Independent Assessment Committee Report

Constituted under Article 8.01 of the

Collective Agreement

Between

Brant Community Health System
Emergency Department

and

Ontario Nurses' Association

May 5, 2024

Sandy Paproski
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Ontario Nurses Association
sandyp@ona.org

Beth Morris
Interim Chief Nursing Officer
Brant Community Health System
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May 5, 2024

Dear Ms. Paproski and Ms. Morris

The members of the Independent Assessment Committee have concluded our review and respectfully submit the Report of the Independent Assessment Committee which was constituted under Article 8.01 of the Collective Agreement between the Brant Community Health System (BCHS) and the Ontario Nurses' Association (ONA).

This Report contains the Independent Assessment Committee's (IAC) findings and recommendations regarding the Professional Workload Complaint submitted by the Registered Nurses working in the Brant Community Health System Emergency Department (BCHS-ED).

The members of the Independent Assessment Committee recognize and appreciate the efforts taken by representatives of BCHS, the Ontario Nurses' Association (ONA), and the Registered Nurses to prepare and present information and responses to our questions prior to and during the three-day hearing, held on March 19, 21, and 22, 2024.

The process undertaken through an Independent Assessment Committee provides a unique opportunity for discussion and dialogue between all parties regarding the complex issues and conditions which underlie a Professional Workload Complaint. The Report includes a number of unanimously submitted recommendations which we hope will assist all parties to mutually agreeable resolutions with regards to nursing workload issues on BCHS-ED.

Respectfully Submitted,

Claire Mallette, RN PhD
Chairperson

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

Stephanie Pearsall, RN, MHS
Nominee for Brant Community Health System

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PART 1: INTRODUCTION

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PART 2: PRESENTATION OF THE PROFESSIONAL RESPONSIBILTY WORKLOAD COMPLAINT

This section presents the context of practice relating to the Registered Nurses' Professional Responsibility Workload Complaint on Brant Community Health System Emergency Department (BCHS-ED); and summarizes the relevant history leading to the referral of the Professional Responsibility Workload Complaint to the IAC.

PART 3: DISCUSSION, ANALYSIS AND RECOMMENDATIONS

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

PART 4: CONCLUSION AND SUMMARY OF RECOMMENDATIONS

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

PART 5: APPENDICES

Supporting data, including from the submissions and exhibits of both parties that were used to guide the writing of this report are incorporated into this section.

1.2 REFERRAL TO THE INDEPENDENT ASSESSMENT COMMITTEE (IAC)

On May 4, 2023 Sandy Paproski, an Ontario Nurses Association (ONA) Professional Practice Specialist submitted a letter (Appendix A) to Martin Ruaux, the Chief Nursing Executive (CNE) at BCHS outlining the professional responsibility and workload issues on BCHS-ED and advising that these concerns were being forwarded to an Independent Assessment Committee (IAC) for resolution (Appendix A).

In the Referral of Professional Practice and Workload Issues at BCHS-ED to an Independent Committee letter, ONA highlighted that since 2021, there have been over 185 Professional Responsibility Workload Report Forms (PRWRFs) being submitted where the RNs expressed concerns related to their current practice, patient care and the workload environment not allowing them to meet the College of Nurses of Ontario (CNO) Standards of Practice and Practice Guidelines, the Standards for Emergency Nursing Practice, Canadian Triage and Acuity Scale Guidelines; or the Employer's policies, procedures, mission, or vision. Practice issues identified were an inadequate baseline RN staffing to manage the volume and acuity of patients, and support safe timely triaging of patients; the lack of RN support for daily transfers to other hospitals; the lack of adequate equipment; adequate supports for education, training and mentorship. A lack of overall leadership support for staff and effective communication were also identified as issues.

1.3 JURISDICTION OF THE INDEPENDENT ASSESSMENT COMMITTEE

The IAC is convened under the authority of article 8.01 on Professional Responsibility in the Central Hospital Collective Agreement between ONA and BCHS as stated below:

ARTICLE 8 – PROFESSIONAL RESPONSIBILITY

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

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

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

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

(a) i) At the time the workload issue occurs, discuss the issue within the unit/program to develop strategies to meet patient care needs using current resources.

ii) If necessary, using established lines of communication as identified by the hospital, seek immediate assistance from an

individual(s) (who could be within the bargaining unit) who has responsibility for timely resolution of workload issues.

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

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

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

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

v) Every effort will be made to resolve workload issues at the unit level. A Union representative shall be involved in any resolution discussions at the unit level. The discussions and actions will be documented.

vi) Failing resolution at the unit level, submit the ONA/Hospital *Professional Responsibility Workload Report Form* to the Hospital-Association Committee within twenty (20) calendar days from the date of the manager's response or when they ought to have responded under (iv) above.

vii) The Chair of the Hospital-Association Committee shall convene a meeting of the Hospital-Association Committee within fifteen (15) calendar days of the filing of the *ONA/Hospital Professional Responsibility Workload Report Form*. The Committee shall hear and attempt to resolve the issue(s) to the satisfaction of both parties and report the outcome to the nurse(s) using the Workload/Professional Responsibility Review Tool to develop joint recommendations (Appendix 9).

viii) Any settlement arrived at under Article 8.01 (a) iii) v), or vi) shall be signed by the parties.

ix) Failing resolution of the issues through the development of joint recommendations within fifteen (15) calendar days of the meeting of the Hospital Association Committee the issue shall be forwarded to an Independent Assessment Committee.

x) Failing development of joint recommendation(s) and prior to the issue(s) being forwarded to the Independent Assessment Committee, the Union will forward a written report outlining the issue(s) and recommendations to the Chief Nursing Executive.

xi) For professionals regulated by the RHPA, other than nurses, the Union may forward a written report outlining the issue(s) and recommendations to the appropriate senior executive as designated by the Hospital.

(Article 8.01 (a), (x), (xiii) and (xiv) and 8.01 (b) applies to nurses only)

xii) The Independent Assessment Committee is composed of three (3) registered nurses; one chosen by the Ontario Nurses' Association, one chosen by the Hospital and one chosen from a panel of independent registered nurses who are well respected within the profession. The member of the Committee chosen from the panel of independent registered nurses shall act as Chair.

If one of the parties fails to appoint its nominee within a period of thirty (30) calendar days of giving notice to proceed to the Independent Assessment Committee, the process will proceed. This will not preclude either party from appointing their nominee prior to the commencement of the Independent Assessment Committee hearing.

A copy of the Procedural Guidelines contained in Appendix 8 shall be provided to all Chairpersons named in Appendix 2.

xiii) The Assessment Committee shall set a date to conduct a hearing into the issue(s) within fourteen (14) calendar days of its appointment and shall be empowered to investigate as is necessary and make what findings as are appropriate in the circumstances. The Assessment Committee shall render its decision, in writing, to the parties within forty-five (45) calendar days following completion of its hearing.

xiv) It is understood and agreed that representatives of the Ontario Nurses' Association, including the Labour Relations Officer(s), may attend meetings held between the Hospital and the Union under this provision.

xv) Any issue(s) lodged under this provision shall be on the form set out in Appendix 6. Alternately, the local parties may agree to an electronic version of the form and a process for signing.

xvi) The Chief Nursing Executive, relevant Clinical Leaders, Bargaining Unit President, and the Hospital-Association Committee, will jointly review the recommendations of the Independent Assessment Committee within thirty (30) calendar days of the release of the IAC recommendations, and develop an implementation plan for mutually agreed changes. Such meeting(s) will be booked prior to leaving the Independent Assessment Committee hearing.

(b) i) The list of Assessment Committee Chairs is attached as Appendix 2. During the term of this Agreement, the central parties shall meet as necessary to review and amend by agreement the list of chairs of Professional Responsibility Assessment Committees.

The parties agree that should a Chair be required; the Ontario Hospital Association and the Ontario Nurses' Association will be contacted. They will provide the name of the person to be utilized on the alphabetical listing of Chairs. The name to be provided will be the top name on the list of Chairs who has not been previously assigned.

Should the Chair who is scheduled to serve decline when requested, or it becomes obvious that they would not be suitable, the next person on the list will be approached to act as Chair.

ii) Each party will bear the cost of its own nominee and will share equally the fee of the Chair and whatever other expenses are incurred by the Assessment Committee in the performance of its responsibilities as set out herein.

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

Hospital Central Agreement – March 31, 2025

Article 8.01 (xiii) states, ‘The Assessment Committee shall render its decision, in writing to the parties within forty-five (45) calendar days following completion of its hearing’, which is May 6, 2024.

The IAC’s jurisdiction thus relates to whether registered nurses are being requested and/or required to assume more work than is consistent with the provision of proper patient care. Workload is influenced by both direct factors (e.g. nurse-patient ratio, patient acuity/complexity of care requirements, patient volume) and indirect factors (e.g. roles and responsibilities of other care providers, physical environment of practice, standards of practice, and systems of care). The

IAC is responsible for examining factors impacting workload, and for making recommendations to address workload issues. Concerns outside of workload are beyond the jurisdiction of the IAC.

In the matter of the Arbitration between Brant Community Health System and the Ontario Nurses Association (1986), both parties acknowledged that while according to the collective agreement the IAC's report is not binding upon the parties, *the report carries considerable weight and is accepted by the parties as a method of obtaining a final dispute resolution in these difficult areas.*

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

For the Ontario Nurses Association:
Cindy Gabrielli

For Brant Community Health System:
Stephanie Pearsall

Chairperson:
Claire Mallette

1.4 PROCEEDINGS OF THE INDEPENDENT ASSESSMENT COMMITTEE

1.4.1 PRE-HEARING

On May 4, 2023, BCHS received a letter from ONA stating that a Referral of Professional Practice and Workload Issues on BCHS-ED was made to an Independent Assessment Committee (Appendix A). On June 6, 2023 ONA confirmed the IAC Chair as Dr. Claire Mallette, identified Ms. Cindy Gabrielli as the IAC ONA Representative, and that Mr. David McCoy, Director Labour Relations at ONA had been notified (Appendix B). BCHS confirmed that Ms. Stephanie Pearsall would be the IAC Hospital Representative on July 10, 2023 (Appendix C). The IAC dates for the hearing were decided upon by email, with the dates of March 19, 21 & 22 being agreed upon by all parties for the IAC Hearing.

On January 26, the IAC members discussed the type of information required in the briefing documents. The identified areas that the IAC asked more information on, is as follows:

- Patient Information for the Emergency Department (ED) for the past three fiscal years April 1, 2021 to March 31, 2022, April 1, 2022 to March 31, 2023, and April 1, 2023 to date
- Unit Organization/Functioning
- Staffing Data for fiscal 2021-to 2022, 2022-2023, 2023 to date
- Budget and Performance Indicators for the past three fiscal years
- Quality of Care Performance Indicators
- Hospital Association Committee (HAC) Agendas and Minutes from 2021, 2022, 2023 and any other Agendas and Minutes of meetings regarding workload complaints in the ED
- ED Staff Meeting Minutes for 2021, 2022, 2023

See Appendix D for the detailed request for information

An email was sent to both ONA and BCHS parties on January 29, 2024 with an attached document outlining next steps and information needed in preparation for the IAC hearing (Appendix E). A request was made by the IAC to receive the documents on March 5, 2024 to provide the IAC adequate time to review the submissions.

On January 29, 2024, First Class Conferencing Facilitation was confirmed to coordinate the virtual technology during the IAC Hearing. Segan Permell, a web conference technician, was assigned to facilitate the technology for the IAC (Appendix F)

On February 5, Beth Morris, the Interim Chief Nursing Officer asked for clarification related to the data request for:

- Patient Information for the ED for the past three fiscal years April 1, 2021 to March 31, 2022, April 1, 2022 to March 31, 2023, and April 1, 2023 to date.

Ms. Morris asked if the IAC could confirm whether the IAC wanted the volumes and wait times for each day from April 2019 to December 2023, as this would be a large volume of data to compile. The IAC made the decision that data on the average volume/month and average volume by day of the week and the volumes by hours for the past 6 months (August 2023-January 30, 2024) be provided (Appendix G)

On March 5, 2024, both ONA and BCHS submitted their documents. ONA sent Supplementary Information related to more PRWRFs, ED RN Schedules, Mental Health Patients Flow Chart and Ambulance Offload Agreement on March 11, 2024. BCHS sent an addendum on March 12, 2024, where Ms. Beth Morris, Interim Chief Nursing Officer informed the IAC and ONA that a discrepancy in BCHS's submission was identified related to the nursing resources in the ED. In the table titled FY 23/24 Scheduled Staffing Hours (Main ED), instead of a total of 17 staff on days and 13 on nights, it should have instead read a total of 16 staff on days and 13 on nights. A mid-shift (flex) RN position from11:00-23:00 is posted and included in the budget for the upcoming fiscal year (Appendix H).

The virtual tour recording of the ED at BGH was done on February 15, 2024, and sent to First Class Conferencing Facilitation on March 12, 2024.

On March 13, 2024, the IAC reviewed the information from the submitted documents via Zoom and prepared for the IAC Hearing.

On March 14, both ONA and BCHS were sent the Final Agenda for the 3 days (Appendix I), and the Attendee Lists (Appendix J).

1.4.2 HEARING

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

Tuesday March 19, 2024	08:30-15:00
Thursday March 21, 2024	08:30-14:30
Friday March 22, 2024	08:30-13:15

Hearing Day One: Tuesday March 19, 2024

The Chair opened the Hearing at 8:30 and thanked everyone for being present and for their commitment to the IAC process over the Hearing dates. Introductions then occurred with the Chair Inviting the IAC members, ONA and BCHS attendees to introduce themselves.

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

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

The IAC Guidelines which were then reviewed are listed below:

1. Adhere to the agenda and timeframes for presentations.

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

3. Speak from your own perspective and experience.

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

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

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

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

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

The virtual video tour of BCHS-ED, coordinated by BCHS, was then viewed. The tour was led by one of the ED nurses who showed the viewers all the different Zones that make up the BCHS-ED. Following viewing the video, the IAC asked clarification questions related to the nursing care provided in each of the 5 ED Zones.

After a short break, Sandy Paproski, ONA Professional Practice Specialist, presented on behalf of ONA. ONA's presentation was based on their written pre-Hearing submission and began with giving an overview of the BCHS catchment area, and BCHS-ED including the current staffing and ONA's recommended staffing. ONA & BCHS's *Items in Agreement* was presented. The issues identified in the PRWRFs related to missed or delayed care, acuity/capacity, skill mix, non-nursing equipment, leadership and communication and morale/toxic environment were also discussed. Following the presentation, ONA responded to clarification questions from the IAC Panel and BCHS members.

After a break for lunch, the BCHS's presentation was shared by Beth Morris. The presentation provided an overview of BCHS including scope of services, the vision, mission and values; strategic plan; and accreditation results. Ms. Morris then gave an overview of the BCHS-ED that included patient information, ED performance indicators, budget, staffing, support, staff wellness, quality of care performance indicators and safety, and PRWRF Overview. After the presentation, the IAC and ONA representatives asked follow-up questions.

Prior to adjourning the meeting, the Chair reviewed the process for the next day. The Chair also requested both parties to share their presentations with the IAC and each other. The Hearing ended at approximately 3:00 pm. Following adjournment, the IAC met to review and synthesize the information provided, and to identify key issues requiring clarification and discussion on the remaining two days of the Hearing.

Hearing Day Two: Thursday March 21, 2024

Day 2 of the hearing occurred on Thursday, instead of Wednesday, to allow both parties to prepare for their response to the presentations and questions on Monday. The Chair opened the Hearing at 08:30 welcoming everyone back. The Chair then provided a review of the previous day and an overview of the agenda for Day Two. All BCHS participants were the same as the

previous day except Grant Nuttal, BCHS's legal representative who did not attend Day 2 and 3 of the Hearing, The ONA attendees remained the same over the 3 days.

Ms. Morris from BCHS presented information first, in response to ONA's submission on Day 1. The presentation focused on giving more information and clarity on the See & Treat Area, time to physician initial assessment (PIA), transfers to other acute areas, unfilled shifts, purchased services focusing on agency nurses, code blue carts, patients with mental health complaints, rapid transfusion, and the PRWRF process, Following the BCHS's response, discussion ensued with questions being asked by IAC members and ONA.

After a short break, Ms. Paproski from ONA responded to BCHS's submission. The presentation included data differences between the numbers of PRWFs completed in the ED. Ms. Paproski did acknowledge that the data collection times differ in that BCHS reports PRWFs by fiscal year from April1 to March 31 of the next year, while ONA uses the calendar year of January to December. The ED Surge Plan and overcapacity protocols, National Emergency Nurses Association standards were then presented. Data was provided and commented on in areas such as the ED Length of Stay, PIA times, EMS Volumes and Offload times, transfers to other acute care facilities and leadership support and morale. Following a lunch break, questions were asked by the IAC and BCHS representatives. The Chair reviewed Day Three's agenda at the end of the day, and the meeting was adjourned at 14:30.

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

Hearing Day Three: Friday March 22, 2024

The Chair opened the final day of the Hearing at 08:30 welcoming the attendees and reviewing the day's proceedings. The participants remained the same as Day 2. The agenda was reviewed, and then the IAC panel members asked further questions to understand a range of issues such as the See & Treat area; the Greeter and Triage process; the EMS process of notifying the ED of a patient being brought to the ED; if Nurse Practitioners (NP) have ever been considered to be part of the ED team; and clarification of what ONA meant by the need for team building. The IAC listened to responses from both parties.

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

Ms. Paproski and Morris then provided closing remarks on behalf of ONA and BCHS respectively.

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

The Chair closed the Hearing at 13:15.

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

1.4.3 POST-HEARING

The IAC panel members met immediately after the Hearing's finished, and then via Zoom in preparing the Final Report on April 6, April, 14, April 20, April 28, May 5 and through emails. All members of the IAC contributed to the final version of the report. The Final report was submitted to ONA and BCHS on May 5, 2024.

PART 2: PRESENTATION OF THE PROFESSIONAL RESPONSIBILITY and WORKLOAD COMPLAINT

2.1 INFORMATION ON BRANT COMMUNITY HEALTH SYSTEM (BCHS)

The Brant Community Health System ("BCHS") is made up of two sites, Brantford General Hospital (regional acute care hospital) and The Willet (urgent care and ambulatory services), located in Paris. The Hospital is located in the Grand River Valley, on lands that have been the traditional territories of the Anishinaabe, Haudenosaunee, Huron-Wendat and Neutral nations. BCHS serves over 150,000 residents in Brantford, the County of Brant, Six Nations of the Grand River, Mississauga's of the Credit First Nation and surrounding communities. BCHS boasts stable, state-of-the-art programs and services for a population which has grown by 10% over the last decade (BCHS Submission, 2024).

BCHS is a full service community hospital system and is also the regional centre for Pediatrics, Mental Health, Obstetrics, Gynaecology, Critical Care, Surgical Services, Ambulatory Care and Emergency Medicine. There are 330 funded beds: 185 medical/surgical; 8 pediatric; 18 mental health; 80 rehabilitation/post-acute; 15 obstetrical, and 24 critical care (increase as of March 11,

2024). The BCHS-ED is an acute care facility which has 299 beds, and the Willett site hosts an Urgent Care as well as an inpatient, post-acute "transitional unit" consisting of 31 funded beds for a total of 330 funded beds.

BCHS is also an integral partner of the Brantford Brant Norfolk Ontario Health Team. By working cooperatively with other healthcare providers, BCHS can maximize its efficiencies, reduce costs and ensure that the people of the area are educated about their own health and always have access, within the region, to the health services they require.

Across the entire system, BCHS employs 2700 staff, 170 physicians and 383 volunteers who are committed to partnering with patients and families to provide high quality, compassionate care. BCHS is an affiliated teaching site of the McMaster University Michael G. DeGroote School of Medicine. In November of 2023, BCHS was awarded the "Accredited with Exemplary Standing" status by Accreditation Canada following an assessment of its policies and procedures. BCHS achieved a 99.5% compliance with all accredited standards, further demonstrating the organization's commitment to providing safe, high-quality care.
(BCHS Submission, 2024).

The Brantford and Brant County population data shows a young community with a median age of 44, and with 72% of the population under 50 years of age, while 29% are below the age of 25. In the BCHS, the median age in Brant's seniors is 65 years and older, and has been the fastest growing population group for the last 15 years currently accounting for 19.3% of the population. There are more seniors in the county (20.4%) compared to Brantford proper (18.9%) (ONA Submission, 2024).

Brant County and the City of Brantford have a number of marginalized communities within its region. This includes those marginalized by factors such as race, culture, language, wealth, immigration status and sexual orientation. More specifically, the Indigenous people comprise 4.8% of Brant's total population, whereas the average proportion of Indigenous people to the Ontario population is 2.9%. There is also a significant proportion of immigrants, which make up 29.8% of Brant's total population (ONA, 2024).

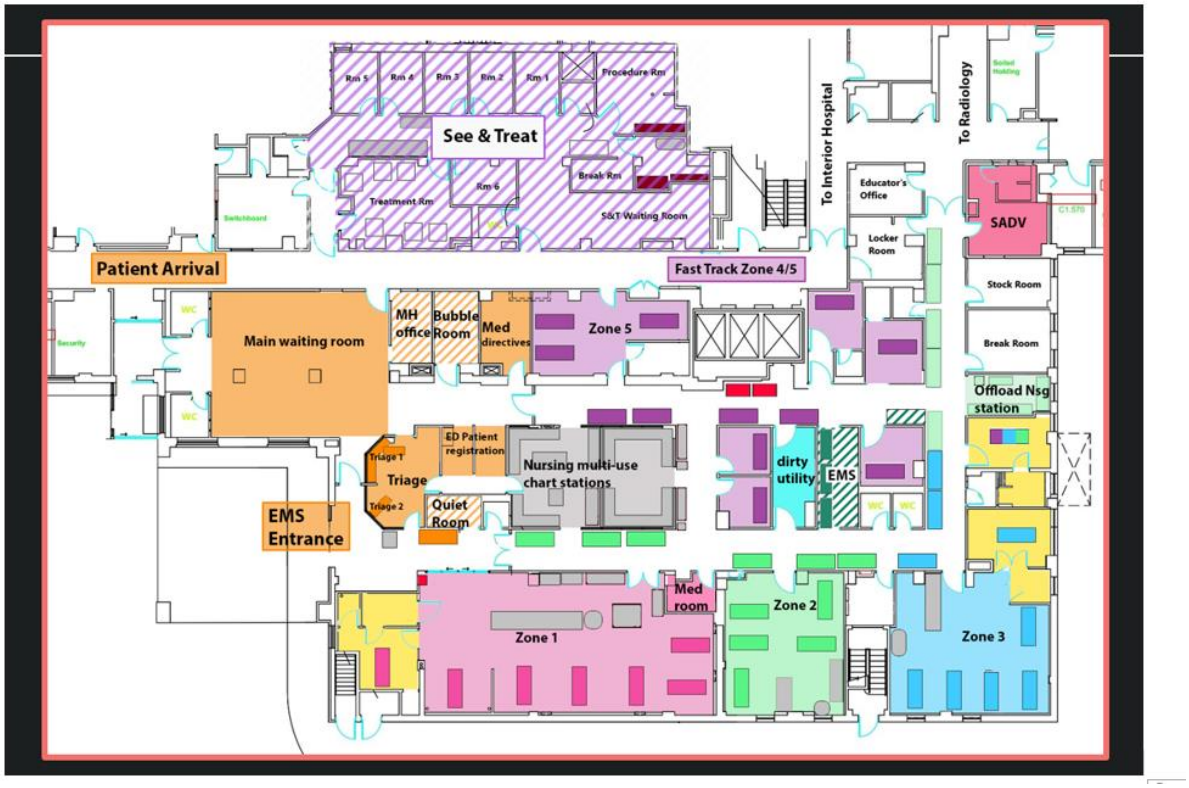
2.2 BRANT COMMUNITY HEALTH SYSTEM-EMERGENCY DEPARTMENT (BCHS-ED)

The ED is a dynamic care environment in which the team is required to make accurate and timely assessments for patients presenting with a broad spectrum of symptoms and injuries. The nature of ED nursing is unpredictable and episodic. The ED operates 24/7 and managed over 54,606 visits in the year 2023, averaging 149 patients per day.

2.2.1 PHYSICAL LAYOUT

BCHS-ED has a normal capacity of 35 care spaces distributed over primarily 5 zones and other spaces. The BCHS-ED Map is seen below in Figure 1. The ED can surge to 45 beds in the event of overcrowding.

Figure 1: BCHS-ED Zones Map



Zone 1: Critical patients

Zone 1 has 7 monitored beds, including one negative-pressure, for the most acute patients that includes patients with trauma, vital signs absent, unstable cardiac symptoms, decreased level of consciousness, high risk mental health crisis, requiring stroke protocols etc., who may require or need immediate resuscitative care

Zone 2: Less acute and more stable

Zone 2 has five curtained beds and 5 hallway beds. Patients that are in Zone 2 are less acute and do not require constant cardiac monitoring. Patients in this zone, present with general weaknesses, pain crisis, surgical patients with predictable outcomes such as fractures and obstructions, and stable mental health complaints.

Zone 3: Constant Cardiac Monitoring
In Zone 3 there are 6 monitored beds and 2 hallway beds. The patients triaged to this zone require constant cardiac monitoring. There is also a negative pressure room that can provide bi-level positive airway pressure (BiPAP) or provide high-flow oxygen to patients who also require telemetry. The room can also be used if an additional resuscitation is needed, when there is an active code running in Zone 1.

Zone 4 & 5: Fast Track
There are 3 beds and another 5 beds in individual fast track rooms, and 2 hallway beds. Patients in these Zones require quick assessment and treatments of non-urgent patients. These zones cover multiple different rooms with stretcher spaces and where patients wait for an in-patient bed. Fast track rooms are used specifically for admissions and holdovers.

Back Hall: Offload
The Back hall is the offload area that contains 5 beds used to decant patients on ambulance offload, and who do not require escalated care or monitoring.

Mental Health Assessment Spaces:
There are 2 assessment spaces used to conduct mental health assessments by the Emergency Room Physician or Emergency Room Mental Health team. These 2 spaces are away from general waiting room and are used as a quiet zone for acute mental health patients. One room is monitored and is known as the ‘Bubble Room’ while the other is a Quiet Room, with no monitoring. Once the patient is assessed and assigned to the appropriate Zone, the patient is moved to the appropriate space.

See & Treat Area:
In this area there is 1 treatment room, 1 procedure room, and 6 individual assessment rooms. This area is open from 08:00-24:00, 7 days/week and sees patients who walk-in and require less urgent care from the ED. The See & Treat Area provides care to approximately 45% of all the ED volumes. When the patient walks into the ED, they are triaged by the Triage Nurse. If the patient meets the See & Treat criteria, and the area is open, the patient will be directed to go across the hall to this area’s separate waiting room.

Sexual Assault Room:
The Sexual Assault Room is located in the back hallway.

2.2.2 STAFFING AND THE MODEL OF CARE ON BCHS-ED

BCHS’s nursing model of care includes Registered Nurses (RNs) and Registered Practical Nurses (RPNs). Together they work with allied health professionals, support staff, and other hospital staff. All RNs and RPNs in the department practice in a team approach and to their full

scope of practice in all areas of the department. In the main ED, the ratio of budgeted RN to RPN hours is approximately 3.65:1 and in the See & Treat area, budgeted RN and RPN hours are almost equal at approximately 0.97:1. The overall ratio for the whole department is approximately 3.07:1 (BCHS Submission, 2024).

The ED has a Charge Nurse 24/7, who is in charge of flow and support in the department and does not have a patient assignment. The Triage Nurses provide professional and nursing assessments, prioritizes treatments according to the urgency of need, and initiates medical care to patients arriving in the ED. The RN and RPN baseline staffing scheduling in the main acute ED is 10 RNs and 3 RPNs on 12-hour day shift (0700 to1900 hours), 9 RNs and 2 RPNs on 12-hour night shift (1900 to 0700 hours). There is 1 mid-shift RN at 1100 to 2300 hours newly added to the schedule in February 2024, however, this role has been difficult to fill. The nursing assignments for days and nights in each area is outlined in Table 1, however, the staff are reallocated depending on the needs in each area.

Table 1: BCHS-ED Daily Staffing

Position	Day Shift 0700-1900	Mid-Shift	Night Shift 1900-0700
Charge Nurse	1 RN		1 RN
Triage	2 RN		2 RN
Zone 1	2 RN		2 RN
Zone 2 Offload	1 RN 1 RPN 1 RPN		1RN 1 RPN 1 RPN
Zone 3	2 RN		2 RN
Zones 4/5	1 RN 1 RPN		1 RN 1 RPN
Flex RN	1 RN	New February 2024 1 RN 1100-2300	
Totals			
Main ED	10 RN 3 RPNs	1 RN 11-2300	9 RN 3 RPNs
See and Treat	08-1600 1 RN 1 RPN	16-2400 1 RN 1 RPN	Closed

A team based approach with the nurses and non-nursing supports is used to deliver care to the ED patients. The Non-Nursing Support Roles are outlined in Table 2.

Table 2: BCHS-ED Non-Support Roles

Role	Area		Coverage		Role
Ward Clerk	Main ED	2	07:00-19:00	7 Days/Week	Responsible for managing patient records, entering orders, coordination tests, transportation, completing receptionist duties, ordering supplies, and coordinating the network of information passing between healthcare personnel.
	Main ED	1	19:00-07:00	7 Days/Week	
	Surge Unit Clerk	1	19:00-23:00	3 Days/Week (Sunday, Monday, & Thursday)	
	See & Treat	1	11:00-19:00	7 Days/Week	
Personal Support Worker	ED	1	24 hours	7 Days/Week	Provides personal care to patients in the ED and can provide additional care as delegated by a regulated healthcare professional.
ED RN Navigator	ED	1	07:00-19:00	7 Days/Week	A RN whose focus is on admission avoidance, and who regularly works with Home and Community Care, as well as external partners.
Intensive Case Manager, Alzheimer's Society	ED	1	08:00-16:00	Monday to Friday	Working closely with the ED staff, the Intensive Case Manager from the Alzheimer's Society works in the Emergency Department with the goal of admission avoidance to help secure the support to enable patients to stay in their homes, and support caregivers with any identified needs.
Home & Community Care Support Services	ED	1	07:00-19:00	7 Days/Week	Works closely with the ED RN Navigator and the Intensive Case Manager from the Alzheimer's Society and ED Staff to avoid admissions and help secure services and equipment for discharge.
Physician Assistant	See & Treat	1	08:00-18:00	7 Days/Week	Provides direct patient care and supports the main ED department for patients requiring Stroke Protocols
		1	16:00-24:00	7 Days/Week	
Physicians	ED	8	24 hours	7 Days/Week	Provides medical care in the ED. There were formerly 10 shifts/day. Other physicians also provide consultation services for various specialties
Physiotherapists	ED	1	07:00-19:00	7 Days/Week On call on weekends for urgent assistance	Assesses patients for safety at discharge, determines treatments to help to prevent deconditioning for patients who are admitted and holding in the ED
Physiotherapy Assistant/Occupational Therapy Assistant	ED	1	08:00-16:00	Monday to Friday	Assists the physiotherapist to carry out treatments related to mobility, assessments of activities of daily living etc.

Security	Triage	1	24 hours	7 Days/Week	Contracted services and work in partnership with the ED staff. Trained in use-of-force training
	Circulates through ED	1			
ED Clinical Educator	ED	1	08:00-16:00	Monday to Friday	Provides education, practice support, training and informal leadership to the nursing staff
Nurse Practitioners	Rapid Addictions Support Team	1	08:00-16:00	Monday to Friday	Provides same-day, on site access to evidence based addictions care for individuals presenting to the ED experiencing opioid withdrawal or requesting help with their opioid use concerns. Works closely with community services
	Led Outreach Team	1	08:00-16:00	Monday to Friday	Provides remote and on-site support to LTC homes through assessing patients to avert preventable ED transfers and hospital admission, reduce hospital length of stay an facilitate sustainable discharges.
Pharmacist	ED	1	08:30-16:30	5 days/week	Provides support in the ED in relation to consultations for medication, medication reconciliation, obtaining best possible medication history for patients.
		1	On call 24 hours	7 Days/Week	
Pharmacy Tech	ED	1	09:00-21:00	7 Days/Week	
Emergency Room Mental Health RN or Social Worker	ED	1	24 hours	7 Days/Week	Supports mental health patients who present to ED. Staffed by RNs & Social Workers from the Mental Health Inpatient Unit.
Sexual Assault & Domestic Violence RN	ED	1	07:00-19:00	7 Days/Week	Provides comprehensive care to sexual assault victims. Can conduct forensic exams and provide support to patients connecting to community resources.
Environmental Service Aide	ED	1	24 hours	7 Days/Week	Provides support related to patient transport and portering, cleaning, seeking supplies.
Medical Lab Assistant & Phlebotomist	ED	1	13:00-21:00	7 Days/Week	Obtains bloodwork and complete ECGs when delegated from the nursing team. Hours of availability reflect the busiest times for patient intake volume
		1	24 Hours on Call	7 Days/Week	

There are also other leadership positions that are available to ED staff in meeting patient care needs. They are as follows:

- Senior Clinical Operations Manager
  - Available 7 days per week, 19:00-07:00 and weekends 07:00-19:00
  - Dietician
    - Available by pager 08:00-16:00/7 days per week.
  - Respiratory Therapist
    - Available by pager 2 4hours /7 days per week
  - Social worker
    - Available by pager 08:00-16:00/7 days per week (dedicated SW support will be added to the FY 24-25 budget).
  - Speech Language Pathologist
    - Available by pager Monday to Friday, 08:00-17:00
  - Clinical Extern Nursing students
    - Available 24 hours /7 days per week, funded by Health Human Resource Funding
  - Clinical Scholar
    - Available 12 hrs/ 7 days 07:00-19:00, continental days, funded by Health Human Resource Funding

2.2.3 BCHS ED PATIENT INFORMATION

I. **Volume**

From 2019-20 to 2022-23 (the last year with full data), the ED saw a decrease in visits of approximately 8%. For the fiscal year 2022-23, 53,014 patients were seen in the ED with ONA data indicating 54, 606, and BCHS projects that the ED will see approximately 50,013 patients by the end of March 2024. As shown in the Table 3, the BCHS-ED had a reduction in visits during the COVID-19 pandemic, with the ED visits still not returning to pre-pandemic levels (BCHS Submission, 2024).

On an annual basis, the ED visits remain consistent, with the busiest hours being from approximately 10:00-17:00, and the most visits occurring between the hours of 10:00-16:00. The data indicates that the highest number of visits, is at 11:00 am. A slight increase in visits also occurs at 20:00. The number of visits then decline from 22:00-08:00. Figure 2 shows the total number of triage visits by time of day for both the ED and See & Treat combined.

Figure 2: Annual ED Visits

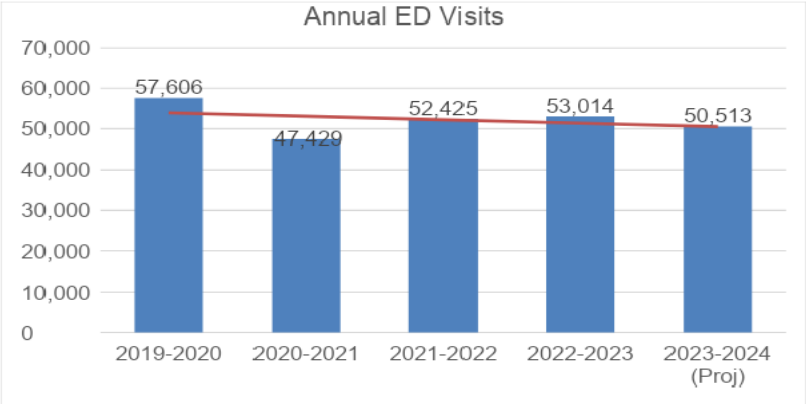


Figure 3 represents the total number of triage visits by time of day for both the ED and See & Treat combined. The time from greet to triage has increased since 2019-20 from 11 minutes to 20.7 minutes in 2023-24.

Figure 3: Triage Visits by Time of Day for ED & See & Treat Combined

ED & See/Treat					
Visits	Fiscal Year				
Triage Hour	2019-2020	2020-2021	2021-2022	2022-2023	2023-2024 Dec
0	1,415	1,132	1,264	1,355	959
1	1,138	886	999	1,033	778
2	916	731	867	932	661
3	855	616	763	786	612
4	812	622	689	712	570
5	782	648	667	764	601
6	928	707	789	886	685
7	1,512	1,264	1,429	1,422	1,022
8	2,247	1,838	2,183	2,153	1,573
9	2,966	2,433	2,753	2,743	1,891
10	3,663	3,143	3,449	3,308	2,288
11	3,999	3,403	3,722	3,701	2,635
12	3,704	3,033	3,299	3,467	2,494
13	3,475	3,035	3,270	3,152	2,321
14	3,410	3,047	3,192	3,224	2,182
15	3,520	2,912	3,278	3,085	2,337
16	3,271	2,725	3,051	2,886	2,152
17	3,059	2,459	2,664	2,591	1,903
18	3,061	2,681	2,836	2,842	1,926
19	3,264	2,497	2,713	2,721	1,952
20	2,965	2,423	2,704	2,925	2,166
21	2,642	2,056	2,342	2,578	1,844
22	2,139	1,674	1,939	2,019	1,498
23	1,863	1,464	1,563	1,729	1,241
Grand Total	57,606	47,429	52,425	53,014	38,291

Charge Nurse 24/7
8x RNs 1900-0700
9x RNs 0700-1900
8x RNs 15-07
3x RPN 24/7
1x UC 1900-0700
2x UCs 0700-1900
1x UC 1907
1 PSW 24/7
2 Security 24/7
ESA 24/7
Care Coordinator 07-19 7 days
Physiotherapist 07-19 M-F
1 Navigator RN 07-19 7 days
Clinical Edu 0800-1600 M-F
2x Manager 0800-1600 M-F

RN Staffing Includes 2x Triage RN

Of note, is that 45% of the visits to the ED are treated in the See & Treat area of the ED once they are triaged. Figure 4 outlines the number of patients who would be treated at the ED, during

the hours of operation of See & Treat (08:00-24:00). With the volume of patients for See & Treat being removed, the data illustrates the number of patients being treated in the main ED while See & Treat is open.

Figure 4: ED Visits Only with See & Treat Volumes Removed

	ED ONLY (See & Treat Open, Volumes Removed)					
	Visits	Fiscal Year				
	Triage Hour	2019-2020	2020-2021	2021-2022	2022-2023	2023-2024 Dec
S&T Closed	0	1,415	1,132	1,264	1,355	959
	1	1,138	886	999	1,033	778
	2	916	731	867	932	661
	3	855	616	763	786	612
	4	812	622	689	712	570
	5	782	648	667	764	601
	6	928	707	789	886	685
	7	1,512	1,264	1,429	1,422	1,022
S&T Open	8	1,213	1,048	1,201	1,141	897
	9	1,602	1,387	1,514	1,454	1,078
	10	1,978	1,792	1,897	1,753	1,304
	11	2,159	1,940	2,047	1,962	1,502
	12	2,000	1,729	1,814	1,838	1,422
	13	1,877	1,730	1,799	1,671	1,323
	14	1,841	1,737	1,756	1,709	1,244
	15	1,901	1,660	1,803	1,635	1,332
	16	1,766	1,553	1,678	1,530	1,227
	17	1,652	1,402	1,465	1,373	1,085
	18	1,653	1,528	1,560	1,506	1,098
	19	1,763	1,423	1,492	1,442	1,113
	20	1,601	1,381	1,487	1,550	1,235
	21	1,427	1,172	1,288	1,366	1,051
	22	1,155	954	1,066	1,070	854
	23	1,006	834	860	916	707
	Grand Total	34,952	29,875	32,194	31,806	24,358

Charge Nurse 24/7 | 8x RNs 1900-0700 | 9x RNs 0700-1900 | 8x RNs 19-07 | 3x RPN 24/7 | 1x UC 1900-0700 | 2x UCs 0700-1900 | 1x UC 19-07 | 1 PSW 24/7 | 2 Security 24/7 | ESA 24/7 | Care Coordinator 07-19 7 days | Physiotherapist 07-19 M-F | 1 Navigator RN 07-19 7 days | Clinical Edu 0800-1600 M-F | 2x Manager 0800-1600 M-F

RN Staffing Includes 2x Triage RN

Within these visits, the proportion of ED visits by seniors over 60 years old has increased from 31% in 2019-20 to 34% in 2023-24. Over 30% of the visits have a mental health or substance use documented in their health record. BCHS has the highest number of ED visits for opioid related overdoses when compared to their comparative hospitals of Cambridge Memorial Hospital, Chatham-Kent Health Alliance, Guelph General Hospital, Joseph Brant Hospital and Woodstock General Hospital. BCHS also has the highest ED visits among the unhoused/transient populations.

II. Acuity

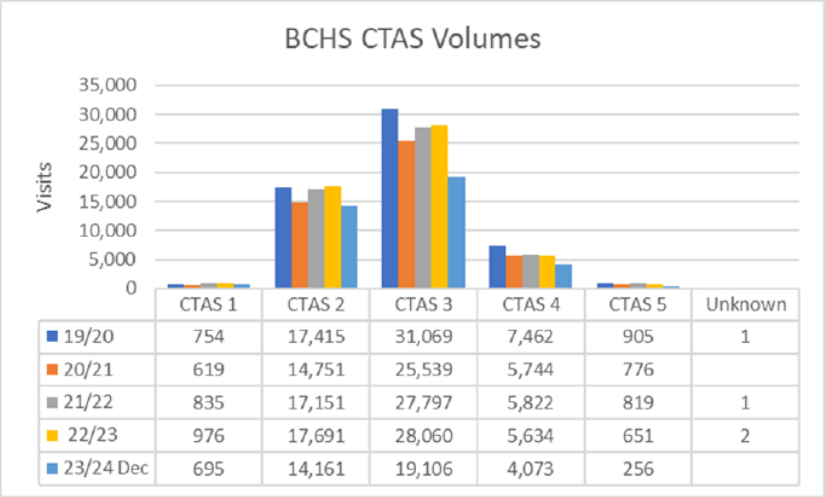
The CTAS Guidelines categorize patients' acuity into 5 levels and estimated times to be seen. They are outlined in Table 3.

TABLE 3: BCHS CTAS Levels and Re-Assessment Guidelines

CTAS levels	1	2	3	4	5
Urgencies	Resuscitation	Emergent	Urgent	Less Urgent	Non-Urgent
Time to physician	IMMEDIATE	≤ 15 minutes	≤ 30 minutes	≤ 1 hour	≤ 2 hours
Re-assessment	Continuous	Every 15 minutes (by Triage RN)	Every 30 Minutes	Every 60 Minutes	Every 120 Minutes

The BCHS-ED data demonstrates that most of the ED visits fall within CTAS 3 with 53% of visits. However, in the fiscal year 2023-24, CTAS 3 decreased to 50% of visits. The next overall highest visit group representing 33% of the visits, are CTAS 2. However, in the fiscal year 2023-24, CTAS 2 visits increased to 37%. Figure 5 compares BCHS CTAS Volumes from 2019-20 to 2023-December 2024.

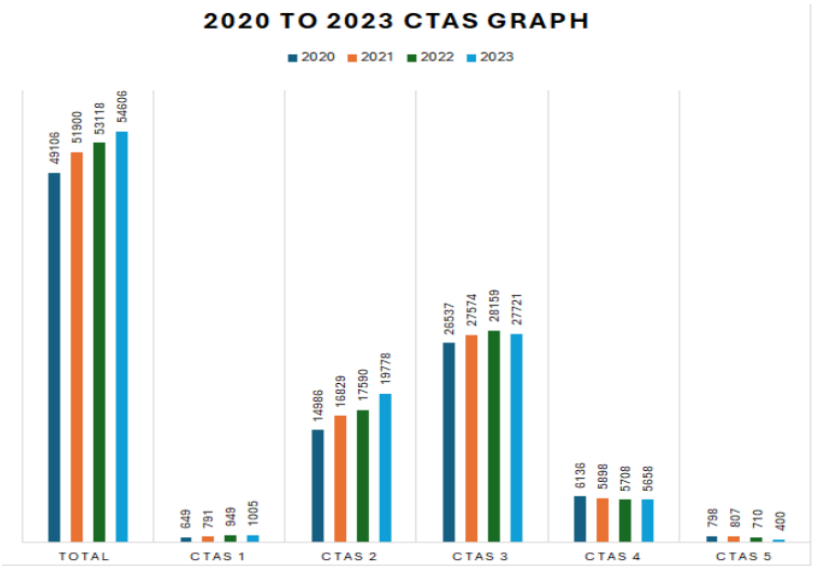
Figure 5: BCHS CTAS Volumes 2019-2020 to 2023-December 2024



	CTAS 1	CTAS 2	CTAS 3	CTAS 4	CTAS 5	Unknown
19/20	754	17,415	31,069	7,462	905	1
20/21	619	14,751	25,539	5,744	776	
21/22	835	17,151	27,797	5,822	819	1
22/23	976	17,691	28,060	5,634	651	2
23/24 Dec	695	14,161	19,106	4,073	256	

As ONA collects data by the annual year, not the fiscal year, their CTAS numbers differ for each group (See Figure 6). However both graphs indicate an increase in CTAS 3 and CTAS 2 patients.

Figure 6: ONA 2020 to 2023 CTAS Graph



The BCHS data also indicates that CTAS 1 patients tend to visit the ED on weekends, and for CTAS 2, 3, and 4, most visits occur earlier in the week on Mondays and Tuesdays. Year over Year CTAS 5 visits, does not show a clear trend.

It has also been demonstrated that historically CTAS 1 visits occurred later in the evenings after 18:00 hours, however in the fiscal year 2023-24, they shifted to mid-day. CTAS 2, 3, and 4 visits usually occur between the hours of 10:0-16:00, while a higher proportion of CTAS 5 visits occur between the hours of 09:00-11:00 hours.

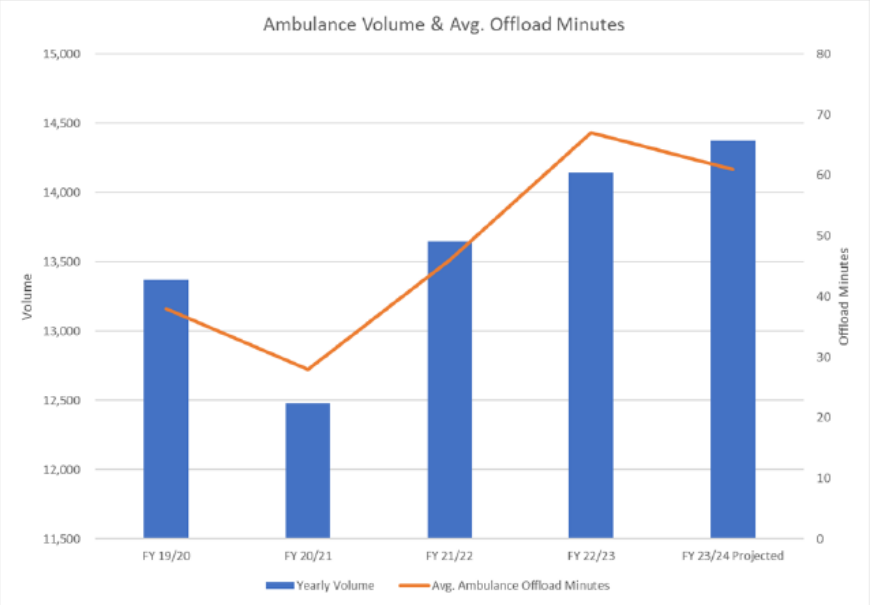
The rate of admissions also increased from 14.5% to a high of 15.9% in the fiscal year 2023-24. As the acuity of patients increased, the higher admissions followed suit.

To address the changing population, on March 11, 2024 BCHS opened an additional 8 critical care beds, and it is expected that this additional critical care capacity will enable CTAS 1 patients to be transferred to the CCU more quickly from the ED.

III. Ambulance Volumes

Using fiscal year BCHS data, ambulance volumes have increased from 13,369 in 2019-20 to 14,146 in 2022-23 which is an increase of 6%. BCHS is projecting to end 2023-24 at a slightly higher number than last year (approx. 14,373). The increase in the number of ambulance arrivals has resulted in higher ambulance offload times, whereby patients are waiting an additional 23 minutes this year compared to 2019-20. Figure 7 depicts the ambulance volumes and average offload minutes.

Figure 7: Ambulance Volumes & Average Offload Minutes



The acuity of patients arriving by ambulance has decreased from 51% CTAS 3 in 2019-20 to 44% CTAS 3 this year. There is also an increase in CTAS 2 patients from a low of 40% in 2019-20 to 50% in 2023-24, resulting in acuity slightly shifting from CTAS 3 to CTAS 2.

IV. Transfers to Other Acute Care Facilities

Some patients require transfer to other acute care facilities when in need of the services provided in a regional program. Examples of this are trauma, cardiac, or stroke patients. Most of these transfers to other acute care facilities occurs generally from 16:00-23:00. Each of these transfers requires accompaniment by an RN as per the EMS Guidelines. BCHS has been able to obtain base funding from EMS to have a mid-shift RN (11:00-23:00) added to the budget in 2024-25, to support these transfers. When there is no transfer taking place, this nurse will work as a flex nurse in the ED. The BCHS data indicates that the number of transfers have been decreasing over the past few years (See Figure 8) from 515 in 2019-20 to 339 in 2023-24 (Dec) or 1.24/day.

Figure 8: Transfers to Other Acute Care Facilities

Transfer to Acute Care Facility Directly from Ambulatory Care	FY 19/20	FY 20/21	FY 21/22	FY 22/23	FY 23/24 Dec
Number of Transfers	515	499	501	410	339
Rate of Transfers out of all Discharge Dispositions	0.9%	1.1%	1.0%	0.8%	0.9%
Rate of Transfers per Day	1.41	1.37	1.37	1.12	1.24

V. Admitted Patients (Admit, No Beds, or ANB)

The average daily number of Admitted Patients (ANB) in the department has remained steady at 22, year over year. The average length of stay for ANB in the ED has remained steady at approximately 13 hours. Data shows that the average number of newly admitted patients to ANB generally peaks from 15:00 to 18:00 hours and then again slightly higher between 21:00 to 24:00 hours with 4.5 patients admitted within that 3-hour span. The hourly occupancy for ANBs on average has decreased from 14.8 patients/hour in 2019-20 to 13.4 in 2023-24.

BCHS also has several admission avoidance strategies such as the Integrated Dementia Resource Team (Dream Team) with an ED Navigator, and Alzheimer's Society and Home Community Care team members who work to avoid admissions. In 2023-24 Quarter 3, 89 admissions were avoided.

The Nurse-Led Outreach Team (NLOT) Nurse Practitioner focuses on developing capacity in Long Term Care to help avoid admissions to the hospital. The partnership between St. Leonard's Society, City of Brantford, Brantford EMS, and Brantford Brant Ontario Health Team (BBOHT) meets on a regular bases to discuss trends/opportunities related to patients presenting with opioid use, unhoused etc. There is also a Rapid Addictions Support Team that includes the St. Leonard's Society Addictions Case Manager and a Nurse Practitioner, a Sexual Assault and Domestic Violence Team, and Mental Health Supports through the Emergency Room Mental Health RN or Social Worker 24 hours/7 days per week that helps support all mental health

complaints from subacute to mental health crisis or psychosis and work with vulnerable patient populations.

VI. Overcapacity

Emergency Department overcrowding is often due in part to the back-up of admitted patients (ANB) waiting to transfer to an appropriate inpatient bed, mainly related to periods of increased hospital occupancy. Additionally, the ED can have at any time unpredictable surges in acuity or a high volume of patients seeking emergency care. To address this in the ED, there is both an external organizational capacity strategy as well as an internal strategy. The BCHS Bed Alert Protocol (ED Overcapacity Protocol) is an organizational surge response that is activated when there is a specific volume of admitted patients in the ED (Appendix K). The protocol outlines the individual roles and responsibilities across the organization to support an urgent response when the ED triggers are met, and requires a coordinated response across the organization. The ED triggers include 15 ANB or 5 admitted patients which require telemetry monitoring. The Bed Alert is resolved once the ED reaches a state of 10 or less admitted patients; or less than 3 admitted patients requiring telemetry.

2.3 PROFESSIONAL RESPONSIBILITY WORKLOAD (PRW) COMPLAINT PROCESS & MEETINGS BETWEEN THE ASSOCIATION AND HOSPITAL PRIOR TO THE IAC

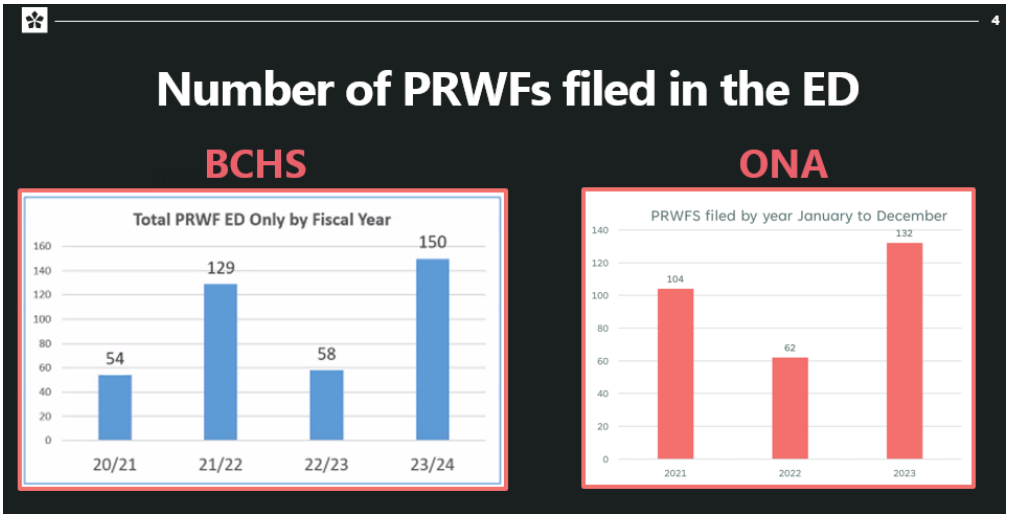
Article 8:01 of the ONA Collective Agreement (2023) provides a process for both the nurses of the bargaining unit and the administration of the hospital to address workload issues. The Professional Responsibility Workload Report Form (PRWRF) is a documentation tool to identify and report workload and practice issues, and to demonstrate ongoing trends and barriers to the provision of safe, competent, and ethical care and any contributing workplace issues. The PRW process was developed to enable collaboration between the nurses and the employer through the difficult and often stressful process of raising and resolving issues related to professional practice, patient acuity, fluctuating workloads and fluctuating staffing, and resolving the concerns in a timely and effective manner.

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

Since 2020-21, there have been 311 Professional Responsibility Workload Report Forms (See Figure 9). As ONA collects data by the annual year of January to December and BCHS collects data by the fiscal year of April 1 to March 31 of the following year, the numbers differ. There

were also an additional 10 being submitted with the ONA Supplemental Information for a total of 321 PRWRFs.

Figure 9: Number of PRWRFS filed in the ED 2020-21 to 2021-23



In the PRWRFs, the RNs expressed concerns related to their current practice, patient care and the workload environment not allowing them to meet the College of Nurses of Ontario (CNO) Standards of Practice and Practice Guidelines, the Standards for Emergency Nursing Practice, Canadian Triage and Acuity Scale Guidelines; or the Employer's policies, procedures, mission, or vision. Practice issues identified were an inadequate baseline RN staffing to manage the volume and acuity of patients, and support safe timely triaging of patients; the lack of RN support for daily transfers to other hospitals; the lack of adequate equipment; adequate supports for education, training and mentorship. A lack of overall leadership support for staff and effective communication were also identified as issues.

Strategies to Mitigate Workload

A total of 10 meetings with BCHS leadership and the ED took place over more than 36 months. Some actions to achieve resolutions of the RNs workload concerns have been agreed to and implemented as seen in the *Items in Agreement* (Appendix L) signed by both parties in January 2024. The *Items in Agreement* includes 32 items on ways to improve staffing, support of nurses and safety. Examples of these are that the Charge Nurse does not have a direct patient assignment 24 hours/7 days per week; 2 RNs at triage 24 hours/7 days per week; a transfer nurse; improved RN orientation and mentorship, a RN triage course, ACLS and PALS courses that time and course costs are paid by the employer; a security officer 24 hours/7 days per week to stay at triage and another security officer to round hourly throughout the ED; all staff have Code White alarm badges; all work zones have been assessed for escape routes; and an overcapacity of bed alert protocol.

PART 3: DISCUSSION, ANALYSIS AND RECOMMENDATIONS

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

1) **STAFFING**
   - 1.1 Flex Nurse
   - 1.2 Triage Nurse
   - 1.3 Transfer Nurse
   - 1.4 Scheduling: Novice to Expert
   - 1.5 Nurse Practitioner
   - 1.6 Physician Assistant

2) SKILL MIX/NOVICE STAFFING AND EDUCATION
   - 2.1 Recruitment & Retention
   - 2.2 Skill Mix

3) PROCESSES
   - 3.1 See & Treat
   - 3.2 Rapid Infuser
   - 3.3 ED Response to Code Blue
   - 3.4 PRWRFs

4) **ENVIRONMENT**
   - 4.1 Mental Health Room
   - 4.2 Safety
   - 4.3 Triage Area
     - 4.3.1 Privacy
     - 4.3.2 EMS Patch Phone
   - 4.4 Non-Nursing Roles/Equipment
     - 4.4.1 Ward Clerk
     - 4.4.2 Environmental Service Aide
     - 4.4.3 Equipment

5) LEADERSHIP
   - 5.1 Point of Care
   - 5.2 Unit Level
   - 5.3 Clinical Managers
   - 5.4 Senior Leadership Team

6) HEALTHY WORK ENVIRONMENT

6.1 Communication
6.2 Well-Being
6.3 Morale

1.0 STAFFING

1.1 FLEX NURSE

The ED at BCHS is similar to most EDs, in presently facing staffing challenges. Patients arrive unscheduled at all hours with unpredictable needs and acuity levels. The ED staff must assess, prioritize, and treat any condition from minor illness to traumatic life threatening events which places pressure on the health providers. Patient's conditions can change rapidly, which was evident in many PRWRF's outlined by the ED nurses and during the IAC. The Emergency Nursing Association of Ontario (ENAO) describes "an emergency nurse as a professional who requires knowledge of scientific principles, basic to health maintenance, treatment of illness, dynamics of interpersonal relationships and human behavior "(ENAO, 2016). The emergency environment is also unique in the volumes of patients arriving with a broad scope of acuity variety of health problems, dynamic nature of patient activity and the unscheduled and unpredictable arrival of patients (ENAO, 2016).

Acuity in the ED at BCHS has increased over the past 4 years. Information gathered from the Canadian Institute for Health Information (CIHI) on Canada's health system, provides information and the health of Canadians. CIHI maintains data bases to provide stakeholders with insight on visit volumes, patient demographic, clinical and service specific data related to emergency departments, day surgery, outpatient and community based clinics (CIHI, n.d.). Based on information ONA obtained from CIHI from January 2020-December 2023, the volume of patients arriving in the BCHS-ED increased by 5500 with 54,606 visits in 2023 (ONA Submission, 2024). This is an average of 149 patients per day. (ONA Submission, 2024). It is important to note the data differs in the volumes indicated by ONA and BCHS, as ONA uses the calendar year per the CIHI data, while the hospital uses the fiscal year of April 1 to March 31 of the next year for data collection.

The BCHS-ED fiscal year data of patient volumes from 2020-23, indicates there were 53,014 patient visits in 2022-23 (BCHS Submission, 2024). BCHS projects for 2023-24, there will be a decrease of visits to 50,013 (BCHS Submission, 2024). Regardless of the two different sets of data, both indicate BCHS-ED remains a high-volume ED.

There has been a shift in the acuity at BCHS-ED from 2020 to 2023. Based on CIHI data gathered by ONA, CTAS 1, defined as requiring emergent care and severely ill, had an increase

of 356 patient visits within this timeframe. CTAS 2, defined as requiring emergent care and rapid medical assessment, has increased by 4794 patient visits, while CTAS 3 defined as urgent non-life threatening, had an increase of 1184 patient visits. CTAS 4 defined as semi-urgent non-life threatening, had a decline of 478 patient visits, and CTAS 5 non-urgent also declined by 398 patient visits (See Figure 10).

Although the volumes used by the hospital and ONA differ, both parties agree there has been an increase in the acuity at BCHS-ED. Using BCHS-ED data from 2020 to 2024, over the past 3 years, CTAS 3 dropped from 53% to 50%. CTAS 2 normally has approximately 33% of visits, however in the 2023-24 fiscal year, CTAS 2 visits increased to 37%. CTAS 4 has remained at 11% since 2021-22 to 2023-24, and CTAS 5 decreased from 2% in the years 2019-20 to 2021-22, to 1% in 2022-2023 to 2023-2023. CTAS 1 visits remain stable over the past 3 years with a 2% increase in visits (See Figure 11).

Figure 10: ONA's CTAS Data 2020-2023

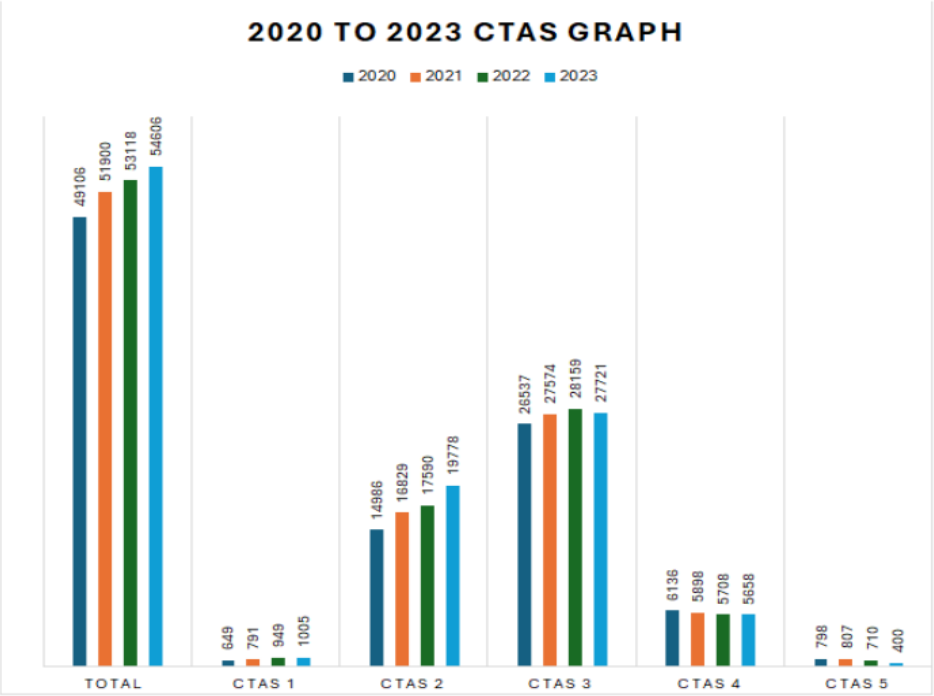


Figure 11: BCHS-ED CTAS Volumes 2019-20 to 2023-December 2024

	CTAS Level																								
	1 - Resuscitation					2 - Emergent					3 - Urgent					4 - Less-Urgent (Semi-Urgent)					5 - Non-Urgent				
Facility	19/20	20/21	21/22	22/23	23/24	19/20	20/21	21/22	22/23	23/24	19/20	20/21	21/22	22/23	23/24	19/20	20/21	21/22	22/23	23/24	19/20	20/21	21/22	22/23	23/24
BRANT COMMUNITY HEALTHCARE	1%	1%	2%	2%	2%	30%	31%	33%	33%	37%	54%	54%	53%	53%	50%	13%	12%	11%	11%	11%	2%	2%	2%	1%	1%

The data indicates that while the higher patient volumes are between 10:00-17:00 hours, with a slight increase at 20:00, patients continue to arrive via walk-in or ambulance outside the higher volume times (See Figure 12). In 2023-December 2024, between the hours of 00:00 to 07:00, there have been 5888 visits to the ED. These totals appear to be lower than previous years, but the total for the fiscal year 2023-24 ends in December 2024 not March 31, 2024. In the fiscal year of 2022-23 from April 1, 2022 to March 31-2023, the total number of visits from 00:00-07:00 hours was 7870 patient visits. This is a difference of approximately 21.6 patient visits over this time frame/day to 16 patient visits/day in 2023 to December 2024.

Figure 12: ED & See & Treat Total Number of Triage Visits by Time of Day

	ED ONLY (See & Treat Open, Volumes Removed)					
	Visits	Fiscal Year				
	Triage Hour	2019-2020	2020-2021	2021-2022	2022-2023	2023-2024 Dec
S&T Closed	0	1,415	1,132	1,264	1,355	959
	1	1,138	886	999	1,033	778
	2	916	731	867	932	661
	3	855	616	763	786	612
	4	812	622	689	712	570
	5	782	648	667	764	601
	6	928	707	789	886	685
	7	1,512	1,264	1,429	1,422	1,022
S&T Open	8	1,213	1,048	1,201	1,141	897
	9	1,602	1,387	1,514	1,454	1,078
	10	1,978	1,792	1,897	1,753	1,304
	11	2,159	1,940	2,047	1,962	1,502
	12	2,000	1,729	1,814	1,838	1,422
	13	1,877	1,730	1,799	1,671	1,323
	14	1,841	1,737	1,756	1,709	1,244
	15	1,901	1,660	1,803	1,635	1,332
	16	1,766	1,553	1,678	1,530	1,227
	17	1,652	1,402	1,465	1,373	1,085
	18	1,653	1,528	1,560	1,506	1,098
	19	1,763	1,423	1,492	1,442	1,113
	20	1,601	1,381	1,487	1,550	1,235
	21	1,427	1,172	1,288	1,366	1,051
	22	1,155	954	1,066	1,070	854
	23	1,006	834	860	916	707
	Grand Total	34,952	29,875	32,194	31,806	24,358

Charge Nurse 24/7
8x RNs 1900-0700
9x RNs 0700-1900
8x RNs 19-07
3x RPN 24/7
1x UC 1900-0700
2x UCs 0700-1900
1x UC 19-07
1 PSW 24/7
2 Security 24/7
ESA 24/7
Care Coordinator 07-19 7 days
Physiotherapist 07-19 M-F
1 Navigator RN 07-19 7 days
Clinical Edu 0800-1600 M-F
2x Manager 0800-1600 M-F

RN Staffing Includes 2x Triage RN

During the IAC Hearing and documented on the PRWRFs, the care given to patients and those arriving is a continual process. There are typically patients remaining from See & Treat following the closure at 24:00. While the above data indicates the busiest times for patient visits at triage, once they are admitted to the different Zones, they continue to require care that may very well extend into the night.

Based on the BCHS data, transfers to other acute care facilities generally occur between the hours of 1600-2300. BCHS has added a nurse from 11:00 to 23:00 for the 2024-25 fiscal year to support the transfers between these hours. This position is funded by Emergency Medical Services (EMS) (BCHS Submission, 2024).

However, transfers can occur anytime of the day including during the night. In the year 2023 until December 2024 from 00:00 to 07:00 hours, a total of 339 transfers occurred in a 24-hour period. For the fiscal year 2023 until December 2024, between the hours of 00:00-07:00, 75 transfers were needed, resulting in 22% of transfers occurring between those hours (See Figure 13). In the previous fiscal year of April 1, 2022 until March 31, 2023, there were 80 transfers between the same hours, which is 19.5% of transfers indicating that transfers during the night shift have increased.

Figure 13: Transfers to Other Acute Care by Hour

Transfer to Acute	Fiscal Year				
Hour of Day	2019-2020	2020-2021	2021-2022	2022-2023	2023-2024
0	23	33	26	18	14
1	21	19	23	13	16
2	24	19	25	14	11
3	13	11	15	13	10
4	16	18	5	6	12
5	8	8	5	6	4
6	7	9	7	6	6
7	6	10	10	4	2
8	16	9	13	15	8
9	14	7	14	8	14
10	13	11	9	9	10
11	15	19	17	16	13
12	18	21	14	15	8
13	27	18	24	15	8
14	25	30	29	35	16
15	35	30	27	20	11
16	26	22	22	25	19
17	22	26	26	18	19
18	38	26	33	18	23
19	27	27	22	18	13
20	32	31	28	31	23
21	37	34	37	39	20
22	19	34	39	20	26
23	34	27	31	28	33
Grand Total	516	499	501	410	339

Ambulance volumes also affect the nurses' workload from triage, offload and the Zone in which the patient is then seen and treated. In BCHS's presentation, it was highlighted that ambulance volumes have increased to the ED by approximately 6%. There has also been a shift in acuity for those arriving by ambulance with an increase in CTAS 2 patients compared to previous years (See Figure 14).

Figure 14: Ambulance Volumes and Offload Times

Rate	FY				
CTAS	2019-2020	2020-2021	2021-2022	2022-2023	2023-2024 Dec
CTAS I	3.51%	3.74%	3.88%	3.90%	3.69%
CTAS II	40.32%	42.24%	43.21%	43.44%	45.69%
CTAS III	51.74%	50.35%	49.83%	49.75%	43.78%
CTAS IV	4.17%	3.48%	2.86%	2.72%	2.75%
CTAS V	0.25%	0.18%	0.21%	0.19%	0.09%
UNIDENTIFIED	0.01%	0.00%	0.01%	0.00%	0.00%
Grand Total	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**

The department is divided into Zones as previously outlined. The nurses have continually documented since December 2020, that with the staffing throughout the emergency department, they have had difficulty maintaining their CNO and NENA standards of practice, delay in care, and missed breaks. The present staffing model is highlighted below. (Figure 15). Of note, the Navigator RN does not have a patient assignment within the emergency department. Their role is for admission avoidance and who regularly works with Home and Community Care as well as external partners, in helping patients through the system and have things in place upon discharge.

Figure 15: Fiscal Year 2023-2024 Scheduled Staffing Hours (Main ED)

FY 23/24 Scheduled Staffing Hours (Main ED)		
Days 0700-1900		**Nights 1900-0700**
Charge (RN)	1	1
Navigator (RN)	1	0
RN*	9	8
RPN	3	3
Midshift RN (11-23)	1 (1100-2300)	
Nursing Total:	14 nurses + Midshift (1100-2300)	12 nurses (Midshift leaves at 2300)
Unit Clerk	2	1
Total Staff	**17**	**13**
* This includes 2 triage nurses 24hrs a day, 7 days a week Note: Additional RN from 1100-2300 is being recruited and is included in the 24/25 Budget. It is not included in these numbers.		

While the IAC understands there are times when the unit is short staffed as a result from basic staffing due to sick time, vacation, LOA etc., that adds to increase workloads of the nurses, there is documentation by the nurses of having workload difficulties while having the basic staffing requirement. This occurs on both days and nights. The model of care includes a flex nurse on the day shift as one of the 9 RNs. There are times in which the flex position is either empty or partially empty, however the IAC believes it is due to sick calls and/or short staffing issues.

Presently, there is only a flex nurse on the day shift from 07:00-19:00. Although as previously discussed, patient's healthcare needs with their unpredictable CTAS acuity levels and the needs of the ED, continue to occur after 19:00. For example, patients who are in CTAS 2 overnight who are of an emergent nature may require being moved to CTAS 1, while the remaining patients in CTAS 2 require more attention than those in the other Zones. There are times as documented in the PRWRFs that patients in the other Zones overnight who require more intense care and deteriorate to a point that they need to be transferred to Zone 1 or 3. The addition of a flex nurse from 19:00-07:00 would assist in caring for patients and addressing the workload issues that occur overnight in all Zones. The flex nurse could also relieve for breaks if not needed to care for patients, which would free up the Charge Nurse to focus on the needs of the Unit and go on transfers.

IAC RECOMMENDATION:

1.1.1 A flex nurse will be added to the base staffing on the night shift (19:00-07:00) 7 days/week. This will be implemented within the next 3 months.

1.2 TRIAGE NURSE

The Canadian Triage and Acuity System (CTAS) is a national triage standard for emergency departments across Canada. The benefits of triage have been identified as the critically ill or injured receive priority attention; acuity is established and anticipated resources needed; predicts how long a patient can safely wait; supports effective utilization of resources and space; supports surveillance; and improves communication and public relations (Canadian Association of Emergency Physicians, 2012).

The Triage nurse's role as per the CTAS Education Manual (2012), is to assess patients and determine acuity, communicate with health professionals, determine the Zone treatment location, and initiate treatment protocols/first aid measures which in the case of the BCHS-ED, the Triage nurse initiates medical directives. The role also includes monitoring and reassessment of patients in the waiting room, patient flow and documentation.

The process of triage at BCHS-ED begins with the critical look by the triage nurse, as the patient walks through the door. This is then followed by the assessment of the patient, including assessing for infectious disease; assigning a CTAS triage level; and identifying whether the patient should be assigned to the waiting room or the most appropriate Zone for treatment; reassessment of patients who remain in the waiting room; and instituting medical directives as appropriate (CTAS, 2012). Several updates in the triage process were made in 2016, including obstetrical and gynecological modifiers, pediatric fever modifiers and frailty to name a few. However, the acuity time targets recommended for the Triage nurse to meet for each CTAS group, remain the same (Bullard et al., 2016).

In the BCHS-ED, the Triage nurses are also responsible for triaging the ambulances, who arrive in the department, alongside being responsible for answering the EMS phone when the paramedics call in to provide information about the incoming patients. Based on both BCHS and ONA's submissions and from information presented in the IAC Hearing, it became clear that the Triage nurses have difficulty meeting the standard time to triage patients within 10 minutes of arrival, assign the appropriate CTAS level and appropriate location for treatment, as well as the reassessments of those who remain in the waiting room based on their assigned CTAS acuity scale. There are times when there is only one Triage nurse which increases the workload and responsibility of the sole Triage nurse.

The hospital does have a Medical Lab Assistant (MLA) for the hours from 13:00-21:00 which is dedicated to triage. Their role includes lab draws and ECGs. This does relieve some of the workload of the Triage nurse, however the MLA is unable to distinguish if the ECG is abnormal. This is the Triage nurses' responsibility and to ensure the physician is aware of the ECG.

As per the *Items in Agreement* (Appendix L), BCHS has instituted having 2 Triage nurses 24 hours/7 days per week. However, the IAC heard from the nurses, as well included in the PRWRF's, that there are times, when this does not occur as a result of not having two nurses on the shift who can be assigned to the Triage role. This then results in only one triage nurse with the Charge Nurse assisting.

During the Hearing, the IAC learned of a Triage Roles & Responsibilities Trial (See Figure 16).

Figure 16: Triage Roles & Responsibilities Trial

Triage 1 (window)	Triage 2 (EMS)	Triage 3 (Greeter)
Staffed 24/7	Staffed 24/7	Staffed when needed/available
1) Greets patients. 2) Triages walk-in patients. a) Flags STAT ECGs At the end of triage, print off any medical directive(s) that apply to the patient and add to the chart for Registration.	1) Does STAT ECGs. 2) Prioritizes triage of EMS. 3) Triages walk-in patients. 4) Reassesses patients in waiting room. 5) Enacts medical directives (priority for cardiac type chest pain and septic work ups). If there is a third nurse in triage, the third nurse will prioritize STAT ECGs. At the end of triage, print off any medical directive(s) that apply to the patient and add to the chart for Registration.	**Registered Nurse in Role** 1. Does STAT ECGs. 2. Triages EMS. 3. Greets Patients. 4. Reassesses patient in waiting room. 5. Ensures Medical Directives (as appropriate) started on patients. At the end of triage, print off any medical directive(s) that apply to the patient and add to the chart for Registration. **Registered Practical Nurse in Role** 1. Does STAT ECGs. 2. Greets patients. 3. Reassesses patients in waiting room. 4. Enacts Medical Directives.

The roles were developed by the BCHS-ED Working Group to better organize and streamline the triage process. When there are 2 Triage nurses, one Triage Nurse will be at the window and triage walk-in patients. The second Triage nurse will primarily triage EMS patients and when able to, also triage walk-in patients. The Working Group has recommended that after 6 hours, the two Triage nurses switch their roles where the Triage 1 nurse will switch to be the Triage 2 nurse.

When there is only one Triage nurse available, a 'greeter' role is being trialed, who is usually an ED RPN. Their role is to do stat ECGs, greet patients, reassesses patients in the waiting room, and enact medical directives. The nurses at the Hearing stated they found the greeter role helpful when there is only one Triage nurse. The IAC supports this position of a greeter within the recognized triage process. The IAC understands this position is filled with RPN from the ED who are/will be trained for this position.

IAC RECOMMENDATIONS:

1.2.1 Ensure there is always 2 Triage nurses 24 hours/day 7 days per week.

1.2.2 All Triage nurses who have a minimum of 2 years ED experience and have received the appropriate certifications, training and orientation will assume the triage role as part of their schedule.

1.2.3 The IAC supports the hospital in moving forward with the trial and evaluation of a greeter role's i.e. hours, role.

1.2.4 Continue to evaluate the greeter role through meeting on a regular basis with those involved, including but not limited to the RPNs involved, nurses who triage, Charge Nurses and the Quality Nurse Manager to determine when and how to use this role.

1.2.5 If the greeter role is adopted within the BCHS-ED, ensure the triage process outlined by NENA is followed which includes the responsibility of the Triage nurse is as follows:

a) To do the critical look of the patients waiting in assessment line. This does not preclude the greeter to communicate to the triage nurse that they are concerned about someone in the line.
b) To do reassessments of those in the waiting room, based on the triage category. Also this does not preclude the greeter to do vital signs, communicate to the triage nurse any concern while walking through the waiting room.

1.3 TRANSFER NURSE

Patients are transferred to other hospitals for various reasons such as the need for a regional program that treats trauma, cardiac or stroke acute treatments.

At the present time, a nurse is required to accompany the patient in the ambulance regardless of acuity. This is a policy of the Emergency Medical Services (EMS). Either RNs or RPNs may be involved in the transfer. RPNs accompany stable transports to regional centres such as for a consult for dialysis, neurology consults, and endoscopic retrograde cholangiopancreatopgrahy (ERCP) (BCHS Presentation, March 19, 2024). Whereas RNs transfer non-stable patients.

Overall, the number of transfers have been decreasing since 2019-20, however the number of transfers is slightly up from 2022-23 and is presently at 0.9% for the present fiscal year (See Figure 17).

Figure 17: Transfers to Other Acute Care Facilities

Transfer to Acute Care Facility Directly from Ambulatory Care	FY 19/20	FY 20/21	FY 21/22	FY 22/23	FY 23/24 Dec
Number of Transfers	515	499	501	410	339
Rate of Transfers out of all Discharge Dispositions	0.9%	1.1%	1.0%	0.8%	0.9%
Rate of Transfers per Day	1.41	1.37	1.37	1.12	1.24

In the 2023-24 fiscal year up until December, the number of transfers via ambulance from BCHS-ED averages at 1.24 per day. BCHS data indicates that the hours where most of the transfers occurred, are between the hours of 1600-2300. When the transfer occurs, the ED is left without that nurse for the time of the transfer. During the IAC Hearing, the nurses explained the transfer could be up to 5-6 hours depending on where they were going. This will then leave the ED short a nurse and will require another nurse to take over the transfer nurse's assignment, resulting in an increased workload. For the fiscal year 2024-25, a mid-shift RN from 11:00-23:00 has been added to the budget as a result of EMS funding. At the time of the Hearing, BCHS has posted a RN position for a transfer nurse, but has not yet been able to fill the position.

The IAC believes that when this position is in place, it will ease some of the workload for the ED nurses.

IAC RECOMMENDATIONS:

1.3.1 The mid-shift transfer nurse position will be incorporated into the schedule effective within the next 3 to 6 months.

1.3.2 The transfer nurse's priority will be to accompany transfers from BCHS-ED to other facilities when a nurse is required.

1.3.3 If not on a transfer, the nurse will triage ambulances arriving in the ED. This will include beginning any medical directives which may be appropriate.

1.3.4 If there are no transfers or ambulances arriving, the nurse will assist within the ED in consultation with the Charge Nurse.

1.4 SCHEDULING: NOVICE to EXPERT

Dr. Patricia Benner, a nursing theorist, developed the "From Novice to Expert" model, which outlines the progression of nurses from novice to expert through five distinct stages. This nursing theory proposes that expert nurses develop skills and understanding of patient care over time through a proper educational background as well as a multitude of experiences. Benner identifies that nurses gain knowledge and skills not only through theory ("knowing how"), but also through clinical experiences ("knowing that") (Benner, 2023).

To provide high-quality care to patients, nurses must continually develop and improve their knowledge and skills. The RN Experience Profile in the BCHS-ED is outlined in Figure 18.

Figure 18: BCHS-ED RN Experience Profile

Count of RNs	Years of ED Department Service								
Years of Nursing Service	<1yr	1-3	3-5	5-10	10-15	15-20	20+	Grand Total	
<1yr	7							**7**	11%
1-3	2							**2**	3%
3-5	4	5	7					**16**	26%
5-10	3	1	5	7				**16**	26%
10-15	1	1	3	1	1			**7**	11%
15-20	2			1		1		**4**	7%
20+						4	5	**9**	15%
Grand Total	**19**	**7**	**15**	**9**	**1**	**5**	**5**	**61**	100%
	31%	11%	25%	15%	2%	8%	8%	100%	

In the ONA Submission (2024), ONA identifies concerns being raised regarding the support of novice nurses. The submission states that novice nurses are the future of the nursing profession and adequate support for training and education must be available to ensure they are well-equipped to provide the necessary care to the patients in the ED. Particularly, emergency nursing is a specialty where the ED nurse encounters patients within a varying range of demographics and physiological processes. Nurses have identified on several PRWRFs that the limited resources available to support novice nurses have had a significant impact on the already increased workload (ONA, 2024). The BCHS Submission (2024) to the IAC panel stated that, in early 2021 at the start of the pandemic, the turnover of new nurses hired was significant and almost 50% were leaving within months of being hired.

Recognizing this, BCHS needed to ensure there was a focus on retention. As a result, a new program was created to support new graduate nurses with a goal of increasing retention. This is the New Graduate Nurse Residency (NGNR) Program. The NGNR Program is a year-long program that supports transition to practice, skill development, and social integration of newly graduated nurses joining BCHS.

The IAC panel recognizes the importance of supporting novice nurses as they develop through each stage in support of their nursing practice. Implementing a structured nursing schedule in the ED is crucial for nurses to progress along the Benner's Novice to Expert continuum (Benner, 2023; Joy, 2023). At the novice stage, novice nurse behavior in the clinical setting is limited. Novices benefit from a well-defined nursing schedule. It provides a structured environment where they can learn and apply theoretical knowledge. A consistent schedule helps novices anticipate patient care situations and develop basic skills. Regular shifts allow for close supervision by experienced nurses, fostering skill development. The Advanced Beginner Stage is one in which nurses have gained some experience but still rely on rules and guidelines. A schedule ensures exposure to diverse cases, allowing advanced beginners to build on their foundational knowledge. Regular shifts provide opportunities for practicing skills and refining techniques. A consistent schedule aids in the transition from novice to competent nurse.

In the competent stage nurses demonstrate proficiency in clinical practice. A well-organized schedule optimizes time management and task prioritization. Competent nurses can handle unexpected situations better, due to their experience. Regular shifts facilitate teamwork and effective communication. In the proficient stage, nurses have a deep understanding of patient care. A consistent schedule allows proficient nurses to engage in complex cases, enhancing their expertise. Proficient nurses may take on leadership roles within the ED. Regular shifts enable them to mentor less experienced colleagues. In the expert stage, nurses possess intuitive knowledge and can adapt flexibly to any situation. Even experts benefit from regular shifts, as they stay updated on best practice. Their consistent presence sets an example for others. A reliable schedule ensures continuity of high-quality patient care.

In summary, a well-structured nursing schedule in the Emergency Department aligns with Benner's theory by supporting nurses at various stages of competence. It fosters learning, skill development, collaboration and ultimately contributes to excellent patient outcomes.

IAC RECOMMENDATIONS:

1.4.1 Implement a new nursing schedule in the Emergency Department that aligns with the novice to expert continuum within 6 months.

1.4.2 With support from the Emergency Department Educator, each nurse will self-identify which stage they align with along the novice to expert continuum. Nurses can make informed decisions based on their understanding of the stages of competence.

1.4.3 The implementation of the new schedule will ensure a balance of novice, intermediate and expert RNs in the master schedule.

1.4.4 ONA Collective agreement language provides guidelines regarding scheduling however it is essential that collaboration occurs. Individual considerations based on nurses'

knowledge and experience levels and patient needs are essential for effective scheduling to support all nurses as well as optimize quality patient outcomes.

1.5 NURSE PRACTITIONER

The emergency department at BCHS-ED is open 24 hours/day to help those in their time of need and is the most vital service provided by the hospital to the community it serves. There are no other resources which exist that provides immediate care to anyone in need of treatment for pain, injury, life threatening trauma, to name a few. The ED is the backbone of the health care system by supporting primary care due to the limited availability of family physicians, providing care

for patients in need of primary care after hours. The ED also provides primary care for repeated and low-acuity visits to the ED, caring for patients with increased complexity of care, older adults visiting the ED, as well as providing complex diagnostic workups for patients needing medical attention (Haas, et al. 2023).

The BCHS-ED staffs the department with physicians, physician assistants (PA), RNs and RPNs, as well as many ancillary staff. The ED also employs positions such as physical therapists, occupational therapists, pharmacists, nurse practitioners (nurse lead outreach and rapid addictions response team), who assist both patients and staff in moving the patients through the healthcare system at the hospital (BCHS Presentation, 2024).

In the BCHS-ED, overflow of patients begins at the time of entry into the department. This includes seeing the triage nurse, time to physician assessment, ambulance volumes and ambulance offloads. All these add to the regular overflow in the ED. BCHS-ED is ranked 67 out of 75 in volumes, making them a high volume ED (BCHS, 2024). When reviewing acuity at BCHS-ED, in 2023-24, CTAS 3 visits dropped to 50% of the total visits, whereas CTAS 2 patients increased to 37% from 33% previously. CTAS 1 has remained consistent over the past 3 fiscal years at 2%, CTAS 4 patients have dropped to 11%, and CTAS 5 visits dropped to 1%.

Other aspects affecting the overcrowding within any ED, is the physician initial assessment (PIA), which can include a patient being seen by a physician, physician assistant, or nurse practitioner. At the BCHS-ED, physicians and physician assistants provide the medical care to patients, not nurse practitioners. BCHS ranks 70 of 75 funding related to PIA times for the fiscal year 2024-25 (BCHS, March 19, 2024). The Physician Assistants in the BCHS-ED help reduce the PIA times. The hospital ranked 73 out of 75 for the ED Pay for Results (P4R) for the PIA in the BCHS-ED. With the middle rank of 4.3 hours for PIA, BCHS ranked at 2.8 hours above this for an average of 7.1 hours PIA on average.

Ambulance volumes have increased in the ED at BCHS-ED by approximately 6%. As a result of increased patient volumes needing ED care, there is an increase in the ambulance offload as well, waiting an additional 23 mins compared to the 2019-20 fiscal year (BCHS Presentation, March 19, 2024). There has also been an increase in the CTAS 2's from 40% in 2019-20 to 50% in

2023-24 being offloaded by ambulance, while CTAS 3 patients have decreased from 51% in 2019-20 to 50% in 2023-24.

There are other areas which contribute to the overcrowding in the ED at BCHC, which include the admissions with no beds (ANB), however, ANB has remained constant at a daily average of 22/day, year over year.

Nurse Practitioners are a valuable resource in Canadian healthcare, especially in the Emergency department. A scoping review of the impact of emergency department nurse practitioners on healthcare outcomes in Canada by Bazavluk et al. (2022), reviewed the outcomes associated with an NP working in the emergency department. They looked at several issues which affect emergency departments including wait times, length of stay, left without being seen, willingness to see a NP and patient satisfaction. All studies were done in the emergency departments in 3 provinces across Canada, including Ontario. Results of the review showed evidence of positive change on outcomes, wait times, left without being seen, and patient satisfaction when there is an NP in the ED.

Nurse practitioners in Ontario are authorized to diagnose, order, interpret tests and prescribe medication and other treatments. NPs work within the College of Nurses of Ontario NP Standards of Practice and are governed under the Regulated Health Professions Act, 1991(College of Nurses of Ontario, 2023a).

A Nurse Practitioner working within their full scope of practice, practices independently and autonomously. The IAC believes there are many areas within the ED that a Nurse Practitioner could improve on the PIA times and contribute to addressing the overflow within the different ED Zones. There would also be no need for the physician to sign off on any patients they care for and RNs and RPNs could accept orders from a NP under the College of Nurses of Ontario Standards.

IAC RECOMMENDATIONS:

1.5.1 The hospital will consider the implementation of a Nurse Practitioner within the emergency department in the next 6-12 months.

1.5.2 The hospital will engage with all healthcare professionals i.e. physicians, nurses, allied healthcare professionals, to understand the role of the NP. This will include scope of practice, and highlighting the benefits, such as improving access to care, patient satisfaction, within a collaborative care model, and allowing the physician to focus on higher acuity patients.

1.5.3 Involve ED staff and ONA in the discussion surrounding the potential implementation of this position. This would include but not limited to where and when the NP would be beneficial.

1.6 PHYSICIAN ASSISTANT

Physician assistants (PA) help support physicians in a variety of health care settings. They work alongside physicians, nurses and other members of the interdisciplinary team involved with patient care (HealthForceOntario, 2020).

PA's in Ontario work in a variety of areas to help reduce wait times and improve access to health care. Some of these areas include EDs. BCHS-ED department is one such healthcare area, in which a PA is employed. The PA's in the ED, primarily work in the See & Treat area, caring for CTAS 4 & 5 patients. They are also involved with initiating stroke protocol within the department, working under the physician.

PAs are unregulated health professionals who provide medical services under the supervision of a physician. Since PA's are an unregulated healthcare provider, they do not have access to perform controlled acts under the Regulated Health Professions Act (RHPA). However, they can perform controlled acts if delegated to them by the physician, but they cannot further delegate these acts to a nurse (CNO, 2023b).

During discussions at the IAC Hearing, nurses described incidents in which the PAs in the ED wanted to delegate regulated activities to the nurses. As they are unregulated professionals, nurses cannot accept these delegations. It is important for nurses to have good communication with the PAs, for both to be aware of their accountabilities to ensure patient care is delivered in a safe and timely manner (CNO, 2023b).

IAC RECOMMENDATIONS:

1.6.1 Effective immediately, delegation of regulated activities from the PA to any class of nurse, will cease.

1.6.2 Nurses and PAs participate in the daily huddles together, to better understand each other's roles and what is occurring in the ED that day.

2.0 NOVICE STAFFING AND EDUCATION/SKILL MIX

2.1 RECRUITMENT AND RETENTION

The Ontario Hospital Association reports the vacancy rate of staff in hospitals as on average being 15.5% in mid-2023. The BCHS Submission (2024) identifies that BCHS is seeing vacancy rates slightly above the rest of the province.

The critical staffing shortage has intensified nurses' job demands, increased hours of work, required redeployment to new patient care settings, and increased job dissatisfaction, job strain, and burnout (Tomblin-Murphy et al., 2022). Marufu et al. (2021)'s systematic review explored factors influencing retention and recruitment. Key factors were related to a number of factors such as professional influences (stress, burnout, high workloads, emotional exhaustion); nursing leadership and management; staffing issues; education and career advancement; organization and work environment issues; support at work; personal factors; demographic issues; and financial and monitory aspects. In fact, based on a meta-analysis, Tomblin-Murphy et al. (2022) suggested that "a supportive work environment is the optimal recommendation to reduce voluntary turnover" (p. 16).

As of February 8, 2024, the RN vacancy rate at BCHS was 16.95%, and in the ED the RN vacancy rate was 21.05%. This is down slightly from April 1, 2023 when the vacancy rate for RNs in the ED was 21.84%. At the time of submission of this report, BCHS-ED had 18 vacancies with 16 being nurses' vacancies as outlined in Figure 19.

Figure 19: BCHS ED Vacancies Overview

ED Vacancies Overview				
Job Classification	**RN**	**RPN**	**Physician Assistant**	**Unit Clerk**
RFT	11	0	0	0
RPT	2	0	0	0
TFT	3	0	0	0
TPT	0	0	1	1
Total Vacancies	**18**			
Total Nursing	**16**			

To strive to fill the ED vacancies, there are weekly meetings and strategizing sessions with BCHS HR Recruiter and the ED Manager to review vacancies applicants and discuss recruitment strategies.

BCHS acknowledges the importance of retention and recruitment and have implemented several initiatives. Examples of these are the following:

- Increased social media presence
- Corporate referral program
- Central education fund (for all staff)
- Paid continuing education for mandatory training
- Revitalization of corporate recognition events (i.e. annual service awards, recognition awards)
- Wellness initiatives
- Regular in-person and virtual job fair attendance

- Focus on Diversity, Equity and Inclusion

Turnover of ED staff has dropped from a high of 38.1% excluding casual part-time transfers in the fiscal year 2021-22 to only 4.8% for the same group in the fiscal year 2023-24. If the transfers of staff to casual part time are included, the vacancy rate decreased from 66.7% in the fiscal year 2021-22 to 4.8% in this fiscal year 2023-24 (See Figure 20).

Figure 20: Fiscal Year/Turnover Rate

FISCAL YEAR / TURNOVER RATE	ORGANIZATION WIDE	EMERGENCY
21/22 TURNOVER RATE *(excluding CPT transfers)*	**19.89%**	**38.10%**
21/22 TURNOVER RATE *(including CPT transfers)*	**34.73%**	**66.67%**
22/23 TURNOVER RATE *(excluding CPT transfers)*	**14.16%**	**8.57%**
22/23 TURNOVER RATE *(including CPT transfers)*	**30.06%**	**25.71%**
23/24 TURNOVER RATE YTD *(excluding CPT transfers)*	**11.48%**	**4.76%**
23/24 TURNOVER RATE YTD *(including CPT transfers)*	**20.22%**	**4.76%**

BCHS data indicates that presently there are 40% of the RNs in the ED that have five or less years total nursing experience, with 67% of ED RNs having worked in the ED for five or less years. Figure 21 identifies the demographics of the BCHS ED Nursing Staff using BCHS data. Figure 22 captures the ONA Seniority chart in the BCHS-ED.

Figure 21: BCHS Demographics of Nursing Staff

Count of RNs	Years of ED Department Service								
Years of Nursing Service	<1yr	1-3	3-5	5-10	10-15	15-20	20+	Grand Total	
<1yr	7							**7**	11%
1-3	2							**2**	3%
3-5	4	5	7					**16**	26%
5-10	3	1	5	7				**16**	26%
10-15	1	1	3	1	1			**7**	11%
15-20	2			1		1		**4**	7%
20+						4	5	**9**	15%
Grand Total	**19**	**7**	**15**	**9**	**1**	**5**	**5**	**61**	100%
	31%	11%	25%	15%	2%	8%	8%	100%	

Figure 22: ONA Seniority Chart

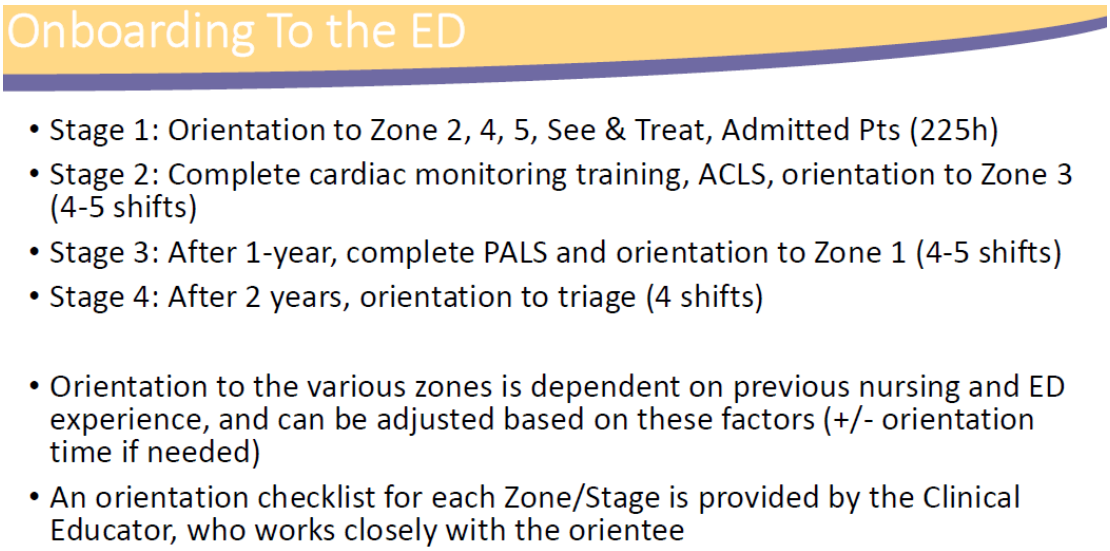
Seniority in years	Full-time time	Part-time	Total
≤ 1 year	10	4	14
2 years	0	0	0
3-4 years	1	0	1
5-9 years	5	1	6
≥ 10 years	6	0	6
Total	22	5	27

In the BCHS Submission and presentation, a number of supports for novice nurses were identified as follows:

- The Clinical Educator focuses on staff support, developing competencies through orientation, education, simulation, development opportunities and at the elbow support.
- The Quality Manager also contributes to a mentoring environment for the newer staff.
- BCHS has utilized the Health Human Resource funding to place a Clinical Scholar in the ED to support staff with less than one year experience. In the IAC Hearing the IAC heard how valuable the Clinical Scholar was in supporting novice nurses, and the hope that the provincial government would continue to fund this position. The Clinical Scholar program pairs an experienced front line nurse as a dedicated mentor with newly graduated nurses, internationally educational nurses and nurses who want to upskill to supports nurses in confidently transitioning into nursing practice (Ontario News Release, 2023).

The BCHS has a general onboarding and orientation week that all new staff attend. New ED RNs then have 225 hours of orientation in Zone 2, 4, and 5, See & Treat, low acuity areas, and with ANB (Admit No Beds) patients. When nurses complete the cardiac monitoring course and ACLS, nurses are then given 48-60 hours of orientation to Zone 3. RNs can then complete PALS training and then will be orientated to Zone 1 for another 48-60 hours, and then triage. As per the *Items in Agreement* (Appendix L), BCHS will pay for the courses and the time it takes to complete them. Normally, new RNs provide care in Zones 2, 3, 4, and 5 before progressing to Zone 1. Nurses will then spend approximately another year in Zone 1 prior to receiving the necessary training and orientation to become a triage nurse. New nurses are also assigned preceptors who they work along with during the orientation period (BCHS Submission, 2024). Onboarding to the ED is outlined in Figure 23.

Figure 23: Onboarding to the ED



IAC RECOMMENDATIONS:

2.1.1 Continue to implement retention and recruitment strategies to retain the ED nurses and decrease the vacancy rate within the ED.

2.1.2 Explore funding opportunities to maintain the Clinical Scholar role.

2.1.3 Ensure the *Items* in the *Items in Agreement* related to retention, recruitment, orientation and professional development continue to be enacted.

2.2 SKILL MIX:

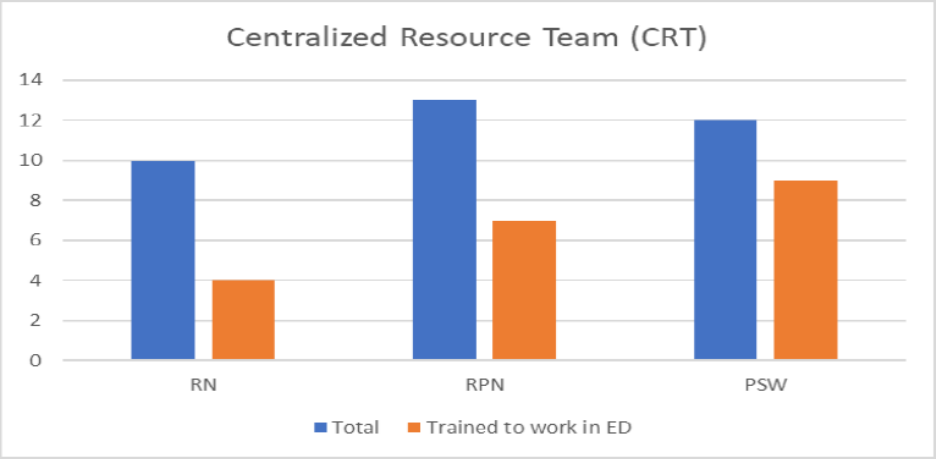
The critical nursing shortage has resulted in the exploration of how to provide the delivery of high quality care to patients through considering a skill mix of staff having varying levels of education, roles and the use of non-regulated staff such as personal support workers (Cermak et al., 2023). Cermak et al. (2023) did a scoping review, examining 14 studies focusing on patient satisfaction and outcomes, cost, nurse perceptions of role changes, quality of care, and skill mix model effectiveness. Key findings highlighted the importance of effective collaboration and delegation, and for this to occur, all healthcare providers need to understand their role and the roles of others in the delivery of patient care.

In ONA's Submission (2024) and presentation at the IAC Hearing, they described ED nurses concerns that they do not have time to support the RPNS, Novice Nurses, Centralized Resource Team (CRT), and Agency Nurses, working in the ED due to their own patient assignments. The ED nurses also expressed concern that at times, it appeared that these nurses may be working

above their scope. There are 3 RPNs scheduled in the Main ED on the day and night shifts. They work in Zones 2, 4 and 5 and 1 RPN works in the See & Treat area on 8 hours shifts (08:00-16:00 and 16:00-24:00).

As a result of the ED vacancy rate, there has been a need to utilize CRT and Agency nurses to have appropriate staffing each shift to care for the patients in the different zones. The CRT or "float pool", is made up of nurses and personal support workers (PSWs) who are trained to work in different areas over BCHS. Currently 40% of RNS, 54% RPNs, and 75% of PSWs in the CRT have been trained to work in the ED. Orientation to the ED is standard for all CRT staff (See Figure 24).

Figure 24: Centralized Resource Team Staffing



The ED has also had to rely on agency nurses to address skill mix needs, such as not having any nurses scheduled who can be assigned to the triage nurse role or being unable to replace sick calls. Presently, agency nurses are being used to fill 800 hours/month or 71 shifts, which is equivalent to 15% of shifts. Between the fiscal years of 2021-23 to 2023-24 there has been a 46% decrease in the need for using agency nurses (See Figure 25).

Figure 25: Agency Nurse Usage

Use of Purchased Services in ED		
FY	Hours	Dollars
21/22	3,266	647,089
22/23	20,803	2,446,694
23/24	9,646	1,237,625

-46%

The CNO (2023a) defines a nurses' (RNs & RPNs) scope of practice as, "a range of activities that nurses' have the legislated authority to perform" (p. 3). The healthcare organizations' policies and practice setting, and the nurse's competence in performing nursing care also influences their decision making, practice, and accountability (CNO 2023a).

When performing nursing practice, the nurse must consider the following 3 concepts:

1. Authority: The nurse must know and consider the legislated scope of practice including controlled acts and the authorizing mechanisms that they can perform.
2. Context: The nurse must assess the practice environment to consider whether the practice setting provides the appropriate supports to implement the required nursing care and has available resources to ensure safe patient care.
3. Competence: Each nurse must ensure they have the knowledge, skill and judgement to implement the required patient care (CNO, 2023a).

IAC RECOMMENDATIONS:

2.2.1 RNs and RPNs practice to their full scope.

2.2.2 The Leadership Team (i.e. Manager, Charge Nurse) assess CRT nurses and/or agency nurses knowledge, competence and ability to provide care in the ED when making the patient assignments.

2.2.3 BCHS-ED staff should be prioritized to be the triage nurse over agency staff.

2.2.4 Agency nurses who assume the triage nurse role, must have the appropriate certification and training.

2.2.5 If RNs, RPNs, and/or PSWs working in the different zones are not familiar with one another, a huddle should occur at the beginning of the shift to identify each of their roles in delivering high quality safe patient care.

2.2.6 All nurses (RNs, RPNs, and Agency Nurses) working in the ED identify when the required patient care is outside of their legal scope of practice, authority, context and/or competence.

2.2.7 All nurses must take the accountability to inform the leadership team (i.e. Manager, Charge Nurse) that they are unable to perform the required nursing care practice.

2.2.8 Leadership team identifies how to support the nurse and make sure the required nursing care is safely implemented.

3.0 ED Processes

3.1 SEE & TREAT

At BCHS, the See & Treat area is located parallel to the main ED, further south along the A-wing main hallway. From the ED main waiting room, the door to See & Treat is located outside the ED waiting room. There is signage and a yellow-coloured pathway (yellow footprints) that directs patients to the See & Treat waiting room. Once a patient enters, they are greeted by the Unit Clerk and sit within the dedicated See & Treat waiting room. This waiting room consists of one patient washroom and holds approximately 18 people. See & Treat is utilized to help flow patients who walk-in and require less urgent care from the ED and patients who are dischargeable within approximately 4 hours. This area of the Emergency Department is open from 0800-2400, 7 days per week, and sees approximately 45% of all of the ED volumes. Patients are triaged by the Triage Nurse then directed across the hall to See & Treat, if they fit the criteria and the area is open. Triage nurses following CTAS guidelines, ensure that patients are assessed against standard protocols that determine the appropriate level of care required. At BCHS, the triage nurse determines if a patient enters See & Treat or the main ED. This assessment ensures the appropriate level of care that is required.

The hours of operation are 0800-2400 hours and is staffed by 1 RN, 1 RPN, 1 Physician Assistant (PA) and 1 Physician. The PA's work in the See & Treat area of the ED, as well as support the main department for patients requiring Stroke Protocol. (BCHS & ONA IAC Briefs, 2024). Optimizing patient care and minimizing the number of patients leaving without being seen is crucial for safe patient care. Based on this, physician and/or PA's should see patients for the maximum duration prior to closing the See & Treat area at 00:00. This approach ensures that as many patients as possible are seen, thereby decreasing wait times in ED particularly after 00:00, as well as increasing patient satisfaction.

In the BCHS presentation on May 21, 2024, it was identified that the See & Treat area sees patients until close at 24:00, but sometimes stops pulling patients from the main waiting room prior to this time. The explanation given for why this can occur, is that the medical staff in the See & Treat area, solely make this decision, based on the physician's estimate of how many patients are waiting, and the time it will take to see them prior to 24:00. The rationale also included that when it becomes close to 24:00, and in the interest of the patient experience, to save patients from moving from the See & Treat area to the main ED room, they see those patients who they can clear prior to 24:00. BCHS identified that this can cause tension between Triage and the See & Treat areas. As a result, a working group led by the Chief of ED has been formed with the medical staff, managers, and nursing staff in See & Treat to create standard work and processes to guide decision making and practices for seeing patients in See & Treat, as well as to guide conflict resolution.

While both areas are co-located, it is important to note that staffing is not integrated. There are two distinct schedules, with the nurses not available to each unit. In the IAC hearing, the panel was made aware that there were several ED staff that would agree to shifts in See & Treat, however this was not the expectation for all staff. Combining the staffing model within both units would enhance efficiency, patient satisfaction and improved patient outcomes.

As See & Treat areas are designed to expedite the care of lower acuity patients, if the designed area is seen as a stand-alone unit there can be disadvantages associated with this. These disadvantages may include the following: the dedication of specific staff and resources; if not managed efficiently, may strain overall ED resources; staffing small zones with a small number of staff can be challenging; and a patient's condition may change and a staff member that is not trained within each zone of an ED may have delayed recognition that could potentially lead to an adverse outcome.

Cross training of staff to work in each zone of the ED is essential to foster collaboration amongst all staff working within the department. When staff members are trained to handle different zones, they can seamlessly transition between areas such as critical care and See & Treat. This ensures that patients receive continuous and consistent care, regardless of the zone they are in. Cross-trained staff can adapt to changing patient volumes and acuity levels. They can flexibly move from high-intensity critical care situations to more routine cases, maintaining an efficient workflow. When staff members are trained to work across zones, it mitigates the impact of staff shortages. If one area is overwhelmed, trained personnel from other zones can provide support. Cross-training also fosters better communication among team members. Staff who understand the challenges and workflows of different zones can collaborate effectively and share critical information. Staff who can seamlessly navigate different zones are better equipped to provide timely interventions, prioritize care, and manage emergencies. This ultimately leads to better patient outcomes (Zagalioti et al., 2023).

In summary, investing in comprehensive training for ED staff across all zones ensures a well-prepared, adaptable workforce that can deliver high-quality care to patients in critical situations.

IAC RECOMMENDATIONS:

3.1.1 The ED team is multidisciplinary, with each discipline working to provide exceptional patient care in all areas of ED. Incorporate See & Treat staff within the ED to promote a collaborative healthcare team.

3.1.2 Ensure all mandatory training is provided to the See & Treat nurses if they have not received this training. This includes Triage (CTAS) training.

3.1.3 RPN's assigned in the See & Treat area are practicing to full scope.

3.1.4 Development of inclusion/exclusion criteria for See & Treat. This could include but not limited to: (to ensure appropriateness of care)
   a) Appropriate CTAS levels
   b) Return for Treatment
   c) Return for Diagnostics
   d) IV medications – Administration
   e) Wound Care-Dressing Change
   f) Nose i.e.) Nasal packing removal, epistaxis
   g) Lacerations
   h) Extremity follow up

3.1.5 All roles and responsibilities of providers in See & Treat are well defined to ensure accountabilities are understood.

3.1.6 The See & Treat area will be scheduled into all nursing assignments.

3.1.7 Physicians and/or Physician Assistants (PAs) should attend to patients for the **maximum duration** before closing the "See & Treat" area. Although the area officially closes at midnight, practitioners have been observed stopping patient consultations as early as 9 PM, even though the area remains open until midnight. Patients should continue to be seen as close to the actual closing time as possible.

3.1.8 The See & Treat staff will attend daily huddles. This will promote teamwork, enhance communication as well as understand the current state of ED and allow planning for the shift ahead.

3.1.9 ED data metrics such as but not limited to patient volume, CTAS levels, Leaving Without Being Seen (LWBS) patient incidents, and escalation of care from See & Treat to main ED, be monitored at a minimum quarterly and shared with staff. This information will inform improvement strategies.

3.1.10 Convey to all staff and implement the developed standard work and processes to guide decision making and practice for the See & Treat area and to guide conflict resolution.

3.2 RAPID INFUSER

The rapid infuser's primary function is the prevention and treatment of clinical shock through rapid infusion of warmed blood or fluids. Common clinical indications that require the rapid infuser, but not limited to are hemorrhage, trauma, and placenta abruptio. In cases like these, administering rapid warm fluids is essential. The BCHS-ED houses the hospital's 2 rapid infusers, which are required when a patient is having a massive hemorrhage. Not all conditions that require the rapid infuser, occur in the BCHS-ED. When the rapid infuser is needed in other

areas of the hospital, there is a massive hemorrhage protocol involving the Code Team, comprised of various healthcare disciplines.

Between April, 2023 and January 24, 2024, 11 of 18 of the cases were in the ED (BCHS Presentation, May 21, 2024). At the present time, if there is a need for the rapid infuser on a unit in the hospital other than the ED, it is the ED Charge Nurse who is responsible for bringing and running the machine during the procedure. As ED Charge Nurses presently are the only nurses educated in operating the machine, the ED Charge Nurse is required to remain with the patient throughout the procedure. This can result in the ED Charge Nurse being away from the ED for up to 4 hours at a time. While the Charge Nurse is away, other nurses in the ED must take over the work of the Charge Nurse, adding to everyone's workload.

Without the Charge Nurse in the ED, there may also be no one available overseeing the flow in the department as well as other duties in which they are required to perform within the ED. To relieve the Charge Nurse of this role, the ED nurses should learn how to use the machine. It is also important for nurses in other areas such as CCU or the Operating Room, who may have these types of patients requiring rapid infusion of fluids, having the ability to run the rapid infuser machine without the ED staff needing to leave their department.

As the rapid infuser is not used on a daily basis, it is important that all staff are provided with a yearly refresher.

IAC RECOMMENDATIONS:

3.2.1 Education be given to all ED RNs on how to run the rapid infuser within the next 3 to 6 months.

3.2.2 Education on how to run the rapid infuser will also be given to nurses in the Critical Care Unit and Operating Room.

3.2.3 The education will be provided by the ED Nurse Educator.

3.2.4 There will be annual and/or skills day refresher education to ensure all staff remain competent in the use of the rapid infuser.

3.2.5 When the infuser is required on another unit, and the emergency staff are required to attend, it will be one of the ED nurses who goes, not the Charge Nurse.

3.3 ED RESPONSE to CODE BLUE

The Code Blue team plays a critical role in hospitals during emergency situations. A Code Blue is an emergency event triggered when a patient experiences sudden cardiac or respiratory arrest. It requires immediate and coordinated action to save the patient's life. The term "Code Blue" is universally recognized as a medical emergency. The Code Blue team must consist of highly trained healthcare professionals who respond quickly when a Code Blue is called. The team in most hospitals consist of but not limited to Physicians, Anesthesiologists, Respiratory Therapists, Critical Care and ED nurses, Security, and Spiritual Care. The staff working within the unit in which the Code is called are an invaluable resource as they are most familiar with the patient. Nurses from ED and CCU, with a critical care skill set, have defined roles within the emergency response. Defibrillation, cardioversion as well as the administration of emergency medications are advanced delegated acts that these staff members have been certified to perform and as such are part of a critical response team.

At BCHS, the ED Charge nurse, is assigned the role to respond to Code Blue calls throughout the hospital. As part of the IAC Hearing, the IAC were made aware of incidents in which the ED Charge nurse, as the assigned Code Blue responder, was out of the ED for prolonged periods of time during a Code Blue event on a unit. The Charge Nurse in ED plays a crucial role in overseeing ED operations, including patient flow, staffing, and resource allocation. In their absence, another nurse may need to step up to manage the ED temporarily. The ED may experience staffing challenges if the Charge Nurse is away for an extended duration. If the ED nurse who responded to the Code Blue is not needed for ongoing critical care, they should be able to return to the ED as quickly as possible. However, this decision depends on the patient's condition and the availability of other staff to continue care during the Code Blue. Ensuring adequate staffing levels during Code Blue responses is essential to maintain patient care across the organization including the ED.

IAC RECOMMENDATIONS:

3.3.1 The ED Code Blue responder role will **NOT** be assigned to the ED Charge Nurse.

3.3.2 The ED Code Blue assignment will be assigned to a nurse that is certified in Life Saving Interventions (Hospital Specific) such as defibrillation and administration of emergency drugs.

3.3.3 Based on the response outside of ED, the ED Code Blue responder will return to ED as soon as possible, due to the dynamic nature of the ED and resources required.

3.3.4 Mock Code Blues will be scheduled on the inpatient units. Regularly practiced mock codes will reinforce skills such as familiarity with documentation and assigned roles and responsibilities for a Code Blue response. This will be invaluable support to the Code Blue team.

3.4 PRWRFs

ONA's Submission (2024) identified there has been 311 PRWRFs submitted since 2020, with an additional 10 submitted in the Supplemental Submission received on March 11, 2024, for a total of 321 PRWRFs.

The purpose of a PRWRF, as per Article 8 of the ONA Collective Agreement, is to address employee concerns relative to their workload issues in the context of their professional responsibility (ONA, 2023). The parties encourage nurses to raise any issues which negatively impact their workload or patient care including but not limited to:

1. Gaps in continuity of care
2. Balance of staff mix
3. Access to contingency staff
4. Appropriate number of nursing staff

The PRWRF is a documentation tool to identify and report workload and practice issues, demonstrate ongoing trends and barriers to safe, ethical care, and any contributing workload problems (ONA Submission, 2024). Article 8 also outlines the process to be followed by the nursing staff, the employers and the IAC, once a PRWRF is submitted (ONA, 2023).

When a PRWRF is submitted, every effort should be made to resolve the workload issues at the unit level, starting with the manager and nurse (s) having a discussion related to what occurred. If the issue is not mutually resolved, the PRWRF is then submitted to the Hospital Association Committee (HAC) level. At BCHS, the HAC meets monthly, in attempt to reach joint resolutions on multiple PRWRF's on multiple units. (ONA Submission, 2024). HAC is the forum for discussing issues brought by the nurses related to workload and practice issues and to allow the parties to propose solutions for resolution of the issues.

The IAC believes that it is important to have all key players involved in the HAC process, including those in a position to make decisions, such as the Chief Nurse Executive (CNE) or designate. The Bargaining Unit President and the Labor Relations Officer have been involved in the HAC since 2021.The Professional Practice Specialist became involved in December 2021. ONA believes over the past 3 years there has been very little resolution or progress for the nurses in the ED (ONA Submission, 2024). However on January 22, 2024, ONA and BCHS have signed an *Item in Agreement* addressing many issues reported by ED nurses in the PRWRFs (Appendix L).

During the Hearing, it appeared that following the submission of PRWRFs, the hospital did not meet regularly with the staff as per Article 8. Instead, all the PRWRFs would be discussed at the HAC meetings. While this has been the practice in the past, BCHS acknowledges this would change and the process outlined in Article 8 will now be followed.

In the ONA Submission (2024) as well as in the presentation, and in reviewing the PRWRF's the responses from BCHS did not consistently address the issues documented by the nurses at the time of the PRWRF being submitted to the manager. It is important to acknowledge the issue(s) at hand to aid, in coming to a resolution, either at the time of submission or during the process outlined in the Collective Agreement.

IAC RECOMMENDATIONS:

3.4.1 Whenever possible, a dialogue as per Article 8 related to concerns between staff and managers will occur at the time of the incident, prior to documenting and/or submitting a PRWRF.

3.4.2 RNs will continue to document their concerns on the PRWRFs in alignment with the Collective Agreement when necessary.

3.4.3 BCHS will meet to discuss the submitted PRWRFs with the nurse(s) as per Article 8 and an ONA representative if they wish. This will begin immediately.

3.4.4 Management will review and engage with the nurse(s) involved as per the Collective Agreement and respond in writing to all PRWRFs within 10 calendar days with the goal of resolving the immediate issue(s) and working towards a long-term resolution. This is to begin immediately.

3.4.5 Outside of the regular business hours the nurse(s) will notify the Senior Clinical Operations Manager on call of the workload issue(s) and the manager on call will respond either by phone and/or visit the unit.

3.4.6 The CNE or their designate attend all HAC meetings, effective immediately.

4.0 Environment

4.1 MENTAL HEALTH ROOMS

At BCHS-ED, there are 2 rooms on either side of the triage space that are designated for mental health patients. Once a patient is triaged and is deemed as requiring a mental health assessment, the patient is placed in one of the rooms adjacent to triage. One of the rooms is specifically designated as the mental health assessment room, often called the "bubble room". The other room is normally used as a "quiet room" but will be used for patients needing a mental health assessment if two mental health assessments are required at the same time. The Emergency Room Mental Health (ERMH) team is then notified that there is a patient that requires a mental health assessment.

The ERMH staff is a member of the Mental Health staff whose position is located in the Emergency Department for the purpose of supporting mental health patients who present to the ED. The position is staffed by both RNs and Social Workers whose home base is the Mental Health Inpatient Unit. Staff from the Mental Health program are also assigned 24 hours/day in the ED to help support all mental health complaints from subacute to mental health crisis or psychosis. These staff work with vulnerable patient populations (such as homeless or under housed), and in collaboration with the ED Navigation team, to arrange for proper resources for patients in the community. These two assessment spaces are used to conduct mental health assessments by the Emergency Room Physician (ERP) or Emergency Room Mental Health (ERMH) team.

The role of the ERMH is an invaluable role to support Mental Health patients when they present to ED. The lengthy and arduous process of psychiatric assessment and intervention tends to disrupt the normal flow of the emergency department. ED staff often believe they lack the skills to assess and treat mental health clients effectively (Clarke, Hughes et al. 2005). The ERMH role conducts accurate and timely assessments, utilizes clinical judgment to assess the patient's situation and identify possible mental health issues and risks. They also assist the Emergency Room Physician (ERP) and psychiatry consult team in assessment, assist with the discharge planning of patients who do not require admission, and ensure safety for both patients and staff.

In the BCHS Presentation on March 21, 2024, it was presented that the median minutes for a patient with mental health issues to be assessed and assigned to a zone was 27 minutes in 2023-24 fiscal year (See Figure 26).

Figure 26: Time to Zone for Patients with a Mental Health Related Complaint

Time to Zone for Patients with MH-related Complaint		
Fiscal Year	Median Hours	Median Minutes
2019-2020	0.13	8
2020-2021	0.15	9
2021-2022	0.35	21
2022-2023	0.53	32
2023-2024	0.45	27

Data from Pulsecheck, and is all CTAS levels

Until the ERMH team can assess the patient, the responsibility for the care of that patient remains with the triage nurse, as the patient does not have an ED nurse assigned to their care. Instead, it is assumed that the triage RNs will provide observation and nursing care until mental health assessments are completed and care transferred. This results in the triage nurses being responsible for initial triage, reassessments of the waiting room, and answering the EMS

dispatch phone, while also having to provide nursing care to mental health patients in the health care spaces on either side of the triage workspace until the ERMH staff come to assess the patient. Once the mental health assessment is complete, the patients are then designated to other areas in the department depending on their need.

ONA's Submission (2024) identifies that although these two rooms are called seclusion rooms, they do not have the ability to lock and only one of the two rooms possess the capability of video monitoring. The video monitor is watched by the triage nurses. The length of time that a patient is one of the treatment rooms is variable depending upon the availability of the ERMH.

IAC RECOMMENDATIONS:

4.1.1 Once a patient is placed in one of the identified Mental Health rooms, there is a transfer of care to a nurse within ED. This accountability is then removed from the triage nurse(s).

4.1.2 ERMH will assess a patient placed in a Mental Health room as soon as possible to identify a plan of care.

4.1.3 If it is deemed that a patient in one of the Mental Health rooms requires admission, the patient is moved to an inpatient Mental Health bed immediately if available. If unavailable, the patient is moved into the ED main area with appropriate and safe monitoring of the patient based on care requirements, as deemed by ERMH assessment.

4.1.4 A camera will be installed in the one room that doesn't presently have one within the next 3 months.

4.1.5 The cameras within the Mental Health assessment rooms should be monitored by security, who will alert the most responsible nurse when required.

4.2 SAFETY

ED staff need to be ready for anything, as they do not know the condition of the patient walking through the doors. Violence against nurses by patients and visitors is on the increase globally in EDs, with nurses being most at risk (Hou, et al., 2022). Duong and Vogel (2022) cite that more than half of nurses working in the ED, experienced verbal or physical abuse in any given week.

As triage is the first contact for patients entering into the ED, the triage nurses are often the ones patients and visitors lash out at, leading to potential safety issues. Patients may become violent and belligerent for various reasons such as the illness itself, the unknown of what is happening, and/or the wait time before they are even seen by the nurse /physician.

The staff should feel safe in their work environment. The need for preventative measures are essential for all ED staff, such as security officers in the ED and personal safety alarms. All staff who work in the ED at BCHS, are supplied with Code White security alarm badges. BCHS has also recently provided a security officer in the waiting room 24 hours/day as well as a security officer making rounds within the department. The security officers are not employees of the hospital but in the IAC Hearing, the IAC learned that the security officers are trained in the use of force training and de-escalation. As per the *Items in Agreement*, all work zones have been assessed for escape routes, and education has been provided to all staff of the routes for each zone. Each escape route should be posted at each workstation (Appendix L).

As mentioned in Section 5.1: Mental Health Rooms, the ED has access to an Emergency Room Mental Health (ERMH) Team. While a mental health patient is waiting to be assessed by the ERMH team, they may be placed in what is called the "bubble room". This room has a CCTV camera which can be viewed at the triage desk. During the IAC Hearing, the IAC heard that this room may have a patient waiting for the ERMH team to assess them, for upwards to an hour. Until the patient is assessed, the triage nurse(s) is responsible for caring for the patient in this room. If there are two patients in need of mental health assessments, there is another room available, which is normally used as the quiet room or for other purposes. It is not the intent of the hospital to have patients waiting for mental health assessments in this room, but the triage nurses frequently need to use this room when there are 2 mental health patients at the same time. Until the patients are assessed by the ERMH team, the triage nurse(s) are responsible for their care. While the bubble room has a CCTV camera, the quiet room does not, which makes it very hard for the triage nurse to monitor any patient who may be in the room as it is not in clear vision for the nurse.

The staff room is located at the back of the department adjacent to the offload area. Staff go in and out of the room for breaks, lunch etc. The hospital has provided a key pad type lock on the door, however during the IAC hearing, nurses told the IAC that entering any number could open the door. As there are patients on stretchers located immediately across from the staff room door, staff were also concerned that they could potentially injure someone or themselves when they swing the door open. During the Hearing, nurses also expressed the need for a peep hole in the staff room door, so they could check the hallway, prior to opening the door and exiting the room.

IAC RECOMMENDATIONS:

4.2.1 BCHS will ensure all security officers assigned to the ED have Use of Force and De-escalation training.

4.2.2 BCHS install a CCTV camera in the quiet room within the next 3 months and security should monitor the video transmissions from both mental health designated rooms.

4.2.3 BCHS will ensure the lock on the break room is functioning properly and is operational with just one code. This is to be done immediately.

4.2.4 The hospital will immediately install a peep hole in the staff break room.

4.3 TRIAGE AREA

4.3.1 Privacy

Respect for privacy and confidentiality have been healthcare professionals' responsibilities throughout history. Nurses have ethical and legal responsibilities to maintain confidentiality and the privacy of patients' health information, while providing care (CNO, 2024). The Personal Health Information Protection Act 2004, governs health care information privacy in Ontario (Ontario, 2023). This includes information collected by nurses during the therapeutic relationship and triage process.

One area of concern related to privacy at BCHS that was viewed on the video presented at the IAC, was the geographical location of the 2 triage nurses. Each nurse has an area to work in with all the required equipment to do their assessment. However, there is no privacy between the two triage areas. There is no curtain, wall, or a barrier of any kind, to separate Triage 1 from Triage 2. This results in not being able to maintain a patient's privacy when the triage nurses do their assessments.

IAC Recommendation:

4.3.1.1 The hospital will provide a type of physical barrier between the triage nurses, to provide a sense of privacy for patients, within the next 3 months.

4.3.2 EMS Patch Phone

The Triage 2 nurse is also responsible for answering the Emergency Medical Services (EMS) Patch Phone that is located within the Triage area. At BCHS, the EMS Patch Phone is a separate phone line, similar to all EDs in Ontario. Paramedics use this phone to alert the ED that they are enroute with a patient and their estimated time of arrival. The report from the paramedics is brief and gives a broad view of the patient's condition for the nurse to receive enough information and a CTAS level (based on the paramedic assessment), to communicate to the charge nurse. This information will then guide the charge nurse in deciding the appropriate zone for the incoming patient. With the phone location being in the triage area, the triage nurse must leave the patient they are assessing to answer the phone, and then relay the information to the charge nurse.

The IAC believes that the EMS Patch Phone would be more appropriate within the main ED. A nurse other than the triage would nurse have the responsibility in answering the phone and

gathering the pertinent information from the paramedics. As the information given is brief, regarding the status of the patient, BCHS may want to consider having the charge nurse answer the EMS Patch Phone, as it is part of the charge nurse's role to maintain flow through the department. The charge nurse also has a better understanding of what is going on in each zone. A follow-up call could then be sent to either the triage nurse or the transfer nurse (if not on a transfer) alerting them to the incoming ambulance, (see the IAC Transfer Nurse Recommendations).

IAC RECOMMENDATIONS:

4.3.2.1 Move the EMS Patch Phone to within the ED department at the desk of the charge nurse within the next 3 months.

4.3.2.2 The triage nurse should not be responsible for answering the EMS Patch Phone once it has been moved.

4.3.2.3 BCHS develop with input from ED nurses, a form to be completed when answering the EMS Patch Phone. This would allow the person answering the phone to collect the information and relay to the CN if they are not at the desk. This will occur within the next 3 months, to coincide with phone being moved from the triage area.

4.3.2.4 ED staff collectively identify the process/person/role for answering the EMS Patch phone and conveying the information to the Charge Nurse for the appropriate placement of the incoming patient.

4.4 NON-NURSING ROLES/EQUIPMENT

4.4.1. WARD CLERK

The ward clerk in the ED is responsible for managing patient records, entering orders, coordinating tests and transportation, completing receptionist duties, ordering supplies, and coordinating the network of information passing between healthcare personnel (BCHS Submission, 2024). The ward clerk of any emergency department also acts as a liaison to staff, patients and the public.

There are ward clerks in the ED 24 hours/7days, with 2 on 12 hour days, 1 on 12 hour nights, and 1 in the See & Treat area. There is additional ward clerk support from 1900-2300 on Sunday, Monday, Thursday, based on data of when patient visits occur.

During the night shift from 19:00-07:00, there remains many orders, patients continue to arrive, nurses must answer calls, many medical directives in which the nurses need to institute, and transferring patients whether out of the hospital or within (ONA Submission, 2024) This will

often take the nurses away from their patient care, as the only ward clerk available on nights is too busy doing their own duties.

IAC RECOMMENDATIONS:

4.4.1.1 BCHS will add an additional ward clerk from 19:00-07:00, 7 days per week effective within the next 3 to 6 months.

4.4.1.2 The added ward clerk responsibilities will include the support of triage- assisting with entering the orders required for any of the directives and support the needs within ED as required

4.4.2 ENVIRONMENTAL SERVICE AIDE

ONA's Submission (2024) identifies that nurses spend an "extraordinary amount of time finding supplies" (p.67), which takes time away from delivering patient care.

The BCHS Submission (2024) states that there is now an environmental service aide 24 hours/7 days a week in the ED. Their role is to provide support to patient transport and portering, cleaning, and seeking supplies (BCHS Submission, 2024). There is also a Material Handler from Stores Department who is scheduled daily to aid with supplies in the department. BCHS has also developed a standard work process for stocking supplies and a global supply list specific to the ED (*Items in Agreement*-Appendix L). In the IAC Hearing, BCHS also added that the PSW and volunteers assist in stocking, making up kits for the different zones and tidying up the department.

BCHS is to be commended for implementing the *Items in Agreement* related to addressing non-nursing activities.

IAC RECOMMENDATION:

4.4.2.1 Continue to implement the *Items in Agreement* related to environmental service.

4.4.3 EQUIPMENT

In ONA's submission, one of the recommendations is to continue to apply the *Items in Agreement* related to equipment. In the *Items in Agreement*, BCHS outlines the following, in Figure 27.

BCHS is to be commended for implementing the *Items in Agreement* related to addressing equipment issues and continue to enact them moving forward.

Figure 27: *Items in Agreement* Related to Equipment

18. Cardiac monitors have been placed at each stretcher space in rooms for Zone 1, 2, and 3. The Employer will ensure nurses working in these zones are trained for cardiac monitoring by January 8, 2024 (this work is in progress and schedules for training are completed).
19. Four Zoll monitors are present in the department: Two in Zone 1, one in Zone 3, and two in the south hallway. Replacements for Zoll monitors are obtainable through Biomed.
20. Every Zone, including See and Treat and Triage, has a dedicated ECG machine.
21. Portable vital sign machines are available throughout the department. Specifically, two vital sign monitors in Zone 4/5 as there is no cardiac monitoring available in these Zones. Additionally, one VS monitor in Zone 2 and 3. There are continuous SpO2 monitors available in Zone 1.
22. The employer has a specific tag out policy for all equipment issues. Issues to be brought to managers' attention daily and discussed at daily huddles on status of repairs. Biomed also rounds every day through the department to fix any BioMed issues.

IAC RECOMMENDATION:

4.4.3.1 Continue to implement the *Items in Agreement* related to equipment concerns in the ED.

5. Leadership

BCHS ED Leadership Team:
Over the years, there have been significant changes in all levels of leadership. For example, in 2018, a new BCHS-ED Manager began and stayed until 2021. The next Manager started in an interim position and then was awarded the position as Manager, and stayed from 2021-2023. Presently, the BCHS-ED is co-managed by 2 managers with the roles of Clinical Manager ED Urgent Care & ED Redevelopment (Operational Manager) and the Clinical Manager, ED Quality & Performance (Quality Manager) introduced in October 2023. The two Managers work in a dyad manager model with all staff being able to contact either one. Both Managers have an open door policy and are highly visible in the ED. The Clinical Operations Manager started on June 1, 2023 and was an ED staff member prior to assuming this role. The ED Quality Manager started in October, 2023.

The Clinical Managers report to the Clinical Director of ED & Urgent Care, Critical Care, Internal Medicine, MH & SADV. This position has recently been recruited, with an anticipated start date of mid-April. Until the new Clinical Director starts, the two BCHS ED Clinical

Managers are reporting to Clinical Director for Maternal Care, Perioperative, & Medical Device Reprocessing.

The Clinical Directors report to the VP Clinical Services & Chief Nursing Executive, however, this position is presently vacant. There is an active recruitment process underway to fill this position. Presently, the Clinical Director of Professional Practice, Corporate Clinical Resources, Stroke and Post-Acute Programs is acting as the Chief Nursing Officer; and the Clinical Director of Pharmacy and Ambulatory Care is acting as the VP of Clinical Services.

In the BCHS Submission, it was recognized that the significant leadership changes in multiple levels of leadership in the BCHS-ED have likely contributed to feelings of unrest in ED staff. The submission also includes that the new leadership team is committed to, "working with staff to create an environment where staff are proud to work and where excellent patient care can be provided to residents in the area" (BCHS Submission, 2024, p. 52).

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

5.1.1 LEADERSHIP AT THE POINT OF CARE

New Graduate Nurse Residency (NGNR) Program:

As a result of recognizing the need to focus on retention of novice nurses within the organization, the NGNR Program was developed. The NGNR program is offered over one year and supports the transition to practice, skill development and social integration into BCHS. There are 2 six-month sections. In the first 6-months, participants attend a monthly 4-hour workshop. The workshop focuses on topics such as what to expect in the first year as a nurse, how to manage emotions they may be feeling, critical thinking, time management, how to receive and provide feedback, how to care for a deteriorating patient, understanding and learning how to use medical directives, and understanding the charge nurse role. The workshops also have a focus on quality improvement, trauma informed care, and common quality and ethical issues that they may experience in their practice.

The second 6-months focus on participants having the opportunity to lead a quality improvement project with the support from leadership and education. The NGNR program is voluntary, but novice nurses are encouraged to participate in them. In the 2024-25 fiscal year, there are plans to enable new nurses to attend by backfilling their time on the unit, when the nurses are attending the workshops.

The IAC commends the BCHS for recognizing not only the needs of novice nurses transitioning from being a graduating nursing student to becoming accountable and responsible for caring for patients independently, but also developing their leadership knowledge and skill for the point of care and beyond. There are nursing students who have strong leadership roles within their nursing programs, sitting on academic committees, leading nursing student associations, and advocating for nursing students and social issues. When they then graduate, they often express discouragement and frustration that there appears to be limited opportunities to implement their leadership abilities within practice. This can result in them looking for other opportunities such as applying to be a nurse practitioner after 2-years full-time nursing practice, transferring to another unit, or leaving the profession.

IAC RECOMMENDATION:

5.1.1 Clinical Managers, Clinical Educator and Clinical Scholar identify and encourage novice nurses within BCHS-ED, who would benefit from the NGNR program, to participate in it.

Triage Nurse:

The BCHS Submission (2024) identifies that there is a gap in skilled nursing staff who are able to assume the triage nurse position. The National Emergency Nurses Association (NENA) pre-requisite standards for triage nurses, require 2-years of experience in the ED or one year working in the BCHS ED, if the nurse is an experienced RN. Those nurses who meet the NENA pre-requisite standards can then receive hourly compensation and time for 48 hours of a triage orientation courses. During the Hearing, the IAC heard that there were nurses who meet the NENA pre-requisites, but were not assuming the triage nurse role.

The IAC commends BCHS-ED for recognizing the need to standardize the roles and responsibilities of the triage nurse, by creating an ED Education and Practice Council Triage Working Group. This working group's goal is to improve the care provided to patients in triage by standardizing triage roles and identifying barriers to provide safe, effective and compassionate care. The group has begun to standardize the roles and responsibilities of the triage nurses and identifying processes that could be modified to enhance efficiencies or improve

care that will assist not only experienced triage nurses, but also new nurses assuming the triage nurse role.

IAC RECOMMENDATIONS:

5.1.2 All BCHS-ED nurses who meet the National Emergency Nurses Association (NENA) pre-requisite standards for triage, will be provided the orientation and training to assume the triage role.

5.1.3 The Clinical Educator and Charge Nurse will work closely with the nurses new to the triage role, to identify if they require more supports or time before assuming the triage role independently.

5.2 LEADERSHIP IN UNIT BASED COUNCILS

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

The BCHS Submission (2024) identifies there are two practice councils in the ED. The first is the ED Education and Practice Council. This Practice Council is co-chaired by the ED Clinical Quality Manager, Clinical Educator and one RN. This Council meets monthly for 4 hours with a focus on process improvements and quality and education initiative.

There is also the ED Practice Council which is chaired by the Clinical Director and the Physician head of service for the ED. This meeting is held monthly and reviews metrics, safety occurrence trends, and any other relevant topics. This Council is attended by ED staff, physicians and a Patient and Family Advisory Council member.

IAC RECOMMENDATION:

5.2.1 ED nursing leaders identify and encourage nurses to participate and become involved with the 2 Unit Practice Councils and/or consider joining the new Nursing Quality Council (NQC) that is a BCHS-wide initiative.

5.3 CLINICAL NURSE MANAGERS:

Many nurses are placed in leadership positions, without the proper support and education in the knowledge and skills necessary to be an effective leader (Cope & Murray, 2017). The Clinical Nurse Managers, play a critical role in job satisfaction, retention of point of care nurses and patient satisfaction and outcomes (Cave et al., 2023).

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

During the IAC Hearing, the IAC learned and observed that both Clinical Managers appeared to have good relationships with staff, were highly visible in the ED, have an open door policy, are approachable, and committed to fostering a quality and healthy work environment, which are all qualities of being transformational leaders.

IAC RECOMMENDATION:

The Clinical Managers continue to provide their authentic, active listening, communication, and transformational leadership with staff.

5.3.1 The Senior Leadership Team provide the Clinical Managers with the support and resources (i.e. leadership development opportunities) required to be successful in their roles.

5.4 SENIOR LEADERSHIP TEAM

As previously identified, there has been turnover in the senior leadership team with an interim role in the Clinical Director of ED & Urgent Care, Critical Care, Internal Medicine, MH & SADV role that has recently been filled with an anticipated start date of mid-April. The VP Clinical Services and Chief Nursing Executive role is presently being done in an acting role by

the Clinical Director of Professional Practice, Corporate Clinical Resources, Stroke and Post-Acute Programs. Presently, there is an active recruitment process underway to fill it.

It is important for the Senior Leadership Team to focus on listening, effective staff engagement, open communication and high visibility ((Bergstedt & Wei, 2020). In the BCHS submission, it was outlined that the Leadership Team understands the importance of stakeholder feedback from staff regarding their workflow, department, and other quality initiatives, and as such there have been several time-limited working groups formed to discuss pertinent issues that require input. Examples of these are working groups related to capital planning for equipment, and staff input related to the ED redevelopment project.

In April, there was also the establishment of a new Nursing Quality Council (NQC). This committee will be supported by the Chief Nurse Executive, and chaired by a Clinical Manager, a front line RN and RPN, and will meet monthly with nursing representation from across the organization. As an advisory, approval and decision-making body with hospital-wide nursing representation, the Nursing Quality Council (NQC) will support, inspire and advance nursing within areas of professional practice, regulation, leadership, quality and patient safety, evidence-informed practice, education, innovation, research and ethics. The NQC will support excellence in nursing practice through alignment with the BCHS vision, mission and values.

IAC RECOMMENDATIONS:

5.4.1 The Senior Leadership Team continue to focus on being highly visible, listening, and implementing qualities of transformational and authentic leadership in their daily interactions with staff.

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

6 Healthy Work Environment

6.1 COMMUNICATION

Communication practices of leaders are essential to build and maintain positive working relationships (Tomblin-Murphy et al., 2022). This includes actively listening and openly communicating in order to improve: trust, engagement, job satisfaction, and organizational commitment (Begstedt et al., 2020; Fowler et al., 2021)). Leaders who demonstrate high

effectiveness in communication skills is also associated with improved patient and staff outcomes and organizational performance (Fowler et al., 2021; Mabona et al., 2022).

Fowler et al. (2021) identify that a leader's communication competence is based on use of clear language, the medium that messages are conveyed in, and the behaviour used to convey the message such as through motivating, openness, transparency, and/or coaching. Leaders' behaviours should also convey being open, empathetic, and honest, while encouraging feedback and open communication (Wu et al. 2020). It is imperative that leaders be visible either in person or electronically to listen and develop transparency with the nurses on the unit. Without these communication tools, there can be a lack of trust and feelings of not being valued by nurses.

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

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

BCHS-ED:

Communication on BCHS-ED is occurring through different strategies. For example, the BCHS-ED Managers or the Clinical Educator when the Managers are absent, are holding daily unit huddles as per the *Items in Agreement*, with the focus on informing staff of staffing issues, security/safety issues, overcapacity issues, broken or missing equipment issues and any other matters that should be shared. While BCHS participants discussed the daily huddles, the IAC does not recall, whether they were interdisciplinary.

ED staff meetings are also held monthly, with the previous meetings minutes being attached to the staff invitation to attend. The meetings are held virtually to enable more team members to attend and are led by the Clinical Managers. An agenda is provided in advance and minutes are

provided afterwards. In the meeting, issues relevant to the ED are discussed. The Charge Nurse team also meets monthly with the Leadership Team to discuss relevant issues. Minutes are also taken in these meetings and available to staff.

Both in the BCHS Submission (2024) and during the hearing, the IAC learned that the two Managers have an open door policy, highly visible on the unit and spend the time daily connecting the staff and getting to know them.

During the IAC Hearing, the IAC heard that there appeared to be some communication issues between the nurses in the See & Treat area and the ED.

IAC RECOMMENDATIONS:

6.1.1 Ensure daily huddles occur, and if they are not interdisciplinary, consider encouraging all staff to attend the huddle, so that everyone is informed of what is occurring on the unit that day.

6.1.2 Managers continue to have a presence on the unit and an open door policy to encourage staff to discuss with them their ideas, concerns, and issues.

6.1.3 Managers discuss with staff the most effective ways to communicate with each other, to convey important information and let staff know of what is occurring in the ED and the organization.

6.1.4 As discussed in the section on the See & Treat area, incorporate See & Treat staff within the ED to promote and foster communication and a collaborative healthcare team.

6.1.5 Consider developing social media strategies with staff, for example through a BCHS-ED private WhatsApp site. Staff would be co-creators to foster engagement, collaboration, building an ED community, and communication on the unit and within the organization.

6.1.6 Ensure policies, procedures, and education are in place, on how to use social media apps appropriately ensuring privacy.

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

6.2 WELL-BEING

During the Hearing, the IAC heard the nurses' lived experiences working at the BCHS-ED. Most described traumatic experiences that had occurred caring for patients in life threatening circumstances, while knowing that other patients were also in need of care. The nurses also identified how they could not take the time to access the available mental health care supports offered by BCHS, as they didn't want to leave their colleagues with one less nurse as they took care of their own mental health needs. They also described how they often went home worrying about what care they may have missed or reliving the traumatic events they had witnessed.

When traumatic events occur, healthcare professionals often feel a sense of duty to continue working even when they are exhausted or they don't ask for help with the fear of being stigmatized or not being able to cope (Kinman et al., 2020). Healthcare providers often justify this by saying they "didn't have time," didn't want to access the resources" or "wasn't aware of the resources and/or how to access them." These resources also require the nurse to be self-motivated to reach out and access them when they are not working or being able to leave the unit, which they may not be able to do.

Tomblin-Murphy et al. (2022) in a rapid review investigating the evidence of nursing shortages and their causes in Canada during the pandemic, identified the importance of establishing psychologically safe and supportive working environments for nurses with better access to mental health care and supports.

In the IAC Hearing, BCHS presented the Peer Support Program that focuses on psychological health and safety, resiliency, sustainability and well-being of staff. The Peer Support Program also can provide critical incident debriefings. The Peer Support team members are staff who work in the healthcare system at BCHS with many who have certifications in Critical Incident Stress Management Training. The Peer Support Team can be called upon to do a Critical Incident Debrief for specific situations and/or will provide in-person or phone support as well.

During the pandemic, BCHS implemented a new emergency code, called Code Lavender. The Code Lavender is an intervention that can be used, when challenging situations threaten unit stability, personal emotional equilibrium, or professional functioning. This is a crisis intervention tool which is used to support any person working at BCHS when a stressful event or series of stressful events occurs inside the hospital. Once the Code is called, a leader within the organization will go to the unit where the Code was called within 30 minutes, to assist to help people meet their immediate responsibilities until a more ongoing solution can be found.

It is critical for leaders and peers to encourage one another to take time to recover mentally and physically to be able to sustain their resilience and prevent burnout (Wu et al., 2020). They should also encourage the expression of colleague's feelings and provide support to one another to develop and convey, that they are all in this together (Polizzi et al., 2020). This strategy has

been found to be important when work is highly stressful and emotionally demanding (Kinman et al.)

Resilience has been identified as serving as a protective role against anxiety, stress, fatigue and insomnia (Labrague, 2021). Resilience is a process in which people can adapt to adversities and remain hopeful despite adverse circumstances (Duncan, 2020).

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

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

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

The IAC also heard in the Hearing that while there is a well-funded Social Committee, it has not been active for some time.

IAC RECOMMENDATIONS:

6.2.1 Invite well-being resources within the organization to attend staff meetings to inform staff of their role and how to contact them. If appropriate internal resources are not available, access external supports.

6.2.2 Arrange for well-being resources within the organization within the next 3 to 6 months to attend staff meetings to assist staff in developing their self-awareness to triggers of stress, and strategies to address them.

6.2.3 In staff meetings, have discussions on how the staff can support each other in developing resilience strategies.

6.2.4 Nurse Managers, Charge Nurse, Clinical Nurse Educator, and Nurse Scholar, and formal and informal leaders, discuss and support nurses individually to access well-being resources when needed and emphasize the need to take care of themselves to be able to take care of others in their professional and personal lives.

6.2.5 Nurse Managers, Charge Nurses, Clinical Nurse Educator, Nurse Scholar and formal and informal leaders strongly encourage nurses who need time after a traumatic event to take it, regardless of what is occurring in the ED at that time.

6.2.6 Nurse Managers identify formal and informal leaders who can provide support to colleagues and encourage them to access well-being resources within the organization when needed.

6.2.7 Formal and informal leaders on the unit, role model calling Code Lavenders and accessing Peer Support resources when needed and encouraging others to also do this when necessary.

6.2.8 Revisit the reactivation of the Social Committee within the next 6 months as another strategy to strengthen peer support and resilience.

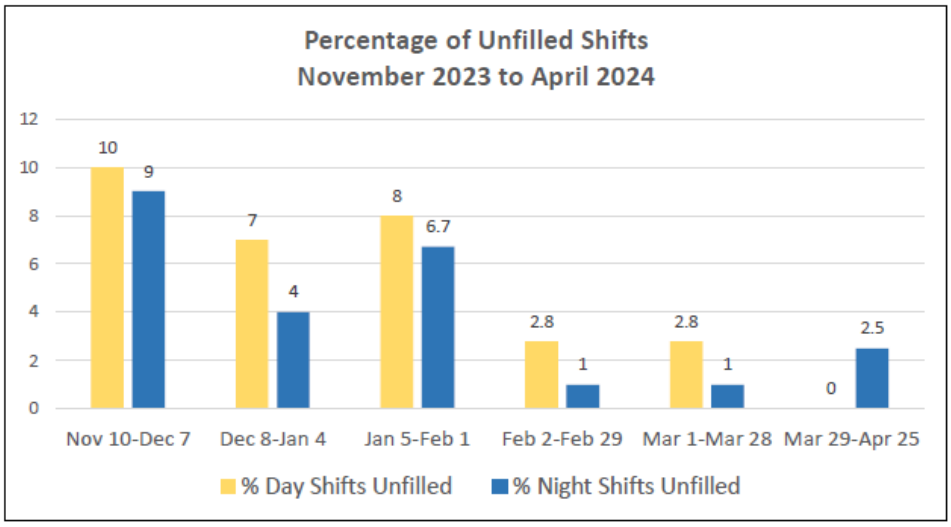
6.3 MORALE

ONA's Submission (2024) describes documented PRWRFs, where nurses describe how they feel "intimidated, overwhelmed, and unsupported by their leadership team" (p. 77). They have also experienced distress that they cannot meet the standards of care due to being short staffed and report being fatigued and experiencing burnout.

While the *Items in Agreement* (Appendix L) include that the charge nurse will not have a patient assignment, there will be 2 triage nurses, and an additional nurse funded by EMS to transfer

patients, there are many times when this does not occur. BCHS acknowledges that many of the issues identified in the PRWRFs is when nurses must work below the baseline, because of unfilled shifts. Of note, is that since there has been an increased focus on recruitment, since February 2024, the percentage of unfilled shifts has decreased (See Figure 28). However, these unfilled shifts, can lead to the staff's perception that base staffing is insufficient.

Figure 28: Unfilled Shifts



Total day shifts per schedule = 280 (10 RNs per day x 28 day rotor)
Total night shifts per schedule = 252 (9 RNs per day x 28 day rotor)

Over the years there has also been significant changes in all levels of leadership, and high vacancy rates in the ED. The new leadership team, which includes 2 new nursing managers, one being a former ED nurse, and the senior nursing leadership team state they are committed to work with staff, " to create an environment where staff are proud to work and where excellent patient care can be provided to patients" (BCHS Submission, 2024, p. 52).

Other issues addressed in the *Items in Agreement* (Appendix L) that both ONA and BCHS agreed upon, focus on improved staffing and morale through addressing nurses concerns related to staffing, orientation and professional development support, safety, non-nursing tasks, and equipment and supplies. Daily huddles have been re-instituted, monthly town hall meetings are occurring, the managers have an open door policy and have high visibility on the unit. All these strategies should also contribute to an improved morale in the ED.

Analysing all the data in the submissions, discussions and presentations, the IAC is of the belief that the low morale is primarily based on the issues addressed in the *Items in Agreement.* Implementation and consistently enacting the strategies, outlined in *Items in Agreement* and the recommendations in this document, should contribute to improving the morale on the unit. A

continued focus on recruitment and addressing the staffing vacancies, alongside the recommendations on how to build resilience and well-being, should also all contribute to improving morale on the unit.

IAC RECOMMENDATIONS:

6.3.1 Continue focused attention on recruitment and retention initiatives and support for new hires and graduate nurses.

6.3.2 Conduct "stay interviews" that are proactive relationship building structured interviews. Leaders conduct these interviews with their staff to foster a culture focusing on nurse engagement and retention. During the interview, leaders explore with staff members why they stay and what actions could be taken to strengthen their engagement and retention on the unit and organization. To learn more about stay interviews process, please refer to Wang et al., (2023). Stay interviews should be implemented within the next 3-6 months.

6.3.3 Conduct an exit interview/survey by a third party for all nurses who leave BCHS-ED for both internal and external opportunities. Review the results semi-annually to identify trends that may need addressing.

6.3.4 Report the findings from both the "stay" and "exit' interviews at the monthly town hall meetings to explore how this data can be used to improve team morale and work environment.

6.3.5 Conduct an ED-specific staff satisfaction survey and explore ways to improve team building and morale by a third party facilitator focusing on implementable activities that the staff could do to support each other to build the morale on the unit.

6.3.6 Explore the re-activation of the social committee.

PART 4: CONCLUSIONS AND SUMMARY OF RECOMMENDATION

This report contains the IAC's findings and 6 areas of recommendations regarding the Professional Responsibility and Workload Complaints submitted by registered nurses on BCHS-ED, that impact their ability to provide quality and safe patient care. The process taken through an IAC Hearing provides a unique opportunity for discussion and dialogue between all parties regarding the complex issues and conditions that underlie a Professional Responsibility and Workload Complaint.

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

IAC RECOMMENDATIONS:

1.0 STAFFING

1.1 FLEX NURSE

1.1.1 A flex nurse will be added to the base staffing on the night shift (19:00-07:00) 7 days/week. This will be implemented within the next 3 months.

1.2 TRIAGE NURSE

1.2.1 Ensure there is always 2 triage nurses 24 hours/7 days per week.

1.2.2 All triage nurses who have a minimum of 2 years ED experience and have received the appropriate certifications, training and orientation will assume the triage role as part of their schedule.

1.2.3 The IAC supports the hospital in moving forward with the trial and evaluation of a greeter role's i.e. hours, role.

1.2.4 Continue to evaluate the greeter role through meeting on a regular basis with those involved, including but not limited to the RPN's involved, nurses who triage, charge nurses and quality nurse manager to determine when and how to use this role.

1.2.5 If the greeter role is adopted within the BCHS-ED, ensure the triage process outlined by NENA is followed which includes the responsibility of the triage nurse is as follows:

c) To do the critical look of the patients waiting in line. This does not preclude the greeter to communicate to the triage nurse that they are concerned about someone in the line.
d) To do reassessments of those in the waiting room, based on the triage category. Also this does not preclude the greeter to do vital signs, communicate to the triage nurse any concern while walking through the waiting room.

1.3 TRANSFER NURSE

1.3.1 The mid-shift transfer nurse position will be incorporated into the master schedule effective within the next 3-6 months

1.3.2 The transfer nurse's priority will be to accompany transfers from BCHS-ED to other facilities when a nurse is required.

1.3.3 If not on a transfer, the nurse will triage ambulances arriving in the ED. This will include beginning any medical directives which may be appropriate.

1.3.4 If there are no transfers or ambulances arriving, the nurse will assist within the ED in consultation with the Charge Nurse.

1.4 SCHEDULING: NOVICE TO EXPERT

1.4.1 Implement a new nursing schedule in the Emergency Department that aligns with the novice to expert continuum within 6 months.

1.4.2 With support from the Emergency Department Educator, each nurse will self-identify which stage they align with along the novice to expert continuum. Nurses can make informed decisions based on their understanding of the stages of competence.

1.4.3 The implementation of the new schedule will ensure a balance of novice, intermediate, and expert RNs in the master schedule.

1.4.4 ONA Collective agreement language provides guidelines regarding scheduling however, it is essential that collaboration occurs. Individual considerations based on nurses' knowledge and experience levels and patient needs are essential for effective scheduling to support all nurses as well as optimize quality patient outcomes.

1.5 NURSE PRACTITIONER

1.5.1 The hospital will consider the implementation of a Nurse Practitioner within the emergency department in the next 6-12 months.

1.5.2 The hospital will engage with all healthcare professionals i.e. physicians, nurses, allied health professionals, to understand the role of the NP. This will include scope of practice, and highlighting the benefits such as improving access to care,

patient satisfaction, within a collaborative care model allowing the physician to focus on higher acuity patients.

1.5.3 Involve ED staff and ONA in the discussion surrounding the potential implementation of this position. This would include but not limited to where and when the NP would be beneficial.

1.6 PHYSICIAN ASSISTANT

1.6.1 Effective immediately, delegation of regulated activities from the PA to any class of nurse, will cease.

1.6.2 Nurses and PAs participate in the daily huddles together, to better understand each other's roles and what is occurring in the ED that day.

2.0 Skill Mix/Novice Staffing and Education

2.1 RECRUITMENT AND RETENTION

2.1.1 Continue to implement retention and recruitment strategies to retain the ED nurses and decrease the vacancy rate within the ED.

2.1.2 Explore funding opportunities to maintain the Clinical Scholar role.

2.1.3 Ensure the *Items* in the *Items in Agreement* related to retention, recruitment, orientation and professional development continue to be enacted

2.2 SKILL MIX

2.2.1 RNs and RPNs practice to their full scope.

2.2.2 The Leadership Team (i.e. Clinical Manager, Charge Nurse) assess CRT nurses and/or agency nurses knowledge, competence and ability to provide care in the ED when making the patient assignments.

2.2.3 BCHS-ED staff should be prioritized to be the triage nurse over agency staff.

2.2.4 Agency nurses who assume the triage nurse role, must have the appropriate certification and training.

2.2.5 If RNs, RPNs, and/or PSWs working in the different zones are not familiar with one another, a huddle should occur at the beginning of the shift to identify each of their roles in delivering high quality safe patient care.

2.2.6 All nurses (RNs, RPNs, and Agency Nurses) working in the ED identify when the required patient care is outside of their legal scope of practice, authority, context and/or competence.

2.2.7 All nurses take the accountability to inform the leadership team (i.e. Manager, Charge Nurse) that they are unable to perform the required nursing care practice.

2.2.8 Leadership team identifies how to support the nurse and make sure the required nursing care is safely implemented.

3.0 ED Processes

3.1 SEE & TREAT

3.1.1 The ED team is multidisciplinary with each discipline working to provide exceptional patient care in all areas of ED. Incorporate See & Treat staff within the Emergency Department to promote a collaborative healthcare team.

3.1.2 Ensure all mandatory training is provided to the See & Treat nurses if they have not received this training. This includes Triage (CTAS) training.

3.1.3 RPN's assigned in the See & Treat area are practicing to full scope.

3.1.4 Development of inclusion/exclusion criteria for See & Treat. This could include but not limited to: (to ensure appropriateness of care)

a) Appropriate CTAS levels
b) Return for Treatment
c) Return for Diagnostics
d) IV medications – Administration
e) Wound Care-Dressing Change
f) Nose i.e.) Nasal packing removal, epistaxis
g) Lacerations
h) Extremity follow up

3.1.5 All roles and responsibilities of providers in See & Treat are well defined to ensure accountabilities are understood.

3.1.6 The See & Treat area will be scheduled into all nursing assignments.

3.1.7 Physicians and/or Physician Assistants (PAs) should attend to patients for the **maximum duration** before closing the "See & Treat" area. Although the area officially closes at midnight, practitioners have been observed stopping patient consultations as early as 9 PM, even though the area remains open until midnight. Patients should continue to be seen as close to the actual closing time as possible.

3.1.8 The See & Treat staff will attend daily huddles. This will promote teamwork, enhance communication as well as understand the current state of ED and allow planning for the shift ahead.

3.1.9 ED data metrics such as but not limited to patient volume, CTAS levels, Leaving Without Being Seen (LWBS) patient incidents, and escalation of care from See & Treat to main ED, be monitored at a minimum quarterly and shared with staff. This information will inform improvement strategies.

3.1.10 Convey to all staff and implement the developed standard work and processes, to guide decision making and practice for the See & Treat area and to guide conflict resolution.

3.2 RAPID INFUSER

3.2.1 Education be given to all ED RNs on how to run the rapid infuser within the next 3 to 6 months.

3.2.2 Education on how to run the rapid infuser will also be given to nurses in the Critical Care Unit and Operating Room.

3.2.3 The education will be provided by the ED Nurse Educator.

3.2.4 There will be annual and/or skills day refresher education to ensure all staff remain competent in the use of the rapid infuser.

3.2.5 When the infuser is required on another unit, and the emergency staff are required to attend, it will be one of the ED nurses who goes, not the Charge Nurse.

3.3 ED RESPONSE to CODE BLUE

3.3.1 The ED Code Blue responder role will **NOT** be assigned to the ED Charge Nurse.

3.3.2 The ED Code Blue assignment will be assigned to a nurse that is certified in Life Saving Interventions (Hospital Specific) such as defibrillation and administration of emergency drugs.

3.3.3 Based on the response outside of ED, the ED Code Blue responder will return to ED as soon as possible, due to the dynamic nature of the ED and resources required.

3.3.4 Mock Code Blues will be scheduled on the inpatient units. Regularly practiced mock codes will reinforce skills such as familiarity with documentation and assigned roles and responsibilities for a Code Blue response. This will be invaluable support to the Code Blue team.

3.4 PRWRFs

3.4.1 Whenever possible, a dialogue as per Article 8 related to concerns between staff and managers will occur at the time of the incident, prior to documenting a submitting a PRWRF.

3.4.2 RNs will continue to document their concerns on the PRWRFs in alignment with the Collective Agreement when necessary.

3.4.3 BCHS will meet to discuss the submitted PRWRFs with the nurse(s) as per Article 8 and an ONA representative if they wish. This will begin immediately.

3.4.4 Management will review and engage with the nurse(s) involved as per the Collective Agreement and respond in writing to all PRWRFs within 10 calendar days with the goal of resolving the immediate issue(s) and working towards a long-term resolution. This is to begin immediately.

3.4.5 Outside of the regular business hours the nurse(s) will notify the Senior Clinical Operations Manager on call of the workload issue(s) and the manager on call will respond either by phone and/or visit the unit.

3.4.6 The CNE or their designate attend all HAC meetings, effective immediately.

4.0 The Environment

4.1 MENTAL HEALTH ROOMS

4.1.1 Once a patient is placed in one of the identified Mental Health rooms, there is a transfer of care to a nurse within ED. This accountability is then removed from the triage nurse(s).

4.1.2 ERMH will assess a patient placed in a Mental Health room as soon as possible to identify a plan of care.

4.1.3 If it is deemed a patient in one of the Mental Health rooms requires admission, the patient is moved to an inpatient Mental Health bed immediately if available. If unavailable the patient is moved into the ED main area with appropriate and safe monitoring of the patient based on care requirements, as deemed by ERMH assessment.

4.1.4 A camera will be installed in the one room that doesn't presently have one within the next 3 months.

4.1.5 The camera within the Mental Health assessment rooms should be monitored by security, who will alert the most responsible nurse when required.

4.2 SAFETY

4.2.1 BCHS will ensure all security officers assigned to the ED have Use of Force and De-escalation training.

4.2.2 BCHS install a CCTV camera in the quiet room within the next 3 months and security should monitor the video transmissions from both mental health designated rooms.

4.2.3 BCHS will ensure the lock on the break room is functioning properly and is operational with just one code. This to be done immediately.

4.2.4 The hospital will immediately install a peep hole in the staff break room

4.3 TRIAGE AREA

4.3.1 PRIVACY

4.3.1.1 The hospital will provide a type of physical barrier between the triage nurses, to provide a sense of privacy for patients, within the next 3 months.

4.3.2 EMS PATCH PHONE

4.3.2.1 Move the EMS Patch Phone to within the ED department at the desk of the charge nurse within the next 3 months.

4.3.2.2 The triage nurse should not be responsible for answering the EMS Patch Phone once it has been moved.

4.3.2.3 BCHS develop, with input from ED nurses, a form to be completed when answering the EMS Patch Phone. This would allow the person answering the phone to collect the information and relay to the CN if they are not at the desk. This will occur within next 3 months to coincide with phone being moved from the triage area.

4.3.2.4 ED staff collectively identify the process/person/role for answering the EMS Patch Phone and conveying the information to the Charge Nurse for the appropriate placement of the incoming patient.

4.4 NON-NURSING ROLES/EQUIPMENT

4.4.1 WARD CLERK

4.4.1.1 BCHS will add an additional ward clerk from 19:00-07:00, 7 days per week effective within the next 3 to 6 months.

4.4.1.2 The added ward clerk responsibilities will include the support of triage- assisting with entering the orders required for any of the directives and support the needs within ED as required.

4.4.2 ENVIRONMENTAL SERVICE AIDE

4.4.2.1 Continue to implement the *Item in Agreement* related to environmental service

4.4.3 EQUIPMENT

4.4.3.1 Continue to implement the *Items in Agreement* related to equipment concerns in the ED.

5.0 Leadership

5.1 LEADERSHIP AT THE POINT OF CARE

5.1.1 Clinical Managers, Clinical Educator and Clinical Scholar, identify and encourage novice nurses within BCHS-ED, who would benefit from the NGNR program, to participate in it.

5.1.2 All BCHS-ED nurses who meet the National Emergency Nurses Association (NENA) pre-requisite standards for triage, will be provided the orientation and training to assume the triage role.

5.1.3 The Clinical Educator and Charge Nurse will work closely with the nurses new to the triage role, to identify if they require more supports or time before assuming the triage role independently.

5.2 LEADERSHIP IN UNIT BASED COUNCILS

5.2.1 ED nursing leaders identify and encourage nurses to participate and become involved with the 2 Unit Practice Councils and/or consider joining the new Nursing Quality Council (NQC) that is a BCHS-wide initiative.

5.3 CLINICAL NURSE MANAGERS

5.3.1 The Senior Leadership Team provide the Clinical Managers with the support and resources (i.e. leadership development opportunities) required to be successful in their roles.

5.4 SENIOR LEADERSHIP TEAM

5.4.1 The Senior Leadership Team continue to focus on being highly visible, listening, and implementing qualities of transformational and authentic leadership in their daily interactions with staff.

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

6.0 Healthy Work Environment

6.1 COMMUNICATION

6.1.1 Ensure daily huddles occur, and if they are not interdisciplinary, consider encouraging all staff to attend the huddle, so that everyone is informed of what is occurring on the unit that day.

6.1.2 Managers continue to have a presence on the unit and an open door policy to encourage staff to discuss with them their ideas, concerns, and issues.

6.1.3 Managers discuss with staff the most effective ways to communicate with each other, to convey important information and let staff know of what is occurring in the ED and the organization.

6.1.4 As discussed in the section on the See & Treat area, incorporate See & Treat staff within the ED to promote and foster communication and a collaborative healthcare team.

6.1.5 Consider developing social media strategies with staff, for example through a BCHS-ED private WhatsApp site. Staff would be co-creators to foster engagement, collaboration, building an ED community, and communication on the unit and within the organization.

6.1.6 Ensure policies, procedures, and education are in place, on how to use social media apps appropriately ensuring privacy.

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

6.2 WELL-BEING

6.2.1 Invite well-being resources within the organization to attend staff meetings to inform staff of their role and how to contact them. If appropriate internal resources are not available access external supports.

6.2.2 Arrange for well-being resources within the organization within the next 3 to 6 months to attend staff meetings to assist staff in developing their self-awareness to triggers of stress, and strategies to address them.

6.2.3 In staff meetings, have discussions on how the staff can support each other in developing resilience strategies.

6.2.4 Nurse Managers, Charge Nurse, Clinical Nurse Educator, and Nurse Scholar, and formal and informal leaders, discuss and support nurses individually to access well-being resources when needed and emphasize the need to take care of themselves to be able to take care of others in their professional and personal lives.

6.2.5 Nurse Managers, Charge Nurses, Clinical Nurse Educator, Nurse Scholar and formal and informal leaders strongly encourage nurses who need time after a traumatic event to take it, regardless of what is occurring in the ED at that time.

6.2.6 Nurse Managers identify formal and informal leaders who can provide support to colleagues and encourage them to access well-being resources within the organization when needed.

6.2.7 Formal and informal leaders on the unit, role model calling Code Lavenders and accessing Peer Support resources when needed and encouraging others to also do this when necessary.

6.2.8 Revisit the reactivation of the Social Committee within the next 6 months as another strategy to strengthen peer support and resilience.

6.3 MORALE

6.3.1 Continue focused attention on recruitment and retention initiatives and support for new hires and graduate nurses.

6.3.2 Conduct “stay interviews” that are proactive relationship building structured interviews. Leaders conduct these interviews with their staff to foster a culture focusing on nurse engagement and retention. During the interview, leaders explore with staff members why they stay and what actions could be taken to strengthen their engagement and retention on the unit and organization. To learn more about stay interviews process please refer to Wang et al., (2023). These should be implemented within the next 3-6 months.

6.3.3 Conduct an exit interview/survey by a third party for all nurses who leave BCHS-ED for both internal and external opportunities. Review the results semi-annually to identify trends that may need addressing.

6.3.4 Report the findings from both the “stay” and “exit’ interviews at the monthly town hall meetings to explore how this data can be used to improve team morale and work environment.

6.3.5 Conduct an ED-specific staff satisfaction survey and explore ways to improve team building and morale by a third party facilitator focusing on implementable activities that the staff could do to support each other to build the morale on the unit.

6.3.6 Explore the re-activation of the social committee.

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APPENDICES

Appendix A: Referral of Professional Practice and Workload Issues at BCHS-ED to an IAC

ONA
www.ona.org

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

May 4, 2023

Martin Ruaux
Chief Nursing Executive
Brantford Community Healthcare System
200 Terrace Hill,
Brantford, Ontario
N3R 1G9

Dear Mr. Ruaux,

Re: Professional Practice and Workload Issues Brantford Community Healthcare System, Emergency Department ONA file # 202110228

This letter is in follow up to our discussions at the Hospital Association Committee (HAC) meetings regarding the ongoing and escalating issues being reported to the Hospital and the Union by the Registered Nurses (RNs) in the Emergency Department and is in accordance with Article 8.01 (a) ix) of the Hospital/Ontario Nurses' Association (ONA) collective agreement.

The RNs working in the Emergency Department at Brantford General Hospital have consistently identified ongoing serious practice and workload issues as evidenced by the data submitted on over 185 Professional Responsibility Workload Report Forms since January 2021 to date.

The RNs have documented that their current practice, patient care and workload environment does not allow them to meet the College of Nurses of Ontario Standards of Practice and Practice Guidelines, the Standards for Emergency Nursing Practice, Canadian Triage and Acuity Scale Guidelines or the Employer's policies, procedures, mission, or vision. They believe they are being asked to perform more work than is consistent with proper patient care. Effective supports have not been provided to respond to patient acuity and volumes, fluctuating workloads, fluctuating staffing, and professional practice issues.

The parties have met regularly since November 2021 to discuss solutions and allow the employer the opportunity to develop strategies and take actions to resolve the practice concerns and workload issues. Despite this, the employer has been unable to propose or agree to sufficient measures to resolve the very serious practice and workload concerns

identified by ONA members. As discussed at the last meeting, actions to date have not sufficiently resolved the workload and practice concerns, have had little impact on nursing workload, patient safety and standards of care. In accordance with the ONA/Hospital Collective Agreement, the union is seeking resolution of the concerns on behalf of our members and the patients that they care for and remains extremely concerned regarding the potential for catastrophic negative patient outcomes.

The parties have attempted to resolve the issues at the HAC meetings by discussing the issues and recommendations documented in our action plan. Despite this, a number of the workload and practice issues identified by ONA members remain unresolved, including but not limited to the inadequate baseline Registered Nurse staffing to manage the volume and acuity of patients, and support safe timely triaging of patients. Further issues include the lack of RN support for daily transfers to other hospitals, the lack of adequate equipment, adequate supports for education, training, and mentorship. There is a lack of effective communication and overall leadership support for staff.

The Union is extremely concerned regarding the potential for negative patient outcomes. We are seeking resolution of the practice and workload issues on behalf of our members, the patients, and community for which they provide care. Timely and effective resolution of Professional Responsibility and Workload Issues is vital to enable the RNs to deliver safe, competent, and ethical patient care. Accordingly, the Union is forwarding the complaint to an Independent Assessment Committee (IAC) as per Article 8 of the Collective Agreement.

A Chairperson will be invited from the list in Appendix 2. Please provide written confirmation concerning the contact information of your nominee including name, mailing address, phone numbers and e-mail address. The Union will provide the name and contact information of our nominee in a subsequent communication.

The Union remains willing to continue to work with the Hospital to further resolve the outstanding issues and believe that the money spent on the IAC could be better utilized to improve the practice and workplace environment for our members and patients. Should the parties resolve the issues prior to the IAC hearing, the request for an IAC hearing will be withdrawn.

Sincerely,

ONTARIO NURSES' ASSOCIATION

Appendix B: BCHS-ED Letter to the IAC Chair Naming the ONA Nominee

June 6, 2023

SENT VIA EMAIL - cmallett@yorku.ca

Claire Mallette
Associate Professor
School of Nursing
York University
354 HNES
4700 Keele Street
Toronto, ON M3J 1P

Dear Chair Mallette,

RE: Brantford Community Health Systems and Ontario Nurses' Association: Professional Responsibility Complaint – Emergency Department – Independent Assessment Committee – ONA File #202110228

Thank you for accepting the nomination to chair an Independent Assessment Committee (IAC) investigating a complaint at Brantford Community Health Systems. ONA has informed Mr. David McCoy, Director Labour Relations at the Ontario Hospital Association, of your agreement to Chair 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. The current Collective Agreement is in arbitration at present. When I receive the most up to date copy, I will forward that to you. If you require any other documents, please do not hesitate to let me know and I can forward them to you.

The attached letter provides the Association's nominee - name and contact information. The Employer has been asked to share their nominee's information, per the timeframes as set out in the Collective Agreement; and the due date was June 4, 2023. Please set dates with the nominees, who will confirm with their respective parties.

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

Name: Cindy Gabrielli
Address: XX.

Phone: XX
Email: XX

Yours very truly,

ONTARIO NURSES' ASSOCIATION

Sandy Paproski, RN
Professional Practice Specialist

C: Allison McKellar, Bargaining Unit President
Melanie Holjak, Local Coordinator
Carol Gunsch, Labour Relations Officer
Martin J. Ruaux, Vice-President Clinical Services & CNE
David McCoy, Director, Labour Relations, OHA
Jackie Kehoe-Donaldson, Manager, Professional Practice
Lorrie Daniels, Manager, Professional Services Learning and Development

Appendix C: BCHS's Letter to ONA Naming the Hospital's Representative

July 10, 2023

Ms. Sandy Paproski
ONA Professional Practice Specialist
Ontario Nurses' Association
85 Grenville Street, Suite 400
Toronto, ON N5S 3A2

The Brantford General
200 Terrace Hill St.
Brantford, ON.
N3R 1G9
519-752-7871

The Willett
238 Grand River St. N.
Paris, ON.
N3L 2N7
519- 442-2251

www.bchsys.org

Dear Ms. Paproski,

This letter is in follow up to our letter dated May 19, 2023 regarding the BCHS Hospital Nominee for the Independent Assessment Committee (IAC). We have selected Stephanie Pearsall to be our representative on the panel.

We are fully committed to working with ONA and the committee to come to a mutually agreeable resolution and are continuing to maintain open lines of communication with our staff, and our union partners. We take the staff concerns very seriously and would like to find collaborative solutions to respond to the issues raised through the nursing workload and practice submissions.

Once again, I would like to reaffirm our commitment to working in collaboration through this process as I believe we all share the same goals for our employees and the patients that we serve.

Sincerely,

Beth Morris
Chief Nursing Officer (Interim)

cc: Erin Sleeth, President and Chief Executive Officer (Interim)
Lisa Keefe, Director (Interim), Human Resources
Lisa Webster, Clinical Director Emergency, Critical Care, Mental Health
Joe Mancini, Manager, Emergency Department

Appendix D: Data Request for the BCHS-ED IAC Hearing

Brant Community Health System Emergency Department & Ontario Nurses Association
Independent Assessment Committee Hearing, March 19-22, 2024
Request for Information

1) Patient Information for the Emergency Department (ED) for the past three fiscal years April 1, 2021 to March 31, 2022, April 1, 2022 to March 31, 2023, and April 1, 2023 to date

Volumes by year, day of the week and by hour of the day
Distribution by CTAS level; by year, day of the week, and hour of the day
Ambulance volumes and offload times by year, day of the week, date, and hour of day
Time to initial assessment by nurse and by doctor
Admission by CTAS level including admission rate
Number of admits with no beds by hour of the day
Time to admission after decision to admit
ED length of stay by day of the week
i) Time to triage

2) Unit Organization/Functioning

a) Structural drawing of the ED layout
b) Description of how the ED is organized; zones and functions (triage, minor, major, other)
c) Organizational Chart for Nursing in the ED
d) Job Descriptions for Team Leader/Charge Nurse, Triage Nurse, Registered Nurse, Registered Practical Nurse, Nurse Practitioner, Advanced Practice Nurse, Nurses Educators, any other registered staff including all allied health professionals; Does Triage Nurse and/or the Team Leader/Charge Nurse have a patient assignment?
e) Triage Assignment Guidelines
f) Orientation Program for RNs, including number of weeks with a preceptor/buddy
g) Support roles, such as, but not limited to Personal Support Worker, Ward Clerk/Clerical Assistant
h) Charting guidelines and/or policies for ED
i) Policies regarding gridlock/overcapacity in the ED and actions to be taken if volumes/admissions exceed capacity; including any procedures/policies regarding calling in additional staff to manage high volumes/admissions
j) Changes or initiatives that have impacted ED in the last three years
   I. External issues that impact patient fl2ow/emergency volumes
   II. Major process changes, model of care changes, technology implementations, special projects in the ED

3) Staffing Data for fiscal 2021-to 2022, 2022-2023, 2023 to date

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

e) Sick-time, overtime in FTE's for RN's and comparison over last three fiscal years
f) Current RN vacancy rate
g) Turnover rate for RNs
h) Experience Profile – number of RNs with ED experience (under 1 year, 2 years, 3 to 5 years, 5 to 10 years, 10 t0 15 years, 15 to 20 years, greater than 20 years
i) Number of nursing staff on modified work or have permanent accommodations
j) Copy of local collective agreement
k) Master schedule: copy of the posted schedules for RNs for the past year and a copy of daily assignment sheets for the past year
l) Actual daily assignment sheet for the previous six weeks
m) Number of Nurse Practitioners, Advanced Practice Nurses, Educators, other non-bedside leadership nursing positions
n) Allocation of Allied Health Professionals (Physiotherapist, Occupational Therapist, Social Workers, Dietitians, Pharmacists, Physician Assistants, other
o) Allocation of support staff such as, but not limited to, Personal Support Workers, Ward Clerk/Clerical Assistants, other
p) If utilized by the ED: the size and utilization of a department or organizational float pool

4) Budget and Performance Indicators for the past three fiscal years

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

5) Quality of Care Performance Indicators

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

6) Hospital Association Committee (HAC) Agendas and Minutes from 2021, 2022, 2023 and any other Agendas and Minutes of meetings regarding workload complaints in the ED

7) ED Staff Meeting Minutes for 2021, 2022, 2023

Appendix E: Email IAC Hearing: Next steps

IAC Hearing: Next Steps

CM Claire Mallette

Reply | Reply all | Forward

To: Morris, Beth <Beth.Morris@bchsys.org>; Sandy Paproski <SandyP@ona.org>

Mon 2024-01-29 8:01 AM

Cc: cgabrielli@cogeco.ca; stephaniepearsall3@gmail.com

Data Request for ED IAC Revi...
Saved to OneDrive

Hello Everyone,
I hope you had a good weekend.

The IAC discussed what is needed for the upcoming IAC Hearing for Brantford General Hospital (BGH) Emergency Department (ED) and ONA. Please find below the next steps.

1. The IAC Hearing will be held via Zoom on March 19, 21 & 22, 2024 (agenda to follow). There is no Hearing on March 20, to enable each of your teams to review the information presented on March 19, and prepare your responses, that will be presented on March 21. Both March 19 and 21 will be full days from approximately 8:30-4:30 pm. March 22 will be from 8:30 to approximately 1:00 pm.

2. We request that the documents you are preparing for the IAC hearing be submitted to the IAC and each other on March 5, 2024.

3. Please start compiling the names of the people in your team who will be attending the IAC Hearing, including their roles and emails. When choosing nurses to speak at the Hearing on March 22, it would be good to hear mostly from nurses who are presently working on the unit, or recently left. I will need these names by March 1, 2024.

4. First Class Conferencing Facilitation (FCCF) will be engaged to oversee the technology during the Hearing.

5. Since the IAC Hearing is virtual, we will need a video of the ED to view at the beginning of the Hearing. This is to provide the IAC with a visual understanding of the unit from both of your perspectives. As such, both parties should be involved in the filming of the video.

   We ask that the video include a walk through, to help us understand the layout of the unit, where the nurses work (for example, where medications are prepared, documenting occurs etc.), where patient care is provided (ensuring no patients are videotaped), utility rooms, break rooms, offices on the unit, safety related items, and anything else that each party wants us to view. Please provide us with an update on when the video will be done

6. Once the video is completed, we will send it to FCCF to have available to view on the Hearing's first day.

7. The data we are asking to be included in BGH's submission is attached to this email.

With thanks,
Claire

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

Appendix F: First Class Conferencing Facilitation Confirmation:

On Mon, 29 Jan 2024 at 08:17, Claire Mallette <cmallett@yorku.ca> wrote:

> Hi McKenzie
>
> I hope you had a good weekend.
>
> I am doing another virtual IAC on Zoom with ONA and Brantford General Hospital on March 19, 21, & 22. It will be similar to the last one I just did where on March 19 & 21 they will be full days from 8:30-4:30 and on March 22 it will be from 08:30-1:00ish.
>
> I am hoping someone will be able to oversee the technology for us.
>
> Thanks,
> Claire
>
> Claire Mallette RN, PhD
> Director, School of Nursing
> York University, Toronto, ON

From: McKenzie Day <mday@firstclassfacilitation.ca>
Sent: January 29, 2024 11:09 AM
To: Claire Mallette <cmallett@yorku.ca>
Cc: Segan Alexandria Permell <spermell@firstclassfacilitation.ca>
Subject: Re: IAC on March 19, 21, & 22

Hi Claire,

I hope you had a good weekend as well!

As a matter of fact, Segan is available for these dates and I have copied her to this email. Once all the details are confirmed for the matter, Segan can work on sending out invites.

Do you know if there will be any videos for this IAC Hearing? Let me know and looking forward to working with you again!

Cheers,
McKenzie Day
CTO | First Class Conferencing Facilitation
e. mday@firstclassfacilitation.ca
m. (647) 373-5986

Appendix G: BCHS Data Request Clarification & IAC Response

Morris, Beth <Beth.Morris@bchsys.org> Feb 5, 2024, 3:24 PM

to Claire, me, Stephanie, stephaniepearsall3@gmail.com, cgabrielli@cogeco.ca

Hello everyone,

Hoping you could provide clarity related to the following request for data:

1) **Patient Information for the Emergency Department (ED) for the past three fiscal years April 1, 2021 to March 31, 2022, April 1, 2022 to March 31, 2023, and April 1, 2023 to date**

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

i) Time to triage

Can you confirm if you want the volumes and wait times **for each day** from April 2019 to December 2023, or just the year, day of week and hour? The word "date" to me implies every single day value, which is a la
period specified.

Thanks very much,

Beth

claire mallette <clairemallette@gmail.com> Feb 6, 2024, 8:02 AM

to Beth, Claire, Stephanie, stephaniepearsall3@gmail.com, cgabrielli@cogeco.ca, Sandy

Good Morning Everyone,

We acknowledge that asking for ambulance volumes and offload times by year, day of the week, date and hour of day for the past 3 fiscal years would be a large amount of data.

As it is very important to get an understanding of ambulance volumes and offload times, can you please provide average volume/month and average volume by day of the week. However, we would also like volumes by hours for the past 6 months (August 2023-January 30, 2024).

Thanks and have a good day,
Claire

Appendix H: Email and Document sent March 12, 2024 from Beth Morris: Clarification to Employer Brief

Clarification to Employer Brief Inbox x

Morris, Beth 4:48 PM (58 minutes ago)

to me, Stephanie, cgabrielli@cogeco.ca, Sandy

Hello everyone, please see the attached letter for your review, to provide a point of clarification regarding information contained in the employer's brief.

Sincerely,
Beth

Beth Morris, RN, BScN, MScN (Pronouns: she/her/hers)
Chief Nursing Officer (Interim)
Clinical Director, Professional Practice, Corporate Clinical Resources
Integrated Stroke & Post Acute Programs
Brant Community Healthcare System
200 Terrace Hill Street
Brantford, ON N3R 1G9
Ph: 519-751-5544 Ext. 2290
email: beth.morris@bchsys.org

Brant Community Healthcare System
The Willett, Paris
The Brantford General

Exceptional Care. Exceptional People.

March 12, 2024

Independent Assessment Committee
Brant Community Healthcare System
and Ontario Nurses' Association

Dear Dr. Mallette, Ms. Pearsall, Ms. Gabrielli, Ms. Paproski

In preparation for the upcoming IAC hearing, I have identified a discrepancy in BCHS' submission related to our nursing resources in the ED. I would direct your attention to page 39 of the employer's brief, to the table titled **FY 23/24 Scheduled Staffing Hours (Main ED).**

In the table we erroneously included the new RN investment for the 2024/25 fiscal year in our staffing numbers. We indicated that we have 17 staff on days; and 13 on nights. This should instead read that there is a total of 16 staff on days; and 13 on nights. The midshift (flex) RN position (1100-2300) is posted and included in the budget for the upcoming fiscal year.

I apologize for any confusion this may have caused and will be happy to address any questions you have during the hearing.

Sincerely,

Beth Morris
Interim Chief Nursing Officer

Appendix I: IAC Hearing Agenda for March 19, 21, & 22

Brant Community Health System (BCHS) & Ontario Nurses Association (ONA)
Brant Community Health System Emergency Department (BCHS-ED)
IAC Hearing Agenda
Tuesday March 19, 2024

Zoom Link:
https://firstclassfacilitation-ca.zoom.us/j/65902188167?pwd=UTRXM0g4STlaOGowdDFzVVZ3NDM2dz09

Time	Item	Participants
08:30-08:45	Welcome and Introductions	C. Mallette (Chair)/All
08:45-08:55	Review of Proceedings of the Day	C. Mallette
8:55-10:00	Watch Virtual Tour of BHG-ED	All
10:00-10:30	Discussion generated from the Video	All
10:30-11:00	Break	All
11:00-12:30	Ontario Nurses' Association Submission Presentation • Presented by: Sandy Paproski	ONA
12:30-1:15	Lunch Break	
1:15-2:00	Response to questions of clarification from: • Independent Assessment Committee • Brant Community Health System	IAC & BCHS
2:00-15:30	Brant Community Health System Submission Presentation • Presented by: Beth Morris	BCHS
15:30-15:45	Break	
15:45-16:30	Response to questions of clarification from: • Independent Assessment Committee • Ontario Nurses' Association	IAC & ONA
16:30-16:45	Review of Process for Thursday March 21, 2024	IAC Chair
16:45	Adjournment	IAC Chair

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

Brant Community Health System (BCHS) & Ontario Nurses Association (ONA)
Brant Community Health System Emergency Department (BCHS-ED)
IAC Hearing Agenda
Thursday March 21, 2024

Zoom link:

https://firstclassfacilitation-ca.zoom.us/j/67894889527?pwd=NFdrV2VrRGpmSmZNUmROblNSTWU3dz09
Meeting ID: 678 9488 9527
Passcode: 1140523011

Time	Item	Participants
08:30-08:35	Welcome	IAC Chair
08:35-08:45	Review of Proceedings of the Day	IAC Chair
08:45-10:15	Brant Community Health System Response to Ontario Nurses' Association Submission Presented by: Beth Morris	BCHS
10:15-10:45	Break	All
10:45-11:45	Response to questions from: • Independent Assessment Committee • Ontario Nurses' Association • Discussion	IAC & ONA
11:45-12:45	Lunch Break	All
12:45-14:15	Ontario Nurses' Association Response to Brant Community Health System Submission Presented by: Sandy Paproski	ONA
14:15-14:45	Break	All
14:45-15:45	Response to questions from: • Independent Assessment Committee • Ontario Nurses' Association • Discussion	IAC & BCHS
15:45-16:00	Review of process for Friday March 22, 2024	IAC Chair
16:00	Adjournment	IAC Chair

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

Brant Community Health System (BCHS) & Ontario Nurses Association (ONA)
Brant Community Health System Emergency Department (BCHS-ED)
IAC Hearing Agenda
Friday March 22, 2024

Zoom link:

https://firstclassfacilitation-ca.zoom.us/j/63474079545?pwd=azMwUDBOOWZVSFlycU80bVpEUndRdz09

Meeting ID: 634 7407 9545
Passcode: 0767496090

Time	Item	Participants
08:30-8:45	Welcome and Review of Proceedings	IAC Chair
08:45-10:15	Questions to both Parties by the Independent Assessment Committee	IAC & All
10:15-10:45	Break	All
10:45-12:15	BCHS-ED Nurses' Lived Experiences	BCHS-ED Nurses
12:15-12:30	Closing Remarks Ontario Nurses Association	ONA
12:30-12:45	Closing Remarks Brant Community Health System	BCHS
12:45-13:15	Closing Remarks and Identification of Next Steps by Chairperson and Closure of Hearing	IAC Chair
13:15	Adjournment	IAC Chair

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

Appendix J: IAC Hearing Attendees & Attendance March 19, 21, & 22

Brant Community Health System (BCHS) & Ontario Nurses Association (ONA)
IAC Hearing: Brant Community Health System Emergency Department (BCHS-ED)

ONA Attendees/Day

Name	Title	March 19	March 21	March 22
Sandy Paproski	Professional Practice Specialist (PPS) ONA	X	X	X
Allison McKellar	Previous Bargaining Unit President (BUP) Labor Relations Officer (LRO) ONA (orientation)	X	X	X
Cathy Cleverdon	BUP	X	X	X
Taylor Rivera	BCHS PRWRF Representative ED RN	X	X	X
Lisa Stulen	ED RN	X	X	X
Amy Farrow	ED RN	X	X	X
Jacqueline Graham	ED RN	X	X	X
Christina Wilhelm	ED RN	X	X	X
Kathrine Armenta	PPS ONA	X	X	X
Kara Northgrave	PPS ONA (orientation)	X	X	X
Carol Gunch	LRO ONA	X	X	X
Jackie Kehoe-Donaldson	PPD Manager ONA	X	X	X
Jill Clark	PRWRF Representative for BGH	X	X	X
Nicolas Baxter	ONA Litigator	NA*****	NA*	NA*
DJ Sanderson	Executive Lead Provincial Services Strategy Team	NA*	NA*	NA*

Grace Pierias	Vice President Region 4	NA*	NA*	NA*
Angela Preocanin	Vice President ONA	NA*	NA*	NA*
Erin Ariss	President ONA	NA*	NA*	NA*
Nicolas Baxter	ONA Litigator	NA*	NA*	NA*

***NA= Not Attended**

BCHS Attendees/Day

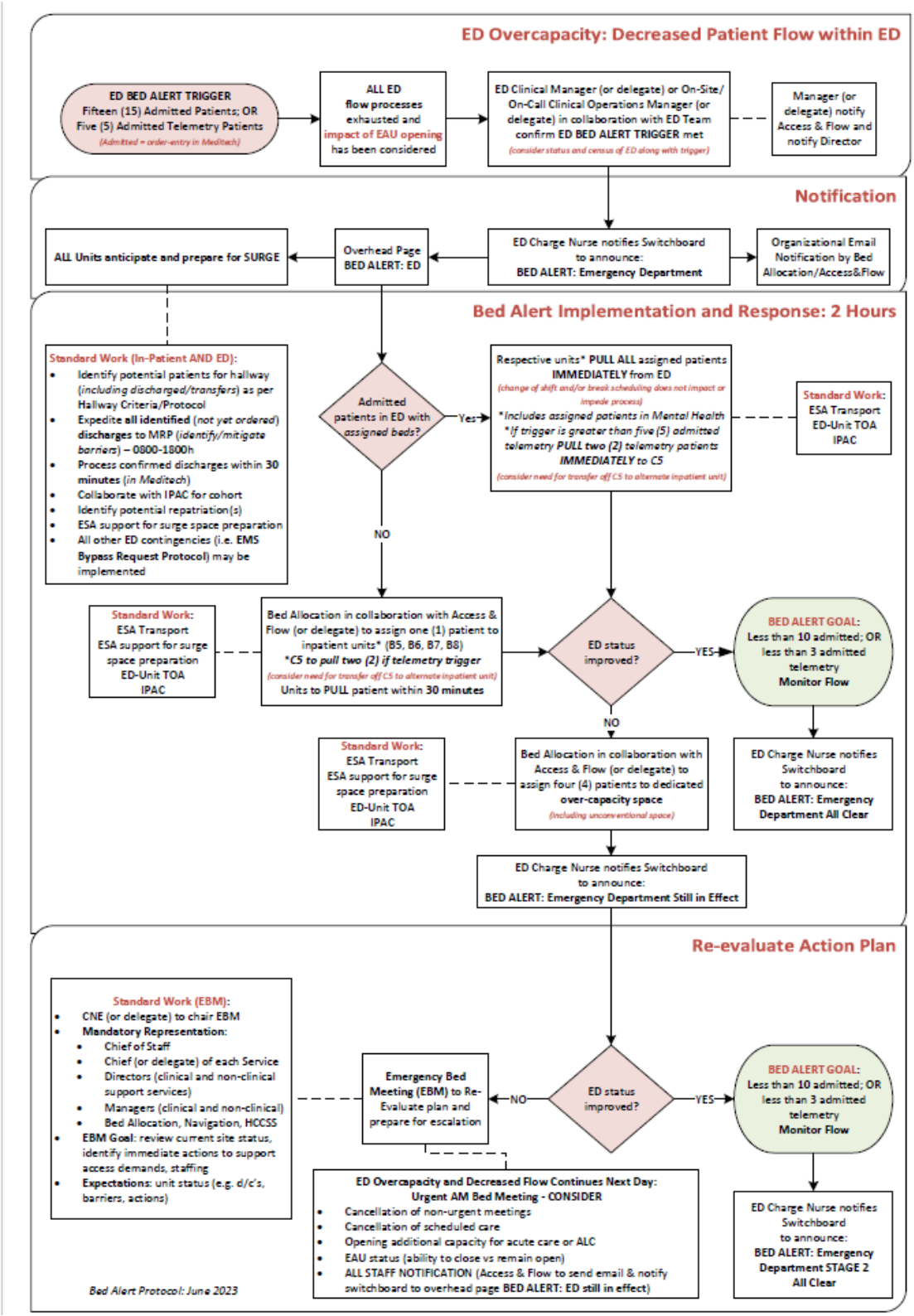
Name	Title/Role	March 19	March 21	March 22
Beth Morris	Interim Chief Nursing Officer	X	X	X
Lisa Keefe	Director, Human Resources	X	X	X
Joseph Mancini	Manager, ED	X	X	X
Will Thomas-Boaz	Manager, ED	X	X	X
Lisa Reeder	Interim VP Clinical Operations	X	X	X
Grant Nuttall	Legal Representative	X	NA*	NA*

***NA=Not Attended**

Independent Assessment Committee Members

Name	Title/Role	March 19	March 21	March 22
Claire Mallette	IAC Chair	X	X	X
Cindy Gabrielli	ONA Nominee	X	X	X
Stephanie Pearsall	BCHS Nominee	X	X	X

Appendix K: ED Overcapacity Decreased Patient Flow within the ED



Appendix L: ITEMS IN AGREEMENT

ITEMS IN AGREEMENT

Between

ONTARIO NURSES' ASSOCIATION
(Hereinafter referred to as "the Union")

And

Brant Community Health System Emergency Department
(Hereinafter referred to as "the Employer")

/hereas a number of professional practice and workload issues have been raised by the ırses on the Emergency Department (ONA File # 202110228) and.

/hereas the parties promote public confidence in, and the provision of, quality nursing are, and recognize that such quality of care is premised, among other things, in a healthy ıd professional work environment.

nd whereas the parties have discussed these issues under Article **8**;

ow therefore the parties have agreed on the following with the understanding that the emaining items left unresolved will continue to be discussed and addressed under Article

1. The Employer has implemented a Charge Nurse without direct patient assignment 24/7.
2. The Employer employs a Security Officer 24/7 to stay at triage.
3. The Employer employs a Security Officer 24/7 to round hourly throughout the Emergency Department as a part of their standard work.
4. The Employer attempts to ensure both these Security Officers have hands-on Training.
5. The Employer has implemented two Registered Nurses at triage 24/7.
6. The Employer has implemented an offload nurse 24/7.
7. The Employer has improved Registered Nurse Orientation, will endeavor to maintain a 1:1 mentorship with an experienced RN, utilizing the New Graduate Guarantee (NGG) program as a model.
8. The orientation program provides 225 hours or twenty 11.25-hour shifts of unit-based orientation with a dedicated mentor as well as ongoing assessment with Clinical Manager, Clinical Educator, Mentor, and new hire. Will provide additional orientation if needed.
9. Each new hire completes corporate orientation as indicated in alignment with other new nurses.

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10. Should staff not require 225 hours based on experience, they would be entitled to 176 hours of orientation. (12x12-hours + 4x8-hours).
11. Hourly rate compensation and time will be provided for the Triage orientation course to all nurses who meet the prerequisite of NENA triage minimal capabilities: 2 years of experience in the emergency department. This may be reduced to prerequisite of one year working in BCHS Emergency Department if the staff is already an experienced RN.
12. The Employer has developed a fulsome orientation for all RNs who are required to do Charge Nurse role. Each RN will receive 2 shifts orientation (12-hour day/12-hour night) prior to expectation to do Charge Nurse role. The employer will endeavor not to place RNs without training in the role. The manager will provide more training if requested.
13. After completing the pre-requisite triage course an RN will receive four 12-hour shifts with an experienced triage mentor. The manager will provide more training if requested.
14. RNs working in the Emergency department for a minimum of six months will obtain ACLS and PALS, time and course costs paid for by employer. All RNs will have completed ACLS and PALS before working in Zone 1. TNCC and NRP are recommended courses that the Employer will make every attempt to enable attendance and course cost is eligible for reimbursement through the central education fund.
15. The Employer has developed a Charge Nurse binder for reference to uncommon issues or events.
16. All staff have been provided with code white security alarm badges.
17. All work zones have been assessed for escape routes, education has been provided to all staff for the plans for each zone and will be posted at each workstation as of January 19, 2024.
18. Cardiac monitors have been placed at each stretcher space in rooms for Zone 1, 2, and 3. The Employer will ensure nurses working in these zones are trained for cardiac monitoring by January 8, 2024 (this work is in progress and schedules for training are completed).
19. Four Zoll monitors are present in the department: Two in Zone 1, one in Zone 3, and two in the south hallway. Replacements for Zoll monitors are obtainable through Biomed.
20. Every Zone, including See and Treat and Triage, has a dedicated ECG machine.
21. Portable vital sign machines are available throughout the department. Specifically, two vital sign monitors in Zone 4/5 as there is no cardiac monitoring available in these Zones. Additionally, one VS monitor in Zone 2 and 3. There are continuous SpO2 monitors available in Zone 1.

22. The employer has a specific tag out policy for all equipment issues. Issues to be brought to managers' attention daily and discussed at daily huddles on status of repairs. Biomed also rounds every day through the department to fix any BioMed issues.
23. The Employer has a staff member (Material Handler from Stores Department) who is scheduled daily to aid with supplies in department; or a process in place to aid with supplies. The Employer has developed a standard work process for stocking supplies.
24. The Employer is developing a global supply list specific to the ED, will be assessed every six months for additions or subtractions that have been noted by staff. Process will be established by the end of January 2024.
25. The Employer has an Overcapacity or Bed Alert Protocol that is to be implemented when 15 admitted patients and/or 5 telemetry admissions are being held in the department with no plan for bed placement. The Employer will communicate this process regularly with Charge Nurses when this protocol is enacted. Regular re-evaluation of this process will occur as a part of the BCHS Pt. Flow Steering Team.
26. The Employer will endeavor to upstaff when holding greater than 10 admitted patients and will utilize the CRT or inpatient nursing staff first.
27. The Employer ensures appropriate Personal Protective Equipment is readily available for each staff member.
28. The Employer ensures unit huddles happen daily. The Employer will attempt for 0830h daily but may adjust depending on department's needs. The daily huddles will inform staff of staffing issues, security/safety issues, overcapacity issues, broken or missing equipment issues and any other matter that should be shared.
29. The Employer is committed to ensuring regular monthly staff meetings for Emergency Department staff, via internet or in person. The agenda is made available to staff one week prior to the meeting for additions. Minutes will be taken at each meeting and posted within one week of the meeting for all staff to read.
30. The Employer meets with HR recruiter weekly to discuss retention and recruitment, utilizing all aspects of governmental programs, and a referral program for staff is in place. The Employer agrees to add recruitment and retention as a standing item to HAC meeting agendas.
31. The Employer agrees to maximize HHR funding to add supports within the department (Clinical Scholar, NGG, Externs etc.).
32. The Employer completes debriefs after every code blue and ad hoc for sensitive events.

These agreed items are binding on the parties and the parties agree that any dispute involving the implementation are enforceable through arbitration.

The parties will evaluate the implementation of the resolutions while the parties work to resolve the outstanding professional practice and workload issues raised by the nurses on this unit. Should professional practice and workload issues related to the items agreed in this agreement continue to arise while the parties are working towards resolution of the outstanding issues, the parties agree these issues will be addressed as part of this professional responsibility file.

DATED THIS 22nd DAY OF JANUARY 2024.

FOR THE EMPLOYER

Chief Nurse Executive

Manager of ED

Professional Practice Manager of ED

HR Director

VP Clinical Services

FOR THE UNION

Sandy Paproski

Professional Practice Officer

Bargaining Unit President

Labour Relations Officer