nurses of Ontario (CNO) Practice Standards and Guidelines:

- Code of Conduct
- Professional Standards Revised 2002, 2018
- RN and RPN Practice – The Client, the Nurse and the Environment, 2018
- Therapeutic Nurse-Client Relationship Revised 2006
- Authorizing Mechanisms, 2020
- Decisions about Procedures and Authority Revised, 2020
- Confidentiality and Privacy – Personal Health Information, 2019
- Ethics, 2019
- Documentation Revised 2008, 2019
- Medication Revised 2008, 2019
- Conflict Prevention and Management, 2018
- Consent, 2017
- Directives, 2020

2.2 Ontario Nurses' Association and Guelph General Hospital Perspectives

The Hearing was structured such that:

- On April 27, 2022 the Association and the Hospital each provided an oral Submission presentation highlighting the key elements of their previously submitted written Brief.
- On April 28, 2021 the Hospital and the Association each provided an oral Response presentation, which included an opportunity for each party to clarify / discuss / challenge / question/rebut the information provided by the other.
- On April 29, 2021, the IAC Panel posed several questions to both parties to obtain a more comprehensive understanding of the issues. All staff in attendance was given the opportunity to share their concerns, make statements and provide us with their own testimonials related to 3C MSSU.

From the Hearing Briefs and supporting Exhibits submitted prior to the Hearing, the presentations, discussion and response to questions at the Hearing, and analysis of information following the Hearing, the IAC Panel understands the Association's and Hospital's perspectives regarding the issues in the Special Care Nursery at the Guelph General Hospital (GGH) to be the following.

2.2.1 Ontario Nurses' Association

The Association identified thirty-six (36) recommendations based on sixty-seven (67) PRWRF's submitted, relating to staffing, patient acuity, fluctuating workloads, and missed care, education, leadership and communication, morale and poor work environment and non-professional duties.¹⁵ The following are ONA's recommendations:

Professional Practice – Staffing

- 1) Increase RN staffing by 1 RN 24/7 for a total of 3 RNs 24/7, immediately.
- 2) The Hospital to hire four (4) full-time RNs and three (3) regular part-time RNs to achieve the required staffing.
- 3) Implement a dedicated Charge RN role in the SCN on both day and night shift.
- 4) Ensure that all vacancies/ vacant shifts and Leaves of Absences are filled as per the Collective Agreement.
- 5) Post schedules that are fully staffed, not leaving vacant shifts at the time of posting.
- 6) Ensure the appropriate skill mix required to meet the required needs to provide quality and safe patient care.
- 7) Ensure adequate and appropriately trained, skilled and qualified SCN RNs.
- 8) Ensure adequate resources to enhance supports during periods of surge, high census / high acuity, in alignment with CNO 3 Factor Framework – The client, the nurse and the environment.

¹⁵ ONA Presentation to the IAC April 27, 2021

Patient Acuity

- 1) Increase the Registered Nurse baseline staffing to three RNs 24/7 immediately to facilitate the safe and ethical care of the neonatal patients and their families.
- 2) The Hospital to hire four (4) full-time RNs and three (3) regular part-time RNs to achieve the required staffing.
- 3) Ensure all RN staff receive regular and ongoing education on new and mandatory skills, equipment, and procedures for the care of infants in Special Care Nursery.
- 4) Ensure all policies are current and maintained, relevant to the needs of Special Care Nursery and the patient population, including updating all policies and procedures related to increased skills for level IIb infant care needs.
- 5) The employer will implement an Acuity Tool, be used to guide decision making related to additional staffing needed for safe staffing in the SCN and related to increasing staff above the proposed baseline to respond to increases in patient acuity and volumes. An example of the proposed Acuity Tool is attached as Exhibit 57.

Fluctuating workloads, and Missed Care

- 1) Increase the baseline RN staffing to 3 RNs 24/7, immediately.
- 2) Ensure all staff assigned to work in the SCN are fully skilled and trained to provide care for the neonatal population at GGH and deliver the critically required specialized nursing care and interventions.
- 3) Ensure all staff received regular and ongoing training to remain current in their skills and competencies.

Education

- 1) The Employer will provide paid mandatory education for all staff required to work in SCN, including paid time, tuition, and materials, for essential certifications and required skills, including but not limited to – Neonatal Resuscitation Program, S.T.A.B.L.E. Program, ACoRN, and Level 2 Breastfeeding Program, in addition to other and new and emerging education and best practices.
- 2) The Employer will provide for the staff, regular monthly education sessions specific to SCN and neonatal care and interventions, including but not limited to: CPAP updates, new skills, procedures, protocols and equipment; to be delivered by the educator, during paid working hours, to provide the opportunity for questions discussion and interaction or skill demonstration.
- 3) The Employer will provide a fulsome and complete CCIS education program for all staff in SCN, utilizing the CCIS educator and program as devised by and utilized provincially for the implementation of the CCIS Newborn data entry system.
- 4) The Employer will develop, update, or revise as necessary all required and relevant policies, to ensure the Special Care Nursery has the most current and accurate policies and evidence to support the practice setting and ensure a quality practice environment.
- 5) The Employer will ensure all staff required to work in the SCN possess the required education, certifications, skills and expertise to provide safe quality patient care to the neonatal population.

Leadership and Communication

- 1) Increase RN staffing by 1 RN 24/7, for a total of 3 RNs 24/7, immediately.
- 2) Implement a dedicated Charge RN role in the SCN, on both day and night shift.
- 3) Implement regular and consistent staff meetings, with nursing input into the agenda.
- 4) Initiate a monthly Maternal Child Program Newsletter to keep each program area informed of changes and updates and other news and information.
- 5) Update, revise and create as needed current relevant policies and protocols for the SCN patient population, SCN neonatal care needs, SCN required interventions, and SCN medical directives.
- 6) Implement an organizational leadership training and development program.
- 7) Budget for regular management and leadership training for all nursing leadership, annually.
- 8) Examine, observe and ensure all nursing leadership maintains professionalism and integrity, in all practices and communications.
- 9) Nursing Leadership will engage positively in the Professional Responsibility Process to create a dynamic and positive culture, to establish collaboration, problem-solving and open and effective communication at all times.

Morale and Poor Work Environment

- 1) Increase RN baseline staffing by 1 RN 24/7, to achieve 3 RNs 24/7, immediately.
- 2) Improve the staffing and the quality practice environment; to improve nurse to patient ratios and foster improved morale, improved job satisfaction and reduce burnout and intention to leave.
- 3) Improving the quality practice environment requires several elements:
 - Effective Communication
 - Authentic and Transformational Leadership
 - Shared Decision Making
 - Patient-centred culture focused on quality care
 - Appropriate Staffing
 - Autonomous Practice
 - Professional Development
 - Teamwork
 - Intra- and Inter-professional Collaboration.

Non-Nursing Duties

- 1) Implement a dedicated Unit Clerk for the Special Care Nursery, with dedicated daily hours.
- 2) Develop a comprehensive Unit Clerk Role Description, with clearly identified duties and responsibilities.
- 3) Ensure the Unit Clerk is assigned and present to support in SCN during high acuity and activity situations e.g. when transferring out a sick baby.

- 4) Provide a fulsome training program for the Unit Clerk of their role, responsibilities, and expectations relevant to the SCN, including reassigning nonprofessional, non-nursing tasks to the Unit Clerk.

2.2.2 Guelph General Hospital

Context of Discussion at the IAC

Guelph General Hospital (GGH) is comprehensive acute care facility providing a full range of services to the 200,000 residents of Guelph and Wellington County. Services include 24-hour emergency coverage, advanced technology and diagnostic support, and specialty programs such as being the Regional provider for general vascular surgery and a designated Provincial Centre of Excellence for Bariatric Surgery.¹⁶

Number of Beds: Total 183

- 10 Intensive Care
- 13 Stepdown
- 62 Surgery
- 8 Pediatrics
- 68 Medicine
- 22 Obstetrics

Guelph General Hospital falls within the Waterloo Wellington Local Health Integration Network (WWLHIN), The WWLHIN serves approximately 775,000 residents in Waterloo Region, Wellington County, the City of Guelph, and the southern part of Grey County.

This covers approximately 4,800 square kilometers, stretching from Proton Station in the north to Ayr in the south, Clifford at the most westerly point and Erin to the east. It also encompasses the major urban centers of Waterloo, Kitchener, Cambridge, and Guelph. 90% of their geography is rural, and 90% of the population lives in urban areas.¹⁷

Aspirations: Moving from 2a to 2b status

Over the years, GGH expressed interest in moving from a level 2a to a level 2b in order to relive pressure within the tertiary settings and to help support our region. Currently North Wellington HealthCare is a level 1, Cambridge Memorial is a level 2a and Grand River Hospital is a 2b. Planning for an eventual change in status began with GGH's Respiratory Therapists, Nurses, Pharmacists and Pediatricians and Obstetricians in 2014. Despite their best efforts, GGH has encountered a number of challenges.

GGH continues to aspire to one day be designated as a Level 2b but this change will not occur without careful planning and full engagement of the interdisciplinary team.

¹⁶ <https://www.gghorg.ca/about-ggh/>

¹⁷ ONA Submission Volume 1

Below is a list of the challenges we have encountered since 2014 and how we have attempted to overcome them.

Barriers and Efforts to Date:

1. **Physician model of care** – No pediatrician ‘in house’ – Model Changed as of March 2020
2. **Pediatrician and Obstetrician practice**- Onboarding of new staff in both disciplines in the past 5 years. Would require investment and additional training to be able to transition to 2b level of care.
3. **No Clinical Educator with clinical expertise to support increased Nursing skills in the SCN**- Pediatric Critical Care Trained RN hired in 2018 as the Clinical Educator (0.9 FTE SCN and Pediatrics and 0.1 FTE Ambulatory Care). Previously there was only 1 Educator who also supported the Family Birthing Unit with minimal expertise in critical care settings or Pediatrics.
4. **Pharmacy** ability to source appropriate TPN solutions in a timely manner and 24-hour Pharmacy to support –Standard solutions sourced but not always available in house.
5. **Respiratory Therapy support** - Expanded support GGH (including the SCN) in April 2020
6. **PICC line Maintenance**- Continue to explore options for diagnostic imaging support, and troubleshooting.¹⁸

Funding for Special Care Nursery Level 2A

GGH is funded for 8 level 2 NICU beds. Funding for the Special Care Nursery has been static since 2009. Please see the funding letter dated November 30, 2009 in appendix 6 where GGH was approved to increase from 6 to 8 bassinets. Physical capacity is 10. The ability to surge to 12 bassinets is problematic in the current physical space.¹⁹ (Appendix 7).

¹⁸IAC Responses to Additional Questions for GGH April 22, 2021

¹⁹ IAC Responses to Additional Questions for GGH April 22, 2021

SECTION III

DISCUSSION AND ANALYSIS

3.1 Introduction

The IAC believes that the Panel (IAC Chairperson and both Nominees) has developed a comprehensive understanding of the professional responsibility concerns of the RNs working in the Special Care Nursery at the Guelph General Hospital.

This understanding was achieved through the following:

- Review and analysis of the written submissions, exhibits, oral presentations and discussions at the IAC Hearing held on April 27th, 28th and 29th, 2021
- Review of information provided by the Hospital and the Association during the IAC Hearing;
- Review of literature available in the public domain regarding models of nursing care and the practice of neonatal nursing, and;
- The IAC Panel's collective practice experience, knowledge and expertise with similar issues.

3.2 Factors Impacting the Practice Environment

Discussion of professional responsibility within a Special Care Nursery environment as is at the Guelph General Hospital must be considered within the context of the practice environment. The IAC Panel's analysis and recommendations are based on assumptions regarding:

- Guelph General Hospital overview,
- Special Care Nursery designation
- Special Care Nursery geographical configuration,
- Special Care Nursery patient population, including patient acuity and complexity, occupancy
- Special Care Nursery nursing resources and support,
- Nursing standards of practice, and
- Healthy work environments.

3.2.1 Guelph General Hospital Overview

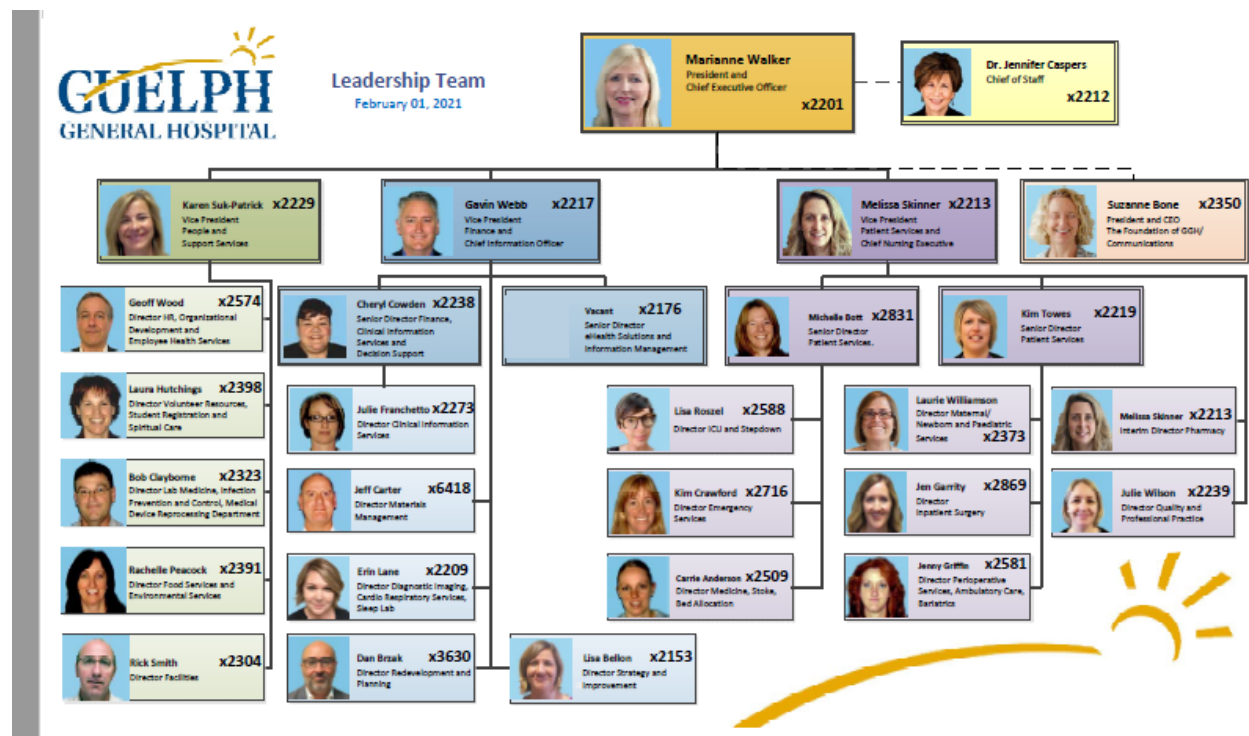
Guelph General Hospital (GGH) is comprehensive acute care 183 bed facility providing a full range of services to the 200,000 residents of Guelph and Wellington County. Services include 24-hour emergency coverage, advanced technology and diagnostic support, and specialty programs such as being the Regional provider for general vascular surgery and a designated Provincial Centre of Excellence for Bariatric Surgery.²⁰

The Maternal Child Program (Mat/ Child) at Guelph General Hospital (GGH) consists of 3 inpatient units that work closely together:

1. **Family Birthing Unit (FBU)** – Average of 1690 births per year (18-22% require admission to the Special Care Nursery)
2. **Paediatric Unit (Peds)** – 8 bed Paediatric Unit, 40-50% occupancy
3. **Special Care Nursery (SCN)** - 10 bed Level 2a Nursery, 50% occupancy

Leadership

The Maternal Child program is supported by a Clinical Director who reports to a Senior Director role. The Senior Director reports directly into the VP of Patient Services. Paediatricians, Obstetricians and Midwives as essential members of our team and GGH is proud to have such close relationships with our Professional Staff.



²⁰ <https://www.gghorg.ca/about-ggh/>
GGH ONA IAC Report April/May 2021

Paediatric Model of Care

Paediatricians provide care for admitted inpatient newborns and children in the Special Care Nursery as well as the Paediatric Units. The model of care changed in 2020 to a hospital-based model, where one Paediatrician is assigned to be in the hospital around the clock and is responsible for all the patients. Prior to this model change the Paediatrics were based in their community offices.

This new model has improved access to the Paediatrics and improved consistency and continuity of care. The new model has drastically reduced concerns regarding delays in Paediatrics attendance at high risk deliveries and for emergencies in both the SCN and Paediatrics.

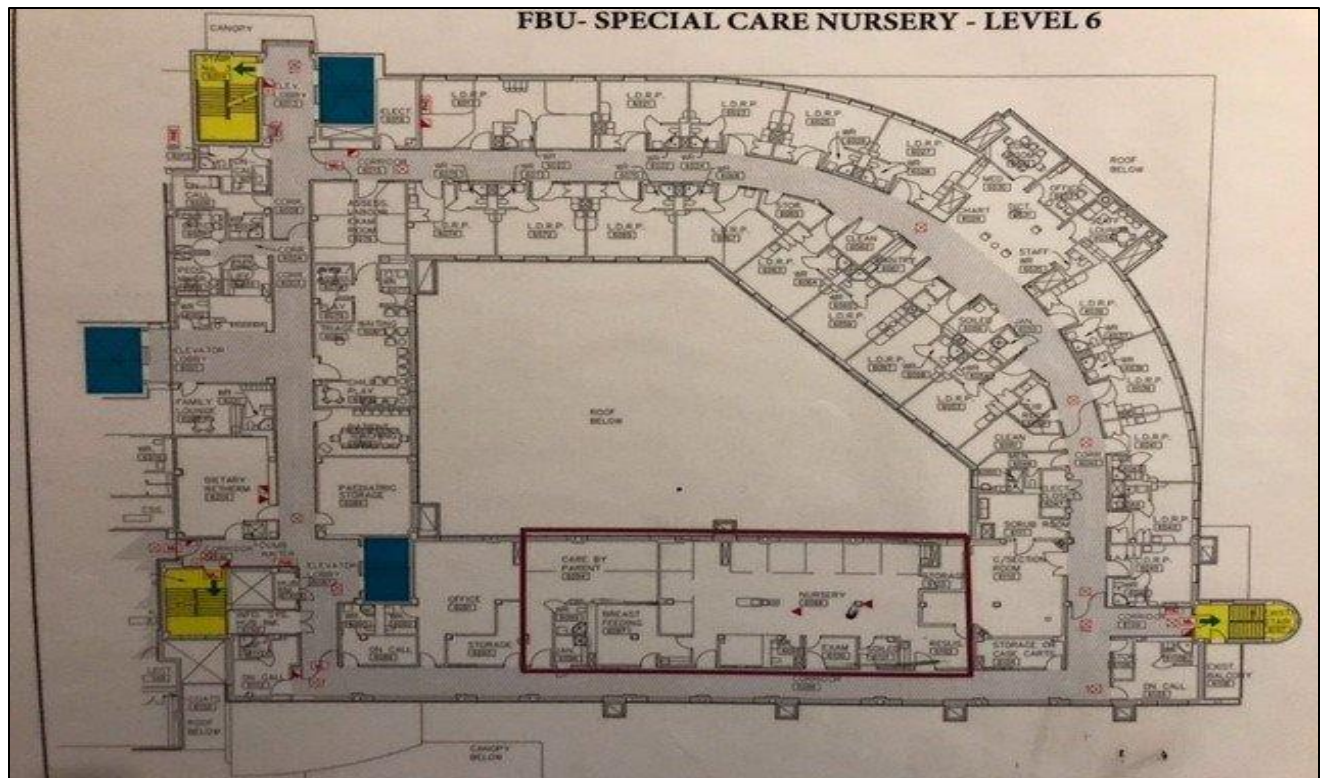
3.2.2 GGH Capital Funding Overview see pages 44-45

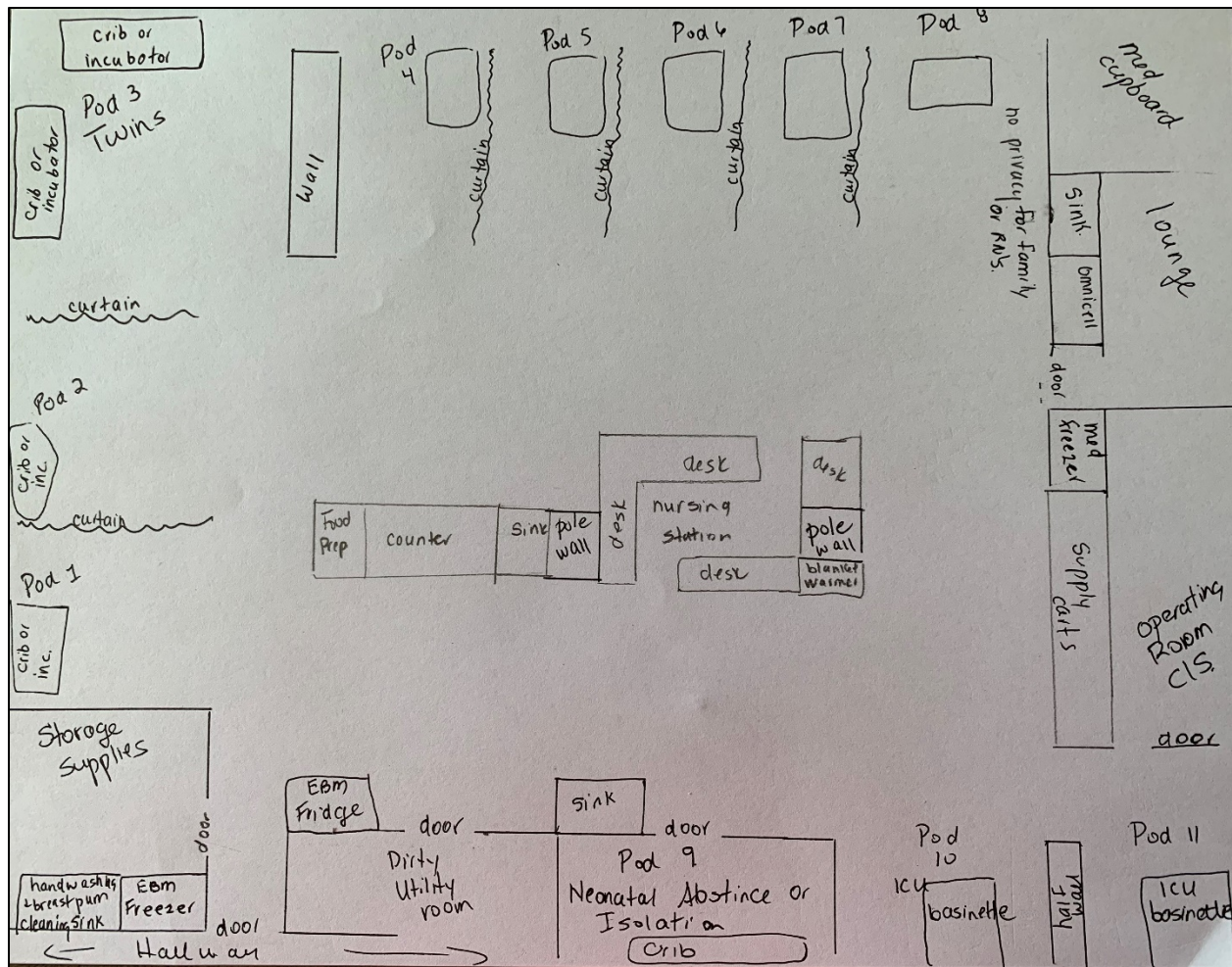
Physical Structure and Layout of the SCN

3.2.3 GGH SCN Geographical Configuration

GGH SCN PROGRAM

Below is a map outlining the geographical layout of the Special Care Nursery as it is, located on the sixth level at GGH and in relation to the Labour and Delivery area (FBU) and the Paediatric Unit, as well.





The above drawing and Unit blueprint provide an overview of the Unit which will become clearer with a tour of the Special Care Nursery. The Special Care Nursery has 12 actual patient locations within the unit, divided in 10 “pods” which when all in use can make the unit is some cases quite tight. All the pods are single bed spaces with the exception of pod 3 which is set up to accommodate twins.

Pod 9 is the only individual patient room generally reserved for infants needing isolation, and more commonly used for neonates with Neonatal Abstinence Syndrome (NAS) to reduce stimuli as recommended in the care of neonates with NAS.

New admissions, critical babies and resuscitations occur in pods 10 and 11. Should this be occurring with babies in pods 1 to 4 and pod 9, visualization is impossible, and there is limited visualization of pod 5, due to walls and posts obstructing the view. The drawing above illustrates some of the key problem areas related to census and staffing. Some issues include if a baby is in Pod 9, neonatal abstinence or isolation patient, one RN may be in the isolation room while the second RN is called to a delivery, leaving the one RN in isolation precautions, potentially in full PPE, also holding down the whole nursery by themselves. From Pod 9 the RN can only visualize the other pods from the doorway, except pods 10

or 11 which cannot be seen. In pod 9, 10 or 11 the RN staff cannot answer the phone or door to the unit when left alone.²¹

Plans for Redevelopment/ Renovation of the GGH SCN

The physical layout of the Special Care Nursery is out-dated and inefficient. The IAC Panel saw evidence of this during our video tour held during the Day 1 of the IAC Hearing.

In 2016 during the Foundation of Guelph Generals “Dream Big” campaign, the SCN was selected as the target for fund raising. By 2018 the project was fully funded and the process for ministry approval began.

Working with staff, patients and families and interdisciplinary staff, the renovation has now completed stage 3B of ministry approval. We anticipate the ground-breaking to begin within the year.

The budget includes not only brick and mortar components but a large investment in capital equipment. To date the SCN has received almost \$500K in capital equipment purchases with the remaining purchases scheduled in 2021/2021 ahead of the actual renovation in an attempt to improve the environment. Please see capital investments below.

Completed Capital Investments 2018/2019- 2020/2021

Year	Description	Cost
2018/19	Bassinets (9)	\$ 35,360
	Chairs - Motion Recliner Primacare (7)	\$ 12,086
	Chair - Glider/Motion Globalcare	\$ 2,599
	Phototherapy Light System	\$ 6,406
	Cart	\$ 2,965
	Cribette	\$ 5,327
	Freezer	\$ 2,140
Total 2018/19		\$ 66,883
2019/20	Pumps, Medfusion (3)	\$ 14,496
	Warmers, Panda (2)	\$ 82,762
	Incubators, Giraffe (8)	\$ 328,030
Total 2019/20		\$ 425,289
2020/21	Phototherapy Light System	\$ 6,460
Grand Total		\$ 498,632

²¹ ONA Submission Volume 1
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Planned Capitol Investments 2021/2022 - 2022-2023

Year	Description	Cost
2021/22	Blanket Warmer	\$ 9,130
	Cart, Breastfeeding Storage	\$ 2,965
	Refrigerator, Microcool	\$ 22,000
Total 2021/22		\$ 34,095
2022/23	SCN Renovation Redesign	\$ 5,142,388
	Minor Renovation - replace sinks, doors, storage	\$ 65,719
Total 2022/23		\$ 5,208,107
Grand Total		\$ 5,242,202

Re-location for Redevelopment

During the renovation period the SCN will be relocated into a 6-bed temporary Nursery in the 6 West Paediatric Day Surgery area, which is located in close proximity (same unit) as the 8 bed Paediatric Unit. During the renovation period (approximately 4-6 months) we will need Paediatrics and SCN working together to help coordinate care for newborns and Paediatrics patients. Flexibility will be critical to support patient flow. Because our SCN will reduce for the renovation period from 6 to 10, there will be the need to utilize rooms on the Paediatric Unit for SCN overflow for appropriate babies.

3.2.4 GGH SCN Patient Population

Level of Care in the SCN

GGH is designated as a level 2a facility by the Provincial Council for Maternal and Child Health (PCMCH). Quarterly we assess demographics related to both gestational age as well as birthweight in order to confirm that we are providing the correct level of care based on our designation. Below is a quick reference guide regarding the criteria for level 2a and 2b²²

Quick Reference Table for Level 2a vs. 2b PCMCH Guidelines

	Level 2a	Level 2b
Gestational Age	34 weeks+	32 weeks+
Birthweight	1800 grams +	1500 grams +

PCMCH 2020 – See Appendix 8

²² GGH Submission April 2, 2021 Overview of the Maternal Child Program

Gestational Age and Weights of the SCN Population

Year over year improvement in the number of babies born less than 34 weeks of gestation age is noted in the table below. Only 3 babies were born and admitted to the SCN this year to date who were less than 34 weeks of gestation. In addition, less than 1% of babies born in the SCN are below 2000 grams (2a criteria = 1800 grams +).

At times, we know that unplanned deliveries or emergency cases may necessitate that a baby is delivered at GGH outside of the criteria but the Hospital working collaboratively with the Obstetricians, endeavour that babies are born within our guidelines as much as possible.

Neonatal care services provided by the registered nurse staff at GGH include many interventions as outlined under the Provincial Council for Maternal and Child Health and Critical Care Services Ontario (CCSO) description which identifies care to a subset of patients described for level IIb by: ²³

- **Level of Risk**
 - Planned/anticipated care of infants with a gestational age greater than or equal to 32 weeks and 0 days and a birth weight greater than 1500 grams.
- **Degree of Illness and interventions**
 - Moderately ill with problems expected to resolve quickly or who are convalescing after intensive care.
 - Continuous Positive Airway Pressure (CPAP), either transitional or extended stable CPAP.
 - May have mechanical ventilation for brief durations (less than 24 hours) Insert and maintain umbilical lines.
 - Maintenance of PICC lines.
 - Peripheral intravenous (PIV) infusion and total parenteral nutrition (TPN).
- **Criteria for Retro -Transfers**
 - Stable neonatal retro-transfers with a corrected over 30 weeks and 0 days, and over 1200 grams and not requiring invasive ventilation, subspecialty support, surgical support, advanced treatments, and investigations.

The RNs in the GGH SCN provide this greater level of care to their patients as reported in the PRWRFs submitted. They frequently report an increased intensity of care related to the increased acuity and complexity of their neonatal population. This greater level of care also requires increased monitoring and attendance to neonatal care needs. The RNs have consistently reported caring for moderately and acutely ill infants, including one or more patients receiving CPAP, either transitional or extended. In the neonatal setting CPAP is used to treat several pathologies including but not limited to Transient Tachypnea of the Newborn (TTN), Respiratory Distress Syndrome (RDS), meconium aspiration and prematurity.

The RN staff also provide care to neonatal patients receiving TPN, infants of a gestation less than 34 weeks or 1800 grams, infants with one or more PIV, at times multiple infants receiving multiple medications, and they assist with and care for infants pre and post lumbar puncture (LP) who may or may not be septic. Frequently, the RNs have reported caring for babies with Neonatal Abstinence Syndrome, infants experiencing apnea and bradycardic episodes, and frequently being required to leave

²³ ONA Submission Volume 1

the unit predominantly to attend high risk cases in the labour and delivery unit, leaving one RN alone to manage a number of patients and competing care requirements.

3.2.5 Nursing Standards of Practice

Nursing Standards of Practice are critical for safe, effective and ethical nursing care.

All RNs are held accountable by the CNO to advocate on behalf of their clients; and to provide, facilitate and promote the best possible care as well as to seek assistance in a timely manner, and take action in situations where client safety and well-being are compromised.

The College of Nurses of Ontario identifies the five (5) most common areas of practice that result in nurses being reported. They are:

- Failure to assess the client,
- Failure to intervene and/or to take the appropriate action,
- Appropriate, complete or timely medication administration and/or documentation issues or errors,
- Failing to ensure client safety and;
- Poor interpersonal or communication skills.

Administrative nurses are also accountable to:

- To ensure that mechanisms in place allow for staffing decisions in the best interest of patients and professional practice;
- to ensure the appropriate **use**, education and supervision of staff;
- to advocate for quality practice settings that support nurses' ability to provide safe, effective and ethical care;
- to critically evaluate research related to outcomes, and advocate for research application in practice;
- to communicate an evidence base for all decisions and measures that impact on practice and create environments that promote and support safe, and ethical practice;
- for knowing how to access resources that enable nurses to provide the best possible care.²⁴

There are specific standards of practice GGH SCN nurses need to meet as well:

- Standards for Neonatal Intensive Care Nursing Practice as outlined by the Canadian Association of Neonatal Nurses (CANN)
- Perinatal Nursing Standards in Canada 2018 - Canadian Association of Perinatal and Women's Health Nurses (CAPWHN)
- National Association of Neonatal Nurses (NANN)
- and the Association of Women's Health Obstetrics and Neonatal Nursing (AWHONN)

²⁴ CNO Professional Standards www.cno.org

3.3 Analysis and Discussion

3.3.1 Introduction

The IAC was requested to examine whether the current RN staffing resources to support quality and safe patient care in the GGH SCN. The IAC has based its analysis on careful review of the extensive information provided by the Association and the Hospital prior to and during the Hearing.

The IAC believes that the result of the IAC Panel's analysis there must be focused attention in the GGH SCN Model of Care and allocated resources, its configuration and patient demographics.

Secondly the IAC deems there must also be a focus on clinical leadership practices, best practices, policies and procedures and quality nursing work life.

The IAC is confident that given the opportunity for those in attendance to openly express concerns and perspectives during the hearing, together with the external objective analysis and associated recommendations will assist both the GGH leadership team and the RNs to jointly commit to finding a common ground. This would allow both parties to move forward in resolving issues in the best interest of quality, safe patient care and a quality work environment.

The Canadian Nurses Association (CNA) and the Canadian Federation of Nurses Unions (CFNU)²⁵ (2014) developed a joint statement outlining seven (7) key principles for practice environments that maximize outcomes for clients, nurses and organizations. They are as follows:

1. **Communication and collaboration** —Communication [and collaboration are) at the foundation of nursing. Quality practice environments promote effective and transparent communication among nurses, between nurses and clients, between nurses and other health and non-health providers, between nurses and unregulated workers, and between nurses and employers. Quality practice environments are based on trust and respect among clients, staff and employers.
2. **Responsibility and accountability** — A quality practice environment helps nurses fulfil their professional, legal, legislative and collective agreement requirements and ensures they can participate in decision-making that affects their work, including developing policies, allocating resources and providing client care.
3. **Safe and realistic workloads** - Quality practice environments support safe and realistic workloads for nurses. Workload is the top issue for Canadian nurses today and is often cited as a key factor in turnover. Sufficient numbers of nurses are required to provide safe, competent and ethical care.
4. **Leadership** — Effective leadership is important in all nursing roles and is an essential element of quality practice environments — for example, nurse managers who involve direct care nurses in decision making that affects the care they provide. At the same time, nurses (including direct care nurses) who act as collaborators, communicators, mentors, role models, visionaries and

²⁵ https://cna-aicc.ca/~media/cna/page-content/pdf-en/practice-environments-maximizing-outcomes-for-clients-nurses-and-organizations_joint-position-statement.pdf

advocates for quality care also provide effective leadership. Therefore, all nurses have an important leadership role that affects their workplace environment and the care they provide.

5. **Support for information and knowledge management** — Quality practice environments include technologies that support critical thinking, enable the provision of safe and effective care, and provide optimal information and knowledge management (e.g., electronic health records and decision support tools). They also ensure that nurses have adequate time to access these technologies.
6. **Professional development** — Quality practice environments are adequately supported and funded to allow nurses to access professional development opportunities. These opportunities can include formal and continuing education, mentoring and online learning resources.
7. **Workplace culture** — A quality practice environment creates a workplace culture that values the wellbeing of clients and employees. This culture is continually assessed to ensure it embraces respect while developing practical knowledge [that] contributes to positive change, disseminating successful practices and strengthening health-care workplace cultures.

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

1. **GGH Special Care Nursery (SCN) Designation**
2. **GGH SCN Staffing**
3. **GGH SCN Nursing Leadership and Governance Structure**
4. **GGH SCN Nursing, Unit Processes, Policies and Procedures**
5. **GGH SCN Continuing Education and Professional Development**

If appropriate commitment and actions are implemented within each of these key areas, the IAC Panel believes that this will ultimately assist GGH SCN to become a quality practice environment reflecting the seven (7) sentinel characteristics as outlined above.

3.3.2 GGH Special Care Nursery (SCN) Designation

3.3.2.1 Recommendation 1: SCN Designation- Determine Level 2A or 2B status for SCN

The IAC panel received, as part of both Guelph General Hospital (GGH) and the Ontario Nurse's Association (ONA) submission, conflicting information in regard to appropriate designation of the Special Care Nursery (SCN) at GGH. Neonatal intensive care has improved outcomes for high-risk infants and appropriate designation of a NICU/SCN is essential. The designation determines the *minimum* standard of care that must be met 24 hours a day, 7 days per week, 365 days per year. Based on a funding letter that was received in 2009, GGH is funded for 8 Level 2 NICU beds which is a 2 bassinet increase from its original funded 6.

Currently, Ontario has 96 hospitals that provide maternal and newborn care and services. Of these, 49 hospitals have Neonatal Intensive Care Units (NICUs) or Special Care Nurseries (SCNs). Working in partnership with the regional and local health organizations, each hospital works to deliver services within standardized levels of care definitions.²⁶

The benefit of establishing and adhering to standardized levels of care is that it fosters an environment of quality maternal newborn care. Acceptance of the definitions provincially allows a universal understanding of each level, accompanying standards of care which are appropriate for the established level, skill expectation of health human resources to mitigate risk as well as identified referral and transfer protocols to support the mother baby dyad.

The Provincial Council for Maternal Child Health (PCMCH) has designated GGH as a 2a in both maternal and neonatal levels of care.

The neonatal level of care for infants in a 2a setting at a minimum

- gestational age greater than or equal to 34 weeks and 0 days and a
- Birth weight greater than 1800 grams.
- Mild illness expected to resolve quickly.
- Care of stable infants who are convalescing after intensive care
- Nasal oxygen with oxygen saturation monitoring (acute and convalescing).
- Ability to initiate and maintain a peripheral intravenous.
- Gavage feeding

Retro-transfers.

- Stable neonatal retro-transfers with a corrected age over 32 weeks and 0 days, and
- a weight greater than 1500 grams and not requiring invasive or non-invasive ventilation
- advanced treatments or investigations

²⁶ Provincial Council for Maternal and Child Health Levels of Newborn Care 2013

Gestational Age	Maternal Care	Newborn Care
Level II	Level IIa	Level IIa
GREATER THAN OR EQUAL TO 34 WEEKS AND 0 DAYS	<p>Care as above PLUS:</p> <p>Risk</p> <ul style="list-style-type: none"> • Women carrying a fetus with anomalies (minor) not likely to need immediate interventions. • Low-to-moderate maternal risk experiencing low risk medical/obstetrical complications where SGA is not suspected. • May care for uncomplicated dichorionic twin pregnancies. If less than 36 weeks and 0 days consider consultation and transfer. <p>Support</p> <ul style="list-style-type: none"> • 24/7 induction and augmentation of labour • 24/7 availability of continuous EFM • Available assessment within 30 minutes by obstetrics, anaesthesia, and paediatrics for emergencies and potential caesarean sections. 	<p>Care as above PLUS:</p> <p>Risk</p> <ul style="list-style-type: none"> • Planned/anticipated care for infants with a gestational age greater than or equal to 34 weeks and 0 days and a birth weight greater than 1800 grams. <p>Illness and intervention</p> <ul style="list-style-type: none"> • Mild illness expected to resolve quickly. • Care of stable infants who are convalescing after intensive care • Nasal oxygen with oxygen saturation monitoring (acute and convalescing). • Ability to initiate and maintain a peripheral intravenous. • Gavage feeding <p>Retro-transfers.</p> <ul style="list-style-type: none"> • Stable neonatal retro-transfers with a corrected age over 32 weeks and 0 days, and a weight greater than 1500 grams and not requiring invasive or non-invasive ventilation, or advanced treatments or investigations.

The Ministry of Health expanded the Critical Care Services of Ontario (CCSO) mandate to include Neonatal Intensive Care (NICU) IN 2017. This includes oversight for NICU capacity planning and for guiding improvements across the NICU system to ensure that Ontario's youngest patients have access to the services they need, where and when they need them.²⁷ CCSO has identified GGH SCN as a level 2a. Identified under the criteria category within 2a – *ventilation* - include intubation prior to transport, ability to initiate positive pressure ventilation with or without initiation of CPAP as well as CPAP management – including ongoing evaluation and management of an infant for up to 4-6 hours or until the transport team has arrived. GGH has identified that they meet this criteria 24 hours a day, 365 days per week.

²⁷ Critical Care Services Ontario Neonatal Intensive Care 2017

Required Standard Criteria for all Neonatal Intensive Care Units			
Criteria for Level 2a NICUs			
Acute Care Criteria: Gestational age \geq 34 weeks and 0 days and a birth weight of $>$ 1800 grams			
Repatriation Criteria: Stable infants with a corrected age of $>$ 32 weeks and 0 days and a weight of $>$ 1500 grams and not requiring ventilator support or advanced treatments or investigations.			
Criteria (category)	Detail of Criteria (as needed)	Availability	Able to Meet (select from the drop-down list)
Oxygen therapy	Short term for stabilization or management	24/365	[YES]
Prostaglandin E ₁	Available for IV administration	24/365	[YES]
Ventilation <i>Recommend consultation with tertiary centre if baby still requires CPAP at 4-6 hours of age.</i>	Surfactant is available for administration after consultation with tertiary site via CritiCall	24/365 or available via on call within 30 minutes	[YES]
	Intubation prior to transport	24/365 or available via on call within 30 minutes	[YES]
	Ability to initiate positive pressure ventilation with or without initiation of CPAP	24/365	[YES]
	CPAP management – including ongoing evaluation and management of an infant for up to 4-6 hours or until transport team arrival.	24/365 or available via on call within 30 minutes	[YES]
IV management for up to 48 hours (short term)		24/365	[YES]

Recommendation 1:

- a. SCN is a Level 2a Neonatal Intensive Care Unit. Based on recent changes including the physician model of care, the recent hire of a clinical educator with a focus on SCN and the Ministry approved renovation of SCN, the hospital continues in its journey to obtain a Level 2b designation to support an increased level of care for babies within the community to further enhance the mother baby dyad.

3.3.2.2 Recommendation 2: SCN Renovations

Plans for Redevelopment/ Renovation of the GGH SCN

The physical layout of the Special Care Nursery is out-dated and inefficient. The IAC Panel saw evidence of this during out video tour held during the Day 1 of the IAC Hearing on April 27, 2021.

In 2016 during the Foundation of Guelph Generals “Dream Big” campaign, the SCN was selected as the target for fund raising. By 2018 the project was fully funded and the process for ministry approval began.

The IAC Panel understands GGH has now completed stage 3B of ministry approval. The IAC Panel heard evidence that GGH anticipates the ground-breaking for this newly renovated space to begin within the year.

Re-location for Redevelopment

During the renovation period the SCN will be relocated into a 6-bed temporary Nursery in the 6 West Paediatric Day Surgery area, which is in close proximity to the 8 bed Paediatric Unit.

During the renovation period (approximately 4-6 months) there will be the need for both Paediatrics and SCN working together to help coordinate care for newborns and Paediatrics patients. Flexibility will be critical to support patient flow. Because our SCN will reduce for the renovation period from 10 to 6 beds there will be the need to utilize rooms on the Paediatric Unit for SCN overflow for appropriate babies.

Recommendation 2:

- a. **Continue to lobby the ministry to advance the SCN renovations for this year as GGH shared with the IAC Panel.**
- b. **Initiate the team building recommendations as soon as possible to support the transition period whereby the SCN and Pediatric staff will be relocated during the period of renovation.**
- c. **Develop an internal and external communication strategy for all key stakeholders to inform them of the changes during the renovations to support this transition period.**

3.3.2.3 Recommendation 3: SCN Capital Equipment

In tandem with the SCN Renovations, the budget includes not only brick and mortar components but a large investment in capital equipment.

To date the SCN has received almost \$500K in capital equipment purchases with the remaining purchases scheduled in 2021/2021 ahead of the actual renovation to improve the environment.

It is evident that there is a strong commitment from GGH to ensure equipment needs have not only be identified but also purchased to support quality and safe patient care as presented below.

An area of concern the staff identified during the IAC hearing as well as the evidence presented in the briefs reviewed by the IAC Panel, was that of the SCN physiological monitors for neonates. It

Completed Capital Investments 2018/2019- 2020/2021

Year	Description	Cost
2018/19	Bassinets (9)	\$ 35,360
	Chairs - Motion Recliner Primacare (7)	\$ 12,086
	Chair - Glider/Motion Globalcare	\$ 2,599
	Phototherapy Light System	\$ 6,406
	Cart	\$ 2,965
	Cribette	\$ 5,327
	Freezer	\$ 2,140
Total 2018/19		\$ 66,883
2019/20	Pumps, Medfusion (3)	\$ 14,496
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2020/21	Phototherapy Light System	\$ 6,460
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Planned Capitol Investments 2021/2022 - 2022-2023

Year	Description	Cost
2021/22	Blanket Warmer	\$ 9,130
	Cart, Breastfeeding Storage	\$ 2,965
	Refrigerator, Microcool	\$ 22,000
Total 2021/22		\$ 34,095
2022/23	SCN Renovation Redesign	\$ 5,142,388
	Minor Renovation - replace sinks, doors, storage	\$ 65,719
Total 2022/23		\$ 5,208,107
Grand Total		\$ 5,242,202

As part of GGH's presentation to the IAC Panel on Wednesday April 28, 2021, there is a commitment to purchase +12 patient monitors with central monitoring capability (IT fleet replacement) at the cost of approximately \$80,000.00 for 2022/2023.

Recommendation 3:

- a. Given the age of the current neonatal physiological monitors, begin the RFP initiative as soon as possible to purchase the new neonatal physiological monitors.

3.3.3. GGH SCN Staffing

3.3.3.1 Recommendation 4: Baseline Staffing for GGH Level 2A Special Care Nursery (SCN)

Baseline staffing was one of the major issues identified at GGH SNC IAC meeting. The IAC Panel read evidence and heard issues related to staffing in the Level 2A SCN.

Based upon the sixty-seven (67) PRWRFs submitted between July 2019 and March 2021, 80% of these reports indicate the need for additional staffing based on patient volumes, acuity, complexity and census.²⁸

The overall staffing issues within the SCN have had a significant effect on the RN staff and their ability to provide the level of care required and expected by the;

- College of Nurses of Ontario Practice Standards,
- Standards for Neonatal Intensive Care Nursing Practice as outlined by the Canadian Association of Neonatal Nurses (CANN),
- Perinatal Nursing Standards in Canada 2018 - Canadian Association of Perinatal and Women's Health Nurses (CAPWHN),
- National Association of Neonatal Nurses (NANN) and,
- Association of Women's Health Obstetrics and Neonatal Nursing (AWHONN).

The RNs working in the Special Care Nursery shared with the IAC Panel they have voicing their concerns about staffing levels for more than 30 months, while the acuity and care interventions required for their patient population have increased dramatically based on multiple patient factors including acuity, complexity and census.²⁹

Other factors impacting staffing is the time off the unit to attend high risk deliveries ranges between 15-16 minutes at a time per shift depending on the clinical situation. Simultaneously, staffing issues have contributed significantly to declining requests for repatriation from other hospitals.³⁰

GGH's leadership team has initiated the following strategies in response to staffing issues:³¹

- Increasing numbers of part time staff trained in the SCN and the hiring of 2 additional part time staff recently.
- There are 3 casual staff. 2 of these staff are being crossed trained in May and moving to part time to increase the pool of available staff for both the SCN and Paediatrics.
- As the Paediatric staff cross train, they will add to the roster of available staff to support the SCN as needed (however, IAC Panel heard that many of the Pediatric staff are uncomfortable with this approach)
- Cross training Pediatric staff 'grow our own' specialized nurses for the SCN and Paediatrics. In 66.6% of workload forms, SCN staff recommended a larger pool of trained staff available to support the SCN.

²⁸ ONA Submission Volume 1

²⁹ ONA Submission Volume 1

³⁰ ONA Submission Volume 1 p 29

³¹ GGH Submission April 22, 2021

GGH SCN Budget³²

The budget for the SCN is comprised of, which are explored in more detail below:

1. Base Budget for staffing
2. Additional Regular Hours
3. Back fill/ replacement hours

1. Base Staffing Budget

The budget for staffing in the SCN has remained unchanged since 2018/2019. The SCN is budgeted for 7 full time Nursing staff and 5.3 part time staff.

In 2006, an accommodated injured worker began a modified schedule working a 0.8 FTE role, resulting in approximately 80% of day shifts being staffed with an additional, third RN. In 2018, the accommodated worker retired, and the hours have not been replaced. We heard during the IAC Hearing that there was an agreement to not replace this position. However, the IAC Panel also learned during this time that ONA clearly indicated that once this position ended, that is when the PRWRF's began to escalate. ³³

	F18-19			F19-20			F20-21		
FTEs	Actual	Budget	Variance	Actual	Budget	Variance	Actual	Budget	Variance
FT	7.43	7		7.2	7		6.95	7	
PT	3.3	5.3		3.54	5.3		3.98	5.3	
Casual	0.72			0.61			0.61		
	11.45	12.3	-0.85	11.35	12.3	-0.95	11.54	12.3	-0.76

2. Additional flexible scheduling hours:

An additional 3,510 hours (not reflected above) has been built into the budget to increase staffing when patient acuity or activity require additional support. These dollars allow for the matching of staffing to patient needs/ patient flow.

3. Backfill and Replacement Dollars

In addition to base staffing dollars as well as flexible scheduling hours. The SCN budget includes a total of 2,670 replacement hours for 'backfill'. This includes 11 days of sick replacement, 12 paid stat days, and an average of 28 vacation days per full time employee.

³² Overview of Maternal Child Care GGH Submission April 2, 2021

³³ ONA Submission Volume 1 p. 22

Staffing in areas of High Fluctuations

Because of the high degree of fluctuation in the census, GGH leadership chose to approach staffing in the SCN differently than we do for areas such as Medicine/ Surgery or ICU who historically have stable occupancy and predictability. Based on the average census of 5 babies and the historical acuity breakdown, the SCN is staffed with a baseline of 2 RNs on days and 2 RN's on nights. There are additional staffing hours (3,510 hours) built into the budget to allow GGN SCN to call in extra staff or schedule additional staff to:

- Accompany a baby to an appointment (ROP clinic for example)
- Provide extra support for an unexpected increase in activity or acuity
- Staff up for a planned activity (scheduled high risk caesarian sections/ births or twin delivery)
- Bring in additional staff to be able to bring back babies from outside centres³⁴

Benefits of Flexible Scheduling³⁵

The benefit is that these hours are filled with part time staff or casual staff, who based on their availability and commitment level, can pick up additional hours to match demands. GGH explored the concept of converting the 3,510 flex hours into pre-scheduled shifts. This was problematic because there was no way to forecast the needs of the unit. There was no guarantee that the staffing would match the activity on that particular shift. The potential of having 3 nurses on days with a very low census/ low acuity and only 2 on days with higher census and acuity exists.

In order to be effective with the flexible scheduling approach GGH identified the need to be as proactive as possible and be supported by the correct number of part time and casual staff, who are available to respond. For example, GGH currently assesses the number of babies expected to be discharged and transferred and based on this review of scheduled / booked procedures and review repatriation requests staffing needs are identified. Based on these factors and the number of women in labour (22% of babies born at GGH will spend time in the SCN), GGH proactively schedules additional nurses for the time period in which they anticipate needing the additional support.

However, what was evident to the IAC Panel is the ongoing challenge to schedule qualified SCN nursery when the patient acuity escalates therefore leaving the nurses in compromising situations whereby they are unable to meet standards of care and/or respond to other babies in the SCN when required.

Sick and Overtime³⁶

The SCN currently has approximately 16 staff who make up the full complement of full time/ part time and casual. The impact of sick on overtime is significant in a small unit with a limited number of staff available for backfill or call in at short notice. Sick time in the SCN is double the hospital average, but in line with our peers.

³⁴ Overview of Maternal Child Care GGH Submission April 2, 2021

³⁵ Overview of Maternal Child Care GGH Submission April 2, 2021

³⁶ Overview of Maternal Child Care GGH Submission April 2, 2021

SCN Patient Census³⁷

The average census in the SCN is approximately 50% or 5 patients (range 48 – 60% in 2020/2021). The following information is specifically related to patient volumes and census information.

Although this reflects the overall patient census it does not indicate patient acuity.

The graph below shows the number of days and number of hours where the census in the SCN was in excess of GGH's funded 8 beds dating back to January 1st of 2019. The time of this data capture was 10 AM. The graph below indicates that less than 4% of the time, in this almost 3.4 year time period GGH had an occupancy that exceeded our funded beds of 8. (53= the number of times and 1103 reflects total number of hours)



Non-Invasive Ventilation in the SCN³⁸

According to the CCSO Neonatal levels of care assessment Level 2a NICUs should have the ability to initiate positive pressure ventilation / CPAP including ongoing evaluation and management for an infant up to 4-6 hours or until transport team arrives. GGH has had a dramatic increase in the number of babies where CPAP was initiated but we do not have an easy way to capture the actual length of time in an objective way at this time. However, GGH is in the process of upgrading their current documentation system to be able to pull the data more easily.

GGH is also running reports on the number of babies where CPAP was initiated who required transfer out (proxy measure for acuity). These reports were not available to the IAC Panel by the April 27th

³⁷ GGH Additional Responses April 22, 2021

³⁸ GGH Additional Responses April 22, 2021

BIPAP & CPAP				
16/17	17/18	18/19	19/20	20/21
36	33	58	72	119
13.2%	12.6%	20.4%	23.4%	49.0%

The IAC Panel also read evidence and heard issues related to staffing, culture, morale, teamwork and presence of leadership in the Level 2A SCN as well. The Hospital Health Survey specific to this portfolio in 2018 identified low scores with interdepartmental cooperation, this trend continued in the 2020 survey³⁹. Collaboration between departments especially those that are interconnected must involve mutual understanding and respect. It is imperative to understand challenges and opportunities from each other's perspective. Trust is the foundation of a high performing team. When trust is achieved staff know that they can depend on each other therefore interdepartmental collaboration is effective and positive. It is through these positive relationships the organization achieves both quality patient outcomes and an engaged, empowered staff.

As identified by both ONA and GGH submissions as well SCN staff statements, morale and culture are low. This was especially evident in the completion of the PRWRF's as well as the root cause analysis performed by the hospital in regard to the Healthy Hospital Survey result. There were a number of factors contributing to this including lack of leadership presence, fewer staff from across the portfolio making themselves available to work in SCN as well as an informal support model from both FBU and pediatrics to support SCN when there is increased acuity and/or vacancies. Evidence was presented that language was at times used to describe colleagues that came to support as "unskilled", "untrained" was often perceived as disrespectful and staff felt undervalued.

The introduction of a 3rd RN in SCN to act as a Resource Nurse scheduled Monday to Friday 0800-1600 hours would provide expertise in neonatal care as well as stability for the program. The informal approach to support SCN is not an effective strategy to meet the identified needs in a speciality critical care area. Responsibilities could include but not limited to:

- Provide leadership and mentorship to the inter professional team to ensure comprehensive integrated care to achieve the best possible outcomes
- Coordinates day to day patient care activities, staffing and resource utilization for SCN
- Adapts to changing workloads, collaborating with colleagues
- Serves as a direct care provider when needs arise or in complex situations
- Supports, coaches and mentors staff communicating appropriate knowledge, skills and judgement.

³⁹ Overview of Maternal Child Care GGH Submission April 2, 2021

Recommendation 4:

- a. Propose adding a third RN- Special Care Nursery Resource Nurse on day shifts Monday-Friday from 0800-1600 hrs.**
- b. Utilize existing flexible scheduling hours as well as backfill replacement budget to fund the position. Ideally this position would offset a portion of the overtime due to call in and sudden fluctuations in acuity due to presence and familiarity of day to day operations and proactive planning within the SCN.**
- c. Once the newly renovated SCN opens and Level 2B designation has been granted there must be three (3) RNs in SCN twenty-four hours per day seven days per week.**

3.3.3.2 Recommendation 5: The Role of the Unit Attendant

The IAC panel through the hearing, presentation and review of documents identified that non nursing duties were often performed by the nurses in the SCN. GGH has an identified job description for the role of the Unit Attendant throughout various departments within the hospital. The Unit Attendant (UA) provides support services to the nursing staff by ensuring all areas are stocked and maintained with appropriate supplies and equipment, ordering supplies, and transporting supplies, equipment and patients both within the department and hospital wide, in a timely manner to accommodate efficient patient flow⁴⁰. SCN shares a UA with the Intensive Care Unit as well as FBU and pediatrics.

Nurses in SCN have a specialized skill set and their ability to provide direct nursing care is paramount to quality, safe patient outcomes. Nurses often undertake tasks which less qualified staff could do while at the other end of the continuum, are unable to use their high-level skills and expertise. This inefficiency in the use of nursing time may also impact negatively on patient outcomes⁴¹.

This creates a dichotomy leading to decreased staff satisfaction within their role. Professional nurses conduct many non-nursing tasks and leave several important nursing tasks left undone. Nursing tasks left undone cause the greatest degree of job dissatisfaction amongst professional nurses⁴²

Recommendation 5:

- a. Devise standard work for the role of the Unit Attendant specific to responsibilities for SCN. This will support SCN nurses to utilize their skill set, trusting non nursing duties will be followed up on.**

⁴⁰GGH IAC Submission Master ONA April 2, 2021

⁴¹ Duffield, C., Gardner, G. and Catling-Paull, C. (2008), Nursing work and the use of nursing time. *Journal of Clinical Nursing*, 17: 3269-3274. <https://doi.org/10.1111/j.1365-2702.2008.02637.x>

⁴² Bekker, M., Coetzee, S.K., Klopper, H.C. & Ellis, S.M. (2015) *Journal of Nursing Management* 23, 1115– 1125. Non-nursing tasks, nursing tasks left undone and job satisfaction among professional nurses in South African hospitals

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- b. **Devise a schedule that aligns with the delivery of ordered supplies to facilitate timely stocking and restocking**
- c. **Develop a special order supply and equipment checklist with support from the SCN staff for ease of ordering to ensure availability of essential equipment when needed.**
- d. **Frequent scheduled check in's between the UA, SCN staff and the Director to ensure the role is being utilized to its potential.**

3.3.3.3 Recommendation 6: The Role of the Unit Clerk

The IAC panel through the hearing, presentation and review of documents identified that non nursing duties were often performed by the nurses in the SCN. As per the ONA submission⁴³ some of these duties include:

- Answering the phones
- Answering the door (unit is locked)
- Fax referrals
- Staff for sick calls or other needs
- Organize repatriations
- Organizing Patient Transfer (PTAC)

There is a Unit Clerk job description within GGH Master Submission⁴⁴. The Unit Clerk role includes essential responsibilities including:

- Reception and clerical duties
- Support of patient care
- Teamwork and collaboration
- Performs cross functional and other duties as assigned and/or requested.

In reference to the job description for the Unit Clerk of the Family Birthing Unit (FBU) it identifies daily responsibilities specific to Ambulatory Care but does not include accountabilities to SCN. Ward clerks are essential members of the healthcare team, providing administrative and organizational support to acute care units and clinics. This role influences such matters as nurses' direct patient-care time, timeliness of patient discharges, and patient safety⁴⁵. For the Unit Clerk to feel a valued member of the team their responsibilities and accountabilities to each department should be specific to the unit(s) and outlined as such.

The Unit Clerk organizational workflow is complex within one unit, adding additional units increases the complexity. The implementation of standard work with appropriate check in's that are established for each unit will assist with efficiency and job satisfaction. An excellent workflow process can accommodate variations that inevitably arise in health care through interaction with other workflow

⁴³ ONA IAC Submission Master ONA April 21, 2021

⁴⁴ GGH IAC Submission Master ONA April 21, 2021

⁴⁵ Kennedy M. The Importance of a Role-Specific, In-Hospital Ward Clerk Education Program. Hosp Top. 2016 Jul-Dec;94(3-4):43-48. doi: 10.1080/00185868.2016.1234312. PMID: 27997300.

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processes, as well as environmental factors such as workload, staff schedules, and patient load⁴⁶. Based on the above please see the recommendations below:

Recommendation 6:

- a. **Devise standard work for the role of the Unit Clerk specific to responsibilities for SCN. This will support SCN nurses to utilize their skill set, trusting non nursing duties will be followed up on and the Unit Clerk will be identified as a valued member of the care team.**
- b. **Standard work should include but not limited to participation in daily status exchange to understand:**
 - **Staffing needs for coming shifts,**
 - **Potential of arranging transportation,**
 - **Receiving repatriations**
 - **Identification of anticipated needs**
- c. **Scheduled check in times with SCN either by rounding or phone check in to understand if support is needed. A process should be put in place that if support is required urgently the Unit Clerk responds or gives a reasonable time frame when she/he will respond.**
- d. **Expectation that if an admission arrives in SCN the Unit Clerk will attend SCN to provide support.**

⁴⁶ Cain C, Haque S. Organizational Workflow and Its Impact on Work Quality. In: Hughes RG, editor. Patient Safety and Quality: An Evidence-Based Handbook for Nurses. Rockville (MD): Agency for Healthcare Research and Quality (US); 2008 Apr. Chapter 31. Available from: <https://www.ncbi.nlm.nih.gov/books/NBK2638/>

3.3.4 GGH SCN Nursing Leadership and Governance Structure

The Registered Nurses Association of Ontario (RNAO) Best Practice Guideline *Developing and Sustaining Nursing Leadership* identifies five evidence-based transformational leadership practices which are fundamental for transforming nurses' work settings into healthy work environments. These transformational practices, which apply to all roles and levels of leadership, including nurses providing direct care are⁴⁷:

- 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.
- 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.
- Creating a culture that supports knowledge and 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.
- Leading and sustaining change involves the active and participative implementation of change, resulting in improved clinical and organizational processes and outcomes.
- 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 share organizational decisions. Proper use of evidence is key.

The IAC believes that these transformational practices must be incorporated into the operational, clinical and point-of-care leadership positions including the Clinical Director, Resource Nurse and the nursing staff within Special Care Nursery, Family Birthing Unit and Pediatrics.

Recommendations for Nursing Leadership and Governance 7:

- a. The GGH Leadership team develop a strategy to implement the Registered Nurses Association of Ontario (RNAO) Best Practice Guideline *Developing and Sustaining Nursing Leadership* for the Special Care Nursery Staff at GGH.**
- b. The Registered Nurses Association of Ontario (RNAO) Best Practice Guideline *Developing and Sustaining Nursing Leadership* become the framework utilized for leadership development for all Special Care Nursery Staff at GGH.**

⁴⁷RNAO Healthy Work Environments: International Affairs and Best Practice Guideline *Developing and Sustaining Nursing Leadership*, 2nd edition, 2013, pg 17

3.3.4.1 Team Building for the GGH Family Birthing Unit SCN

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

Nursing leadership during trying times like our COVID-19 Pandemic ⁴⁸ has never been more important. The IAC Panel believes that these three key themes are essential given the evidence presented during the IAC Hearing and for leadership to consider. Moore (2020) suggests three key themes when leading in crisis leadership:

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

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

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

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

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

Nurses who effectively deal with conflict demonstrate respect for their clients, their colleagues and the profession. Conflict that remains unresolved can have far reaching effects that ultimately influence every aspect of client care.⁴⁹

Healthy work environments are practice settings that:

- (a) maximize the health and well-being of nurses and other health workers and
- (b) improve organizational performance and patient, client, resident and societal outcomes.⁵⁰

When managing change, two critical assessments are needed at the onset of the change.

The first assessment is the **change** itself. This assessment examines the scope, depth and overall impact of the change. Specific items that should be addressed by this change assessment are as follows:

- Scope of the change (workgroup, department, division, enterprise);
- Number of stakeholders impacted;

⁴⁸ <https://www.nursingtimes.net/clinical-archive/leadership/nurse-leadership-during-a-crisis-ideas-to-support-you-and-your-team-16-11-2020/> Citation: Moore C (2020) Nurse leadership during a crisis: ideas to support you and your team. *Nursing Times* [online]; 116: 12, 34-37.

⁴⁹ CNO https://www.cno.org/globalassets/docs/prac/47004_conflict_prev.pdf

⁵⁰ https://rnao.ca/sites/rnao-ca/files/bpg/Preventing_violence_harrassment_and_bullying_against_health_workers_final.pdf

- Type of change (process, technology, organization, job roles, merger, strategy);
- Amount of change from where we are today.

This assessment of the change and a thoughtful review of the nature of the change is essential to plan an organization's change strategy.

An important evaluation is an **organizational (Program/Unit) assessment**. Each organization has unique characteristics that make change management either easy or challenging.

This assessment would cover areas such as:

a) Culture and value system

The culture and value system play a major role in how an organization reacts to change. Considering this factor, one is able to predict certain reactions in the group and plan accordingly to deal with those reactions.

b) Capacity for change (and how much change is already taking place)

Organizations have a limited capacity for change. If your organization is already experiencing a large degree of change, then implementing yet another change can be challenging.

c) Leadership styles and power distribution

Leadership styles play an important role in change management planning. Because sponsorship and management support is a key success factor for change management, it is important that you take time to assess the leadership styles and power distribution in the organization;

d) Residual effects of past changes

Past changes may have left a residual effect that could work in one's favor, or make change management more challenging. The organization's history is part of the starting point when managing change;

e) Middle management's predisposition toward the change

In many organizations, there are middle managers who have a high degree of control over their peers and employees. These middle managers will play a significant role in the change process;

f) Employee readiness for change

Employee readiness for change is a gauge of how prepared and able employees are for change, and whether one can expect high or low employee resistance, and why.⁵¹

Given the depth and breadth of change within SCN as they embark on a major renovation and change in geographical location, an effective change management strategy and support measures need to be integrated as part of this unit's culture. Each individual responds to change differently.

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

⁵¹ Best Practices in Change Management Benchmarking Report, Prosci, 2019

Team Building Recommendation 8:

- a. **The Hospital engage either an internal or external expert to facilitate team building sessions to enhance a unit culture that is founded on the principles that underpins GGH's code of conduct, mission, vision and values.**

This should include change management, teambuilding, conflict resolution and communication activities that engage staff participation.

3.3.4.2 Recommendation 9: Staff Meetings

Unit based Communication/ Leadership⁵²

The Hospital has a standard approach to daily communication organization wide. These structures have been in place since 2017. A brief summary of each component is listed below:

1. **Daily unit status exchange (M-F):** This is an opportunity for the unit Director to check in on each of the Maternal Child units first thing in the morning. There is a standard work document that is used to ensure that all critical information is collected. The purpose of the status exchange is to proactively address issues, plan and provide support for staff. Please see appendix XXX for the standard check in document that is used for Mat/ Child Programs.
2. **Daily All Hospital Leadership Huddle (M-F and PRN):** All leadership check in daily on issues organization wide related to staffing, patient flow, staff safety and any risk or quality issues. This is also the avenue used to identify key information to be taken back to the individual areas for their unit-based huddles.
3. **Daily Unit based Huddles (M-F):** Each day the unit Director conducts a department huddle on each of their respective units. Staff gather for 10 min at each units 'board' and review hospital wide metrics, issues, concerns and unit specific project updates, communication from the Leadership huddle is shared here. Key information is documented and posted on the board and available for staff to review between shifts. Members of the Senior Leadership Team including the CEO attend a minimum of 3 unit-based huddle across GGH per week. This is an excellent way for staff to build relationships with members of the Senior Team and for the Senior team to stay connected to issues and concerns occurring close to the bedside.
4. **Resource Nurse Check in:** The SCN shares a resource nurse with the FBU. Over the past year, staff selected this project to work on as part of the ONA Professional Practice process. A template with key information that the SCN felt was critical for the Resource Nurse to be aware of was developed with the expectation of a check in at least 3 time per 12-hour shift and as needed. This process is less formally established among the charge nurses, but we hope to extend the check in project to include this group over the next 6 months.

⁵² GGH IAC Submission Master ONA April 2, 2021

5. **Staff Meetings:** This is an area of opportunity across the mat child program. With COVID, attempts have been made to move to virtual staff meetings to make it easier for staff to attend, with some success. The Hospital has made it a priority this year to have regular staff meetings, at a minimum of quarterly and as needed in each of the 3 areas of the program.

Regularly scheduled staff meetings were identified as an area for improvement within the Maternal Child Program. Because of COVID, the program has been able to utilize the Webex system and have held virtual meetings, which GGH hoped allowed a more convenient approach for staff to attend. GGH leadership also recognized that the day to day huddles and staff exchanges are not a replacement for regular staff meetings.⁵³

One of the requests to GGH leadership was asked for were previous Staff Meeting minutes, unfortunately there were none shared with the IAC Panel. It is evident that this is an area that requires significant improvement.

Staff Rounding

Rounding for outcomes⁵⁴ is a consistent practice of asking questions of key stakeholders – leaders, staff, physicians and patients to obtain actionable information. Studer's evidence-based practices to improve performance, patient satisfaction and engagement through staff rounding is an excellent approach to ensure staff engagement with the intent to enhance quality patient care and outcomes.

The focus for questions during staff rounding is to⁵⁵:

- ▶ **Build relationships** (e.g. "How is your family?" ("Did your daughter graduate last week?")
- ▶ **Harvest "wins" to learn what is going well**, what is working, and who has been helpful (e.g. "Are there any physicians I need to recognize today?")
- ▶ **Identify process improvement areas** ("What systems can be working better?")
- ▶ **Repair and monitor systems** to ensure chronic issues have been resolved (i.e. "Do you have the tools and equipment to do your job?" or even more specifically: "How long did it take you to find an IV pump today?")
- ▶ **Ensure that key behavior standards in the organization are "hardwired"** (or being consistently executed) to reward those who are following the standards and coach those who are not.

⁵³ IAC Additional Questions April 22, 2021

⁵⁴ Studer, Hardwiring for Excellence

⁵⁵ Studer, Hardwiring for Excellence

Relationship-building questions during rounding build communication at all levels of an organization because they demonstrate to employees that leaders care about them as people a very important issue we heard during the IAC Hearings.

Because many health care employees tend to notice what is wrong or not working—instead of what is right and working—it's particularly important to ask questions that look for the positive. While diagnosing what's wrong is critical to ensuring quality clinical outcomes in patients, it serves as an obstacle in an organization's effort to create a positive work culture, so we must build in opportunities to notice what's right.

By identifying and preventing employee frustrations and delays, organizations increase staff productivity and communication. In this way, rounding can provide a quick return on investment by reducing medically unnecessary days due to inefficiencies.

Given the discussions throughout the IAC hearing related to staff not seeing their manager, lack of trust and poor communication, rounding for outcomes with staff is a meaningful way to develop trust, engage in meaningful dialogue with staff and to understand issues relevant to them.

Simultaneously, holding regularly scheduled staff meetings is of equal importance for staff and leadership to stay engaged and feel empowered to bring forward issues.

Recommendation 9:

- a. **The Clinical Director implement staff rounding twice per week to foster collaboration, trust and support for the SCN staff.**
- b. **Conduct weekly staff meetings on the same day of the week at 7am (shift change) for a 6-month pilot led and facilitated by the Clinical Director. The Senior Director should attend as well.**
- c. **SCN and FBU staff must be given the opportunity to submit agenda items and have the opportunity to address these items during the meeting.**
- d. **SCN and FBU Staff should make every effort to attend staff meetings that are planned and be part of the process to make improvements and provide suggestions. It is also the staff's responsibility to read minutes of staff meetings that are posted or shared by email.**
- e. **GGH should consider different options to engage staff in attending staff meetings for example arranging meetings to be conducted via teleconference, Webex, Microsoft Teams, Zoom so staff can be engaged.**

3.3.4.3 Recommendation 10 – The Role of the Senior Director

The IAC panel upon review of submissions as well as through the hearing proceedings heard the request for leadership visibility throughout the clinical portfolio. The presence of leadership is paramount in the development of trust, accountability and open, transparent communication.

In health care organizations, where many workers have strong professional identifications, trust of leadership by subordinates often reflects the extent to which leadership is committed to the values inherent in the professions of medicine and nursing⁵⁶. GGH has developed an organizational safety and communication strategy for all leaders within the organization. This strategy encompasses patient and staff safety as well as engagement. Members of the Senior Leadership Team including the CEO attend a minimum of 3 unit-based huddle across GGH per week. This is an excellent way for staff to build relationships with members of the Senior Team and for the senior team to stay connected to issues and concerns occurring close to the bedside⁵⁷.

Recommendation 10:

- a. Senior Director will attend unit huddles at a minimum once per week. This will increase visibility, garner trust and develop relationships with staff in SCN.**
- b. In the absence of the Clinical Director, the Senior Director should ensure there is appropriate coverage for daily status exchange and unit huddles. This is to ensure continuity of shared information, communication as well as identification of issues and concerns.**

3.3.4.4 Recommendation 11 - FBU Clinical Director – Increasing Support/Visibility in SCN

The IAC panel through the hearing including Special Care Nursery (SCN) staff testimonials, received feedback regarding the lack of support the SCN staff was experiencing with leadership presence and visibility within their unit. Emerging research shows that leader involvement correlates with employee engagement.⁵⁸ As employee engagement rises it is directly correlated with improved patient outcomes as well as decreasing employee turnover. These principles are foundational for a high functioning unit.

The Clinical Director for this portfolio at GGH has oversight of three programs – Maternal/Newborn and Pediatrics. The panel did not receive the number of direct reports this director has in her portfolio, therefore unable to understand the span of control. Span of control is influenced by many factors including complexity of work, experience of the leader and capability of staff. While there is limited

⁵⁶ Bunderson J. 2001. How work ideologies shape the psychological contracts of professional employees: Doctors responses to perceived breach. *Journal of Organizational Behavior* 22:717–741.

⁵⁷ GGH Submission April 21, 2021

⁵⁸ Xu J, Thomas HC. How can leaders achieve high employee engagement. *Leadership & Organization Development J.* 2011;32(4):399–416.

evidence on the impact of span of control, patient satisfaction is lower on units where managers have larger spans of control and staff turnover is higher⁵⁹

GGH has developed an organizational safety and communication strategy for all leaders within the organization. This strategy encompasses patient and staff safety as well as engagement. Leader standard work has been developed which includes daily status exchange, departmental huddle(s), organization wide huddle(s) as well as program leadership. Participation in the daily status exchange as well as the unit based huddles is an opportunity to understand the unit(s) specific needs proactively as opposed to reactively. This is an organized, scheduled and established strategy for the director to be visible in the units. This visibility can lead to an openness with staff that will build trust and facilitate communication. 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 partnerships⁶⁰. The development of these relationships in all areas of responsibility for the director will lead to the formation of positive and collegial working relationships across the portfolio. This will also contribute to a work environment that is empowering leading to positive patient outcomes and increased staff satisfaction.

The Professional Responsibility Workload Report Form is to be utilized as a document to facilitate discussion to initiate a problem solving and collaborative process between staff and the hospital. It is the responsibility of the manager/director/designate to provide a written response within 10 days of receiving the form. The follow up should be timely with input from the staff that have been involved and actionable follow up identified where possible. These should be discussed at the Hospital Advisory committee with agreed upon recommendations.

Recommendation 11:

- a. Review Span of Control considering complexity of program(s), experience of leader as well as experience profile of staff.**
- b. The Director or designate should participate in daily status exchanges and departmental huddles with all units as part of the organizations established leader standard work. Huddles should also be instituted if a situation arises that requires additional support. This increased visibility will open the line of communication as well as foster relationships built on trust.**
- c. Timely follow up on all PWRWF is an agreed upon accountability between ONA and the hospital and must be followed to facilitate collaborative and problem-solving discussion. All forms should have follow-up within the 10 day time period understanding follow up maybe ongoing over a period of time.**

⁵⁹ 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.

⁶⁰ Registered Nurses of Ontario (2013) Developing and Sustaining Nursing Leadership. 2ND ed. Toronto, ON:.

3.3.3.5 Recommendation 12: Nurse Educator Role

The IAC Panel reviewed and listened to issues related to absence of Educator support in the SCN, no updates or training on neonatal practices and no support during increased patient loads and high acuity.

In house education and updates is pertinent to maintaining the standards of care in the Special Care Nursery. One of the roles of the Nurse Educator is to teach best practices related to neonatal care. In the same way that our neonatal patients deserve care based on best evidence, staff should receive education on current evidence-based practice.⁶¹ This can be presented and communicated in many ways with new and innovative teaching strategies in this technological world.

The Nurse Educator is responsible for a variety of training and development duties in the Special Care Nursery. Much of their work focuses on ensuring that nurses have the skills and training to succeed in the neonatal unit.⁶² This means that they need to coordinate with the Clinical Director to find areas of training needed and then formulate plans on how to implement this training.

Knowing where additional training is necessary is only one part of the battle, the Nurse Educators need to facilitate the training. They help do this by finding effective training programs such as STABLE (Figure 1) and ACoRN (Figure 2) that staff can participate in to support their learning. There is in house training the Educator can work with experts within the organization to assist with training sessions such as mock code pink drills to support the multidisciplinary team in their performance.

Figure 1 ⁶³

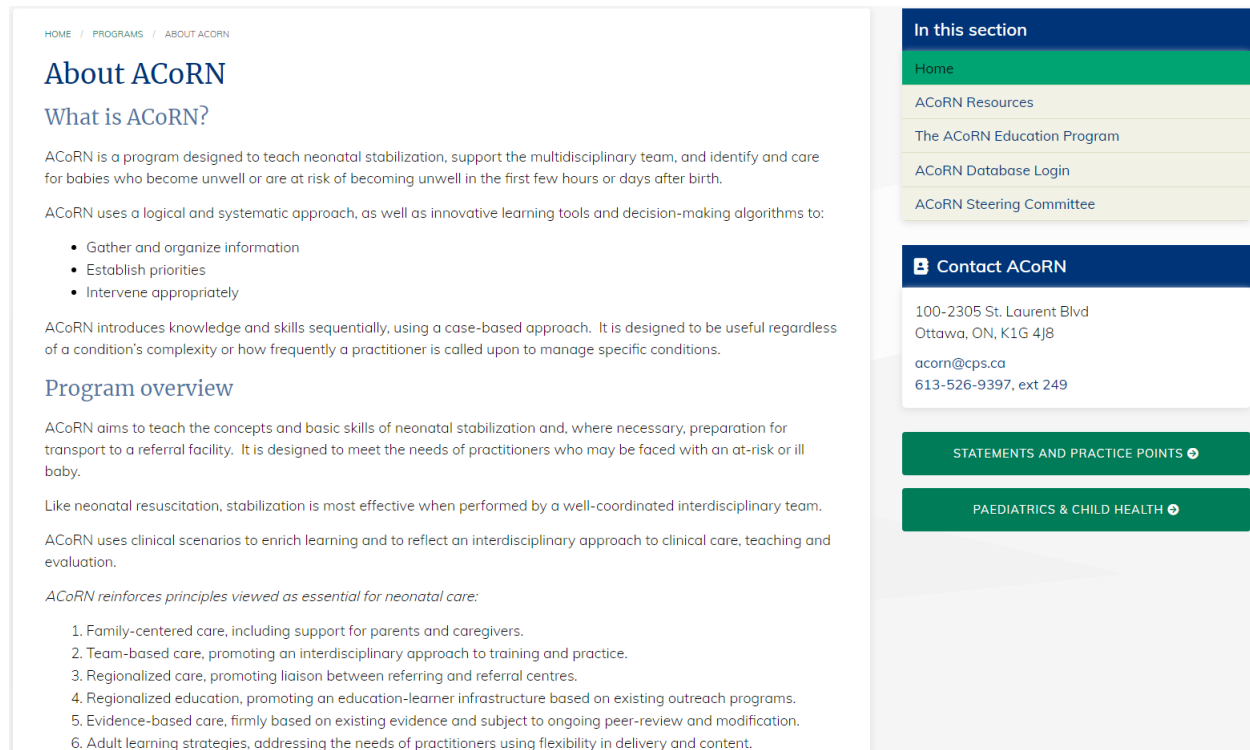


⁶¹ Herrman, J. W. (2019). *Creative teaching strategies for the nurse educator*. FA Davis.

⁶² Pilcher, J. (2013). NICU nurse educators: what evidence supports your teaching strategies? *Neonatal Network*, 32(4), 281-284.

⁶³ <https://stableprogram.org/>

Figure 2 ⁶⁴



The Nurse Educator plays an important role in ensuring patient and staff safety by conducting in-service training sessions for staff⁶⁵, by presenting the current teaching updates and evidence-based practice changes. It is important for staff to have hands on practice simulation so they can integrate theory and practice⁶⁶, this reduces the staff stress level significantly and allows them to feel competent in practice.

The Nurse Educator is recognized as a nursing resource for the Special Care Nursery. It is important that when questions arise the Educator will be able to source the answer to support the staff. The Educator is recognized as a leader in the organization and needs to build a good working relationship with the staff in the unit so the staff feel safe and supported should the need arise.

The IAC recognized the gap between the staff education request and the absence of the Nurse Educator in the Special Care Nursery. Effective training programs can be outsourced and regular mock drills involving the multidisciplinary team need to be planned. The Nurse Educator role and responsibility is to meet daily with the SCN Resource Nurse and staff to review the neonatal patients and acuity in the unit. She will provide just in time teaching and educational support and will arrange educational resources to support practice.

⁶⁴ <https://www.cps.ca/en/acorn>

⁶⁵ Verklan, M. T., Walden, M., & Forest, S. (Eds.). (2020). *Core curriculum for neonatal intensive care nursing e-book*. Elsevier Health Sciences.

⁶⁶ Chernikova, O., Heitzmann, N., Stadler, M., Holzberger, D., Seidel, T., & Fischer, F. (2020). Simulation-based learning in higher education: A meta-analysis. *Review of Educational Research*, 90(4), 499-541.

Recommendation 12:

- a. The Educator should meet with the staff in SCN daily, the Charge Nurse will review the status of the unit and the Educator will provide resources to support the staff. This will build a stronger collegial relationship between the Educator and the staff.
- b. The Nurse Educator will perform a needs analysis in the SCN unit,(within the next 3-6 months). Based on her findings, an education schedule will be provided in priority of findings. The education schedule will provide all staff the opportunity to participate, an attendance sheet will be used to track the participants completion of education.
- c. The Educator should outsource effective training programs, suggested sources:
 - STABLE – McMaster has a program and will come to Guelph Hospital for training
 - ACoRN – CPS provides the ACoRN information and contacts <https://www.cps.ca/en/acorn>
- d. The hospital must fund annual membership of neonatal websites to support the nurse educator and the staff, recommended websites:
 - Canadian Association of Neonatal Nurses (CANN)
 - National Association of Neonatal Nurses (NANN)
- e. The Clinical Director and Nurse Educator should participate in network meetings:
 - Southern Ontario Obstetrical and Neonatal Network (SOONN)
- f. The Educator should schedule in house training with experts within the hospital to provide:
 - Mock Pink drills

3.3.4.6 Recommendation 13 - The Role of the FBU Resource Nurse

A theme that was demonstrated through both GGH and ONA submissions as well as in SCN staff reporting is the inconsistent approach and presence of the FBU resource nurse. The visibility as well as leadership is dependent upon whom is covering the role as per both GGH and ONA submission(s). A job description for the FBU Resource Nurse was provided as per GGH SCN IAC Master Document – April 21. The essential responsibilities and activities include⁶⁷:

- Clinical Resource and Leadership
- Patient Care
- Collaboration and Coordination
- Leadership and Professional Practice
- Performs cross functional and other duties as assigned/requested

In the position requirements specifically for the FBU Resource nurse it includes:

- Minimum 5 years current Family Birthing experience
- Current NRP
- Demonstrated current Perinatal experience (5 years)
- Current certification in Electronic Fetal Monitoring

⁶⁷ GGH IAC Submission Master ONA April 21, 2021

- Membership in PNC © an asset
- Willingness to participate in committee

Responsibilities, accountabilities and knowledge of SCN are not identified as part of the role. Job descriptions that clearly set out objectives, responsibilities, authority and lines of accountability are consistently associated with improved achievement of work goal⁶⁸. Subsequently in a position description that was provided in the GGH submission from 2013 under the heading Clinical Expert - it states the Resource Nurse must have advanced clinical knowledge and expertise in all areas of FBU (SCN, OR, Labor and Delivery, postpartum, surgical and triage). The identification of all areas elevates the knowledge and accountabilities specific to this leadership role.

Charge nurses are recognized for their communication and organizational skills, as well as their ability to delegate, think critically, troubleshoot, and remain proactive. Experts indicate that behaviors the charge nurse may use to gain trust, foster cooperation, and promote job satisfaction include fairness, consistency, support, recognizing individuals for their efforts, and checking with them during their shift⁶⁹. These qualities foster trusting relationships therefore improving both quality outcomes and staff satisfaction. Nurses must pay attention to the relational needs of different team members to promote caring and supportive practice setting⁷⁰

Recommendation 13:

- Redefine the Job Description for the FBU Resource Nurse role to include all areas of the role as well as defined roles responsibilities.**
- The FBU Resource Nurse or designate should participate in daily status exchanges and departmental huddles with all units as part of the organizations established leader standard work. Huddles should also be instituted if a situation arises that requires additional support. This increased visibility will open the line of communication as well as foster relationships built on trust.**
- Implement standard times for rounding in each unit to increase visibility and facilitate communication between team members as well as across units**
- Use of companion phone for availability – defined for hand off when not available**

⁶⁸ Felistus Ndanu Musyoka, Maureen Atieno Adoyo, Musa Oluoch Ongombe. Influence of Job Description on Performance of Health Workers in Public Hospitals: A Case of Mbagathi Hospital, Nairobi City County. *Science Journal of Public Health*. Vol. 4, No. 2, 2016, pp. 88-93. doi: 10.11648/j.sjph.20160402.12

⁶⁹ Hughes, Candace RN, MSN; Kring, Daria RN, BC, MSN Consistent charge nurses improve teamwork, *Nursing Management (Springhouse)*: October 2005 - Volume 36 - Issue 10 - p 16

⁷⁰ Julie Apker, Kathleen M. Propp, Wendy S. Zabava Ford, Nancee Hofmeister, Collaboration, Credibility, Compassion, and Coordination: Professional Nurse Communication Skill Sets in Health Care Team Interactions, *Journal of Professional Nursing*, Volume 22, Issue 3, 2006, Pages 180-189, ISSN 8755-7223, <https://doi.org/10.1016/j.profnurs.2006.03.002>.

3.3.4.7 Recommendation - 14: LEAN Project in SCN

The IAC panel read and heard evidence regarding the non- nursing duties that are performed by nursing staff in SCN. The panel also viewed a video tour of SCN as well as reviewed documentation and planning for a newly redesigned SCN. This project is fully donor funded. Stage 3B is completed, submitted and GGH is awaiting Ministry approval. As per GGH's submission they recognize there are gaps in the current space. These gaps include⁷¹

- Curtained areas
- 2 resuscitation bays that are open/cramped
- Cabinetry is dated and broken
- Small bays do not fit required equipment/staff/parent
- Noisy, limited privacy
- Cramped
- Poor lighting
- Care by parent room is dated, does not allow partners, inadequate size
- Nursing station is large but not well designed
- No equipment cleaning room to wash isolette parts
- Inadequate storage
- No space for meeting/rest
- Cluttered staff space

Based on the above concerns including the video tour as well as pictures of the space in the submission, it is the panel's recommendation that a LEAN project focusing on the 5 S method be implemented within three months of receiving the IAC report. The 5S management method is recognized as the foundation of lean healthcare approaches, which maximize value-added levels by removing all factors that do not generate values⁷². In a less than ideal space it is important to sort, set in order, shine, standardize and sustain. 5S is intended for the physical work environment and is the simplest to implement for organizing, standardizing and maintaining the workplace⁷³.

Staff satisfaction increases with a well-organized work space and frustration decreases when equipment and supplies are where they are supposed to be. Despite resource constraints and other demotivating factors present in health care, the 5S program creates changes in the work environment, including fewer unwanted items, improved orderliness, and improved labeling and directional indicators of service units. These efforts engender changes in the quality of services (e.g. making services more efficient, patient-centered, and safe), and in the attitude and behavior of staff and patients⁷⁴.

⁷¹ GGH Submission April 2, 2021

⁷² Womak J, Jones D, Roos D. *The machine that changed the world*. New York, NY: Rawson Associates; 1990

⁷³ Kilpatrick, J. (2003). Lean principles. [Online] Available: <http://www.inmatech.nl/res/pdfs/leanprinciples.pdf> (June 4, 2014)

⁷⁴ Kanamori, S., Sow, S., Castro, M. C., Matsuno, R., Tsuru, A., & Jimba, M. (2015). Implementation of 5S management method for lean healthcare at a health center in Senegal: a qualitative study of staff perception. *Global health action*, 8, 27256. <https://doi.org/10.3402/gha.v8.27256>

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Recommendation 14:

- a. Implement a 5S LEAN project within the existing SCN within 3 months of receiving the IAC report. This project should utilize SCN staff, Infection Prevention and Control resources as well as a process improvement resource if available. This project will create a well-organized work area contributing to improved staff satisfaction, decreased frustration, improved teamwork, and a positive impact on patients in SCN.**

3.3.4.8 Recommendation 15: PRC Process with GGH and ONA

Article 8:01 of the ONA Collective Agreement provides a process in which staff nurses as well as administration is 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 GGH SCN utilized the AR process as a resource for the staff, and the staff worked well as a team for their patients in times of need.

The GGH FBU has a Resource Nurse available Monday through Friday, followed by an on call manager 7 days per week.

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 next day that the manager and the nurse are both working or within (10) calendar days, which ever is sooner. During the hearing, it became apparent meetings within this time frame were very few, the hospital felt challenged in meeting this 10 day turnaround.

The IAC understands there is a difference between a one-time situation and an ongoing issue. In a one-time situation, the nurses are expected to call the supervisor/manager to provide them with the opportunity to address or resolve the issue. However, if the workload is an ongoing issue, the RN's are not required to contact the management staff at the time of occurrence.

In the GGH SCN, many of the workload issues have been ongoing since 2018. This in itself provides evidence the RN's have attempted to communicate their issues/concerns to the management staff. In some instances, the GGH leadership has not responded or failed to meet. This gives the impression to the staff their concern about workload issues is not important. During the hearing the hospital expressed their beliefs in the importance of discussing the issues and does not disrespect the concerns of the nurses.

Recommendation 15:

- a. The IAC encourages GGH and the local association to work together to improve the PRC process with the goal of implementing a collaborative approach to resolving workload concerns. This will include commitment on both sides to follow the steps in the collective agreement including timelines established in this process.**

3.3.5 GGH SCN Nursing Practice, Unit Processes, Policies and Procedures

3.3.5.1 Recommendation 16: Communication Devices

The IAC Panel read evidence and heard issues related to the amount of time that SCN staff members were off the unit and one staff member was left in SCN to manage the babies on their own. There is no communication device for the SCN staff member to carry when they leave the SCN.

Vocera offers the leading platform for communication and workflow optimization. A number of organizations have invested in Vocera as it simplifies and improves the lives of healthcare professionals and patients, while enabling hospitals to enhance quality of care and operational efficiency.⁷⁵

Companion phones are a valid tool to improve communication within the hospital. Healthcare workers are able to answer the phones throughout the hospital and respond accordingly.⁷⁶ A benefit if a nurse is unable to answer the phone after five rings it transfers to the clerical staff. The companion phone has the capability of activating the “release lock” on the entrance door to allow the family member to enter the unit.

The IAC panel believes that Guelph General Hospital has options of utilizing mobile communication devices to improve the lives of healthcare professionals and enhance quality of care and operational efficiency.

Recommendation 16:

- a. The hospital is to explore options of communication devices for nurses when leaving the SCN unit.**

⁷⁵ Friend, T. H., Jennings, S. J., Copenhaver, M. S., & Levine, W. C. (2017). Implementation of the Vocera communication system in a quaternary perioperative environment. *Journal of medical systems*, 41(1), 1-6.

⁷⁶ Lavoie, P., Clarke, S. P., Clausen, C., Purden, M., Emed, J., Mailhot, T., & Frunchak, V. (2018). Acceptability and feasibility of recruitment and data collection in a field study of hospital nurses' handoffs using mobile devices. *Pilot and feasibility studies*, 4(1), 1-11.

3.3.5.2 Recommendation 17: SCN Acuity Tool

The IAC Panel read evidence and heard issues related to the quality and safety in the Special Care Nursery related to workload, insufficient skilled staff, and delay in care for a vulnerable population.

The nurses stated that they had reached out to management on several occasions informing them that the acuity was high in the nursery and they needed a third nurse. Management looked at the number of babies in the nursery and responded saying that the numbers did not warrant a third nurse. The nurses were frustrated as they felt that management did not recognize the acuity of the babies in the SCN and were only looking at the numbers.

Quality and safety in neonatal care is intricately linked to staff levels, nurse to patient ratios, and the specialised levels of education and experience of nurses delivering care⁷⁷. The National Association of Neonatal Nurses (NANN) and the Canadian Association of Neonatal Nurses (CANN) has a key role in promoting quality and safety and ensuring staffing levels meet the Standards of Neonatal Nursing.^{78 79} The aim of the acuity tool is to improve patient quality and safety by having a standardized practical risk assessment tool.

The neonatal acuity tool should reflect on well-established indicators that best describe the standard of care that infants should receive in the Special Care Nursery. It permits nursing staff in to record the level of clinical dependency of each infant and uses that measurement as the foundation of a risk assessment, which links to the number of nurses required on each shift. The tool links to the escalation policies that promotes good communication between the Special Care Nursery and the Family Birthing unit and gives an early warning if capacity is escalating. The acuity tool allows clear identification of the additional resources needed to maintain quality of care and safe practice in the Special Care Nursery.

Guelph Hospital reported that average census in the SCN is approximately 50% or 5 patients (range 48 – 60% in 2020/2021), but it did not indicate patient acuity. The sixty-seven (67) PRWRFs submitted by the Special Care Nursery nurses between July 2019 and March 2021, 80% of these reports indicated the need for additional staffing based on patient volumes, acuity, complexity and census. The Special Care Nursery nurses used the Winnipeg Assessment of Neonatal Nurses Needs Tool (WANNNT)^{80 81a} validated neonatal tool to show the acuity. Guelph Hospital felt that they had not been involved in development of the tool.

Garcia⁸² identifies 10 must have features for an acuity model before it can be implemented:

⁷⁷ Davies, W.L. (2015). An Operational Neonatal Patient Acuity Tool for measuring clinical dependency for each infant on the unit. *Infant*, 11(2), 51-53.

⁷⁸ Canadian Association of Neonatal Nurses (CANN)., (2018). *Neonatal Nursing Standards of Practice*.

⁷⁹ National Association of Neonatal Nurses (NANN)., (2014). RN Staffing in Neonatal Intensive Care Units. *Position Statement #3061*

⁸⁰ Sawatzky-Dickson, D. & Bodnaryk, K. (2009). Validation of a tool to measure neonatal nursing workload. *Journal of nursing management*, 17(1), 84-91.

⁸¹ Tubbs-Cooley, H. L., Mara, C. A., Carle, A. C., Mark, B. A., & Pickler, R. H. (2019). Association of nurse workload with missed nursing care in the neonatal intensive care unit. *JAMA pediatrics*, 173(1), 44-51.

⁸² Garcia, A. (2013). A Patient Acuity Checklist for the Digital Age. *Nursing Critical Care*.

1. Reliable & Objective: When determining the nursing care requirements, it should be noted that not all nurses have the same productivity or the same interpretation of whether a shift is busy or not. Acuity models should provide objective scores, resulting in a reliable measurement of the nursing care requirements.
2. Valid: The results of an acuity model should accurately represent the nurses' workload. If the model indicates a busy shift, the observed situation should be busy too. This can be tested by correlating the scores with the nurses' perception of workload that shift.
3. Patient-centered: The acuity model should include all nursing time required to address all care needed by a patient.
4. Efficient: Using the system should not take too much time.
5. Inclusive and Collaborative: Information from other departments should be present and used to help the scoring.
6. Aligned: The results from the scores should be aligned with the actual length of stay and in the long run be a reliable forecast of remaining length of stay.
7. Predictive: Knowing the total acuity on the unit can help predict nursing care requirements.
8. Outcomes driven: The model should be able to alarm irregular patient behavior
9. Actionable: The acuity model should be updated when necessary and provide up to date information.
10. Informative: Long-term trends and data should be derived from the model to improve the value of the model. Examples of these trends are nursing care requirements throughout the year to help plan vacation days or extra staffing, estimate the financial value of one hour of nursing care, and benchmark nurses' performance.

Given the fluctuating census in the SCN and the inability of the unit to increase staffing in real time, an acuity tool would be a valuable risk assessment tool to improve neonatal patient quality and risk. A team approach involving the collaboration between the Clinical Director, Nurse Educator and the SCN Staff in the development of the acuity tool, would be an effective change strategy and support measures of improving communication and building better professional relationships.

The IAC panel believe the acuity tool would provide valuable information that would measure the nursing care requirements and the acuity in the SCN, it would promote good communication to Family Birthing Unit in providing early warning that the capacity in SCN is escalating. The acuity tool would provide Management with clear indicators of the status of the SCN, including staffing, patient volumes, acuity complexity and census.

Recommendation 17:

- a. The Hospital is to develop and SCN Acuity Tool to measure the current state of the SCN, and needs to meet the following criteria:
- Accurately representing the complete neonatal care requirements
 - Easy to use.
 - Applicable to the entire Maternal Child Program
 - Quantifiable

- b. The SCN Acuity Tool Development Group/Team require the following members:

- Clinical Director
- Nurse Educator
- SCN Resource Nurse
- SCN Nurses

All team members are required to sign a binding agreement document to show consensus of SCN Acuity Tool between management and staff.

- c. The SCN Acuity Tool should be developed within 3-4 months, a trial of one month to evaluate and make changes that are agreed upon and signed by the SCN Acuity Tool Development Group/Team. The SCN Acuity Tool is to be reviewed quarterly by the SCN Acuity Tool Development Group/Team to ensure the well-established indicators meet the standards of care of the neonatal patient in SCN.
- d. The SCN Acuity Tool is to be placed on a shared drive that is accessible by the Maternal Child Program. The SCN staff will input the data into the SCN Acuity Tool every shift.
- e. The SCN Acuity Tool Development Group/Team can use the Halton Healthcare SCN Patient Acuity and Workload Tool ⁸³ (Figure 1), which is a level 2C SCN, as a platform for development of the SCN Acuity Tool.
- f. The SCN Acuity Tool can be build in Microsoft Excel, below is an example of Halton Health Care Excel Spreadsheet.

⁸³ Halton Healthcare SCN Acuity Tool 2021

Date: _____

Shift: _____

Unit Status	
Census at start of	
# of RN's	
# of Admits	
# of	
Census at end of	
Potential Admits	

Workload				
Level of Care	# of	Ratio	%	Total % per LOC
1		3:1	0.33	
2		2:1	0.5	
3		1:1	1.0	
Care by Parent			0.25	
Total Percentage of Nurse Required _____				

Admissions/Retrotransfers					
From	Time	Level of Care	Gestation	Diagnosis	Other Info

Discharges/Transfers	
Destination	Time

Staffing	Day Shift	Night Shift
Required # of RN's		
Actual # of RN's		
Reason for inadequate Inadequate staffing?		
Strategy to correct inadequate staffing?		

Tasks off Unit/Transfers		
Location	Length of Time	Reason (Code PINK, delivery, IV start, MCU S/L, etc)

Declined Admissions/Retrotransfer		
From	Gestation/Diagnosis/other info	Reason (Census/Staffing/Acuity)

Definitions of Acuity

Level 1 (3:1)	Level 2 (2:1)	Level 3 (1:1)
*Stable feeder & grower *Stable & working up on feeds/weaning off IVF (hypoglycemia, TTN, etc) *Low Flow Phototherapy	*Non-invasive ventilation (CPAP, High Flow) requiring frequent monitoring *Frequent monitoring <ul style="list-style-type: none"> - Multiple spells requiring intervention - Unstable hypoglycemia - IVIG - Blood transfusion - FSWU *PICC,UVL, TPN * NAS	*Code Pink (initial stabilization) *Sick/unstable admission *Intubated & ventilated *Critically ill requiring immediate transfer to tertiary centre *Cardiac requiring immediate intervention *Surgical requiring immediate intervention

Level 1 = 0.33% RN

Level 2 = 0.5% RN

Level 3 = 1.0% RN

Care by Parent = 0.25% RN

3.3.5.3 Recommendation 18: Admission/Discharge/Transfer Tool

The IAC Panel read evidence and heard issues related to the lack of documentation related to admissions, discharges and transfers.

Guelph Hospital presented the use of the HIG tool, which is an Ontario Health Based Allocation Model, to indicate the length of stay on the neonatal patients in SCN. The SCN nurses discussed that there was far more inter unit transfers occurring that the HIG tool did not capture.

With today's technology, it can improve the efficiency of a hospital and improve the quality of care delivered to neonatal patients.⁸⁴ A Microsoft excel program⁸⁵ is a user-friendly program that can capture pertinent data for SCN Admissions, Discharges and Transfers.

The IAC panel believes that creating a tool in excel spreadsheet would capture the valuable Admission/Discharge/Transfer information that can be easily accessed by the Clinical Director son SCN staff.

Recommendation 18:

- a. The Clinical Director, Nurse Educator and SCN Resources nurse are to develop an electronic Admission/Discharge/Transfer Tool that is placed on a shared drive to monitor the activity in the SCN.**

⁸⁴ Lavin, M. A., Harper, E., & Barr, N. (2015). Health information technology, patient safety, and professional nursing care documentation in acute care settings. *Online J Issues Nurs*, 20(6).

⁸⁵ Selwyn, N. (2020). 'Just playing around with Excel and pivot tables'-the realities of data-driven schooling. *Research Papers in Education*, 1-20.

3.3.5.4 Recommendation 19: Special Care Nursery Admission Criteria

The IAC Panel read evidence regarding the documentation of Special Care Nursery Admission Criteria Policy, updated April 2019, on the use of Naloxone in the SCN unit

The IAC panel asked the SCN staff regarding the statement on the Special Care Nursery Admission Criteria Policy on the use of Naloxone in the unit. The nurses responded that this practice stopped in 2016 and the policy updated. The Canadian Paediatric Society (CPS) released a statement in 2016 that Naloxone is no longer on the Neonatal Resuscitation Program Medication Chart, as there is insufficient evidence to evaluate the safety and efficacy of this practice.⁸⁶ The CPS published an article to support its statement: Managing infants born to mothers who have used opioids during pregnancy.⁸⁷

The IAC panel believe that the current Special Care Nursery Admission Criteria Policy needs to reflect the current standard of practice in the SCN unit.

Recommendation 19:

- a. The Special Care Nursery Admission Criteria Policy is to be reviewed and updated to reflect best practice.**
- b. The policies and procedures can be extended to a third party with neonatal knowledge and experience for review.**

⁸⁶ Canadian Paediatric Society (CPS), (2016). *Neonatal Resuscitation Text book*, 7th Edition, page 257

⁸⁷ Lacaze-Masmonteil, T., & O'Flaherty, P. (2018). Managing infants born to mothers who have used opioids during pregnancy. *Paediatrics & child health*, 23(3), 220-226.

3.3.5.5 Recommendation 20: SCN Nurses' Attendance at Deliveries

The SCN nurses are part of the Neonatal Resuscitation Team (NRT) along with the Paediatrician and the Respiratory Therapist. This is best practice.

The following is the list of deliveries/ complications by type, where the NRT team are expected to attend because of the heightened risk to the newborn:

NRT Attendance at Delivery:

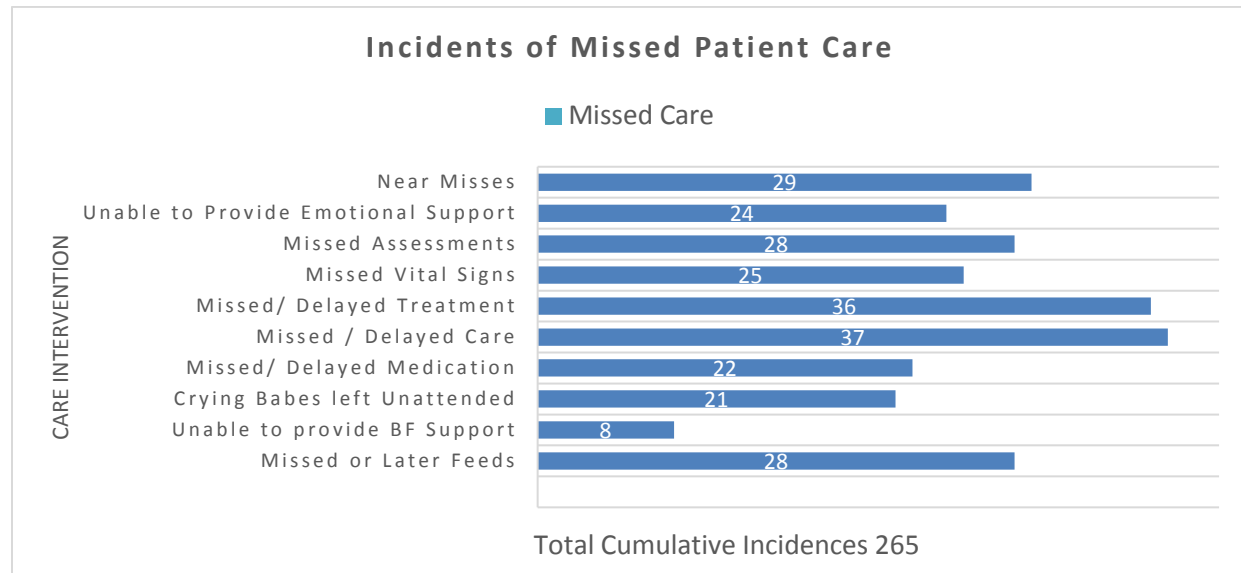
- Meconium
- Pre-eclampsia/eclampsia
- Gestational age under 37 weeks
- IUGR
- Operative vaginal delivery (forceps, vacuum)
- Shoulder dystocia
- Abnormal Fetal Health Surveillance
- Multiple gestations
- Maternal use of narcotics within 2 hours of delivery
- Significant Maternal alcohol or illicit/recreational drug use
- Significant antepartum/intrapartum hemorrhage
- Prolapsed cord
- Placental abruption
- Ruptured uterus
- Vaginal breech delivery
- General anaesthetic
- Any previous consult by paediatrician where presence of neonatal resuscitation team at delivery has been recommended

The IAC Panel read and heard evidence that the SCN RNs are also being asked to be baby nurse for those deliveries that do not warrant the need for their highly specialized knowledge, skills and abilities. This is an issue for the SCN staff as they need to leave SCN for extended periods of time which may negatively impact much required care for the patient population they are caring for.

The SCN RNs described incidents of missed or late feeds, crying babes left unattended, inability to support breast feeding mothers, missed or delayed medication, care, treatment or assessments including vital signs, IV checks, NAS scoring, and more, as well as a lack of emotional or observational

support for families. There was ample documentation in the 67 PRWR forms submitted described some aspect of missed, delayed, or rationed care.

These are examples of the reasons why we need to ensure the right staff are providing the right care for the right patients at the right time.



Recommendations 20:

- b. All staff in the GGH FBU be certified in NRP and their certification is maintained annually.
- c. Review and revise the “Attendance at Delivery” policy/guideline based on evidence and best practices. Consider engaging a subject matter expert with Neonatal ICU experience to facilitate this revision.
- d. SCN staff attend ONLY those deliveries that are deem at risk and that they no longer be requested by FBU staff to attend “normal deliveries as baby nurse.

3.3.5.6 Recommendation 21: Critical Care Information System (CCIS)

The IAC Panel read evidence and heard issues related to the lack of support of CCIS training and education.

Guelph General Hospital provided information in their brief that outlined that the staff training in CCIS, which included a video and learning modules. The SCN staff verbalized concerns that they did not feel supported in the CCIS training and received an email with instructions.

CCIS provides all education by CCIS educators and they facilitate a number of dates and times, the sessions include a video and allow a questions and answers at the end of the presentation to support the staff.⁸⁸ The staff then have access to CCIS educators to send emails if they have any questions or follow-ups after their training. When new staff join Guelph General Hospital SCN, CCIS educators will work with the new staff member to provide the same support.

Recommendations 21:

- a. **Guelph General Hospital is to contact CCIS educators (CCISTraining@criticalll.org) to review the training and education.**
- b. **All new staff will receive training by CCIS educator, this education and support will be during their orientation period.**

3.3.5.7 Recommendation 22: Policy and Procedures for SCN

The IAC panel read and heard issues related to clinical practice in the SCN, a lack of educational support and a limited number of Policies and Procedures to guide practice in the SCN.

The SCN nursing staff shared personal clinical experiences of practices that occurred in the SCN that they had not been trained on and there were limited and/or outdated policies and procedures to support their professional nursing practice. One experience nurse spoke of how she had to manage a baby on BiPAP and she had to ask the Respiratory Therapist what she needed to do. Another staff member spoke of her experience of providing passive cooling for hypoxic-ischemic encephalopathy (HIE) and she had never been trained. Another nurse spoke of a baby that had a bloody stool and the baby was being transferred to McMaster for investigations of necrotizing enterocolitis. This nurse was asked to insert an oral gastric tube and connect it to low-intermittent suction, she had to wait for the transport team to arrive, which delayed care, as she had not been trained.

⁸⁸ Critical Care Service Ontario (CCSO), (2020). Resources. Retrieved from: <https://criticalcareontario.ca/resources/?resource-type=education-training-modules>

Policies, procedures, and competencies are the foundation of neonatal patient care and drive nursing practice.^{89 90} Protecting human health is the goal for all healthcare practitioners, the high-risk neonatal infants especially require greater care and closer observation. Immediately after birth, high-risk infants are admitted to the Special Care Nursery, where they spend time with highly trained neonatal staff, who play a critical role in their survival and eventual thriving.⁹¹ SCN nurses provide various treatments and nursing care to newborns, including oxygen therapy, mechanical ventilation, noninvasive ventilation, maintenance of vital signs, nutritional supplementation, and infection prevention. Most newborns in SCN experience various respiratory issues while transitioning to voluntary breathing, which may lead to emergency situations. It is in these emergency situations that neonatal nurses are vital, as they have excellent clinical decision-making skills, to provide timely, accurate nursing care depending on the newborns condition. Clinical decision-making skills in neonatal nurses are one of those nursing competencies that increase the quality of nursing and provides positive influence on the treatment outcomes in the newborn.⁹²

The SCN nurses have been asking for policies and procedures to guide and maintain best practice in their unit. Competencies, policies, and procedures based on the most current evidence is essential in the practice of neonatal nursing.⁹⁰ The ONA brief stated that the SCN nurses have been advocating for education and Policies and Procedures for the following practices:

- CPAP
- BiPAP
- Humidified High-Flo
- Low flow nasal prongs
- Passive Cooling for hypoxic-ischemic encephalopathy (HIE)
- Gastric Low-intermittent suctioning
- Rapid Sequence Intubation (RSI) and medication administration
- Chest tubes
- Feeding protocols (Standardized Feeding Protocols)
- Trophic Feeding
- IV infusion and maintenance for neonates
- UVC maintenance
- Developmental Care
- Cue Base Feeding

⁸⁹ Verklan, M. T., Walden, M., & Forest, S. (Eds.). (2020). *Core curriculum for neonatal intensive care nursing e-book*. Elsevier Health Sciences.

⁹⁰ National Association of Neonatal Nurses (NANN)., (2021). *Policies, Procedures and Competencies for Neonatal Nursing*. 6th Edition.

⁹¹Braun, D., Braun, E., Chiu, V., Burgos, A. E., Gupta, M., Volodarskiy, M., & Getahun, D. (2020). Trends in neonatal intensive care unit utilization in a large integrated health care system. *JAMA network open*, 3(6), e205239-e205239.

⁹² Banning, M. (2008). Clinical reasoning and its application to nursing: concepts and research studies. *Nurse education in practice*, 8(3), 177-183.

Given the inadequate education, limited Nurse Educator support and absence of policies and procedures in the SCN, an effective educational strategy and document to support measures needs to be developed and implemented in the GGH SCN.

The IAC believes that utilizing neonatal resources, perhaps a third party subject matter expert and purchasing Neonatal Policies and Procedure packages to adapt for the SCN would support education and documentation that the unit requires.

Recommendation 22:

- a. **The Hospital has provided an updated Policy and Procedure for CPAP prior to the IAC hearing, the hospital needs to provide an effective Policy and Procedure development strategy with timelines for the development of the following Policies and Procedures:**
 - **BiPAP**
 - **Humidified High-Flo**
 - **Low flow nasal prongs**
 - **Passive Cooling for hypoxic-ischemic encephalopathy (HIE)**
 - **Gastric Low-intermittent suctioning**
 - **Rapid Sequence Intubation (RSI) and medication administration**
 - **Chest tubes**
 - **Feeding protocols (Standardized Feeding Protocols)**
 - **Trophic Feeding**
 - **IV infusion and maintenance for neonates**
 - **UVC maintenance**
 - **Developmental Care**
 - **Cue Base Feeding**
- b. **The Policies and Procedures can be extended to a third party with neonatal knowledge and experience for review.**
- c. **The hospital can network with the Southern Ontario Obstetrical and Neonatal Nursing (SOONN) group requesting Policies and Procedures that can be utilized and adapted for the hospital.**
- d. **The hospital has the option of purchasing the National Association of Neonatal Nurses (NANN) Policies, Procedures and Competencies for Neonatal Nursing Care, 6th Ed and adapting them accordingly.**

3.3.5.8 Recommendation 23: SCN Orientation

The IAC Panel read evidence and heard issues related to the staff orientation to SCN, the need for an orientation program that would better support the nurses training and competencies.

The nursing staff in SCN verbalized their concerns regarding training new staff while managing a high acuity assignment. The SCN staff member is informed that they will be precepting a new staff member, but no additional information regarding the experience and skills set are shared.

The use of computer media in nursing education has many benefits, including convenience, consistency of content delivery and the ability to individualize learning. Technology allows interactivity with learning, research found that computer use in education supports adult learning principals.^{93 94} Computer training programs with interactive capabilities and the ability for each learner to advance at their own pace supported the principals that adults have a variety of backgrounds and different learning styles.

Researchers found that the use of an online critical care orientation, applicable to adult, neonatal and paediatric settings created a flexible environment that supported adult learning techniques.^{93 94} The layout of the orientation content organized into body systems and integrated didactic content with clinical experience. The new staff are active participants in the learning process and the educator supports as a facilitator, which improves transition into practice.⁹⁵

Structured orientation programs utilized for critical care areas for new staff have shown to promote critical thinking skills, effective management and delivery of neonatal care and self-esteem. This has a positive impact on the new staff that gave them a higher sense of belonging and influenced their interaction with the unit staff.^{96 97} Having all new staff compete standardized orientation program in the SCN would support the SCN nurses in having a better understanding of the clinical competencies that they need to review.

The IAC panel believes that a standardized computer-based neonatal orientation training would be more interactive and cost-effective. It would decrease the number of orientation hours required, support the SCN staff in their preceptorship role and allow the Nurse Educator more time to facilitate orientation.

Recommendation 23:

- a. The Hospital is to provide a standardized computer-based orientation neonatal training program that would underpin the standard of practice in SCN. This should include online**

⁹³ Alston, G., & Hansman, C. A. (2020). Mentoring in adult and continuing education. *Handbook for adult and continuing education*, 107-115.

⁹⁴ Isa, K. Q., Ibrahim, M. A., Abdul-Manan, H. H., Mohd-Salleh, Z. A. H., Abdul-Mumin, K. H., & Rahman, H. A. (2019). Strategies used to cope with stress by emergency and critical care nurses. *British journal of nursing*, 28(1), 38-42.

⁹⁵ Square, N. D. (2010). Modeling clinical applications in intensive care settings for nursing orientation. *Advances in Neonatal Care*, 10(6), 325-329.

⁹⁶ Fiske, E. (2018). Nurse stressors and satisfiers in the NICU. *Advances in Neonatal Care*, 18(4), 276-284.

⁹⁷ Walden, M., Janssen, D. W., & Lovenstein, A. (2020). What Keeps Neonatal Nurses Up at Night and What Gets Them Up in the Morning?. *Advances in Neonatal Care*, 20(6), E102-E110.

training, integrated didactic content with clinical content that facilitated by the Nurse Educator.

- b. The Nurse Educator and the SCN staff are to develop core clinical competencies that new staff require for orientation to the SCN.**
- c. The hospital has the option of purchasing a standardised Orientation Program from AWHONN: The Neonatal Orientation and Education Program, Fourth Edition (NOEP) is a comprehensive, educational program that is highly effective in providing evidence-based, clinical education to neonatal nurses. NOEP helps to mitigate neonatal risk, increase staff efficiency, and promote optimal neonatal outcomes while saving your healthcare system time and money. With NOEP, your facility can establish consistent provision of high-quality care for high-risk and vulnerable newborns.**

<https://www.awhonn.org/education/neonatal-orientation-and-education-program-fourth-edition-noep/>



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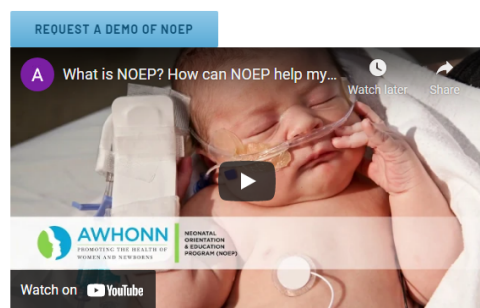
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Program Features 15 Modules to Improve Care and Safety

NOEP includes several updated features:

- Diverse photos and images reflective of the NICU environment, videos, and knowledge checks
- Module 15: Lactation Support in the NICU
- NICU Validation Tools include orientation lists, comprehensive and focused physical assessments, and competencies
- More Case Scenarios

Program Overview

- Module 1 – Transition to Extrauterine Life
- Module 2 – The Respiratory System
- Module 3 – The Cardiovascular System
- Module 4 – Metabolic and Nutritional Support
- Module 5 – Renal and Endocrine Disorders
- Module 6 – Hematology and Immunology
- Module 7 – The Gastrointestinal System
- Module 8 – The Neurologic System
- Module 9 – Newborn Skin and Skin Care
- Module 10 – Issues Affecting the Late Preterm Infant
- Module 11 – Genetic Disorders and Congenital Anomalies
- Module 12 – Developmental Care and Management of Pain
- Module 13 – Families in Crisis
- Module 14 – Neonatal Procedures
- Module 15 – Lactation Support in the NICU

3.3.5.9 Recommendation 24– Transfer of babies from SCN to Pediatrics

The IAC panel read and heard evidence regarding concern with transfers of babies from SCN to the Pediatric unit. The Right care/Right Place/Right time Project - Planning for the Future that GGH identifies in their submission the limitations of SCN in its current state. The goals of the approach are⁹⁸

- Match the needs of the babies to the right level of care in the right setting
- Increase family centered care and ability to “room in” with babies
- Help families transition from an ICU level of care and environment
- Increase ability to repatriate babies from tertiary centers back to GGH SCN by freeing up capacity within SCN
- Increase the flow of appropriate patients out of SCN to help support patient flow during the renovation period when SCN will reduce from 10 beds to 6
- Build teamwork increase the confidence in care of staff in FBU and Pediatrics

Staff verbalized in their testimonials of feeling that this was an unsafe practice and one in which they felt that the pediatric staff were not prepared for. The transfer of babies from a higher level of care to a lower level of care occurs across the health care system for a variety of reasons. These reasons include moving the infant closer to home and determining the infant is stable and requires support to grow. This creates capacity within the system. Transferring infants who no longer require intensive care to community hospitals closer to home has many potential advantages, including decreased family stress, earlier involvement of primary providers, and more efficient use of resources within a care network⁹⁹. Given the identified limitations in the current SCN space for those infants that are deemed stable and appropriate, in consultation with both the pediatrician as well as the SCN nursing staff, consideration be given to this plan. Parents’ active involvement in their child’s in-hospital care, preparation for their baby’s discharge home, and post hospital care are critical to facilitating the transition from hospital to home.

⁹⁸ GGH Submission April 2, 2021

⁹⁹Kunz, S. N., Dukhovny, D., Profit, J., Mao, W., Miedema, D., & Zupancic, J. (2019). Predicting Successful Neonatal Retro-Transfer to a Lower Level of Care. *The Journal of pediatrics*, 205, 272–276.e1.

<https://doi.org/10.1016/j.jpeds.2018.09.010>

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Recommendation 24:

- a. **Create a checklist to determine appropriate and safe recommendation for transfer. This checklist is completed with all members of the care team including parents. Consideration should be given but not limited to:**
 - a. **Age and weight**
 - b. **Cardio-respiratory status**
 - c. **Growth**
 - d. **Nutritional status**
 - e. **Treatment, tests and procedures**
- b. **Comprehensive TOA template developed with Pediatric staff input in the development**

3.3.5.10 Recommendation 25: Cross Training

The IAC Panel read evidence and heard issues related to cross training staff from Paediatrics to SCN, as a solution to the staffing concern in SCN.

Guelph Hospital presented a cross training plan and documentation stating that all nurses in paediatrics will be cross trained to SCN. Once these paediatric nurses completed the cross-training program, the cross-trained staff are added to the SCN schedule to work as a second nurse. The nurses in SCN verbalized their concerns and informed leadership that the pediatric cross-trained nurses would be helpful as a third nurse, as they needed the second nurse to have neonatal skills and experience for acuity and safety reasons. One cross-trained nurse stated that after a year of being cross-trained and working in SCN, she has come to realize that the nurses in SCN are experts in the field of neonatology. She stated that she has an intensive care background and she quickly recognized that the SCN does not staff for acuity and safety but for census only.

Cross training of nursing staff has been in hospitals to reduce labor cost, provide scheduling flexibility, and meet patient demand effectively.¹⁰⁰ However, cross-trained nurses may not be as productive as specialized neonatal nurses in carrying out their tasks because of a new work environment and limited protocols in the SCN unit. The added stressor for the SCN staff is working with nurses who are perceived to lack the degree of knowledge and expertise for the level of care required, perceived powerlessness of critical thinking skills and the decreased knowledge base to communicate with the families in caring for this vulnerable neonatal population.^{101 102 103} Paediatric nurse training focusses on a broader age

¹⁰⁰ Gnanlet, A., & Gilland, W. G. (2014). Impact of productivity on cross-training configurations and optimal staffing decisions in hospitals. *European Journal of Operational Research*, 238(1), 254-269.

¹⁰¹ Pannell, Lisa M. MSN, ARNP, CPNP, NNP-BC; Rowe, Lynn PhD, RN; Tully, Salena PhD, RN Stress Resiliency Practices in Neonatal Nurses, *Advances in Neonatal Care*: August 2017 - Volume 17 - Issue 4 - p 274-281

¹⁰² Walden, Marlene PhD, APRN, NNP-BC, CCNS, FAAN; Janssen, Dalton W. MSN, RNC-NIC; Lovenstein, Austin MA, BS What Keeps Neonatal Nurses Up at Night and What Gets Them Up in the Morning?, *Advances in Neonatal Care*: December 2020 - Volume 20 - Issue 6 - p E102-E110

¹⁰³ Fiske, Elizabeth PhD, RN, CNE, PCNS- BC Nurse Stressors and Satisfiers in the NICU, *Advances in Neonatal Care*: August 2018 - Volume 18 - Issue 4 - p 276-284

group of birth to nineteen years of age, which is significantly different from neonatal nurse training, which in itself is a specialized training for premature babies up to 28 days of life.

Cross training within a discipline and multicompetent practice can be successful when staff and management are both at the table and in agreement with the plan. When implementing this cross training model there has to be very clear guidelines for the selection of potential trainees, criteria for identification of potential trainees:^{104 105}

- Voluntary participation or self-selection: voluntary participation will achieve higher productivity and identify the most desirable and qualified staff
- Possession of baseline knowledge or competencies that trainees must have prior to being cross-trained. One means of identifying individuals with the appropriate knowledge base or minimal competencies is to select trainees with select licensure or accreditation.
- Possession of analytical assessment skills and a large skill base. These qualities facilitate adding new skills through cross training.
- Experience working within a care team framework.
- Having time to perform and practice newly acquired cross-trained duties and competencies.

The key to cross training is what type of training and evaluation is required for the most applicable assignment for the paediatric nurses to manage in SCN. The cross training program focusses on the appropriate category of neonatal patients to ensure that:

- Skill development is founded on sufficient theory to enable trainees to identify and solve clinical problems.
- Selected trainees understand the need for safety procedures, practice in a safe manner, and recognize when safety is being breeched.
- Trainees recognize the limits of their abilities and ask for help when needed.

The paediatric nurses should be cross-trained to manage a less acute assignment in the SCN, this would alleviate potential stressors for the cross-trained staff.^{100 101 102 103} The SCN staff would know the skill set of the cross-trained pediatric staff and would be able to support them as a third nurse. The category of neonatal patients that the cross-trained paediatric nurses would manage are:

- Infant greater than 34 weeks not requiring oxygen
- Feeder-growers greater than 1500 grams on room air managed in giraffe bed, isolette or warmer
- Infant of diabetic mothers with blood glucose less than 2.8 mmol requiring frequent feeding and IV management and lab draws

¹⁰⁴ Nowrouzi, B., Lightfoot, N., Carter, L., Larivière, M., Rukholm, E., Schinke, R., & Belanger-Gardner, D. (2015). The relationship between quality of work life and location of cross-training among obstetric nurses in urban northeastern Ontario, Canada: a population-based cross sectional study. *International Journal of Occupational Medicine and Environmental Health*, 28(3), 571.

¹⁰⁵ Manelski, M. J., Wagner, S. P., & Norris-Grant, D. M. (2013). The Pearls and Perils of Cross-Training: A Collaboration of Antepartum and Labor and Delivery Room Nurses. *Journal of Obstetric, Gynecologic & Neonatal Nursing*, 42, S51-S52.

- Infants in open cribs receiving less than 70% of feeding volume orally.
- Infants in open cribs on nasal cannula
- Infants receiving IV fluids
- Infants on phototherapy and all oral feeds

Attention to staffing is paramount for the SCN nurses, cross-training pediatric nurses can be successful when the appropriate guidelines are in place. NANN position statement 3061 provides guidelines for safe staffing in the NICU.¹⁰⁶ Implementing the guidelines and considering cross-trained staff to allow for flexibility and more collaboration when unanticipated needs arise will reduce nurse's stress.

The patient-acuity assessment and the professional nursing skill mix are important components of staffing decisions, high-quality care and safe outcomes should be the overall goals of staffing.¹⁰⁶ Facilities that care for newborns should evaluate nurse staffing-sensitive outcomes to evaluate the appropriateness of their staffing plans for the unit.

Given the depth and breadth of staffing issues in the SCN, an effective cross-training program needs to be integrated into the staffing model allowing the pediatric staff to manage a less acute assignments.

The IAC Panel believes that a supportive cross training model can be implemented allowing the pediatric cross-trained nurses to volunteer to participate in the program.

Recommendation 25:

a. The Hospital will establish a SCN/Paeds Cross-training group with the following members:

- Clinical Director
- Paediatric and SCN Educator
- SCN Resource Nurse
- SCN Nurses
- Paediatric Nurses

b. The SCN/Paeds Cross-training group will develop and effective cross-training program incorporating:

Criteria for Identification of staff:

- Voluntary participation or self-selection: voluntary participation will achieve higher productivity and identify the most desirable and qualified staff
- Possession of baseline knowledge or competencies that trainees must have prior to being cross-trained. One means of identifying individuals with the appropriate knowledge base or minimal competencies is to select trainees with select licensure or accreditation.
- Possession of analytical assessment skills and a large skill base. These qualities facilitate adding new skills through cross training.
- Experience working within a care team framework.

¹⁰⁶ National Association of Neonatal Nurses (NANN)., (2017). *RN staffing in the neonatal intensive care unit*.

Position Statement #3061. Retrieved from:

http://nann.org/uploads/About/PositionPDFS/1.4.6_RN%20Staffing%20in%20the%20NICU.pdf

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- Having time to perform and practice newly acquired cross-trained duties and competencies.

Category of Neonatal Patients for Paediatric Cross-Trained Nurses:

- Infant greater than 34 weeks not requiring oxygen
- Feeder-growers greater than 1500 grams on room air managed in giraffe bed, isolette or warmer
- Infant of diabetic mothers with blood glucose less than 2.8 mmol requiring frequent feeding and IV management and lab draws
- Infants in open cribs receiving less than 70% of feeding volume orally.
- Infants in open cribs on nasal cannula
- Infants receiving IV fluids
- Infants on phototherapy and all oral feeds

3.3.5.11 Recommendation 26: Late Preterm Infant

The IAC Panel read evidence and heard issues related to infants in the SCN termed stable “feeders and growers”.

The SCN nurses shared situations that have occurred in the SCN unit where a stable “feeder and grower” infant had a dusky spell and needed to be stimulated. Another infant who was “skin to skin” with mother when the SCN nurse recognized the change in colour of the infant and needed to intervene. One nurse shared how she was caring for a stable “feeder and grower” who was day 16 of life when suddenly the infant became apneic and needed positive pressure ventilation. This infant started on CPAP and needed it for a few days.

A preterm infant is defined as any infant born at less than 37 weeks gestation. Late preterm describes a subset of premature infants born between 34 ⁰/₇ and 36 ⁶/₇ weeks gestation. Late preterm infants have been described as “greater pretenders and masqueraders” as they resemble a term infant in size, yet have significant risks for early morbidities and complications compared to term infants.^{107 108 109}

Late preterm infants remain at much higher risk of developing respiratory requiring respiratory support when compared to term neonates. These include respiratory distress syndrome (RDS), transient tachypnea of the newborn (TTN), pneumonia, apnea, bradycardia and pulmonary hypertension.^{107 109} The overall incidence for late preterm infants admitted to neonatal units with respiratory compromise requiring intervention is high. These late preterm infants are likely to present with hyperbilirubinemia, feeding difficulties, hypoglycemia, temperature instability and cold stress and sepsis.

¹⁰⁷ Lohr, Kimberly A. DNP, RN, NNP-BC, PPCNP-BC Improving the Quality of Nursing Care for Late Preterm Infants, *Advances in Neonatal Care*: September 30, 2020 - Volume Publish Ahead of Print

¹⁰⁸ Quinn, Jenny M. MSN, NNP-BC, MHA; Sparks, Marteen MSN, RN; Gephart, Sheila M. PhD, RN Discharge Criteria for the Late Preterm Infant, *Advances in Neonatal Care*: October 2017 - Volume 17 - Issue 5 - p 362-371

¹⁰⁹ Karnati, S., Kollikonda, S., & Abu-Shaweesh, J. (2020). Late preterm infants—Changing trends and continuing challenges. *International Journal of Pediatrics and Adolescent Medicine*, 7(1), 38-46.

One hospital developed standardized evidence-based guidelines for the care of the late preterm infants, which resulted in reduced variability of care and decreased length of stay.¹⁰⁷ The nurses completed an educational module about the late preterm infant, which increased their knowledge, and the nurses felt supported implementing the nursing care guidelines for the late preterm infant. This shows that the late preterm infants need more time and closer observation to develop and grow.

The IAC panel believes that developing standardized evidence-based guidelines for the care of the late preterm infant would provide a comprehensive evaluation of the infants in the SCN unit.

Recommendation 26:

- a. **The SCN is to set up a group to develop standardized evidence-based guidelines for the care of late preterm infants, the group must include the following members:**
 - Paediatrician
 - Nurse Educator
 - SCN Resource Nurse
 - SCN Nurses
- b. **The SCN Group for development of standardized evidence-based guidelines for care of the late preterm infants will:**
 - Review the literature of nursing interventions for late premature infants
 - Develop standardized evidence-based care guidelines for the late preterm infants in SCN

3.3.5.12 Recommendation 27: Non-Invasive Ventilation

The IAC Panel read evidence and heard issues related to the lack of training on non-invasive ventilation, including Hi-Flo, BiPAP and CPAP and no policy and procedure for Hi-Flo and BiPAP.

The SCN staff stated that they did not receive training on non-invasive ventilation, they would ask the respiratory therapist to explain what numbers they needed to monitor during this treatment. The SCN nurses and the respiratory therapist would discuss the clinical signs and symptoms they needed to monitored. The SCN staff stated that an updated CPAP policy and procedure is currently been provided, but there is no policy and procedure for Hi-Flow or BiPAP.

Guelph General Hospital falls in the Waterloo Wellington LHIN ¹¹⁰ that has McMaster Hospital as the tertiary centre, McMaster has provided many in-services to acute community hospitals to support non-invasive education and training. This is would provide a great opportunity for a neonatologist and respiratory therapist from McMaster to provide an educational support to the multidisciplinary team at Guelph General Hospital SCN.

¹¹⁰ Local Health and Integration Network (LHIN), (2020). *Home and Community Support Services*. Retrieved from: <http://www.lhins.on.ca/>

The IAC Panel believe that reaching out to McMaster tertiary centre for non-invasive education would build better relationship with the tertiary centre and would improve no-invasive ventilation education and communication in the multidisciplinary team.

Recommendation 27:

- a. Guelph General Hospital is to reach out to the McMaster Neonatologist and Respiratory therapist to provide education and training to the Guelph General Hospital SCN multidisciplinary team on non-invasive ventilation.**

3.3.6 GGH SCN Continuing Education and Professional Development

3.3.6.1 Recommendation 28: Professional Development

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

For professional nurses continuing education is essential for safe and effective nursing care in the neonatal population. The amount of knowledge required to take care of critically ill patients cannot be obtained simply through experience on the unit or at bedside.¹¹¹

Even though neonatal care has changed rapidly over the past 20 years the time for new information to be incorporated into the bedside care is now.^{111 112} There is continued increasing emphasis on the need to demonstrate ongoing education and competency. Nurses have a professional and legal responsibility to update their knowledge and apply their knowledge to the bedside.

Despite the abundance of continuing education that is offered, many nurses do not participate in them. Several barriers have been cited in the literature, including financial considerations and the lack of institution support, time constraints and family commitments.^{113 114 115} These barriers are real and must be addressed by individuals and institutions. Research shows that institutions must make a much more stronger commitment of lifelong continuing education of nurses and other healthcare providers.¹¹³ Support for education is too susceptible to random budget cuts in the time of economic evaluation, and many institutions do not provide time or money for nurses or other professionals to attend conferences or and other continuing education events.¹¹¹

The following education programs may be mandatory for health care provider so health care facilities can meet regulatory requirements for evidence of education programs that support competency-base practice of neonatal resuscitation^{112 116}

- Basic Life Support (BLS) Health Care Provider Course
- Neonatal Resuscitation Program (NRP)
- The STABLE Program
- Neonatal Intensive Care Nursing (RNC-NIC) Certified by National Certification Corporation (NCC)

¹¹¹ Witt, C. L. (2011). Continuing education: A personal responsibility. *Advances in neonatal care: official journal of the National Association of Neonatal Nurses*, 11(4), 227-228.

¹¹² Association Of Women's Health, Obstetrics and Neonatal Nurses (AWHONN)., (June 2019). *Neonatal Nursing: Clinical Competency and Education Guide*. 7th Edition.

¹¹³ Fawaz, M. A., Hamdan-Mansour, A. M., & Tassi, A. (2018). Challenges facing nursing education in the advanced healthcare environment. *International journal of Africa nursing sciences*, 9, 105-110.

¹¹⁴ Sarver, W., Cichra, N., & Kline, M. (2015). Perceived benefits, motivators, and barriers to advancing nurse education: Removing barriers to improve success. *Nursing Education Perspectives*, 36(3), 153-156.

¹¹⁵ Saifan, A., AbuRuz, M. E., & Masa'deh, R. (2015). Theory practice gaps in nursing education: A qualitative perspective. *Journal of Social Sciences/Sosyal Bilimler Dergisi*, 11(1).

¹¹⁶ Canadian Association of Neonatal Nurses (CANN)., (2018). *Neonatal Nursing Standards of Practice*.

- ACoRN

Given that there has been a number of shifts requiring neonatal resuscitation, stabilization and transfer out of the SCN, effective education programs that support competency-based practice of neonatal resuscitation should be integrated into the mandatory annual education requirement for SCN.

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

Recommendation 28:

- The hospital provides funded mandatory annual educational programs, in house or external, that will demonstrate ongoing current education, and support competency-base practice for neonatal resuscitation in SCN**

The funded annual educational programs should include:

- Basic Life Support (BLS) Health Care Provider Course
- Neonatal Resuscitation Program (NRP)
- The STABLE Program
- ACoRN

- The Hospital will continue working towards the SCN Level 2B status, it is highly recommended that staff will be funded for the George Brown Perinatal Intensive Care Nursing Course.**

3.3.6.2 Recommendation 29: Neonatal Resuscitation Program (NRP) Certification

The IAC Panel read evidence and heard issues related to the SCN staff spending a significant amount of time off the unit, it was evident that a high percentage of this time was in FBU to attend to the baby.

There were a number of PRWRFs forms submitted indicating that SCN staff were responsible for the baby in the FBU. The SCN staff shared a number of incidences where they were responsible for the baby during a delivery, while leaving the SCN understaffed.

NRP is an educational program that introduces the concepts and skills of neonatal resuscitation.¹¹⁷ All staff working in the Maternal Child area are required to be NRP certified.^{118 119}

The IAC panel believes that having all maternal child staff certified in NRP would improve the skills and competencies of neonatal resuscitation.

¹¹⁷ Canadian Paediatric Society (CPS)., (2020). Neonatal Resuscitation Program (NRP) retrieved from: <https://www.cps.ca/en/nrp-prn>

¹¹⁸ Chabra, Shilpi MD Evolution of Delivery Room Management for Meconium-Stained Infants, *Advances in Neonatal Care*: August 2018 - Volume 18 - Issue 4 - p 267-275

¹¹⁹ Niermeyer, S. (2015, October). From the Neonatal Resuscitation Program to Helping Babies Breathe: Global impact of educational programs in neonatal resuscitation. In *Seminars in Fetal and Neonatal Medicine* (Vol. 20, No. 5, pp. 300-308). WB Saunders.

Recommendation 29:

- a. It is a requirement that all staff in Maternal Child Area are NRP certified.
- b. FBU nurse will be responsible for the baby and will call SCN staff based on the “Attendance at Delivery Protocol”
- c. The Nurse Educator should set up Mock Code Pinks involving the multidisciplinary team and a regular basis. This will build the team’s confidence and skill set for neonatal resuscitation.

3.3.6.3 Recommendation 30: Critical Care Education Funding

The IAC Panel read evidence and heard issues related to the lack of funded education, limited opportunities for education and no updated education reviews.

The SCN nursing staff stated that they had not had a funded neonatal education day in a number of years. Guelph hospital stated that they provide every full time staff with \$900.00 dollars and part-time staff \$500.00 dollars annually, this can be used for education. Guelph hospital stated that if the nurses do not utilize the funding during the fiscal year the money is used for equipment.

Neonatal updates and education are critical to keep neonatal nurses practices current.^{120 121 122} The hospital has options, seeking other funding sources:

- CCSO Funding: Hospitals can apply for funding each year via the application process as managed by Critical Care Services Ontario (CCSO).¹²³
- Formula Companies Education Fund: The focus of Mead Johnson Nutrition grant funding is based on high-quality continuing education for healthcare providers to provide infants and children the best start in life.¹²⁴

A number of hospitals in the Southern Ontario Obstetric and Neonatal Network (SOONN) group have utilized the funding sources for the following professional development education:

- George Brown Perinatal Course
- Neonatal Education Day
- STABLE

¹²⁰ Cunningham, C., Moore, Z., Connor, T. O., Patton, D., Bux, D., & Nugent, L. (2020). eHealth for neonatal nurse education despite Covid-19. *Journal of Neonatal Nursing*.

¹²¹ Turrill, S. (2011). Setting standards for specialised neonatal nurse education. *Infant*, 7(6), 174-175.

¹²² Fiske, Elizabeth PhD, RN, CNE, PCNS- BC Nurse Stressors and Satisfiers in the NICU, *Advances in Neonatal Care*: August 2018 - Volume 18 - Issue 4 - p 276-284

¹²³ Ontario Ministry of Health and Long Term Care (MOH)., (2020)., Critical Care Nurse Training Fund. Retrieved from: <https://www.health.gov.on.ca/en/pro/programs/criticalcare/nursetrainingfund.aspx>

¹²⁴ Mead Johnson Nutrition., 2021. Medical Education Grant. Retrieved from: <https://www.meadjohnson.com/research-and-innovation/medical-education>

- AcORN

The IAC panel believes that there are funding options to fund professional development for the SCN staff.

Recommendation 30:

- Guelph Hospital is part of CCSO, the hospital must complete a CCSO application for SCN staff professional development on an annual basis.**
- Guelph Hospital must explore the educational funding with the formula company that SCN uses to support ongoing professional development in the SCN.**

3.3.6.4 Recommendation 31: SCN Competency Skills Checklist

The IAC Panel read evidence and heard issues related to the quality and safety in the Special Care Nurse related to workload and resources to support fluctuating patient needs. Numerous situations were presented to leadership informing them of the increased patient acuity coupled with the need for resources with SCN knowledge, skill and expertise.

Quality and safety in neonatal care is intricately linked to staff levels, nurse to patient ratios, and the specialised levels of education and experience of nurses delivering care¹²⁵. The National Association of Neonatal Nurses (NANN) and the Canadian Association of Neonatal Nurses (CANN) has a key role in promoting quality and safety and ensuring staffing levels meet the Standards of Neonatal Nursing.^{126 127} It is for this reason it is imperative there is a comprehensive SCN Competency Skills Checklist that reflects the patient population's needs to improve patient quality and safety by having a standardized practical tool.

The competency skills checklist should reflect clear core competencies nurses must have to meet standards of care for this vulnerable patient population.

The IAC panel believes a comprehensive competency skills checklist developed and validated by a third party would be extremely valuable to ensure all core competencies are identified.

¹²⁵ Davies, W.L. (2015). An Operational Neonatal Patient Acuity Tool for measuring clinical dependency for each infant on the unit. *Infant, 11(2)*, 51-53.

¹²⁶ Canadian Association of Neonatal Nurses (CANN)., (2018). *Neonatal Nursing Standards of Practice*.

¹²⁷ National Association of Neonatal Nurses (NANN)., (2014). RN Staffing in Neonatal Intensive Care Units. *Position Statement #3061*

Recommendation 31:

- a. The Hospital is to develop and SCN Competency Skills Checklist to ensure education for new staff are well defined to meet the following criteria:
 - Accurately representing the complete neonatal care requirements
 - Easy to use.
 - Applicable to the entire Maternal Child Program
 - Quantifiable
- b. The SCN Competency Skills Checklist should be developed within 3-4 month to ensure the well-established core competencies meet the standards of care of the neonatal patient in SCN.
- c. The Competency Skills Checklist for new learners should be discussed during rounds to ensure new staff can acquire their core competencies based on the activities within the program.

SECTION IV

CONCLUSION AND SUMMARY OF RECOMMENDATIONS

4.1 Conclusion

Article 8.01 of the Collective Agreement between the Ontario Nurses' Association and GGH SCN the Independent Assessment Committee to specifically address the issue of whether or not RNs are being requested to perform more work than is consistent with proper patient care.

The IAC Panel completed a thorough analysis, which included an in-depth review of information received prior to and during the IAC Hearings held April 27-29, 2021 in relation to the literature relating to neonatal nursing and care, consideration of factors impacting the GGH SCN practice environment, and integration of the Panel's cumulative practice, knowledge, experience and expertise.

The IAC Panel concluded that while the current number of RNs assigned over a 24-hour period is not appropriate, the manner in which the care delivery model and associated staffing and unit processes have been implemented has resulted in the RNs being unable to provide proper patient care. This has been accentuated by a number of clinical unit practices which have not supported effective care provision.

4.2 Summary of Recommendations

The IAC Panel identified thirty-one (31) recommendations, in the areas of SCN Designation, SNC Staffing, Leadership and Governance, Nursing Practice, Unit Processes, Policies and Procedures, Continuing Education and Professional Development.

Recommendation 1:

- a. SCN is a Level 2a Neonatal Intensive Care Unit. Based on recent changes including the physician model of care, the recent hire of a clinical educator with a focus on SCN and the Ministry approved renovation of SCN, the hospital continues in its journey to obtain a Level 2b designation to support an increased level of care for babies within the community to further enhance the mother baby dyad.**

Recommendation 2:

- a. Continue to lobby the ministry to advance the SCN renovations for this year as GGH shared with the IAC Panel.
- b. Initiate the team building recommendations as soon as possible to support the transition period whereby the SCN and Pediatric staff will be relocated during the period of renovation.
- c. Develop an internal and external communication strategy for all key stakeholders to inform them of the changes during the renovations to support this transition period.

Recommendation 3:

- a. Given the age of the current neonatal physiological monitors, begin the RFP initiative as soon as possible to purchase the new neonatal physiological monitors.

Recommendation 4:

- a. Propose adding a third RN (Resource Nurse -see next recommendation for further details) on day shifts Monday-Friday from 0800-1600 hrs.
- b. Utilize existing flexible scheduling hours as well as backfill replacement budget to fund the position. Ideally this position would offset a portion of the overtime due to call in and sudden fluctuations in acuity due to presence and familiarity of day to day operations and proactive planning
- c. Once the newly renovated SCN opens and Level 2B designation has been granted there must be three (3) RNs in SCN twenty-four hours per day seven days per week.

Recommendation 5:

- a. Devise standard work for the role of the Unit Attendant specific to responsibilities for SCN. This will support SCN nurses to utilize their skill set, trusting non nursing duties will be followed up on.
- b. Devise a schedule that aligns with the delivery of ordered supplies to facilitate timely stocking and restocking
- c. Develop a special order supply and equipment checklist with support from the SCN staff for ease of ordering to ensure availability of essential equipment when needed.
- d. Frequent scheduled check in's between the UA, SCN staff and the Director to ensure the role is being utilized to its potential.

Recommendation 6:

- a. Devise standard work for the role of the Unit Clerk specific to responsibilities for SCN. This will support SCN nurses to utilize their skill set, trusting non nursing duties will be followed up on and the Unit Clerk will be identified as a valued member of the care team.

- b. Standard work should include but not limited to participation in daily status exchange to understand:
 - Staffing needs for coming shifts,
 - Potential of arranging transportation,
 - Receiving repatriations
 - Identification of anticipated needs
- c. Scheduled check in times with SCN either by rounding or phone check in to understand if support is needed. A process should be put in place that if support is required urgently the Unit Clerk responds or gives a reasonable time frame when she/he will respond.
- d. Expectation that if an admission arrives in SCN the Unit Clerk will attend SCN to provide support.

Recommendation 7: for Nursing Leadership and Governance:

- a. The GGH Leadership team develop a strategy to implement the Registered Nurses Association of Ontario (RNAO) Best Practice Guideline Developing and Sustaining Nursing Leadership for the Special Care Nursery Staff at GGH.
- b. The Registered Nurses Association of Ontario (RNAO) Best Practice Guideline Developing and Sustaining Nursing Leadership become the framework utilized for leadership development for all Special Care Nursery Staff at GGH.

Team Building Recommendation 8:

- a. The Hospital engage either an internal or external expert to facilitate team building sessions to enhance a unit culture that is founded on the principles that underpins GGH's code of conduct, mission, vision and values. This should include change management, teambuilding, conflict resolution and communication activities that engage staff participation.

Recommendation 9:

- a. The Clinical Director implement staff rounding twice per week to foster collaboration, trust and support for the SCN staff.
- b. Conduct weekly staff meetings on the same day of the week at 7am (shift change) for a 6-month pilot led and facilitated by the Clinical Director. The Senior Director should attend as well.
- c. SCN and FBU staff must be given the opportunity to submit agenda items and have the opportunity to address these items during the meeting.

- d. SCN and FBU Staff should make every effort to attend staff meetings that are planned and be part of the process to make improvements and provide suggestions. It is also the staff's responsibility to read minutes of staff meetings that are posted or shared by email.
- e. GGH should consider different options to engage staff in attending staff meetings for example arranging meetings to be conducted via teleconference, Webex, Microsoft Teams, Zoom so staff can be engaged.

Recommendation 10:

- a. Senior Director will attend unit huddles at a minimum once per week. This will increase visibility, garner trust and develop relationships with staff in SCN.
- b. In the absence of the Clinical Director, the Senior Director should ensure there is appropriate coverage for daily status exchange and unit huddles. This is to ensure continuity of shared information, communication as well as identification of issues and concerns.

Recommendation 11:

- a. Review Span of Control considering complexity of program(s), experience of leader as well as experience profile of staff.
- b. The Director or designate should participate in daily status exchanges and departmental huddles with all units as part of the organizations established leader standard work. Huddles should also be instituted if a situation arises that requires additional support. This increased visibility will open the line of communication as well as foster relationships built on trust.
- c. Timely follow up on all PWRWF is an agreed upon accountability between ONA and the hospital and must be followed to facilitate collaborative and problem-solving discussion. All forms should have follow-up within the 10 day time period understanding follow up maybe ongoing over a period of time.

Recommendation 12:

- a. The Educator should meet with the staff in SCN daily, the Charge Nurse will review the status of the unit and the Educator will provide resources to support the staff. This will build a stronger collegial relationship between the Educator and the staff.
- b. The Nurse Educator will perform a needs analysis in the SCN unit,(within the next 3-6 months). Based on her findings, an education schedule will be provided in priority of findings. The education schedule will provide all staff the opportunity to participate, an attendance sheet will be used to track the participants completion of education.
- c. The Educator should outsource effective training programs, suggested sources:

- STABLE – McMaster has a program and will come to Guelph Hospital for training
- ACoRN – CPS provides the ACoRN information and contacts <https://www.cps.ca/en/acorn>
- d. The hospital must fund annual membership of neonatal websites to support the nurse educator and the staff, recommended websites:
 - Canadian Association of Neonatal Nurses (CANN)
 - National Association of Neonatal Nurses (NANN)
- e. The Clinical Director and Nurse Educator should participate in network meetings:
 - Southern Ontario Obstetrical and Neonatal Network (SOONN)
- f. The Educator should schedule in house training with experts within the hospital to provide:
 - Mock Pink drills

Recommendation 13:

- a. Redefine the Job Description for the FBU Resource Nurse role to include all areas of the role as well as defined roles responsibilities.
- b. The FBU Resource Nurse or designate should participate in daily status exchanges and departmental huddles with all units as part of the organizations established leader standard work. Huddles should also be instituted if a situation arises that requires additional support. This increased visibility will open the line of communication as well as foster relationships built on trust.
- c. Implement standard times for rounding in each unit to increase visibility and facilitate communication between team members as well as across units
- d. Use of companion phone for availability – defined for hand off when not available

Recommendation 14:

- a. Implement a 5S LEAN project within the existing SCN within 3 months of receiving the IAC report. This project should utilize SCN staff, Infection Prevention and Control resources as well as a process improvement resource if available. This project will create a well-organized work area contributing to improved staff satisfaction, decreased frustration, improved teamwork, and a positive impact on patients in SCN.

Recommendation 15:

- a. The IAC encourages GGH and the local association to work together to improve the PRC 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.

Recommendation 16:

- a. The hospital is to explore options of communication devices for nurses when leaving the SCN unit.

Recommendation 17:

- a. The Hospital is to develop and SCN Acuity Tool to measure the current state of the SCN, and needs to meet the following criteria:
 - Accurately representing the complete neonatal care requirements
 - Easy to use.
 - Applicable to the entire Maternal Child Program
 - Quantifiable

- b. The SCN Acuity Tool Development Group/Team require the following members:
 - Clinical Director
 - Nurse Educator
 - SCN Resource Nurse
 - SCN Nurses

All team members are required to sign a binding agreement document to show consensus of SCN Acuity Tool between management and staff.

- c. The SCN Acuity Tool should be developed within 3-4 months, a trial of one month to evaluate and make changes that are agreed upon and signed by the SCN Acuity Tool Development Group/Team. The SCN Acuity Tool is to be reviewed quarterly by the SCN Acuity Tool Development Group/Team to ensure the well-established indicators meet the standards of care of the neonatal patient in SCN.
- d. The SCN Acuity Tool is to be placed on a shared drive that is accessible by the Maternal Child Program. The SCN staff will input the data into the SCN Acuity Tool every shift.
- e. The SCN Acuity Tool Development Group/Team can use the Halton Healthcare SCN Patient Acuity and Workload Tool ¹²⁸ (Figure 1), which is a level 2C SCN, as a platform for development of the SCN Acuity Tool.
- f. The SCN Acuity Tool can be build in Microsoft Excel, in appendix ____, is an example of Halton Health Care Excel Spreadsheet.

¹²⁸ Halton Healthcare SCN Acuity Tool 2021

Recommendation 18:

- a. The Clinical Director, Nurse Educator and SCN Resources nurse are to develop an electronic Admission/Discharge/Transfer Tool that is placed on a shared drive to monitor the activity in the SCN.

Recommendation 19:

- b. The Special Care Nursery Admission Criteria Policy is to be reviewed and updated to reflect best practice.
- b. The policies and procedures can be extended to a third party with neonatal knowledge and experience for review.

Recommendation 20:

- a. All staff in the GGH FBU be certified in NRP and their certification is maintained annually.
- b. Review and revise the “Attendance at Delivery” policy/guideline based on evidence and best practices. Consider engaging a subject matter expert with Neonatal ICU experience to facilitate this revision.
- c. SCN staff attend ONLY those deliveries that are deemed at risk and that they no longer be requested by FBU staff to attend “normal deliveries as baby nurse.

Recommendation 21:

- a. Guelph General Hospital is to contact CCIS educators (CCISTraining@criticall.org) to review the training and education.
- b. All new staff will receive training by CCIS educator, this education and support will be during their orientation period.

Recommendation 22:

- A. The Hospital has provided an updated Policy and Procedure for CPAP prior to the IAC hearing, the hospital needs to provide an effective Policy and Procedure development strategy with timelines for the development of the following Policies and Procedures:
 - BiPAP
 - Humidified High-Flo
 - Low flow nasal prongs
 - Passive Cooling for hypoxic-ischemic encephalopathy (HIE)
 - Gastric Low-intermittent suctioning
 - Rapid Sequence Intubation (RSI) and medication administration

- Chest tubes
 - Feeding protocols (Standardized Feeding Protocols)
 - Trophic Feeding
 - IV infusion and maintenance for neonates
 - UVC maintenance
 - Developmental Care
 - Cue Base Feeding
- B. The Policies and Procedures can be extended to a third party with neonatal knowledge and experience for review.
- C. The hospital can network with the Southern Ontario Obstetrical and Neonatal Nursing (SOONN) group requesting Policies and Procedures that can be utilized and adapted for the hospital.
- D. The hospital has the option of purchasing the National Association of Neonatal Nurses (NANN) Policies, Procedures and Competencies for Neonatal Nursing Care, 6th Ed and adapting them accordingly.

Recommendation 23:

- A. The Hospital is to provide a standardized computer-based orientation neonatal training program that would underpin the standard of practice in SCN. This should include online training, integrated didactic content with clinical content that facilitated by the Nurse Educator.
- B. The Nurse Educator and the SCN staff are to develop core clinical competencies that new staff require for orientation to the SCN.
- C. The hospital has the option of purchasing a standardised Orientation Program from AWHONN: The Neonatal Orientation and Education Program, Fourth Edition (NOEP) is a comprehensive, educational program that is highly effective in providing evidence-based, clinical education to neonatal nurses. NOEP helps to mitigate neonatal risk, increase staff efficiency, and promote optimal neonatal outcomes while saving your healthcare system time and money. With NOEP, your facility can establish consistent provision of high-quality care for high-risk and vulnerable newborns.
<https://www.awhonn.org/education/neonatal-orientation-and-education-program-fourth-edition-noep/>

Recommendation 24:

- a. Create a checklist to determine appropriate and safe recommendation for transfer. This checklist is completed with all members of the care team including parents. Consideration should be given but not limited to:
 - a. Age and weight
 - b. Cardio-respiratory status
 - c. Growth
 - d. Nutritional status
 - e. Treatment, tests and procedures
- b. Comprehensive TOA template developed with Pediatric staff input in the development

Recommendation 25:

- A. The Hospital will establish a SCN/Paeds Cross-training group with the following members:
 - Clinical Director
 - Paediatric and SCN Educator
 - SCN Resource Nurse
 - SCN Nurses
 - Paediatric Nurses

- B. The SCN/Paeds Cross-training group will develop and effective cross-training program incorporating:

Criteria for Identification of staff:

- Voluntary participation or self-selection: voluntary participation will achieve higher productivity and identify the most desirable and qualified staff
- Possession of baseline knowledge or competencies that trainees must have prior to being cross-trained. One means of identifying individuals with the appropriate knowledge base or minimal competencies is to select trainees with select licensure or accreditation.
- Possession of analytical assessment skills and a large skill base. These qualities facilitate adding new skills through cross training.
- Experience working within a care team framework.
- Having time to perform and practice newly acquired cross-trained duties and competencies.

Category of Neonatal Patients for Paediatric Cross-Trained Nurses:

- Infant greater than 34 weeks not requiring oxygen
- Feeder-growers greater than 1500 grams on room air managed in giraffe bed, isolette or warmer
- Infant of diabetic mothers with blood glucose less than 2.8 mmol requiring frequent feeding and IV management and lab draws
- Infants in open cribs receiving less than 70% of feeding volume orally.
- Infants in open cribs on nasal cannula
- Infants receiving IV fluids
- Infants on phototherapy and all oral feeds

Recommendation 26:

- A. The SCN is to set up a group to develop standardized evidence-based guidelines for the care of late preterm infants, the group must include the following members:**
- Paediatrician
 - Nurse Educator
 - SCN Resource Nurse
 - SCN Nurses
- B. The SCN Group for development of standardized evidence-based guidelines for care of the late preterm infants will:**
- Review the literature of nursing interventions for late premature infants
 - Develop standardized evidence-based care guidelines for the late preterm infants in SCN

Recommendation 27:

- a. Guelph General Hospital is to reach out to the McMaster Neonatologist and Respiratory therapist to provide education and training to the Guelph General Hospital SCN multidisciplinary team on non-invasive ventilation.**

Recommendation 28:

- a. The hospital provides funded mandatory annual educational programs, in house or external, that will demonstrate ongoing current education, and support competency-base practice for neonatal resuscitation in SCN**
- The funded annual educational programs should include:**
- Basic Life Support (BLS) Health Care Provider Course
 - Neonatal Resuscitation Program (NRP)
 - The STABLE Program
 - ACoRN
- b. The Hospital will continue working towards the SCN Level 2B status, it is highly recommended that staff will be funded for the George Brown Perinatal Intensive Care Nursing Course.**

Recommendation 29:

- A. It is a requirement that all staff in Maternal Child Area are NRP certified.**
- B. FBU nurse will be responsible for the baby and will call SCN staff based on the “Attendance at Delivery Protocol”**
- C. The Nurse Educator should set up Mock Code Pinks involving the multidisciplinary team and a regular basis. This will build the team’s confidence and skill set for neonatal resuscitation.**

Recommendation 30:

- A. Guelph Hospital is part of CCSO, the hospital must complete a CCSO application for SCN staff professional development on an annual basis.**
- B. Guelph Hospital must explore the educational funding with the formula company that SCN uses to support ongoing professional development in the SCN.**

Recommendation 31:

- A. The Hospital is to develop and SCN Competency Skills Checklist to ensure education for new staff are well defined to meet the following criteria:**
 - Accurately representing the complete neonatal care requirements**
 - Easy to use.**
 - Applicable to the entire Maternal Child Program**
 - Quantifiable**
- B. The SCN Competency Skills Checklist should be developed within 3-4 month to ensure the well-established core competencies meet the standards of care of the neonatal patient in SCN.**
- C. The Competency Skills Checklist for new learners should be discussed during rounds to ensure new staff can acquire their core competencies based on the activities within the program.**

SECTION V

Appendices



ARTICLE 8
CHANGES.docx

Appendix 1: Article 8.01: Professional Responsibility

Appendix 2: GGH Nominee

RE: GGH Response to ONA re IAC - January 16 2021



Skinner, Melissa <MSkinner@gghorg.ca>

To: Rothwell, Donna

Cc: Lorrie Daniels; Riley, Richard (Lukas)

Retention Policy Full Mailbox - Never Delete (Never)

You replied to this message on 2/7/2021 6:53 PM.

Expires Never

Reply Reply All Forward

Sun 2/7/2021 6:09 PM

Enterprise Vault

Hello Donna,

I am so very sorry that I am just responding to this email now. I have been deployed to a Retirement Home setting to help with an outbreak since the 24th. I have not had much time to keep up with all of my email.

I apologize. Please see the name of our nominee below.

Stephanie Pearsall, Director, Surgical Program and Professional Practice | 519-749-6578 Ext 1406 | spearsall@smgh.ca

Again, I apologize for the delay, there is no internet at the retirement home I have been stationed at, so its been very challenging.

Take care,

Melissa

From: Rothwell, Donna <Donna.Rothwell@stantec.com>

Appendix 3: ONA Nominee



Ontario Nurses' Association

85 Grenville Street, Suite 400, Toronto, Ontario M5S 3A2

TEL: (416) 964-8833 FAX: (416) 964-8864

January 14, 2021

SENT BY EMAIL

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

Dear Donna,

Thank you for accepting the nomination to chair the Independent Assessment Committee (IAC) investigating a complaint in the Special Care Nursery at Guelph General Hospital. I have contacted Mr. David McCoy, Director, Labour Relations at the Ontario Hospital Association and the parties have agreed to you chairing this IAC.

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

The attached letter provides you with the name and contact information of the Ontario Nurses' Association's nominee to the IAC Committee – and requests that the employer provide you with that information for their nominee within the timeframes set out in the Collective Agreement by January 17, 2021.

The Ontario Nurses' Association's nominee to the IAC is Pauline Jones.

Pauline's contact information is:

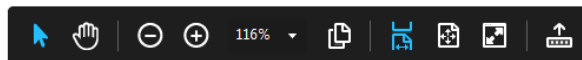
Pauline Jones, RN, BScN, M.N.
559 Rexford Drive,
Hamilton, ON L8W 3G9
Phone - (905) 484-4315
Email - pjones2367@gmail.com

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

Yours truly,

ONTARIO NURSES ASSOCIATION

Lorrie Daniels,



Additional Questions for Guelph Hospital

April 15, 2021

1. **Level of Care: 2a or 2b:** - we need clarity on this designation
How do you monitor the patient acuity and activity in the SCN?
How many beds are you funded for in Special Care Nursery?
2. **Training:**
Shared line between Pediatrics and SCN: Who decides which unit requires this staff member?
Cross training: number of days staff are cross trained and competency checklist, can staff member care for a 3/4 baby assignment? Has this staff member been trained to document electronically – SCN document in ISP – neonate, whereas Paediatrics document in Meditech
Are Pediatric staff NRP certified?
3. **Communication:**
Are there huddles with charge nurses every shift to discuss status in maternal child units?
Do SCN staff attend every delivery?
4. **Transferring babies:**
Pediatrics:
What criteria is required to transfer a baby to Pediatrics?
Are these babies been discharged from CCIS when transferred to Pediatrics?
Do the staff in Pediatrics have access to the ISP Neonatal to see the history of the neonate from SCN?
Return Transfers/Repatriation:
When babies are received from other hospitals how do you enter them into ISP neonate:
 - Under babies name?
 - Under mothers name?
5. **Education:**
Is NRP mandatory for SCN staff?
What other external education funding is available for the SCN staff to stay current and competent?
Do you fund staff to attend conferences or other programs required like STABLE, AcORN?
What education does the Nurse Educator provide for the SCN staff?
What percentage of time does the Nurse Educator spend in SCN?

6. Policies and Procedures:

Does SCN have a Standards of Care Policy?

Please provide a list of Policies and Procedures for Special Care Nursery including the revision dates

Do you have a Surge Plan Policy for Special Care Nursery?

7. Equipment:

What type of monitor do you have for cardiorespiratory monitoring?

Do you have a central monitoring system?

Do you have an isolation room in SCN? If not where do these babies go if they need isolation?

8. Cesarean Sections:

What is your current cesarean section rate?

What days and times are your elective cesarean sections scheduled for?

Do SCN nurses attend all cesarean section deliveries?

9. Accreditation Recommendations:

Can you share with us any Accreditation recommendations there were for FBU and/or SCN?

10. Staff Meeting Minutes:

Can you please share with us minutes of your last six (6) staff meetings held with staff in SCN?

11. SCN Master schedule:

It is noted on the master schedule many overages approximately 45%. (ie., there are a number of days/shifts where there are three (3) RNs on. Clarification initially thought this was related to a nurse on modified however the document states that this nurse has retired. Do these overages currently exist?

How many staff are on every shift in the SCN?

How many unit clerk/clerical hours are dedicated to SCN and how is this time utilized?

Do you have a casual pool of staff for SCN?

Do you have an "on call" option for staff in SCN?

Additional 3500 hours plus significant sick hours built in – history behind this?

Independent Assessment Committee Hearing

Ontario Nurses' Association (ONA) / Guelph General Hospital (GGH)

Agenda

Tuesday April 27th, 2021

08:00 – 09:00	<i>Independent Assessment Committee Meeting (Committee Members only)</i>
09:00 – 10:00	Tour of the GGH Special Care Nursery ♦Attending: to be determined
1015	Commencement of Hearing
10:00-10:15	•Introduction and Review of Proceedings by Chairperson
10:15 – 11:45	•Ontario Nurses' Association Submission Presentation ♦Response to questions of clarification by ·Independent Assessment Committee ·Guelph General Hospital
11:45-12:00	Break
12:00 – 13:30	•Guelph General Hospital Submission Presentation ♦Response to questions of clarification by ·Independent Assessment Committee ·Ontario Nurses' Association
13:30 – 13:45	•Review of Process for Wednesday April 28 th , 2021 by IAC Chairperson
13:45	Adjournment of Hearing

Note: The timing of the agenda may fluctuate given our current situation with the COVID-19 Pandemic. If the ONA presentation is concluded before the allotted time frame, we will proceed with the GGH presentation. The Hearing will adjourn at 13:45 at the latest.

Independent Assessment Committee Hearing

Ontario Nurses' Association / Guelph General Hospital

Agenda

Wednesday April 28, 2021

07:30 – 08:30	<i>Independent Assessment Committee Meeting (Committee members only)</i>
08:30	Continuation of Hearing
08:30 – 11:30	<ul style="list-style-type: none">•Guelph General Hospital Response to Ontario Nurses' Association Submission<ul style="list-style-type: none">♦Response to questions from<ul style="list-style-type: none">•Independent Assessment Committee•Ontario Nurses' Association♦Discussion
11:30 – 12:30	Lunch Break
12:30 – 15:30	<ul style="list-style-type: none">•Ontario Nurses' Association Response to Guelph General Hospital Submission<ul style="list-style-type: none">♦Response to questions from<ul style="list-style-type: none">•Independent Assessment Committee•Guelph General Hospital♦Discussion
15:30 – 15:45	<ul style="list-style-type: none">•Review of Process for Thursday April 29th, 2021 by Chairperson
15:45	Adjournment of Hearing
16:00 – 20:30	<i>Independent Assessment Committee Meeting (Committee members only)</i>

Note: The timing of the agenda may fluctuate given our current situation with the COVID-19 Pandemic. If the Guelph General Hospital Response submission/discussion is concluded before lunch, we will proceed with the ONA Response submission/discussion before the lunch break. If the ONA

Response submission/discussion concludes before 15:30, the Hearing will adjourn. The Hearing will adjourn at 16:00 at the latest.

Independent Assessment Committee Hearing

Ontario Nurses' Association / Guelph General Hospital

Agenda

Thursday April 29th, 2021

08:30	Continuation of Hearing
08:30 – 12:30	●Questions to both ONA and GGH by IAC
12:30 – 13:00	●Closing Remarks and Discussion of Next Steps by Chairperson
13:00	Closure of Hearing
13:00 – 15:00	<i>Independent Assessment Committee Meeting (Committee members only)</i>

Appendix 6 Attendee List

ONA Attendees Guelph General Hospital Special Care Nursery IAC

Who	Position	Email	Phone Number	Date and Time
Lorrie Daniels	RN, ONA PPS	lorried@ona.org	905-321-3926	April 27, 28, 29, 2021
Danielle Richard	RN, ONA PPS	danieller@ona.org	705-669-7181	April 27, 28, 29, 2021
Andrea Fagan	RN, ONA PPS	andrea@ona.org	519-434-8707	April 27, 28, 29, 2021
Jennifer Dorling	RN, GGH Bargaining Unit President	Local025BUP575@ona.org	519-837-7141	April 27, 28, 29, 2021
Robert McGregor	RN, SLRO ONA	rpbertm@ona.org		As Able
Sarah Clarke	SCN RN GGH	hebertsarah@hotmail.com	519-820-7165	April 27, 28, 29, 2021
Karen Horsfall	SCN RN GGH	khorsfall1@hotmail.com	518-803-2322	April 27, 28, 29, 2021
Cindy Kranendonk	SCN RN GGH	cindy_and_jeff@sympatico.ca	519-994-3386	April 27, 28, 29, 2021
Amy Tettman	SCN RN GGH	amy_tettman@hotmail.com	226-218-2031	April 27, 28, 29, 2021
Susan Delisle Gosse	RN, ONA PP Manager	susand@ona.org	647-225-3854	April 27, 28, 29, 2021
Angela Preocanin	ONA Region 4VP, BOD	angelao@ona.org	905-512-7413	April 27, 28 2021
Cathryn Hoy	ONA 1 st VP	cathrynhi@ona.org	613-331-6886	April 27, 28 2021
Matthew Stout	ONA Manager, Labour Relations West District Service Team	matthews@ona.org		April 27
Athena Brown	ONA Manager, PST	athenab@ona.org		April 28, 29
Vicki McKenna	ONA Provincial President	vickim@ona.org		As Able
Kaitlin Carr	GGH SCN RN, ONA Member Observer	Kaitlin.carr16@gmail.com	647-515-8642	April 27, 28, 2021
Marcia Barry	ONA Litigation Manager	marciab@ona.org		April 27, 28, 29, 2021
Haifaa Khadour	RN, ONA PPS	haifaak@ona.org	226-747-4751	April 27, 28, 29, 2021

GGH Attendees

- Melissa Skinner, VP & CNE
- Geoff Wood, Director of HR
- Kim Tows, Sr. Director of Patient Services
- Karen Suk-Patrick, VP of HR

Waterloo Wellington LHIN

55 Wyndham St. N, Suite 212
Guelph, ON N1H 7T8
Tel: 519 822 6208
Toll Free: 1 866 306 5446 • Fax: 519 822 5807
www.wwlhlin.on.ca

November 30, 2009

Mr. Richard Ernst
President and Chief Executive Officer
Guelph General Hospital
115 Delhi Street
Guelph, Ontario
N1E 4J4

Richard
Dear Mr. Ernst:

The Waterloo Wellington Local Health Integration Network (the LHIN) is pleased to advise you that the Guelph General Hospital (the Hospital) will be receiving funding to enhance the operations and capacity of the Neonatal Intensive Care Unit (NICU).

This funding is part of a broader ministry initiative to enhance capacity in Ontario's newborn intensive care unit system. In 2008/09 the Provincial Council for Maternal, Child and Youth Health (formerly Provincial Council for Children's Health), undertook a review of current

capacity, bottlenecks and gaps in services in the NICU system. Recommendations from the Work Group have identified the LHIN as one where investment is required to improve capacity in order to facilitate treatment as close to home as possible, and ensure that women and newborns receive the safest and highest quality care.

The funding and the terms and conditions on which the funding will be provided to the Hospital are set out in Schedule A to this letter. Subject to the Hospital's acceptance of the funding and the conditions on which it is provided, the service accountability agreement between the hospital and the LHIN (the H-SAA) will be amended with effect as of the date of this letter.

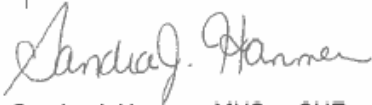
To the extent that there are any conflicts between what is in the H-SAA in respect of the services described in Schedule A, and what has been added to the H-SAA by this letter, the terms of this letter and the accompanying Schedule A will govern. All other terms and conditions in the H-SAA will remain the same.

Please indicate the Hospital's acceptance of the proposed funding, the conditions on which it is provided, and the Hospital's agreement to the amendment of the H-SAA by signing below and returning one original copy of this letter to the LHIN, attention of Teresa Van Parys, Administrative Assistant, by December 14, 2009.

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If you have any questions or concerns please contact Mr. Tim Lewis, by phone at (519) 822-6208 extension 207, or by email at tim.lewis@lhins.on.ca

Sincerely,



Sandra J. Hanmer, MHSc., CHE
Chief Executive Officer

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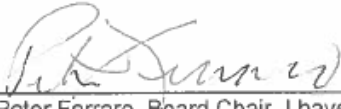
Enclosed: Schedule A

c: Mr. Peter Ferraro, Board Chair, Guelph General Hospital
Ms. Kathy Durst, Chair, Waterloo Wellington LHIN

ACCEPTED BY AND AGREED TO:

Guelph General Hospital

By:



Mr. Peter Ferraro, Board Chair, I have the authority to bind Guelph General Hospital