

# **Independent Assessment Committee Report**

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

**between**

**Winchester Memorial District Hospital**

**and**

**Ontario Nurses' Association**

**January 30<sup>th</sup>, February 1<sup>st</sup>, and February 2<sup>nd</sup>, 2024**

# Independent Assessment Committee Winchester Memorial District Hospital and The Ontario Nurses' Association

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Vice President of Clinical Services and Chief Nursing Executive  
Winchester District Memorial Hospital

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Professional Practice Specialist  
Ontario Nurses' Association

The members of the Independent Assessment Committee Panel respectfully submit the attached Report with findings and recommendations regarding the Professional Responsibility Complaint presented by the Registered Nurses working in the Labor and Delivery Unit at Winchester District Memorial Hospital.

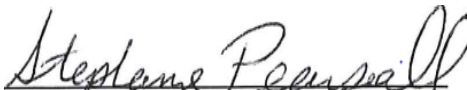
The Professional Responsibility Complaint was presented to the Independent Assessment Committee, in accordance with Article 8.01 of the Collective Agreement between the Winchester District Memorial Hospital and the Ontario Nurses' Association, at a Hearing held January 30<sup>th</sup>, 2024, February 2<sup>nd</sup> and February 3<sup>rd</sup>, 2024.

The Independent Assessment Committee Panel recognizes and appreciates, the time, energy, and thoughtfulness provided by representatives of the Winchester District Memorial Hospital, the Ontario Nurses' Association and the Registered Nurses working in the Family Birthing Unit to prepare and present information regarding the Professional Responsibility Complaint, and to respond to the Panel's questions. The attached Report contains unanimously supported recommendations, which we hope will assist all parties to continue to work together, within the context of a quality practice environment which supports professional practice, provide quality and safe patient care to the patients presenting in the Labor and Delivery Unit.

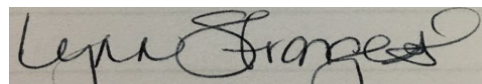
Respectfully submitted on Monday March 18, 2024.



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



Stephanie Pearsall, BScN, MHS  
Guelph General Hospital Nominee



Lynn Stranges, RN, BScN  
Ontario Nurses' Association Nominee

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## 1.1 Organization of the Independent Assessment Committee Report

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

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

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

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

**Section IV** presents the IAC Panel’s conclusions and recommendations.

**Section V** contains the Appendices referenced throughout the IAC Report.

## 1.2 Jurisdiction of the Independent Assessment Committee

### ARTICLE 8 – PROFESSIONAL RESPONSIBILITY<sup>1</sup>

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

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

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

If the Hospital assigns several 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:

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<sup>1</sup> Collective Agreement Ontario Nurses Association Expires March 31, 2025.

- (a) i) At the time the workload issue occurs, discuss the issue within the unit/program to develop strategies to meet patient care needs using current resources.
- ii) If necessary, using established lines of communication as identified by the hospital, seek immediate assistance from an individual(s) (who could be within the bargaining unit) who has responsibility for timely resolution of workload issues.
- iii) Failing resolution of the workload issue at the time of occurrence or if the issue is ongoing the nurse(s) will discuss the issue with 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) may request the assistance of a Union representative 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) may request the assistance of a Union representative 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.

8.02 The delegation of Controlled Acts shall be in accordance with the *Regulated Health Professions Act*, Medical Directives, and related statutes and regulations and in accordance with guidelines established by the College of Nurses of Ontario from time to time, and any hospital policy related thereto, provided that if the Union is of the opinion that such delegation would be detrimental to quality patient care, the Union may refer the issue to the Hospital-Association Committee.

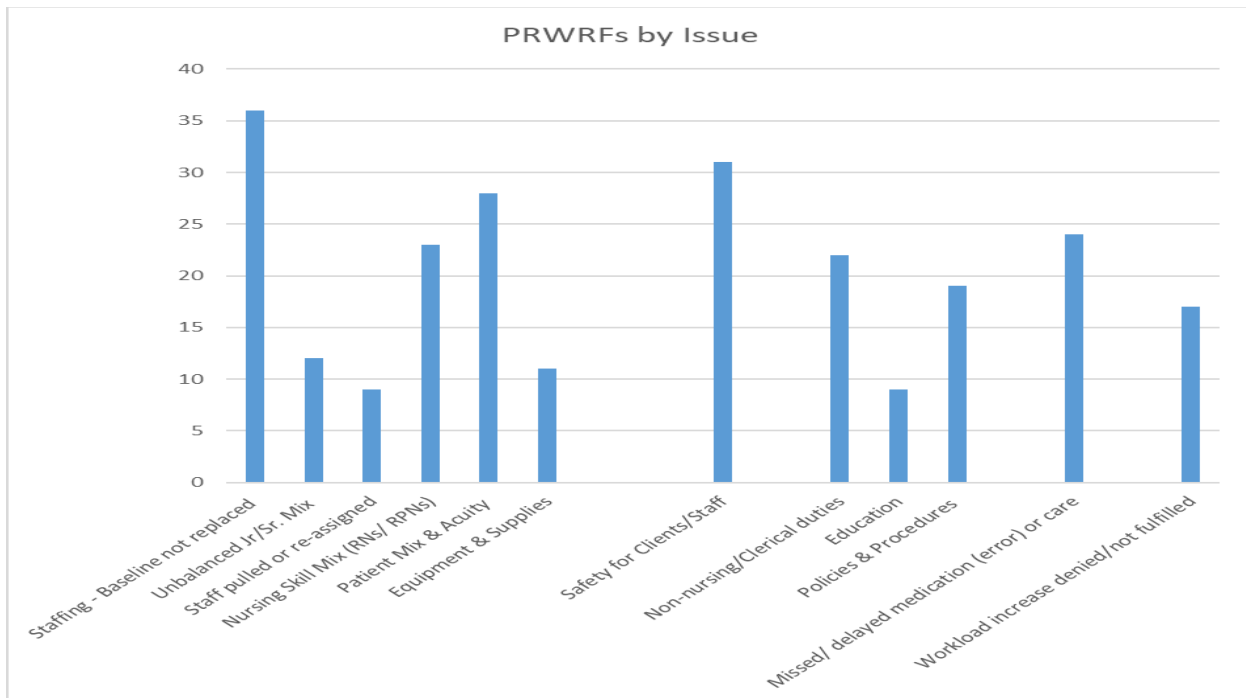
NOTE: Where an employee is in a position other than in a registered nursing position with duties and responsibilities which are subject to the *Regulated Health Professions Act*, they shall be treated in a manner consistent with this Article.



- 8.03 The Hospital will notify the nurse when it reports them to the College of Nurses of Ontario and refer them to the Union as a resource.
- 8.04 Should an employee, who is a Health Professional under the *Regulated Health Professions Act*, be required to provide their Regulatory College with proof of liability insurance, the Hospital, upon request from the employee, will provide the employee with a letter outlining the Hospital's liability coverage for Health Professionals in the Hospital's employ.

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

The Registered Nurses (RNs) working in the Family Birthing Unit at Winchester District Memorial Hospital have identified ongoing nursing practice and workload issues as evidenced by the information and data submitted from the Professional Workload Report Forms (PRWRF) since January 2021 as evidenced by ONA’s submission dated January 8, 2024, and received by the IAC Chairperson and Committee January 8, 2024. <sup>2</sup> **(See Section 2.1.2 Events Following Referral of the Professional Responsibility Complaint for further details)**



ONA followed up with emails to the OHA (August 22, 2022) and a letter (August 24, 2022) confirming the IAC Chair. The Employer responded in writing to confirm their nominee, on May 29<sup>th</sup>, 2022. <sup>3</sup>

Donna Rothwell RN, BScN, MN was identified as the Chair of the IAC as per the ONA/Hospital Central Agreement list of Committee Chairs on April 13, 2023. ONA forwarded this correspondence to the Chair, naming ONA’s nominee, Lynn Stranges RN, BScN May 5<sup>th</sup>, 2023. <sup>4</sup> Winchester District Memorial Hospital named their nominee for the IAC, Stephanie Pearsall, BScN, MHS on May 29<sup>th</sup>, 2023. <sup>5</sup>

<sup>2</sup> ONA Submission to IAC Volume 1: ONA Brief and PRWRF Tracking Report January 8, 2024

<sup>3</sup> ONA Submission to IAC Volume 1: ONA Brief and PRWRF Tracking Report January 8, 2024

<sup>4</sup> Appendix 2

<sup>5</sup> Appendix 3

## **1.4 Proceedings of the Independent Assessment Committee**

### **1.4.1 Pre-Hearing**

#### **1.4.1.1 Nominee Selection**

In accordance with Article 8.01 (a), (x), (xiii) and (xiv) and 8.01 (b) applies to nurses only the Association and the Hospital identified their Nominees to the IAC. The IAC Chairperson received notification of the Association's Nominee, Lynn Stranges, RN, BScN on May 5<sup>th</sup>, 2023 (*Appendix 3*) and the Hospital's Nominee, Stephanie Pearsall, BScN, MHS on May 29<sup>th</sup>, 2023. (*Appendix 2*).<sup>6</sup>

#### **1.4.1.2 IAC Introductory Teleconference**

The IAC Chairperson contacted the Nominees on November 18, 2023, and provided copies of correspondence related to IAC Guidelines and Nominee Role. ONA's correspondence related to Winchester Memorial District Hospital Family Birthing Unit overview of the issues and a list of items for the Hospital to submit as requested for the upcoming IAC for the Nominees to review.

On November 23, 2023, both the Ontario Nurses Association and Winchester District Memorial Hospital received a draft agenda for the IAC hearing scheduled for January 30<sup>th</sup>, February 1<sup>st</sup> and February 2<sup>nd</sup>, 2024, and correspondence from the IAC Chairperson and both nominees were copied on this correspondence.

Several email exchanges occurred prior to the IAC Panel's introductory meeting held virtually on December 14, 2023. The Chairperson reviewed the jurisdiction of the IAC within the Collective Agreement, discussed the role of the Nominees and Chairperson, reviewed the three phases of the IAC process, and discussed logistics associated with scheduling the Hearing and the process for review of the Hearing Briefs.

It was then decided that the IAC Panel members would meet on January 16<sup>th</sup>, 2024, following receipt of the Association's and Winchester District Memorial Hospital submissions to discuss any issues or concerns. The meeting occurred with the IAC Chairperson and the Nominees. It was decided following our January 16<sup>th</sup>, 2024, meeting we would meet again on January 22, 2024 and January 29, 2024 prior to the IAC Hearing.

#### **1.4.1.3 Hearing Confirmation and Hearing Brief Distribution**

The date for the Hearing was confirmed on November 27, 2023.

It was mutually decided by the Windsor District Memorial Hospital and the Ontario Nurses Association the IAC would be scheduled for January 30<sup>th</sup>, February 1<sup>st</sup>, and February 2<sup>nd</sup>, 2024, and would be held

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<sup>6</sup> As noted above.

virtually. The Chairperson secured a third party to support the virtual meeting held between the IAC Chairperson, Nominees, the Windsor District Memorial Hospital, and the Ontario Nurses Association. The IAC Chairperson wrote to the Hospital and the Association on November 23, 2023, respectively to confirm the date of the Hearing and to provide the draft Hearing Agenda. Respecting the principle of full disclosure and to streamline the process of the Hearing by enabling the IAC to become familiar with the issues in advance, the IAC requested the Hospital and the Association to submit a Hearing Brief to the Chairperson Monday January 8<sup>th</sup>, 2024.

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

- Ontario Nurses Association Brief and Winchester District Memorial Hospital Brief received on January 8, 2024, and distributed to the IAC Panel, ONA and the Hospital on January 8, 2024.
- IAC Panel held an initial call to review materials and respond to any questions in preparation for the IAC hearing January 16<sup>th</sup>, 2024.
- IAC Chairperson received from the Ontario Nurses Association, Supplemental Information Volume IV<sup>7</sup> Brief on January 15, 2024, and was shared with the Winchester District Memorial Hospital and the Nominees the same day.
- IAC Panel met again to review the responses as previously outlined above for the upcoming sessions at the IAC Hearing.

#### **1.4.1.4 IAC Panel Pre-Hearing Meetings**

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

#### **1.4.1.5 Virtual Meeting and the Winchester Memorial District Hospital Tour of the Family Birthing Unit**

The Association, Hospital and IAC Chairperson discussed how best to proceed with the tour given the IAC hearing was going to be held virtually. The agenda was revised to ensure there was adequate time on day one for the entire panel and those in attendance to preview the virtual video. The Hospital developed an initial video and shared it with the Association and IAC Panel on January 8<sup>th</sup>, 2024, to be viewed in advance and will be shown on day one of the IAC Hearing.

#### **1.4.1.6 Winchester District Memorial Hospital Family Birthing Unit Tour**

On the morning of Tuesday January 30<sup>th</sup>, 2024, the IAC Panel and those in attendance from the Ontario Nurses Association and Winchester District Memorial Hospital observed a Site Tour of the Family Birthing Unit at Winchester District Memorial Hospital developed in collaboration with ONA representation.

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<sup>7</sup> ONA Supplemental Brief Volume IV January 15, 2024.

The Tour provided an opportunity to understand the patient population being cared for in the Family Birthing Unit at Winchester District Memorial Hospital, the practice environment, care provision, supplies, equipment, communication, and the geographical configuration.

## 1.4.2 IAC Hearing

### 1.4.2.1 IAC Hearing Schedule

The Hearing convened via Zoom for all participants at 0830 hours. The Hearing was held over three days as follows utilizing Zoom as our virtual platform.

Tuesday January 30, 2024: 08:30 – 13:50 hours

Thursday February 1<sup>st</sup>, 2024: 08:30 – 13:15 hours

Friday February 2<sup>nd</sup>, 2024: 08:30 – 11:02 hours

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

### 1.4.2.2 Hearing Day 1: Tuesday January 30, 2024

The IAC Chairperson opened the Hearing at 0830 hours. Following introduction of the three IAC Panel members and round-table introduction of the Hospital and Association participants, the IAC Chairperson reviewed the following ground rules and IAC Chair Responsibilities:

- Welcome and Introductions
- I would like to begin by acknowledging the tremendous time and effort that has been undertaken for this week's IAC Hearing by both Winchester District Memorial Hospital and the Ontario Nurses Association.
- Both parties have provided excellent submissions and briefs to inform our hospital nominee Stephanie Pearsall, our ONA nominee Lynn Stranges, myself as your Chair of the IAC Panel, and both parties of the issues at the Winchester District Memorial Hospital 's Family Birthing Unit.
- It is important for both parties to be reassured that your IAC panel has read and reread in detail all your submissions and supporting documents in preparation for this week's IAC Hearing.
- It is my responsibility as your Chair to ensure throughout this week's hearing we have an environment where both parties can fully participate and be engaged in this process.
- My role is to ensure we stay focused on the issues.
- I will be adjusting our timelines throughout the IAC hearings if either party finishes their presentations earlier than the allotted timeframes as outlined in the agenda. However, we will not exceed the timelines that have been allocated for these presentations.
- The IAC hearing is to be kept confidential. All information discussed and shared must remain confidential even after the hearing ends.
- It is important that the IAC hearing be a safe environment for all attendees to ask questions and share their issues and stories openly and honestly. I want to reassure all ONA members that

there will be no negative repercussions because of any information shared during or following the hearing.

- The goal is to permit both parties to feel heard, respected and treated equally throughout this process so the IAC panel can develop some key recommendations based on the issues presented.
- I am going to ask that during the IAC Hearing that we turn our cameras off and only the speaker have their camera on so that we can prevent issues with bandwidth.

The Association's presentation to the IAC Panel and the Hospital was presented by Tanya Beattie, ONA Professional Practice Specialist. The presentation included an overview of Article 8.01, CNO Professional Standards, a historical overview, concerns identified by ONA members in the WMDH Family Birthing unit and recommendations.

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

A break was held between the Association and Hospital presentations.

The Hospital presentation began at 1230 hours and was presented by Janie Desroches, Vice President of Clinical Services and Chief Nurse Executive Winchester District Memorial Hospital. An overview of the Family Birthing Unit, Program Goals and services, the current challenges, what is working well, improvement initiatives, and next steps. Following the presentation, the Hospital responded to questions of clarity related to the Hospital's presentation from the Association and the IAC Panel members.

The IAC Chairperson adjourned the Hearing at 1350 hours.

### **1.4.2.3 Hearing Day 2: Thursday February 1<sup>st</sup>, 2024**

The IAC Chairperson opened the Hearing at 0830 hours.

Janie Desroches, supported by members of the Winchester District Memorial Hospital IAC Hearing team, provided the Hospital's response to the ONA Hearing Submission. Following a break, Tanya Beattie , supported by members of the Ontario Nurses Association IAC Hearing team, provided the Association's response to the Hospital Hearing Submission.

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

The Chairperson adjourned the Hearing at 1315 hours.

### **1.4.2.4 IAC Panel Intra-Hearing Meeting**

The IAC Panel met January 31, 2024, and February 1<sup>st</sup>, 2024, prior to and after the meeting. The IAC Panel met during the morning and afternoon on January 29<sup>th</sup>, 2024, February 1<sup>st</sup>, and 2<sup>nd</sup> 2024. The intent was to review and synthesize the data collected and the wealth of information presented through the written submissions, supporting documents, presentations, and discussion during the Hearing, to identify key questions to lead and engage in meaningful dialogue for the purposes of Hearing discussions on Day 3 of the Hearing.

### 1.4.2.5 Hearing Day 3: Friday February 2<sup>nd</sup>, 2024

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

The IAC Chairperson welcomed all those in attendance at today's hearing and thanked them for their participation the last two days. The IAC Panel asked a series of questions for clarification. Staff shared their lived experiences, personal stories in person, through correspondence and video.

Janie Desroches VP and CNE on behalf of the Hospital, and Tanya Beattie, Professional Practice Specialist on behalf of the Association, provided closing remarks following the staff testimonials.

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

- Acknowledged the tremendous time and effort by both the Hospital and Association that was undertaken for the IAC Hearing and the excellent submissions and presentations to inform the IAC Panel and both parties of the issues in the Family Birthing Unit at the Windsor District Memorial Hospital.
- Thanked the staff who were in attendance and acknowledged their active participation in the IAC Hearing and their willingness to bring forward important issues related to quality and safe patient care.
- Thanked all those in attendance for their openness, honesty, and willingness to share their personal stories, thoughts, patient experiences and concerns related to workload, professional responsibilities, and accountabilities.
- Respecting the "ground rules" throughout the IAC hearing.
- Reconfirmed that the IAC process is intended to provide an independent objective external perspective to aid in the resolution of outstanding issues, and that although the recommendations are non-binding, it is hoped they will provide a foundation from which both parties can move forward constructively;
- Confirmed the IAC Report would be submitted within forty-five (45) calendar day timeframe as stipulated in Article 8.01 (a) (viii) of the Collective Agreement.
- I hope everyone who participated in this process will reflect on discussions held these past two- and one-half days to understand the importance of how both parties can move forward in a positive, professional, and collegial manner to bring about the required changes in the best interest of quality, ethical and safe patient care.
- I also want to thank the IAC Panel – Lynn and Stephanie for your contributions, knowledge, and expertise as we have collaborated over the past several weeks and as we move forward with the development of the key recommendations for the IAC Report

### 1.4.3 Post-Hearing

#### 1.4.3.1 IAC Report Development

The initial draft of the IAC report was prepared over several days prior to, during and following the IAC hearing. It was circulated to the IAC Panel members on February 18, 2024, to the Nominees to provide more detail of the proposed recommendations in preparation for an IAC Panel teleconference to be held

on Saturday February 3<sup>rd</sup>, 2024. The purpose of this call was to discuss the overall framework of the IAC report and recommendations.

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

The IAC conducted a series of teleconferences during February and March 2024, to review the various drafts of the IAC report.

#### **1.4.3.2 IAC Report Submission**

The IAC Report was submitted to the Association and the Hospital by email, in PDF format, on Monday March 18, 2024.



# SECTION II: PRESENTATION OF THE PROFESSIONAL RESPONSIBILITY COMPLAINT (PRC)

## 2.1 Development of the Professional Responsibility Complaint (PRC)

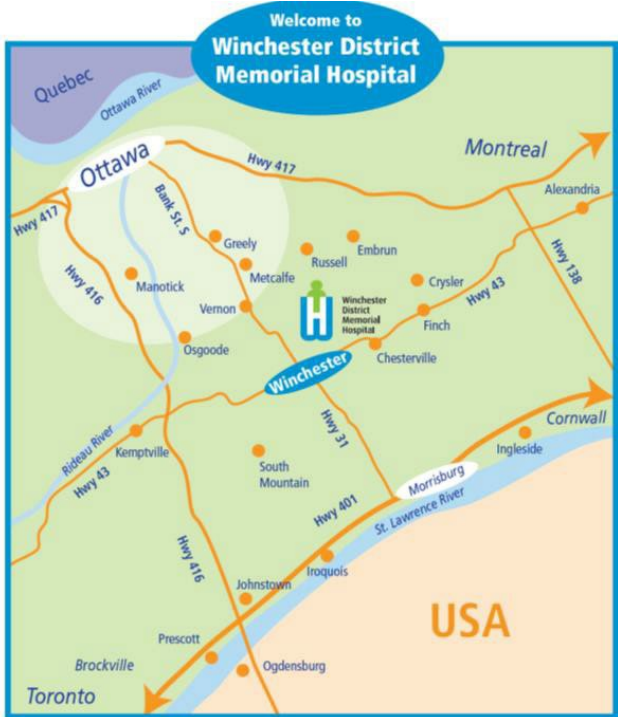
### 2.1.1 Events Prior to Referral of the Professional Development Complaint (PRC)

#### About the Hospital

The Winchester District Memorial Hospital (“WDMH” or the “Hospital”) is a comprehensive, full-service, 49-bed rural teaching hospital in the heart of the Township of North Dundas, a small and friendly community of just over 12,000 residents, located south- east of Ottawa. Established in 1948, WDMH serves a catchment area with a population of over 90,000. Today, the hospital provides 24/7 emergency services, diagnostic imaging services including X-Rays, Ultrasound, Mammography and CT scans. It has a family birthing center, in-patient medical and surgical services, as well as day surgery and outpatient specialty clinics. WDMH is also a hub site for cancer care and dialysis.

In the past year, more than 80,000 patients have been cared for by close to 900 staff, physicians, volunteers, and students. On average, annually, there are:

- > 4000 surgeries completed (General, oncology, gynecology, plastics, ENT, urology, dental and ophthalmology)
- > 20,000 ER visits
- > 600 babies delivered.
- > 2,600 chemotherapy visits
- > 33,000 imaging / x-ray procedures
- > 25 outpatient clinics, including dialysis.<sup>8</sup>



<sup>8</sup> Winchester District Memorial Hospital Brief January 8, 2024, p. 3.

*Patient Profile - WDMH Family Birthing Unit*

WDMH Family Birthing Unit provides perinatal and birthing Level 1b care, and Level 1 newborn care. (Table a and b) (Exhibit 4). High-risk pregnancies and those less than 36 weeks gestation, are transferred to a tertiary care hospital (i.e., The Ottawa Hospital).<sup>9</sup>

Table A

**Perinatal and Birthing Levels of Care Criteria: Level 1b**

| Gestational Age             | Level 1b <sup>17</sup>  |  |                     |
|-----------------------------|---|--|---------------------|
| ≥ 36 weeks and 0 days       | <b>Definition</b>   | <ul style="list-style-type: none"> <li>• Singleton pregnancies.</li> <li>• Low risk pregnancies.<sup>18</sup></li> <li>• Hospital can provide caesarean section which would allow for a planned birth for a person who may be 1) requiring induction of labour and 2) at a higher risk for caesarean section.</li> </ul> |                     |
|                             | <b>Criteria</b>   |  | <b>Availability</b> |
|                             | Labour analgesia (example: PCA narcotics or nitrous oxide)  |  | 24/7                |
|                             | Electronic Fetal Monitoring   |  | 24/7                |
|                             | Outlet vacuum assisted vaginal delivery   |  | 24/7                |
|                             | Administration of blood products  |  | 24/7                |
|                             | Augmentation and Induction of Labour  |  | 24/7                |
|                             | Caesarean Section   |  | 24/7                |
|                             | D&C   |  | 24/7                |
|                             | Designated Level 1 for neonatal care  |  | 24/7                |
| <b>Healthcare Providers</b> | <ul style="list-style-type: none"> <li>• Assessment and care by an anaesthesiologist or family physician (FP) anaesthetist for operative deliveries.</li> </ul> |  |                     |

Table B

**Newborn Levels of Care Criteria: Level 1**

| Gestational Age       | Level 1 <sup>11</sup>                                  |   |  |
|-----------------------|--|---|--|
| ≥ 36 weeks and 0 days | <b>Definition</b>                                      | <ul style="list-style-type: none"> <li>• Provides planned neonatal services to low risk newborns at ≥36 weeks in a mother/baby dyad care model; including minor transient conditions related to physiological adaptation.</li> <li>• Provides postnatal care of newborns including education and support for parenting, bonding, feeding and lactation.</li> <li>• Documented process in place for consultation and referral to higher level of care</li> <li>• Low risk.<sup>12</sup></li> </ul> |  |
|                       | <b>General Laboratory Criteria</b>                     |   | <b>Availability</b>  |
|                       | Bacterial and viral studies, including Bacterial Smear |   | <ul style="list-style-type: none"> <li>• Specimen collection available 24/7</li> <li>• Can be analyzed on- or off-site</li> <li>• Micro technique for all routine bloodwork and newborn screening</li> </ul> |
|                       | Blood Type and Coombs                                  |   |  |
|                       | Drug Screening   |   |  |
|                       | Neonatal Bilirubin Screening                           |   |  |
|                       | Newborn Screening                                      |   |  |
|                       | Point of Care Testing, e.g., Glucose                   |   |  |
| Umbilical Cord pH     |  |   |  |

<sup>13</sup> Perinatal, Birthing and Newborn Levels of Care Criteria: While these criteria detail a minimum standard, some hospitals may provide services that are typically available at a higher LOC hospital depending on local resources and skill.

<sup>14</sup> As per CPS Guidelines for Neonatal Resuscitation Program, a qualified team with full resuscitation skills should be immediately available for every resuscitation. Full resuscitation skills may include ventilation, intubation, chest compressions, umbilical venous catheter insertion, medication administration and fluid resuscitation as well as the skills necessary to manage evacuation of a pneumothorax.

<sup>9</sup> ONA Brief Volume I January 8, 2024, p. 3-4.

### *Professional Responsibility and Workload Process<sup>10</sup>*

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

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

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

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

The 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 problems; and provides a process and forum for RNs to make recommendations to the employer to address the issues. The PRWRF promotes a problem-solving approach by means of facilitating discussion with, and requiring a written response from, the Manager. Once the employer has been made aware of the Professional Responsibility and Workload Issue(s), it is the administrative nurses' accountability to their own CNO Standards to advocate for and pursue resolution.

The Hospital collective agreement between the Ontario Nurses' Association (ONA) and the Ontario Hospital Association (OHA) representing the Participating Hospitals have contained a Professional Responsibility provision since the arbitration board chaired by Arbitrator Kevin Burkett first awarded the language in a Hospital Labour Disputes Arbitration Act (HLDA) hearing between ONA and Mount Sinai Hospital in 1977. The Board recognized, "the concern by the nurses that their professional integrity be safeguarded...the interrelationship of staffing, workload and professional responsibility gives rise to a complex problem which raises questions of life and death". The Board subsequently awarded language which provided a process such that, should the parties be unable to resolve Professional Responsibility and Workload issues "through the vehicle of the union management committee, the Board has established an independent committee with authority to assess the merits of a complaint and report to the parties." (Exhibit 5)

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<sup>10</sup> ONA Submission to IAC Volume 1: ONA Brief and PRWRF January 8, 2024, p. 6-9.

The PRW process included a documentation tool which concerned RNs submitted to their employer called the Notification of Improper Work Assignment form. This form was revised in 2002, 2011, 2014 and 2020, and is now referred to as the Professional-Responsibility Workload Report Form. This form is found at Appendix 6 (Exhibit 6) of the Central Hospital Collective Agreement between ONA and the Participating Hospitals

This request for a review of professional practice, patient acuity, fluctuating workloads and fluctuating staffing arises out of Article 8 of the current Collective Agreement between the parties; and the College of Nurses of Ontario (CNO) Code of Conduct Practice Standard, 2023 (Exhibit 7), Principle 6.4 Nurses **report** any error, unsafe behaviour, unethical conduct or system issue to relevant individuals, including employers, CNO and other regulatory colleges, whether or not harm has occurred. Principle 6.5 Nurses participate and advocate for improving the quality of their practice setting to support safe client care.

Article 8.01 of the current Central Hospital Collective Agreement which expires March 31, 2025, (Collective Agreement, exhibit 8), provides for union representation when a nurse meets with their manager to discuss the PRWRF(s), requires a written response from the Manager within 10 days of receipt of the PRWRF, states that every effort will be made to resolve the issue at the unit level. Upon referral of the issues to an Independent Assessment Committee (IAC), it requires the parties to name a nominee within 30 calendar days. The process also provides 45 calendar days for the IAC to render its findings and states that the Chief Nursing Executive, Bargaining Unit President, and Hospital-Association Committee will jointly review the recommendations of the IAC and develop an implementation plan for mutually agreed changes.

This IAC has been formed pursuant to Article 8 – Professional Responsibility, and in particular Article 8.01 ix).

### 2.1.2 Events Following Referral of the Professional Responsibility Complaint

The FBU RN staff began raising professional responsibility and workload issues in January 2021 by submitting PRWRFs to report their concerns of insufficient, unsafe staffing levels, an inappropriate skill mix and inadequate orientation. The RNs reported their concerns for safe quality patient care to nursing leadership, the clinical manager (CM), and Vice President, Clinical Services & Chief Nursing Executive (CNE).<sup>11</sup>

Prior to January 2022, the Hospital-Association Committee (HAC) met every two months unless otherwise agreed and required under Article 8.01 (a) (iv) of the collective agreement. The last HAC meeting took place on January 27, 2022, and a timeline of prior and subsequent events is listed below.

**January 27, 2021 – March 15, 2021** – 5 PRWRFs submitted by FBU RNs received no follow up meeting between manager and nurses who completed PRWRF, and no manager comments on forms.

**March 26, 2021** – Management stated at HAC that they feel no need to deal with workloads due to recruitment issues.

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<sup>11</sup> ONA Brief Volume I January 8, 2024, p. 6-14.

**April 7, 2021** - ONA Servicing Labour Relations Officer (SLRO) consulted ONA Professional Practice.

**July 20, 2021** – Meeting with ONA SLRO, Bargaining Unit President (BUP), ONA FBU Rep, Clinical Manager and CFO. (Exhibit 9).

SLRO provided a brief review of workload situations and the need to support new hires with the appropriate orientation process and the fundamental theoretical knowledge needed to perform the duties of the job.

CM states suggestions from ONA – having Team Lead present on the unit, helping with non-stress tests etc., keeping orientees on OBS before being used as Heavy Workload increase on PP, are not a solution and she is at a loss and doesn't know what else to do. SLRO put clinical manager on notice for failing to follow Article 8 of the collective agreement.

Between July 20, 2021, and October 19, 2021, the FBU RNs submitted 5 PRWRFs dated July 28 & 29, August 3 & 18, and September 11, 2021. Despite identifying multiple patient safety issues related to census, acuity and skill mix, the manager did not respond to the workloads or meet with the members to discuss their concerns.

**October 19, 2021** - CNE states at HAC that all PRWRFs will go through her or HR as they feel management is being targeted.

**November 4, 2021** – A discussion was held by ONA SLRO at HAC regarding the employer not dealing with outstanding PRWRFs.

**January 25, 2022** – ONA SLRO compiled OBS RN suggestions from PRWRFs since January 2021 into MOS and submitted this to the employer for a January 27, 2022, HAC meeting (Exhibit 10).

**January 27, 2022** - CNE does not want to discuss the MOS. She discusses FBU staff sleeping on shift which cost her \$1.8 million dollars and many other issues. Employer informed ONA they were having a mandatory meeting with all FBU staff the next day.

**January 28, 2022** - the CNE holds a mandatory meeting for all FBU staff where management present list of complaints about staff (Exhibit 11).

**Jan 29, 2022** - GPOB DR writes letter to CNE to support nurses and told to stay out of it (Exhibit 13).

**Feb 8, 2022** - SLRO meets with employer and CNE apologizes for behaviour at meeting. No positive changes made. *Cameras were installed on unit.* This also attributed to the resignation of experienced OBS RNs.

**Feb 9, 2022** -Employer proposes to meet with staff to discuss concerns from January 28, 2022, meeting, staff do not want to attend for fear of further retaliation.

**Feb 12, 2022** – First PRWRF submitted since September 2021. In addition to unaddressed issues on FBU more responsibility and liability is added (Exhibit PRWRF 20220212).

**Feb 14, 2022** - Employer responds to MOS sent by SLRO for January 27, 2022, HAC meeting. (Exhibit 13)

**May 3, 2022** – SLRO resent proposed MOS to employer to facilitate a discussion between the parties. (Exhibit 14)

**June 15, 2022** – File advanced to Pre-Complaint with Professional Practice Specialist (PPS).

**June 30, 2022** – Notice of file advancement sent to CNE (Exhibit 15).

**September 13, 2022** – Pre-IAC meeting # 1 meeting between employer, ONA PPS, and RN members. ONA presented Action Plan (Exhibit 16).

**October 20, 2022** – Pre-IAC meeting # 2 (Exhibit 17).

**November 29, 2022** – Pre-IAC meeting # 3 booked. Meeting agenda included review of ONA proposed MOS (Exhibit 18).

Employer did not give notice of cancellation or show up to the meeting. PPS sent email to CNE and CEO. (Exhibit 19).

**December 6, 2022** – Hospital VP/CFO sends email correspondence to PPS indicating all further communication between employer and ONA will be through employer’s legal counsel. (Exhibit 20).

**January 8, 2023** – CNE declined ONA PP meeting booked for January 9, 2023

**January 9, 2023** – Hospital VP/CFO declined ONA PP meeting booked for same day.

None of the PRWRFs submitted in 2021 received a manager response and no meetings between the manager and the RNs occurred as per the collective agreement. The RNs report that since the current clinical manager has been in the position (September 16, 2022) she has been more responsive to meeting with members following a PRWRF submission, however the identified workload and professional practice issues are unresolved and ongoing.

The diagrams below represent the total number of PRWRFs submitted since 2021 and show that less than 25 % received manager response and none were resolved. The previous clinical manager did respond by email on a few occasions to staff re return of a PRWRF submitted August 13, due to proper procedure not being followed (manager stated no meeting was held with manager or delegate prior to

completion of the form) and perceived errors in their completion of the form. The email quoted a section of Article 8 of the collective agreement and the manager's misinterpretation of the language (Exhibit 21). The RNs followed Article 8 procedure correctly.

Nurses have reported ongoing issues with insufficient RN staffing, an inappropriate skill mix for patient population, their inability to meet CNO and perinatal nursing standards and hospital policies and procedures, as well as insufficient education, orientation, and mentorship for all staff. In addition, staff report a history of unsupportive toxic leadership behaviours which resulted in a large turnover of experienced staff, declining staff morale, fear of reprisal and increased burnout.

The Employer has not followed the Article 8 process, and a grievance was filed for this violation. The Union is grieving that the Employer has violated the Collective Agreement, Articles 1, B, in not meeting with the Union to discuss issues at HAC as outlined in article C.2 and 6.03 and in not meeting to discuss Professional Workload forms as per article C.6 and 8.

A Letter forwarding the unresolved issues to the IAC was submitted by the Union to the (IAC) Chairperson on May 24, 2023. As indicated in the Union's Letter of Referral, ONA respectfully requests that the IAC assess the nursing practice and workload concerns put before them from the perspective of being able to provide safe, ethical, competent, and professional quality patient care in a quality practice setting according to relevant professional and specialty standards, and supporting research and literature, including the following CNO Practice Standards and Guidelines:

- Code of Conduct, 2023 (Exhibit 8)
- Scope of Practice July 1, 2023 (Exhibit 22)
- Therapeutic Nurse-Client Relationship Revised 2006, 2019 (Exhibit 23)
- Confidentiality and Privacy – Personal Health Information, 2019 (Exhibit 24)
- Documentation Revised 2008, 2019 (Exhibit 25)
- Medication Revised 2008, 2019 (Exhibit 26)
- Consent, 2017 (Exhibit 27)

## 2.2 Ontario Nurses' Association and Winchester District Memorial Hospital (WDMH) Perspectives

The Hearing was structured such that:

- On January 30<sup>th</sup>, 2024, the Ontario Nurses Association, and the Winchester District Memorial Hospital each provided an oral Submission presentation highlighting the key elements of their previously submitted written Brief.
- On February 1<sup>st</sup>, 2024, the Winchester District Memorial Hospital, and the Ontario Nurses Association each provided an oral Response presentation, which included an opportunity for each party to clarify / discuss / challenge / question/rebut the information provided by the other.
- On February 2<sup>nd</sup>, 2024, the IAC Panel posed several questions to both parties to obtain a more comprehensive understanding of the issues. All staff in attendance was given the opportunity to share their concerns, make statements and provide us with their own testimonials related to Winchester District Memorial Hospital Family Birthing Unit.

From the Hearing Briefs and supporting Exhibits submitted prior to the Hearing, the presentations, discussion, and response to questions at the Hearing, and analysis of information following the Hearing, the IAC Panel understands the Ontario Nurses Association's and Winchester District Memorial Hospital's perspectives related to professional practice issues, staffing and workplace safety issues.

### 2.2.1 Ontario Nurses' Association

The Association identified sixty-seven (67) recommendations based on PRWRF's submitted, relating to staffing, patient acuity and complexity, missed or delayed care, orientation and education, leadership and communication, physician related issues, non-nursing duties, policies, and procedures.<sup>12</sup>

The following are ONA's recommendations:

Since January 2021, the dedicated Family Birthing Unit RN staff have consistently met their professional obligations by reporting their concerns to the employer and advocating for workplace changes to support the provision of safe patient care and nursing professional practice. The employer has not met their obligations to respond to the reported concerns or to provide a quality practice environment that facilitates and permits nurses to meet CNO standards.

The RNs are experiencing moral distress because of how overall staffing issues are negatively impacting every aspect of the RNs ability to provide safe, effective nursing care and meet nursing standards.

Despite the effects of facing toxic leadership and a residual fear of retribution, these RNs continue to be a voice for their patients, their community, themselves, and their colleagues.

#### **ONA Recommendations**

##### **Staffing**

- Addition of one Registered Nurse to baseline staffing on the OBS unit 24/7, such that there are three RNs scheduled on the day shift and three RNs scheduled on the night shift.

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<sup>12</sup> ONA Submission to IAC presentation Day One of the IAC Hearing January 29, 2024.



- Addition of one Registered Nurse to baseline staffing on the PP unit 24/7, such that there is one RN and one RPN 24/7.
- Addition of a Registered Nurse “float” position from 1100 to 2300 daily.
- Update current Family Birthing Unit Team Leader Job Description to reflect role and responsibilities.
- Replace Team Lead for all scheduled and unplanned absences from the unit or when working from home, with an equivalently experienced and skilled nurse. This will ensure teaching and in the moment support for the novice RNs.
- Charge duties will be assigned to a FBU RN from 1500 to 0700 hours seven days per week, in addition to 0700 to 1500 hours on weekends.
- RNs will be provided with charge nurse training prior to being assigned in charge duties.
- New hires will have worked for a minimum equivalent of 12 months full-time on the FBU prior to receiving charge nurse training or being assigned in charge.
- The RNs will be compensated for charge nurse duties as per the collective agreement.
- Conduct a review of staff skill mix and establish a balance of novice to expert RNs and RPNs per shift. Ensure the master schedule is balanced with sufficient expert RNs on each shift to support the learning and growth needs of all staff especially the novice RN and RPN staff. Benner’s Model of Novice to Expert is a recognized tool for this purpose.
- Ensure all staff receive regular and ongoing training, to remain current in their skills and competencies, along with regular refreshers, annual skills days and required certifications.

#### Acuity and Complexity

- Addition of one Registered Nurse to baseline staffing on the OBS unit 24/7, such that there are three RNs scheduled on the day shift and three RNs scheduled on the night shift.
- Addition of one Registered Nurse to baseline staffing on the PP unit 24/7, such that there is one RN and one RPN 24/7.
- Addition of a Registered Nurse “float” position from 1100 to 2300 daily.
- Replace Team Lead for all scheduled and unplanned absences from the unit or when working from home, with an equivalently experienced and skilled nurse.
- Charge duties will be assigned to a FBU RN from 1500 to 0700 hours seven days per week, in addition to 0700 to 1500 hours on weekends.
- Ensure all staff receive regular and ongoing training, to remain current in their skills and competencies, along with regular refreshers, annual skills days and required certifications.

#### Missed or Delayed Care

- Addition of one Registered Nurse to baseline staffing on the OBS unit 24/7, such that there are three RNs scheduled on the day shift and three RNs scheduled on the night shift.
- Addition of one Registered Nurse to baseline staffing on the PP unit 24/7, such that there is one RN and one RPN 24/7.
- Addition of a Registered Nurse “float” position from 1100 to 2300 daily.
- Replace Team Lead for all scheduled and unplanned absences from the unit or when working from home, with an equivalently experienced and skilled nurse.
- Charge duties will be assigned to a FBU RN from 1500 to 0700 hours seven days per week, in addition to 0700 to 1500 hours on weekends.

## **Orientation and Education**

- The absence of an educator is negatively impacting the patient care environment, and the employer must make considerable efforts to recruit a 1.0 FTE RN to fulfill the role within the organization, to promote and facilitate the professional development of the nursing staff.
- The employer will conduct a fulsome review of their current FBU orientation process, and with the FBU RNs collaboration and input, determine required courses for orientation and timelines for completion.
- The employer will develop a comprehensive mentorship program or explore available community programs such as the Canadian Nurse Educators Institute Preceptor-Mentor Training Program (Exhibit 41) The mentorship program will be offered to all FBU RNs to support new nurses and nurses new to the role in a safe, quality transition to practice, while also promoting retention and job satisfaction.
- The employer will conduct a learning needs assessment on the FBU OBS and PP units immediately, and annually thereafter, to identify educational needs and opportunities identified by the nursing staff to enable them to provide quality patient care.
- The employer will arrange and facilitate, on paid time, an annual skills / education day based on the needs identified by the RNs in the learning needs assessments.
- Routine check points will be scheduled with the mentor, mentee, and clinical manager during orientation.
- Additional mentored shifts will be offered to orientees as deemed necessary in consultation with the mentor, mentee, Team Leader, and clinical manager.
- The employer will initiate immediately a mandatory paid education program for RN staff in Obstetric Triage. New graduate and novice staff will complete this education after they have worked for a minimum of six months in FBU. Ensure all staff assigned to work in the FBU are fully trained and skilled to deliver the specialized nursing care and interventions required for the perinatal patient population.
- The employer must ensure all new RN hires to the FBU have successfully completed the NRP and FHS training PRIOR to being independently assigned a patient load.
- The employer will immediately conduct a review of staff skill mix and establish a balanced schedule of novice to expert RNs and RPNs per shift. This will support the learning and growth needs of all staff. Benner's Model of Novice to Expert is a recognized tool for this purpose.
- Assessment of all FBU RNs and RPNs using Benner's Model will be completed annually. This information will be used by management to ensure a balanced master schedule.
- The employer acknowledges their accountability in supporting nurse compliance with CNO Standards and Guidelines, and their accountability to ensure all policies and procedures for the Family Birthing Unit are developed in collaboration and consultation with the nursing staff.
- The Employer will ensure all staff required to work in the FBU possess the required education, certifications, skills, and expertise to provide safe quality patient care to the patient population.
- The employer will ensure that if reassignment of FBU RNs to other WDMH departments is required, the RN must have the knowledge, skills, and abilities to competently provide nursing care.

## **Leadership and Communication**

- Clinical Manager to establish regular staff meetings with nursing input into the agenda.
- Clinical Manager to implement daily huddles to review the following key areas: staffing issues, patient care requirements, safety concerns, corporate and department policy updates and

changes, equipment/supply issues, and provide positive feedback such as staff recognition and patient feedback.

- The CNE will participate in FBU huddles once per week to foster collaboration and trust with the staff.
- The employer will notify staff of any planned or unplanned absences of the clinical manager or Team Leader and provide alternate onsite management / leadership coverage.
- Team Leader absences will be replaced to ensure in-the-moment support is available to staff on the unit.
- The employer will ensure leadership, as well as staff adhere to organizational policies.
- Care Coordinators will consistently round through FBU each shift and review patient activity, volumes, and acuity, and facilitate patient/bed flow and staffing needs.
- Nursing Leadership will engage positively in the Professional Responsibility and Workload Process to create a dynamic and positive culture, without any form of reprisal or retaliation.
- The Employer will provide education to all managers and clinical co-ordinators on Article 8 of the Hospital Central Collective Agreement, Professional Responsibility, the Workload Report Process, and CNO professional standards.
- The Employer will implement an organizational leadership training and development program for all leadership roles, including Charge Nurses, Clinical Managers, Directors, VPs and the CNE.
- Ensure nursing leadership maintains professionalism and integrity, in all practices and communications.
- Ensure all levels of Nursing Leadership at WDMH adhere to the CNO Code of Conduct.

#### **Physician Related Issues**

- Effective immediately, the employer will ensure that physician practice of inappropriate use of verbal orders ceases.
- The employer will maintain their accountability to the CNO by supporting a safe environment for patient care and nursing practice and maintaining practice standards.
- The employer will enforce messaging with the physician group that verbal orders will only be accepted in urgent / emergency situations as nurses are otherwise in breach of CNO Scope of Practice standard (2023), and that this practice is not supported by the WDMH senior leadership team.
- The employer will facilitate the creation of a working group, consisting of organization wide representation, whose mandate will be to create a code of conduct policy within six months of their formation.
- Provide mandatory hospital-wide education for all staff about the impact of disrespectful behavior and appropriate professional behavior as defined by the code of conduct policy.
- Provide skill-based training in communication methods, relationship building, behavioral techniques to confront and address disrespect, conflict resolution, assertiveness training, team training, and how to report disrespectful behaviors.
- Include an escalation process within the code of conduct policy for instances when standard processes fail to resolve an issue.
- The CNE will report physician practice and behaviour issues to the Chief of Staff.

#### **Policy and Procedures**

- Within three months, the employer, in collaboration with the FBU RNs and appropriate stakeholders, will develop a policy and procedure for:
  - Care of the Obstetrical Patient on Magnesium Sulfate Infusion

- Cervical ripening
- Post-partum hemorrhage
- Perinatal loss
- Intermittent Auscultation
- Use of the transcutaneous bilirubin monitor
- Use of the cuddle cot
- Working Alone
- Within three months, the employer in collaboration with the FBU RNs and the Joint Health and Safety Committee will complete a security coverage gap analysis to identify areas of opportunity and develop a Working Alone policy.
- Within three months, the employer, in collaboration with the FBU RNs and appropriate stakeholders, will review existing FBU policies and procedures and identify updates required. Policies and procedures identified as requiring updates will be completed within three months.
- The employer will review, on a yearly basis and in collaboration with nurses, the current FBU policies and procedures.
- The employer will provide education to the nurses on how to efficiently access policies and procedures within the practice area.
- The employer will provide timely education and notification to all stakeholders on any changes to current policies and procedures.
- Policy and procedure education will be included during orientation.
- RNs provide input and feedback to all policies and procedures.

#### **Non-nursing Duties**

- Provide Unit Clerk support to the FBU 7.5 hours per day / seven days per week.
- Develop a comprehensive Unit Clerk Role Description, with clearly identified roles and responsibilities, including support for maintaining/ordering supplies.
- Explore expansion of the current environmental services role with consideration for reducing the burden of non-nursing work on RNs.

## **2.2.2 Winchester District Memorial Hospital**

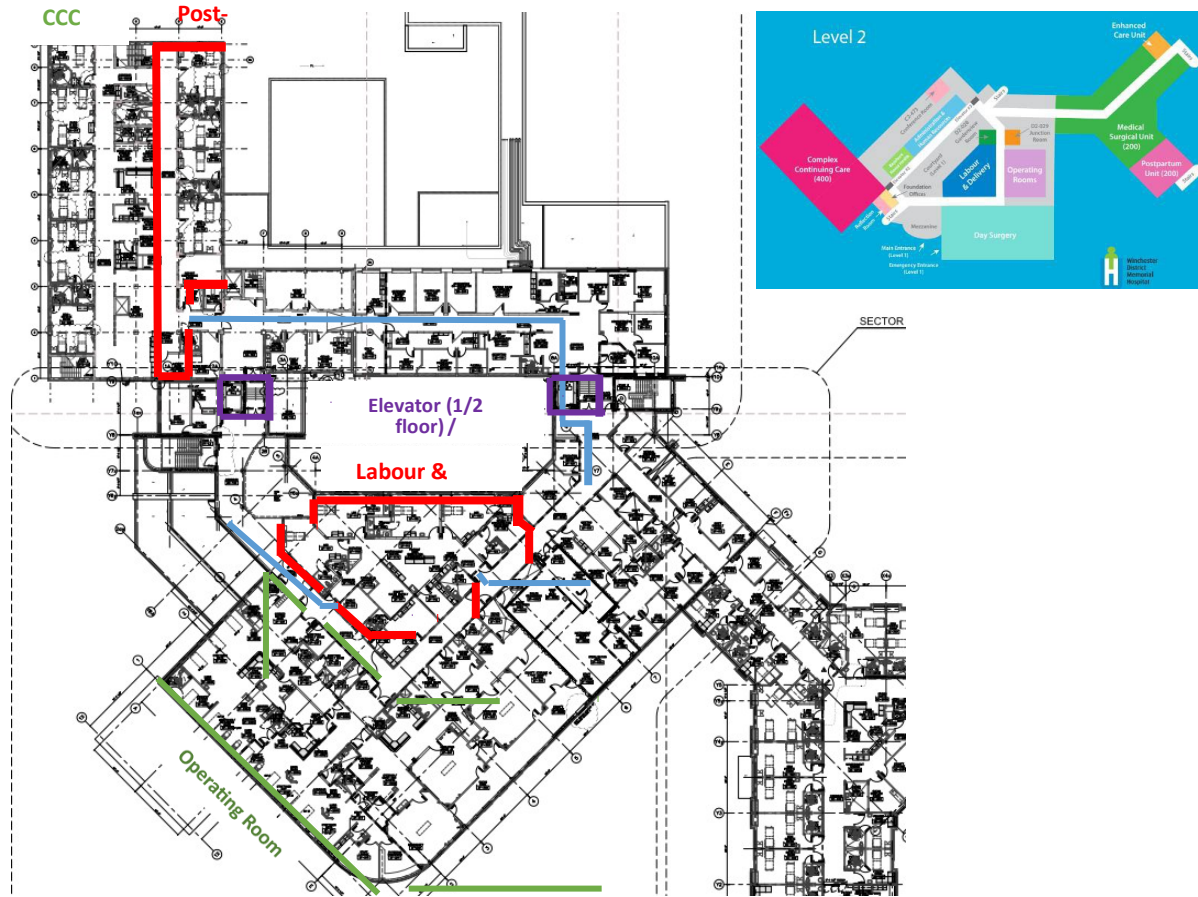
### Context of Discussion at the IAC

#### **Winchester District Memorial Hospital Family Birthing Unit**

The Family Birthing Unit (the “Unit”) provides a Level 1b perinatal, birthing, and newborn level of care. The Unit provides care for moms, babies, and families at WDMH, by offering a home-like setting that has been recognized for its family-centered care. The Unit’s goal is to create a setting that provides physical and emotional comfort, while providing the highest quality of care, and respecting individual choices, cultures, and customs.

The Unit is proud of the quality of service it provides to the hundreds of families it serves annually. The Department has consistently received high praises from patients, shining through patient satisfaction surveys, donations, and compliment letters. The Unit also carries a strong positive reputation amongst partner hospitals, Accreditation Canada (100% conformity in 2017 and 2021) and organizations such as the Champlain Maternal Newborn

Regional Program (CMNRP).<sup>13</sup>The hospital is approved and funded for operating 4 labor and delivery beds and 8 post-partum beds.



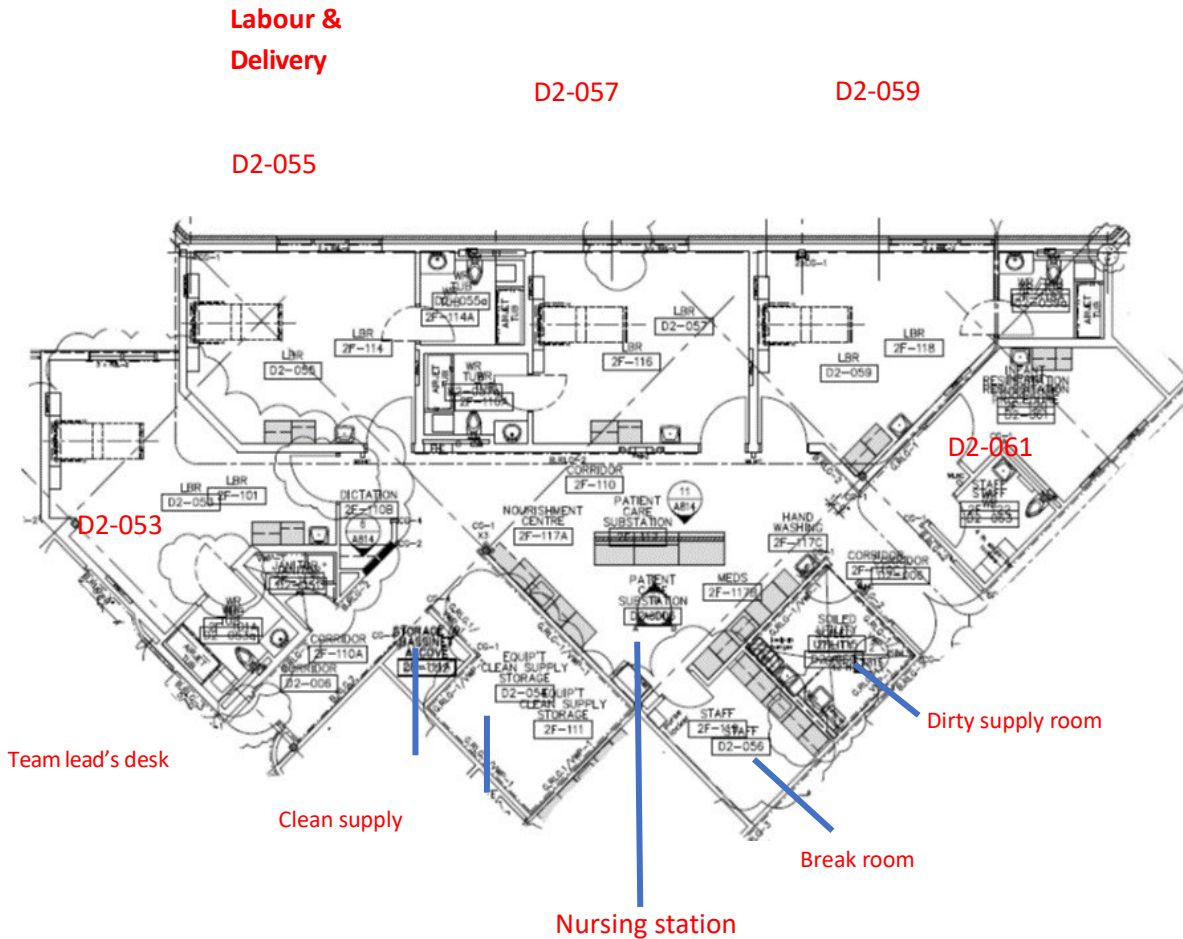
The L&D area is in the center of the Hospital’s second floor, adjacent to the Operating Room area and has a total of 5 rooms. Three of these rooms are private rooms typically used for active labor (D2-055, 57 and 59), one room is typically used for outpatients (D2-053), and one room is a waiting area (D2-061). The distribution of the beds is:

- D2-053
  - D2-053 bed 1: Assessment (outpatient) or labour if needed.
  - D2-053 bed 2: Assessment (outpatient) or labour if needed.
- D2-055-1
  - Private room: Labour Room
- D2-057-1
  - Private room: Labour Room
- D2-059-1

<sup>13</sup> Winchester District Memorial Hospital Brief January 8, 2024, p, 6-8.

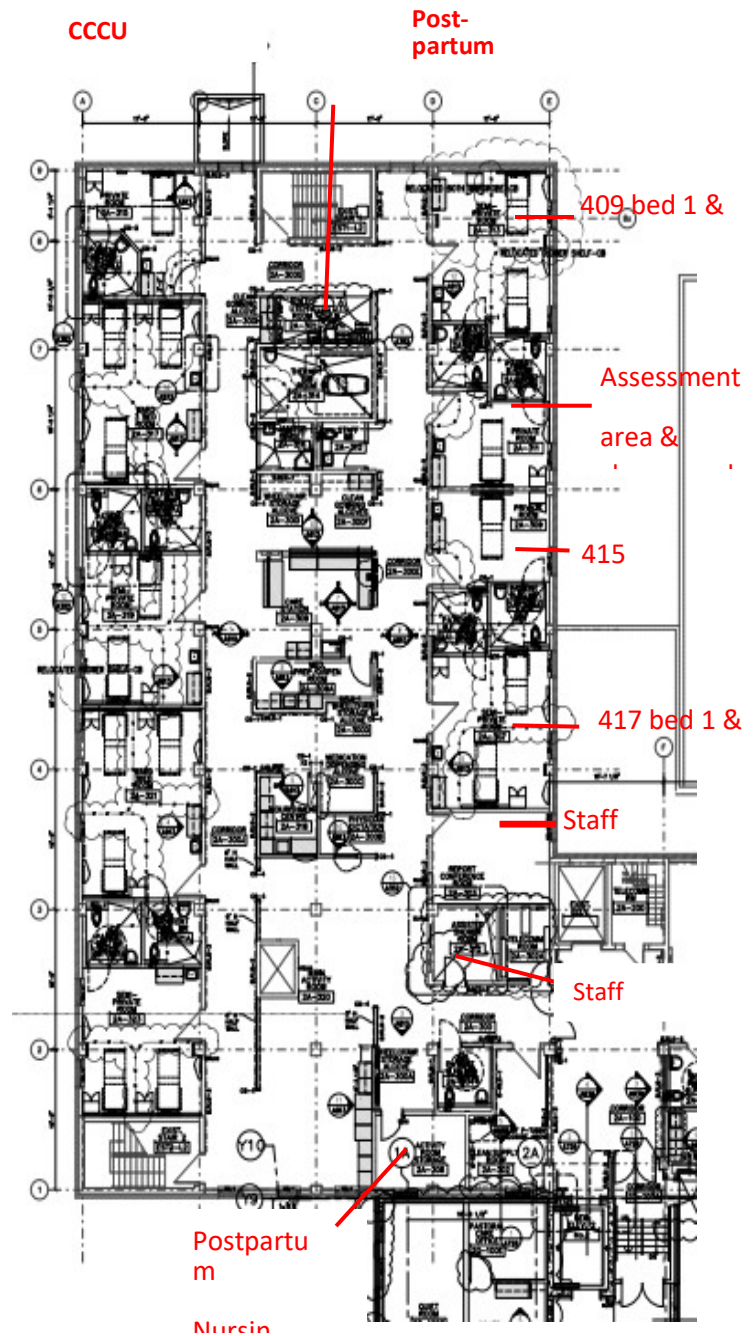
- Private room: Labour Room
- D2-061
  - D2-061: waiting area / assessment (outpatient)

Each labor room is equipped with a delivery bed, a glider chair (sleeping chair), an infant bassinet, fetal monitor, cluster cart, computer desk, and a Panda warmer with integrated resuscitation equipment. Each labor room also has a private bathroom with a tub. In the L&D area, there is also a central nursing desk station, a staff break room, a staff washroom, an equipment/supply room, a soiled utility room, and the team leader desk.





The Postpartum area has historically been on the second unit by the med/surg unit (see **Annex 1**). However, due to high needs of private rooms with med/surg patients during the pandemic, the postpartum area was moved adjacent to the Complex Continuing Care unit (CCCU). From July to December 2023, the postpartum unit had returned to its original location due to predicted higher volumes of births and for the decreased need for private rooms in med/surg. Unfortunately, due to tremendous pressures on bed flow and increased needs for isolation rooms during the respiratory illness season, postpartum was required to move back to CCCU as of December 14, 2023. Its current location, adjacent to the CCCU, is also located on the second floor of the Hospital, but in the older section of the Hospital. As a result of building codes when the new building was built, there is the equivalent of ½ floor difference between the two sections. Thus, an elevator (or stairs) is required to go from the L&D area to the Postpartum area. RPNs working in the postpartum unit have provided overwhelmingly positive comments about the current location (i.e. adjacent to the CCCU). The current Postpartum area has 5 beds distributed amongst 3 rooms: one private room and 2 semi-private rooms:





## **SECTION III: DISCUSSION AND ANALYSIS**

### **3.1 Introduction**

The IAC believes that the Panel (IAC Chairperson and both Nominees) has developed a comprehensive understanding of the professional responsibility concerns of the RNs working in the Family Birthing Unit at Winchester District Memorial Hospital.

This understanding was achieved through the following:

- Review and analysis of the written submissions, exhibits, oral presentations, and discussions at the IAC Hearing held on January 29<sup>th</sup>, 2024, February 1<sup>st</sup>, 2024, and February 2<sup>nd</sup>, 2024.
- Review of information provided by the Winchester District Memorial Hospital and the Ontario Nurses Association during the IAC Hearing.
- Review of literature available in the public domain regarding models of nursing care and the practice of Perinatal and Neonatal Nursing, and.
- The IAC Panel's collective practice experience, knowledge, and expertise with similar issues.

### **3.2 Factors Impacting the Practice Environment**

Discussion of professional responsibility within a Family Birthing Unit at Winchester District Memorial Hospital must be considered within the context of the practice environment.

The IAC Panel's analysis and recommendations are based on assumptions regarding:

- Winchester District Memorial Hospital's (WDMH) overview.
- ONA's Submissions and Brief.
- WDMH Family Birthing Unit geographical configuration.
- WDMH Family Birthing Unit patient population, including patient acuity and complexity, occupancy.
- WDMH nursing resources and support.
- Nursing standards of practice.
- Healthy work environments.

### 3.2.1 Winchester District Memorial Hospital Overview

#### *About the Hospital*

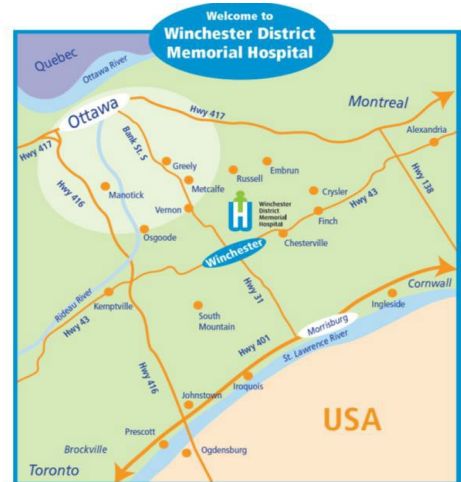
The Winchester District Memorial Hospital (“WDMH” or the “Hospital”) is a comprehensive, full-service, 49-bed rural teaching hospital in the heart of the Township of North Dundas, a small and friendly community of just over 12,000 residents, located south-east of Ottawa. Established in 1948, WDMH serves a catchment area with a population of over 90,000. Today, the hospital provides 24/7 emergency services, diagnostic imaging services including X-Rays, Ultrasound, Mammography and CT scans. It has a family birthing center, in-patient medical and surgical services, as well as day surgery and outpatient specialty clinics. WDMH is also a hub site for cancer care and dialysis.

In the past year, more than 80,000 patients have been cared for by close to 900 staff, physicians, volunteers, and students. On average, annually, there are:

- > 4000 surgeries completed (General, oncology, gynecology, plastics, ENT, urology, dental and ophthalmology)
- > 20,000 ER visits
- > 600 babies delivered.
- > 2,600 chemotherapy visits
- > 33,000 imaging / x-ray procedures
- > 25 outpatient clinics, including dialysis.

Compassionate excellence is the foundation of the Hospital’s mission, vision, and values. Our Commitment states:

- We are here to care for our patients with compassion – close to home and with our partners.
- We pursue excellence in all we do.
- We are one team. We value respect, accountability, innovation, and learning.



To support the Hospital in pursuing its commitment statement, its Strategic Plan for the 2019- 2024 period focuses on four central themes:

- Quality / Services
- Our people
- Partnerships / Integration
- Accountability

The Strategic Plan was developed by the Strategic Planning Steering Committee composed of staff, physicians, volunteers, and patients, in collaboration with the WDMH Board of Directors. The process included extensive research and consultation and reconfirms the team’s commitment to patient and family-centered care.<sup>14</sup>

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## OUR STRATEGIC PLAN 2019 to 2024

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| Quality/<br>Services   | Our People  | Partnerships/<br>Integration  | Accountability  |
|--|---|---|---|
| <p><b>We will provide high-quality services to achieve the best possible patient experience and outcomes.</b></p> <p><i>We will:</i></p> <ul style="list-style-type: none"> <li>• Partner with patients to improve their care</li> <li>• Serve as a collaboration hub to address community needs throughout all stages of life</li> <li>• Enhance patient access and interaction, including new digital opportunities</li> <li>• Conduct rural health research and apply evidence to support quality improvement</li> <li>• Ensure public awareness and understanding of patient services</li> </ul> | <p><b>We value our staff, physicians, volunteers and learners, and will foster a workplace where everyone is empowered to work to their full potential.</b></p> <p><i>We will:</i></p> <ul style="list-style-type: none"> <li>• Live our Commitment Statement</li> <li>• Provide opportunities for growth and learning</li> <li>• Communicate effectively</li> <li>• Strengthen health, safety and wellness in our workplace</li> <li>• Be a workplace-of-choice for new applicants and our current team</li> <li>• Continue to foster engagement in WDMH decisions and activities</li> </ul> | <p><b>We will collaborate to improve our patients’ transitions.</b></p> <p><i>We will:</i></p> <ul style="list-style-type: none"> <li>• Share resources, including knowledge, information, education, technology, programs and advocacy efforts</li> <li>• Explore new opportunities, including those involving virtual services</li> <li>• Partner with physician organizations to address community needs</li> <li>• Partner with educational organizations to facilitate the transfer of knowledge and skills</li> </ul> | <p><b>We will demonstrate accountability in all relationships and ensure responsible stewardship of all resources.</b></p> <p><i>We will:</i></p> <ul style="list-style-type: none"> <li>• Make decisions ethically, consistently and transparently</li> <li>• Actively engage in change involving the broader health system</li> <li>• Nurture a strong community relationship that encourages continuous investment in WDMH</li> <li>• Strategically invest in infrastructure, equipment and technology</li> <li>• Practice environmental responsibility</li> </ul> |

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<sup>14</sup> Winchester District Memorial Hospital Brief January 8, 2024.

## 3.3 Analysis and Discussion

### 3.3.1 Introduction

The IAC was requested to examine the resources within the Family Birthing Unit at Winchester District Memorial Hospital including staffing that would support quality and safe patient care. The IAC has based its analysis on careful review of the extensive information provided by the Ontario Nurses Association and the Winchester District Memorial Hospital prior to and during the IAC Hearing.

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

The Canadian Nurses Association (CNA) and the Canadian Federation of Nurses Unions (CFNU)<sup>15</sup> (2014) developed a joint statement outlining seven (7) key principles for practice environments that maximize outcomes for clients, nurses, and organizations. They are as follows:

1. **Communication and collaboration** — Communication [and collaboration are) at the foundation of nursing. Quality practice environments promote effective and transparent communication among nurses, between nurses and clients, between nurses and other health and non-health providers, between nurses and unregulated workers, and between nurses and employers. Quality practice environments are based on trust and respect among clients, staff and employers.
2. **Responsibility and accountability** — A quality practice environment helps nurses fulfil their professional, legal, legislative, and collective agreement requirements and ensures they can participate in decision-making that affects their work, including developing policies, allocating resources, and providing client care.
3. **Safe and realistic workloads** - Quality practice environments support safe and realistic workloads for nurses. Workload is the top issue for Canadian nurses today and is often cited as a key factor in turnover. Enough nurses are required to provide safe, competent and ethical care.
4. **Leadership** — Effective leadership is important in all nursing roles and is an essential element of quality practice environments — for example, nurse managers who involve direct care nurses in decision making that affects the care they provide. At the same time, nurses (including direct care nurses) who act as collaborators, communicators, mentors, role models, visionaries and advocates for quality care also provide effective leadership. Therefore, all nurses have an important leadership role that affects their workplace environment and the care they provide.
5. **Support for information and knowledge management** — Quality practice environments include technologies that support critical thinking, enable the provision of safe and effective care, and provide optimal information and knowledge management (e.g., electronic health records and decision support tools). They also ensure that nurses have adequate time to access these technologies.
6. **Professional development** — Quality practice environments are adequately supported and funded to allow nurses to access professional development opportunities. These opportunities can include formal and continuing education, mentoring and online learning resources.

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<sup>15</sup> [https://cna-aiic.ca/~media/cna/page-content/pdf-en/practice-environments-maximizing-outcomes-for-clients-nurses-and-organizations\\_joint-position-statement.pdf](https://cna-aiic.ca/~media/cna/page-content/pdf-en/practice-environments-maximizing-outcomes-for-clients-nurses-and-organizations_joint-position-statement.pdf).

7. **Workplace culture** — A quality practice environment creates a workplace culture that values the wellbeing of clients and employees. This culture is continually assessed to ensure it embraces respect while developing practical knowledge [that] contributes to positive change, disseminating successful practices and strengthening health-care workplace cultures.

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

1. Health Human Resources - Staffing
2. Model of Care for the Winchester District Memorial Hospital Family Birthing Unit
3. Leadership and Communication
4. Orientation
5. Professional Development
6. Family Birthing Unit Outpatient Visits
7. Obstetrical Triage Tool
8. Safety and Security
9. Equipment
10. Policies and Procedures
11. Use of Verbal Orders
12. Professional Responsibility Workload Report Forms (PRWRF)
13. Hospital Association Committee (HAC)

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

## **1 Health Human Resources- Staffing**

### *1. The Role of the Team Leader*

The team leader plays a crucial leadership role in the Family Birthing Unit (FBU) at Winchester District and Memorial Hospital (WDMH). Leadership is the process of influencing others to understand and agree about what needs to be done and how to do it, and the process of facilitating individual and collective efforts to accomplish shared objectives<sup>16</sup>. The team leader acts as a role model for best practices and inspires the entire team to deliver high-quality care.

Nurses, moreover, in their daily routine of the hospital environment, work primarily in groups, as members of an interdisciplinary team. Regarding the nursing team, its proper functioning is associated with the provision of safe and quality care and with the emergence of positive health results of patients. The nursing leadership, the behavior of which guides, encourages, inspires, and supports nurses, is an important factor in the success of the nursing team<sup>17</sup>. The effectiveness of nursing team is closely linked to leadership. The effectiveness of the care provided by the nursing team and the positive impact on patient health is largely related to the behavior of the leadership.<sup>18</sup>

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<sup>16</sup> Leadership in healthcare organizations: A guide to joint commission leadership standards, a governance institute white paper. PM Schyve – 2009.

<sup>17</sup> Robbins S, Judge T (2011) Organizational Behavior: Basic Concepts and Modern Approaches. Criticism Publications, Athens.

<sup>18</sup> Bien MU, Schermerhorn J, Osborn R (2016) Organizational Behavior. Broken Hill Publishers LTD. Nicosia Cyprus.

The team leader role in the WDMH Vol.1 brief <sup>19</sup> is described as a role that provides leadership and oversight of FBU. The role assists the clinical manager in several functions. It is described as a role that does not typically have a patient assignment, coordinates staffing levels, coordinates patient assignments, replaces and orders equipment, responsible for the orientation of new staff members, and supports ongoing education and development of current staff to ensure standard of care is being met. It is described as a liaising resource in team efforts with physicians, department staff and internal/external partners.

The ONA Volume 1 brief<sup>20</sup> identifies concerns that the roles and responsibilities of the team lead role as evidenced by the Hospital's job description are not being met as the team lead is not replaced when off on planned or unplanned leaves or if working at home. There is additional concern identified that in the off shift, outside the regular team lead scheduled hours, there is no assigned charge responsibilities to the RN's that are working.

The absence of a team leader or designated charge nurse in an obstetrics unit can lead to increased risk. The role is pivotal in coordinating patient care. Their absence may result in inefficiencies, missed assessments, or delayed interventions. Charge nurses make real-time decisions during emergencies or complex cases. Their absence can cause delays in decision-making. In obstetrics, timely decisions are crucial for maternal and fetal well-being.

It was evident on numerous PRWRFs and staff testimonials during the IAC Hearing, the absence of the team leader as well as an assigned charge nurse in her absence contributes to a suboptimal work environment. Team leaders provide support and guidance to staff. Their absence can impact morale due to feeling unsupported which may have an impact on retention of skilled nursing staff. In summary, the absence of a team leader or an identified charge nurse can jeopardize patient safety, teamwork, and overall unit functioning in obstetrics. Ensuring timely replacements and effective leadership is essential for optimal care.

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

1. The Team Leader must be supported in their leadership role by the Clinical Manager as evidenced by daily status exchange/touch points. These exchanges will review potential issues such as staffing, patient flow and assign appropriate escalation if required.
2. The Team Leader role will be reviewed to ensure their hours of work align with needs of the unit. The role is currently scheduled from 0700-1500 hours Monday to Friday. Planned inductions as well as planned Caesarean sections are scheduled Monday to Friday. The hospital is encouraged to engage in a robust review and documentation of team leader standard work and align hours to acuity and activity of the unit. Consider shifting to a Monday to Friday 0830—1630 model to incorporate day ahead planning for assignments and procedures as well as availability on the unit when a number of deliveries occur.
3. The Team Leader role will be replaced for all scheduled and unscheduled absences.
4. A Charge Nurse will be designated in the absence of the team lead. This includes weekends and statutory holidays. This assignment will be compensated as per the ONA collective agreement.

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<sup>19</sup> WDMH Brief Vol.1.

<sup>20</sup> ONA Brief Vol. 1

5. The Team Leader will develop a standard work document that is shared with FBU staff. Standard work documents increase understanding of the role, improve communication within the team and enhance patient safety.
6. A Charge Nurse roles and responsibility description/document will be devised with input from FBU staff.
7. The Team Leader and Clinical Manager will identify specific RNs to place in the Charge Nurse role in the absence of the team leader. Education, including the use of standard work tool will be provided to ensure charge nurses understand the role and accountabilities associated with the role.
8. RNs assuming the Charge Nurse role will be offered four buddied shifts.
9. The Team Leader and designated Charge Nurses are encouraged to participate in leadership development opportunities that are available. Opportunities may be available through the Champlain, Maternal, Newborn Regional Committee. Staff are encouraged to utilize the hospital's education policy for reimbursement.
10. Update Team Leader job description to reflect accountabilities.

## 2. Flexible Staffing Model

Increasing staffing in perinatal units while balancing the unpredictability of patient activity can be challenging. In 2021, Provincial Council for Maternal and Child Health (PCMCH) convened a Maternal Levels of Care (MLOC) and Neonatal Levels of Care (NLOC) Task Forces to revise the Standardized Maternal and Newborn Levels of Care Definitions.<sup>21</sup> The impact of transferring to a higher or lower level of care on the pregnant individual, newborn and family needs to be balanced with local resources, knowledge, competencies, experience, and skills. Winchester District and Memorial Hospital meet the identified Perinatal, Birthing and Newborn levels of care. This is reflected in their transfer to a higher level of care data as demonstrated in the table below<sup>22</sup> which is consistently decreasing.

| Transfers out to other facilities | Delivered Moms | Rate of transfers of delivered Moms (Based on Total Deliveries) | Babies | Rate of transfers babies (Based on Total Births) |
|-----------------------------------|----------------|---|--------|--|
| 2018-19                           | 5              | 0.70%   | 25     | 3.39%  |
| 2019-20                           | 3              | 0.44%   | 16     | 2.37%  |
| 2020-21                           | 2              | 0.28%   | 14     | 1.93%  |
| 2021-22                           | 6              | 0.79%   | 19     | 0.79%  |
| 2022-23                           | 2              | 0.34%   | 15     | 0.34%  |
| 2023 Apr-Dec                      | 4              | 0.81%   | 14     | 0.80%  |

Flexible staffing models allow for adjustments of staffing based on patient volume. In response to unpredictability within FBU, WDMH has implemented a heavy workload process that allows nurses to call in when high activity is expected or occurs to support patient care. Surge of activity is confirmed by frontline staff and the Team Leader<sup>23</sup>. WDMH in their Day One presentation defined heavy workload in Labor and Delivery as two plus patients in active labor, expected twin deliveries, ongoing unplanned

<sup>21</sup> PCMCH Guidance Document: Perinatal, Birthing and Newborn Levels of Care. Retrieved : [Perinatal Birthing Newborn Levels of Care Guidance Document.pdf \(pcmch.on.ca\)](https://www.pcmch.on.ca/Perinatal_Birthing_Newborn_Levels_of_Care_Guidance_Document.pdf).

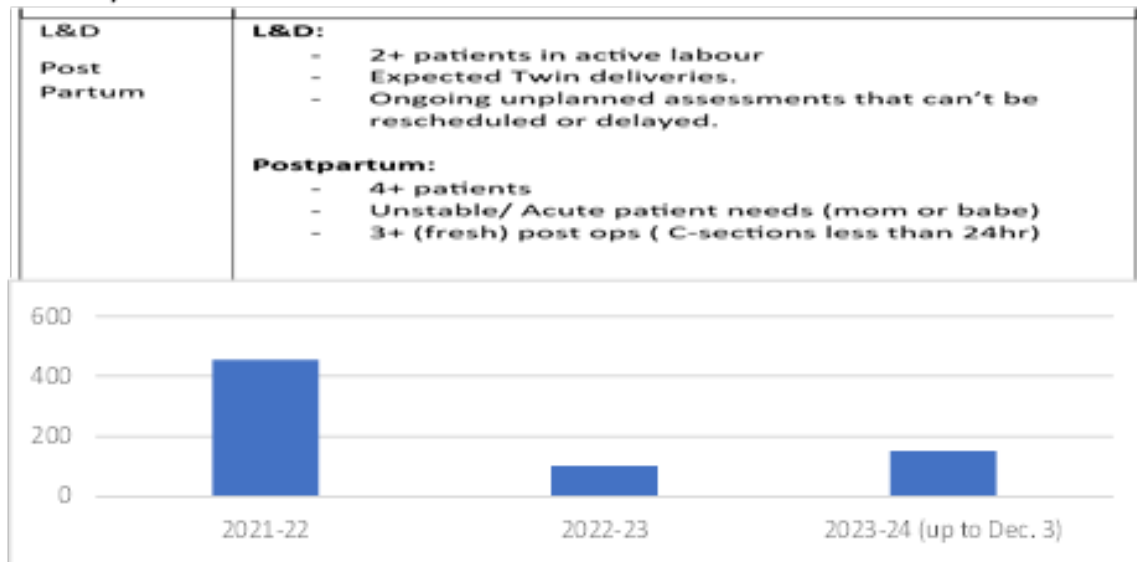
<sup>22</sup> WDMH IAC Presentation Day 1.

<sup>23</sup> WDMH Brief Vol. 1.



assessments that can not be delayed and in Postpartum four plus patients, unstable/acute patient needs and three plus (fresh) post ops (C section less than 24 hours). WDMH has also provided the number of hours that heavy workload was utilized. While the number of hours is decreasing it does support the transient and unpredictability of this specific patient population.

## Heavy Workload



In ONA's brief Vol. 1<sup>24</sup> as well as documented on numerous PRWRF's there are identified gaps in the process, many heavy workload requests do not secure additional staffing due to lack of availability of nurses at short notice.

With the use of predictive analytics, the ability to forecast patient activity may guide staffing decisions based on historical patient presentation data. With this data, the use of the heavy workload process may be implemented proactively as opposed to reactively. This forecasting should be utilized for scheduling of outpatient procedures as well as planned procedures such as inductions and Caesarean sections to ensure that appropriate resources are scheduled.

It is important to note that a combination of evidence-based approaches, flexibility, and collaboration can help optimize staffing in the Labor and Delivery and Postpartum units.

### The IAC Panel Recommends:

1. Planned Caesarean sections are scheduled by the operating room clerk when requested. Coupled with scheduled outpatient procedures, each week based on planned heavy workload additional resources are requested. This request for heavy workload will be filled with an RN. The RN with an increased scope of practice can be deployed to either Labor and Delivery or Postpartum to provide the assistance that is required. This flexibility ensures that staff can adapt to changing demands.

<sup>24</sup> ONA Vol. 1 : ONA Brief and Workload Tracking Report.



2. The Hospital will review all patient activity through the Family Birthing Unit Care Team meeting to identify trends, issues, and scheduling opportunities. This review will maximize scheduling and ensure appropriate resource allocation for scheduled activity. This activity should include but not limited to:
  - Scheduling of outpatient procedures
  - Types of patients being scheduled for outpatient appointments.
  - Triage visits (not scheduled) change in status.
  - Most Responsible Provider Activity – Consider provider scorecards.
  - Scheduled Inductions – Use of Induction tool – Medically Indicated
  - Scheduled Caesarean Sections.
3. The results of the patient activity review will be shared with the Clinical Manager and Team Leader for program planning. The results will be shared with staff to promote transparency and trust.
4. Quality and Performance indicators specific to FBU are to be shared at huddles and staff meetings. Regularly reviewing data, involving multidisciplinary teams, and collaboration with stakeholders will enhance obstetrical care across the program.

### *3. Role of the Ward Clerk*

Ward clerks are essential members of the hospital health care team, who provide organizational and administrative support to the health care team staff. This allows for the nurses to concentrate on direct bedside patient care that is not delayed by non-nursing duties. Winchester District Memorial Hospital has a role specific job description.<sup>25</sup>

The job description entails many duties to support and assist the family birthing unit and post-partum unit. It was discussed not only in the three (3) days of the hearing but also in ONA's report<sup>26</sup> and PRWRF's.<sup>27</sup> Many of the duties listed in the job description have become the responsibility for nursing staff, as the 2 hours, 12:00-14:00<sup>28</sup> allotted for the ward clerk are insufficient. These tasks then get delayed to the next day or passed on to the already taxed nursing staff thus taking away from direct patient care.

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

1. A review of the Ward Clerk job description, roles, and responsibilities as it pertains to the FBU within three months following the IAC Report submission Consider the following roles and responsibilities during the review.
  - a. Answering of the phones, assisting in the booking of outpatient appointments
  - b. Assisting with transfer paperwork if needed.
  - c. Assisting in the FBU when needed to assist FBU with administrative duties.

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<sup>25</sup> Winchester District Memorial Hospital Annex 13, OBS Ward Clerk Duties, Winchester Brief January 8, 2024.

<sup>26</sup> ONA Brief Volume II.

<sup>27</sup> ONA Brief Volume III, PRWRF's.

<sup>28</sup> Winchester District Memorial Hospital Brief.

2. Increase the ward clerk hours from 2 hours per day to 4 hours per day.
3. The employer will explore the resources available within the hospital to assist the clerical team with the assembly of FBU health teaching packages and educational information pamphlet restocking

#### 4. *Role of the Care Coordinator*

Winchester District and Memorial Hospital (WDMH) in their brief <sup>29</sup> identify the role of a Care coordinator. This role is described as an onsite representative of leadership that supports teams with continued operations, such as bed flow, address staffing situations, support during acute situations, and trouble shoot various clinical and nonclinical situations. The Care Coordinators are present in the hospital outside of regular business hours. This includes both weekends and statutory holidays.

The ONA Volume 1 brief <sup>30</sup> as well as in PRWRF's describe incidents within FBU that staff feel unsupported on many occasions as the coordinator(s) are not always aware of perinatal nursing standards, FBU policies and procedures.

A clinical coordinator ensures that patient care remains consistent and efficient even when leadership is not present. Their oversight helps prevent gaps in care and ensures timely responses to emergencies. While not an expert in all aspects of hospital functions and clinical care, the role of the Care Coordinator should exhibit strong leadership skills and the ability to access the information and resources that may be required.

Besides leadership and clinical expertise, recent research identified the following key skills necessary for this leadership role.<sup>3132</sup>

- **Effective communication** is essential when discussing an issue with patients, nursing staff, physicians, or other departments, as well as when listening to their concerns and working together for a solution.<sup>7</sup> It also fosters teamwork, as administrative supervisors keep staff updated on admissions and what is going on in the rest of the hospital, enlist the cooperation of other departments, and support other units with additional nursing staff during busier times.<sup>7</sup>
- **Conflict management** involves fielding any complaints and concerns that escalate during a shift. Conflict resolution approaches help administrative supervisors to handle a multitude of issues that may arise between staff, physicians, patients, and families. Sometimes, patients and families respond differently to someone in a white lab coat; other times, the supervisor may have to deescalate a situation before discovering what the patient really needs. Occasionally, the assistance of the on-call administrator is needed to help resolve an issue.
- **Time management** is critical because administrative supervisors often need to respond to multiple situations happening at the same time. With less staff on the evening and night shifts, delegation is not typically a possibility for these leaders. Supervisors must learn how to

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<sup>29</sup> WDMH Brief Vol.1.

<sup>30</sup> ONA Vol.1 ONA Brief and Workload Tracking Report.

<sup>31</sup> Weaver S. *Exploring the Administrative Supervisor Role and its Perceived Impact on Nurse and Patient Safety*. Ann Arbor, MI: ProQuest Dissertations Publishing; 2016.

<sup>32</sup> Weaver S, Cadmus E, Lindgren T. Profile of the administrative supervisor: what do we know. *Nurse Leader*. 2018;16(2):134–141.

complete their time-sensitive responsibilities while responding to emergencies and weaving in their other responsibilities throughout the shift.

Care Coordinators play a vital role in maintaining efficient healthcare operations and ensuring patient well-being. Their combination of clinical knowledge, and organizational skills contributes significantly to the overall functioning of the hospital.

**The IAC Panel Recommends:**

1. The Care Coordinator Job description is shared with all members of the FBU team to promote understanding of the role.
2. The Care Coordinator should huddle within FBU utilizing a status exchange tool (similar to the Team Leader tool) to review potential issues, appropriate escalation as well as planning and accountability assigned for follow up. This should be completed at regular designated intervals during times of high volume, high acuity to ensure that staff are supported.
3. The Care Coordinator, upon review of the organization's staffing and acuity needs will have the authorization to call in staff as needed. This will proactively address FBU and hospital staffing issues.
4. The Care Coordinator will contribute to managerial written responses to the PRWRFs when the issues raised by the RNs occur on their shift, in accordance with the collective agreement timelines.
5. The Care Coordinator should attend skills days provided by the organization to increase understanding of the FBU acuity and activity. This learning will be beneficial if called upon for support.

*5. The Role of the Clinical Scholar*

The Clinical Scholar program has been launched by the Ministry of Health for fiscal year 2023-24. The Clinical Scholar program is designed to assist with retention of experienced and new nurses in clinical setting through dedicated leadership and mentorship opportunities. Through the program, experienced nurses with frontline experience will be employed as clinical scholars to provide mentorship to new nurses and support their transition into the workforce<sup>33</sup>.

The Clinical Scholar role is a supernumerary role, and the candidate is an experienced nurse in frontline practice. The experienced can gain mentorship experience as a Clinical Scholar and a newly graduated/novice nurse receives at the elbow clinical support.

All publicly funded hospitals were eligible to apply for the Clinical Scholar program. Winchester District and Memorial Hospital (WDMH) has secured funding for the Clinical Scholar role to support the Family Birthing Unit (FBU). This role was starting in January 2024. As WDMH does not have a dedicated educator role, the support from the Clinical Scholar is imperative. The mentorship that the Clinical Scholar will provide helps build confidence and competence among new nurses as they begin their professional career.

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<sup>33</sup> Nursing and Professional Practice Division. MOH. Clinical Scholar Program.

**The IAC Panel Recommends:**

1. Clinical Scholar Funding was available from June 1, 2023-March 31, 2024. The hospital will reapply for this funding if extended into fiscal year 2024/2025.
2. The Clinical Scholar within FBU will capture baseline metrics of the support that has been provided (understanding this role was implemented for a short period of time) such as number of nurses supported, hours required for support as well as successes and areas of opportunity. These performance metrics will demonstrate the need for increased funding as well as any improvements that may enhance the program.

**2. Model of Care**

**Model of Care Recommendation**

Winchester District Memorial Hospital (WDMH) is a comprehensive, full service, 49 bed rural teaching hospital<sup>34</sup>. Providing effective, safe obstetrical care is crucial in ensuring the well being of pregnant individuals and their babies within the community. WDMH provides a Level 1b perinatal, birthing, and newborn level of care.<sup>35</sup> Care to obstetrical patients within the hospital is provided by an Obstetrician, General Practitioner (GPOB) and/or midwifery as well as Registered Nurses (RN) and Registered Practical Nurses (RPN). The care journey includes antenatal to postpartum.

The obstetrical unit at WDMH is funded for four labor and delivery beds, however the area in which Labor and Delivery is located has five bed spaces. Three rooms are private rooms often used for active labor, one room has two assessment areas, is primarily used for outpatient assessments and one room is utilized as a awaiting area. In the ONA Brief Volume 1 it describes the Obstetrical unit as five beds<sup>36</sup>. The postpartum area is described in both briefs as having available rooms for the care of up to ten mother/baby dyads. Both units are supported by a clinical manager.

Monitoring of a program’s data including volume, acuity, as well as provider are essential elements when planning for a safe model of care. Below is a table from WDMH’s Brief identifying by calendar year type of delivery, volume, and provider<sup>37</sup>. This is coded hospital data.

| Type of Delivery | 2021       | 2022       | 2023 (to Oct. 31) |
|------------------|------------|------------|-------------------|
| <b>TOTAL</b>     | <b>793</b> | <b>620</b> | <b>529</b>        |
| Vaginal          | 617 (78%)  | 469 (76%)  | 379 (72%)         |
| C-Sections       | 176 (22%)  | 151 (24%)  | 150 (28%)         |
| Inductions       | 258 (33%)  | 229 (37%)  | 147 (28%)         |

<sup>34</sup> Winchester District Memorial Hospital Brief.

<sup>35</sup> Perinatal, Birthing and Newborn Levels of Care. Retrieved: [Perinatal, Birthing and Newborn Levels of Care – PCMCH.](#)

<sup>36</sup> ONA Brief and Workload Tracking Report Volume 1 pg.5.

<sup>37</sup> Winchester District Memorial Hospital Brief.

There is further data to support that approximately 70% of deliveries are supported by an Obstetrician, 20% by midwife and 10% by GPOB.

The Labor and Delivery unit staffing includes:

- Team Leader role – RN - Monday-Friday 0700-1500
- 2 RN's – 24 hours per day 7 days per week.

The postpartum area staffing includes:

- RPN – 1 - 24 hours per day 7 days per week
- Team Leader has oversight of the post partum area as well.

There are also several allied health professionals that support the hospital including Labor and Delivery and postpartum. These include respiratory therapy, pharmacy, physiotherapy, social work, and a dietician. These resources are not available 24/7 but can be consulted.

For planned Caesarean sections there is a process in place that the operating room booking clerk (each Thursday) will notify the staffing team that an additional RPN should be booked at various points throughout the week due to an identified heavy workload due to these planned procedures. There is also a heavy workload protocol in place for the program which describes calling in of additional resources for high acuity and high volume. This is done in consultation with the team leader, clinical manager, or clinical coordinator. It is important to note this additional resource maybe difficult to secure with a short notice call in.

There have been several changes in the location of the post partum unit within WDMH. Historically the unit was embedded in the medical surgical inpatient unit adjacent to labor and delivery. The hospital brief describes the pandemic bed pressures of patients requiring isolation as a factor in the relocation the postpartum unit adjacent to the Complex Continuing Care Unit. This relocation allowed the hospital to place respiratory patients in private rooms on the inpatient unit as per provincial direction. For the period of six months in 2023 the postpartum unit returned to its original location however increasing bed pressures especially for placement of patients requiring isolation a decision was made to move the post partum unit again. Staff have identified feeling isolated working in the post partum area.

Collaboration is essential to improving health care delivery and leveraging a strengths-based approach for all disciplines will leverage knowledge and skills of all team members. Innovative interprofessional models should be implemented as part of the solution for high-quality, collaborative, and integrated care for rural obstetrical care<sup>38</sup>.

**The IAC Panel recommends:**

1. Complete an environmental scan to explore the possibility of geographically locating both the Labor and Delivery and Postpartum units in the same space. Sharing the space provides an opportunity to gain supportive efficiencies based on patient care needs within the unit.

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<sup>38</sup> Rural Maternity Care Retrieved: [Rural Maternity Care \(jogc.com\)](https://jogc.com)

2. Consider in the shared space a coordinated care team approach which focuses on an interprofessional collaboration. In this approach every patient is assigned a most responsible nurse during each shift. Most responsible nurse is an RN or RPN depending on patient acuity and is the person ultimately responsible for the direct care the patient receives<sup>39</sup>.
3. Optimize scope of practice to provide role clarity between RN's and RPN's. Clear understanding of each team members scope of practice encourages coordinated work. This will build internal flexibility within the program.
4. Provide education to staff regarding role clarity and scope of practice. This will enhance key understanding and promote collaboration.
5. Explore enhanced clinical supports such as clinical scholars to provide education and at the elbow support for team members.
6. Explore external resources such as Public Health to provide discharge support.
7. If implemented, monitor staff and patient satisfaction indicators to demonstrate improvement.
8. Monitoring and reviewing staffing levels in FBU is crucial to ensure safe and effective care. Closely monitor volumes of births by provider each fiscal quarter to ensure staffing levels are appropriate. This proactive approach will inform hospital budget requests for enhancements if required.
9. In supporting the Model of Care, Professional Staff and Midwifery staff are held accountable to their credentialing and privileges as set out by the hospital. Organizational policies such as Code of Conduct, availability, and standard response times if off site must be adhered to. Failure to do so should be escalated as per hospital policy.

### 3. Leadership and Communication

#### 1. Professional Practice Advisory Committee (PPAC)

Winchester District Memorial Hospital initiated the PPAC meeting in September 2023 with its overall purpose to serve as an interprofessional committee that provides advice/direction on matters concerning professional practice, education and research related to health disciplines at WDMH.<sup>40</sup>

The PPAC meets the Hospital Central Agreement<sup>41</sup> article 6.12 whereby there is a forum for bargaining unit members to actively participate in issues related to professional nursing practice. The terms of reference are currently in draft form, still seeking input for final approval.

#### The IAC Panel Recommends:

1. A standing agenda item for each meeting be related specifically to Nursing Practice related issues.
2. The PPAC Terms of Reference be finalized within three (3) months of the submission of this report.
3. Meetings be held monthly.

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<sup>39</sup> Michael Garron Hospital Toronto, Ontario, Canada. Advisory Board interviews and Analysis.

<sup>40</sup> Winchester District Memorial Hospital Presentation February 1, 2024, p. 9.

<sup>41</sup> Hospital Central Agreement March 2025 ONA Brief Volume II p. 134.

4. Consider adding a Human Resources representative to membership.

### *2. Family Birthing Unit Care Team Meetings and Maternal Child Care Team Meetings*

As evidenced by Winchester’s District Memorial Hospital’s submission and appendices to the report <sup>42</sup> there are regularly scheduled Family Birthing Unit Care Team meetings and Maternal Child Care Team meetings with attendance lists and minutes available. All staff are encouraged to attend these meetings.

Staff meetings provide a forum for shared communication. These occur less frequently than a huddle and are often of longer duration. This is an opportunity to provide staff with organizational and departmental updates, discuss the potential impact of any upcoming changes as well as recognition of staff. Staff can also provide feedback regarding changes that have occurred, opportunities for improvement as well as recognition of colleagues.

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

1. Family Birthing Unit Care Team meetings continue monthly to address policies, procedures, medical directives, evidence-based practice, and other relevant issues.
2. Maternal Child Care Team meetings to be held monthly. There should be an established meeting time, so it becomes familiar with options for in person or virtual attendance.
3. The agenda should be circulated one (1) week prior to the meeting to all staff in the department with a call for agenda items to be discussed.
4. An updated agenda should be circulated 5 days prior to the meeting to ensure informed participation.
5. Minutes will be distributed to all staff.

### *3. Huddles and Staff Rounding*

To optimize communication, teams should plan to meet regularly. Regularly scheduled huddles and staff meetings are an effective way to engage frontline staff in problem identification and build a culture of collaboration and quality, thereby enhancing the ability to deliver safe patient care.

#### **Huddles**

A huddle, in the context of healthcare delivery, is a short meeting involving interdisciplinary healthcare team members– no more than 10-15 minutes in duration – that proactively enables teams to focus on patient safety, thereby facilitating team communication. The purpose of the huddle is to share information and highlight concerns to be followed up – not solve issues. Ideally, concerns raised during huddles are then directed to the appropriate person or groups for resolution, such as supervisors or patient safety committees (Shaikh, 2020). It occurs at a consistent time daily, generally at the beginning of a shift. There is a standard work document (status exchange) that is used to ensure that all critical information is collected. The purpose of the status exchange is to proactively address issues, plan and provide support for staff. Please see the sample tool attached.<sup>43</sup>

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<sup>42</sup> Winchester District Memorial Hospital Appendix January 8, 2024, p. 462.

<sup>43</sup> Shaikh, Ulfat (2020). Improving Patient Safety and Team Communication through Daily huddles. <https://psnet.ahrq.gov/primer/improving-patient-safety-and-team-communication-through-daily-huddles>.

## Staff Rounding

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

The focus for questions during staff rounding is to:

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

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

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

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

Given the discussions throughout the IAC hearing, rounding for outcomes with staff is a meaningful way to enhance trust, engage in meaningful dialogue with staff and to understand issues relevant to them. Simultaneously, holding huddles and regularly scheduled staff meetings is of equal importance for staff and leadership to stay engaged and feel empowered to bring forward issues.

### The IAC Panel Recommends:

1. The CNE participates in staff rounding monthly to foster collaboration and trust with the Family Birthing Unit staff effective immediately.



2. Implement huddles with the Manager/Team Leader daily utilizing a status exchange tool<sup>44</sup> to review potential issues of the day, appropriate escalation as well as planning and accountability assigned for follow up effective immediately.
3. Manager to round daily checking with the Team Leader or delegate to understand patient flow, staffing or other concerns effective immediately.
4. Manager is encouraged to share her schedule with the Team Leader or delegate to facilitate communication and accessibility if needed effective immediately.

|  |  | ED Daily Status Sheet Exchange |      |     |       |     | Actions/Close the Loop |
|---|--|--------------------------------|------|-----|-------|-----|------------------------|
| Date:   |  | Mon                            | Tues | Wed | Thurs | Fri |                        |
| <b>Safety</b>   | Are there any patient or staff safety concerns?                        |                                |      |     |       |     |                        |
|   | Have there been any safety incidents? Falls, med errors, violence etc. |                                |      |     |       |     |                        |
| <b>Quality</b>  | Patient concerns   |                                |      |     |       |     |                        |
|   | Any supply / equipment issues?   |                                |      |     |       |     |                        |
| <b>Patient and Family Centered Care</b>   | Number of patients? How many admits to no bed? Discharges?             |                                |      |     |       |     |                        |
|   | Are there any special care needs? 1:1 ?                                |                                |      |     |       |     |                        |
|   | Any Flagged patients?  |                                |      |     |       |     |                        |
| <b>People</b>   | Staffing issues today?   |                                |      |     |       |     |                        |
|   | What challenges came up yesterday that we didn't plan for?             |                                |      |     |       |     |                        |
|   | Any staff issues/concerns?   |                                |      |     |       |     |                        |
| <b>Any other Issues?</b>  | Any other Issues?  |                                |      |     |       |     |                        |
|   | Are there any outstanding  |                                |      |     |       |     |                        |

<sup>44</sup> Cambridge Memorial Hospital ED Daily Status Sheet Exchange Tool.

#### 4. Orientation

Formalized orientation programs for new staff nurses have shown to promote critical thinking skills and effective management and the delivery of care. A comprehensive unit specific orientation program lends itself to the retention of new staff as they feel supported in a specialty area such as the Family Birthing Unit (FBU). The IAC panel read and heard concerns related to the inconsistencies of the orientation program specific to the FBU program related to structure and length of orientation.<sup>45</sup>

The current unit specific orientation consists of new hires receiving twelve (12) hours of labor and delivery theory-based education in class. This is conducted by the Team Leader as there is no designated clinical educator for the FBU. The IAC panel does recognize the new position of the Clinical Scholar will be a positive addition to support staff as an “at the elbow” team resource. The new hire is then assigned to a dedicated mentor nurse for six (6) weeks. In this time frame the hospital has a competency checklist that has been developed by the CMNRP.<sup>46</sup> The on boarding of new hires is frequently interrupted by staff shortages, sick calls, vacation, and acuity of the unit.<sup>47</sup> Also of note there is not a formal mentorship program in place to assist in the mentor’s role.

There are approximately 23% novice nurses currently in the FBU unit that would benefit from working collaboratively with experienced staff given the specialty of the FBU. The IAC Panel heard throughout the hearing and read through the briefs how Winchester Memorial District Hospital is a rural hospital. Being a rural hospital having a consistent evidence-based orientation program with continued support to their novice staff will set them up for success. A rural hospital model of care does not have available resources 24hours per day in the hospital setting. The rural hospital setting lends itself to unique situations that staff must be set up for success from the beginning to handle and excel in their specialty areas.

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

1. The employer will conduct a thorough review of the current orientation program in collaboration with the Champlain Maternal Newborn Regional Program.
2. The employer will implement and maintain a structured, consistent orientation program, that will include all methods of adult learning to promote success for the learners.
3. The employer will establish and maintain a thorough orientation program with a minimum of one week in class theory education provided by a designated clinical educator who has Perinatal background and knowledge. The educator will provide didactic lectures and discussion, in person interaction, and hands on skill training.
4. The orientation program will be extended to twelve (12) weeks specific to the unit above the corporate orientation.
5. The employer will ensure all RN’s that are in a mentorship role are offered and supported by mentorship training such as the Canadian Nurse Educators Institute Preceptor Training Program. Evaluation of the new hire will be scheduled for every four (4) weeks to consist of the manager, mentor and clinical educator (if one exists).
6. The mentee’s orientation will not be decreased in length unless it has been agreed upon by all parties.

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<sup>45</sup> ONA Brief Volume II PRWRF’s.

<sup>46</sup> ONA Brief Volume I, p.30.

<sup>47</sup> ONA Brief Volume II PRWRF’s.

7. The employer will implement and utilize the Champlain Maternal Competency check list as part of their standard orientation for new hires. This will allow for standardized, and an organized. measure of progress.
8. The employer will explore the collaboration with community partners to access, share and utilize their resources to assist in the continued learning needs of their staff.
9. When a new hire is with their mentor for their required shift it should be discussed at morning huddle the absence of completion of any core competencies not yet achieved. This will allow for greater opportunity and exposure for the new hire to take advantage of even if not with their mentor.
10. Prior to onboarding of a new hire off the orientation program, it will be mandatory they have Fetal Health Surveillance and Neonatal Resuscitation as it was stated in the hearing by clinical manager, Winchester District Memorial Hospital has in house instructors to complete this.
11. The employer will continue to support ongoing education opportunities for staff. This will include the exploration of community partners to bring specialized education opportunities to Winchester District Memorial Hospital. e.g. STABLE, ACORN or MORE OB programs.
12. The employer will arrange and facilitate monthly on-going skills days for staff to attend. These skills days will also be available to ER staff, Care Coordinators, Midwives, GPOB, Obstetricians, Anesthesiologist. This will allow for continued success amongst team members that may be called upon to help the FBU.
13. The employer will initiate paid education in Obstetric Triage. Once new hires have been onboarded and unit specific competencies achieved, new staff will have the opportunity to add this to their skill mix, approximately at the 6-month mark.
14. All new staff will have training and access to birth registration procedures during in class training

## 5. Professional Development

Comprehensive patient safety programs should be an integral part of rural maternity care. The characteristics of these safety programs should be comprehensive, patient focused, and applied within a culture of safety. They should identify system failures, analyze the factors that contribute to the failures, and redesign the care process to prevent errors in the future. A key component is the review of events based on “a culture of openness to all relevant perspectives in which those involved in adverse events are treated as partners in learning, these reviews should be carried out with an understanding of the rural environment.”<sup>48</sup>To promote consistent and evidenced-based practice, continuing professional development programs must be available for rural caregivers. Rural communities are ideally suited to this improved model because the health care professional teams are small, and strong collaboration is essential. Education that supports all members of the team to provide high-quality rural maternity care is optimal so that the whole team has the same knowledge base. Locally delivered continuing professional development contributes to the culture of safety while building collaborative teams and ensuring that the content is relevant to the rural reality.

WDMH has an education policy to support ongoing education of hospital staff. The policy allows each hospital staff member 6 days paid (7.5 hours/day) for continuing education per fiscal year. This is inclusive of both mandatory and optional trainings provided by the hospital or an external organization. The RN’s at WDMH also have access to the Perinatal Professional Development Program (PPDP)

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<sup>48</sup> Rural Maternity Care. Retrieved: [Rural Maternity Care \(jogc.com\)](http://jogc.com).

provided by the Champlain Maternal Newborn Regional Program (CMNRP. This is an online training resource that provides speciality specific training through modules and workshops.<sup>49</sup>

Simulation or mock drills in the spirit of continuous quality improvement may play a role in improving team function, as many participants state that implementing new protocols and participating in drills as a team has allowed for structured conversations to help clarify the roles of all the maternity providers and ensure “everybody is all on board” to complete the task at hand.<sup>50</sup>

In ONA’s Volume 1 brief as well as identified on PRWLF’s physician insistence on nursing acceptance of verbal orders in non urgent situations as well as consulting other physicians on their behalf have been identified. This type of practice does not align with nursing practice standards.

Participation in programs designed to reduce obstetrical risk are encouraged where possible. These programs can create, build, and sustain a working environment where professional autonomous silos, organizational hierarchy, communication gaps and uncoordinated teamwork are eliminated. The elimination of these barriers improves patient outcomes as well as improve staff satisfaction.

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

1. The Clinical Manager, Team Leader, and/or Clinical Scholar discuss with nurses/staff members asking them to identify professional educational opportunities that would enhance and benefit their learning as part of an annual learning needs assessment.
2. To improve access to professional development activities, develop a process of scheduling nurses and backfilling if necessary to attend educational sessions.
3. Encourage nurses to participate in the PPDP provided by CMNRP. This could be coordinated with the Team Lead and Clinical Scholar to promote continuous learning and ongoing professional development.
4. Implement simulation of mock drills such as Mock Code Pink and responding to Obstetrical Emergencies immediately. This will support improved team function and increase understanding of defined roles and responsibilities in an emergent situation.
5. All staff must adhere to the organization’s Code of Conduct policy. Education must be provided to all staff including professional staff to ensure compliance. Embedded within the policy is an escalation process when behaviour does not meet the policy standard.
6. Explore possibility of participating in programs to reduce obstetrical risk such as Salus Global More OB or reviewing the PROMPT program<sup>51</sup>. This is an evidence based multi-professional training package for obstetric emergencies. It is associated with direct improvements in outcomes for mothers and babies through improvement in knowledge, clinical skills, and human factors. Retrieved: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8532559/>. WDMH is encouraged to explore sharing costs with other hospitals within the region.

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<sup>49</sup> WDMH Hospital Brief Vol.1.

<sup>50</sup> System interventions to support rural access to maternity care: an analysis of the rural surgical obstetrical networks program (2023). Retrieved: [System interventions to support rural access to maternity care: an analysis of the rural surgical obstetrical networks program | BMC Pregnancy and Childbirth | Full Text \(biomedcentral.com\)](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8532559/)

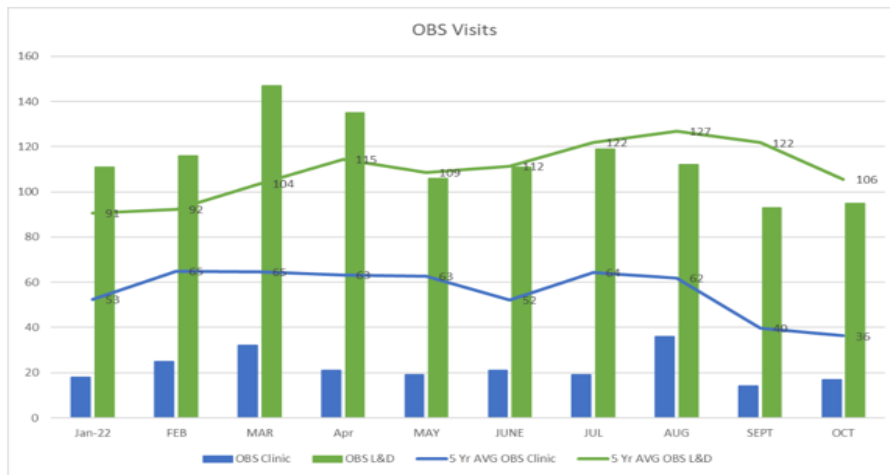
<sup>51</sup> PROMPT Wales project: national scaling of an evidence-based intervention to improve safety and training in maternity. Retrieved: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8532559/>

7. Conduct an annual educational needs assessment to determine educational needs and planning for the following year.

## 6. Family Birthing Unit Outpatient Visits

Winchester District Memorial Hospital’s Family Birthing Unit provides outpatient services for both the obstetrical and postpartum patients. Within L&D, assessments are conducted (ex. non stress tests) as well as admissions for labor and delivery. Based on the Ontario Nurses Association, their reported data indicated that in 2022-2023 there was a total of 1236 outpatient visits. This is an average of 3.5 visits per day based on their report.<sup>52</sup>

Looking at historical data over the past 5 years, on average, there have been approximately 110 assessments per month (see 5 yr. avg OBS L&D line), representing 3 to 4 assessments per 24-hr period within the labor and delivery unit. These assessments will be conducted by the Registered Nurses of the Unit. Postpartum out-patient follow-ups (ex. bilirubin verifications) are most often completed by the postpartum RPN. Looking at historical trends there are on average 56 visits per month, representing 1 to 2 visit per day.<sup>53</sup>



Source: QCPR – Taken Sept 2023, of January 2022 to October 2022 time frame. OBS Clinic data represents outpatients seen by Postpartum nurse and includes WinRho appointments in Medical Day Care Unit. OBS L&D data represents assessments completed by RNs in L&D]

### The IAC Panel Recommends:

1. Develop an outpatient schedule to book all outpatient visits both antenatal and postpartum at regular scheduled intervals to anticipate the need for additional staff to provide this care.
2. Develop a plan to transition to the Outpatient Lab Services to conduct newborn bilirubin tests.

<sup>52</sup> ONA Brief Volume I p. 6 January 8, 2024.

<sup>53</sup> Winchester Brief p. 9.

## 7. Obstetrical Triage Tool

### Telephone/SBAR Triage Tool

Proper assessment of patients is pivotal in the assessment and care that they receive. Standardized tools allow for consistent, reliable guided assessments. The IAC panel heard and read that it is a common process for patients to call the FBU prior to their arrival for assessment purposes. It was also documented in multiple PRWRF's about the amount of telephone triage calls that take place on the unit.<sup>5455</sup> Supplemental forms were provided by Winchester District Memorial Hospital and form # T-906 was viewed as the telephone triage record for nursing staff to record the telephone conversation they had and the instructions that were given to the patient to proceed with. This form was also utilized in the report given to physicians from the staff that had completed the triage. This form is very open ended and leaves variances for personal interpretation.

The creation and implementation of a definitive tool would decrease the risk of interpretation by the staff member assessing the situation. Standardized screening tools such as the OTAS tool lend themselves to reliability and validity. Something like the OTAS screening tool would benefit the staff in the FBU.<sup>56</sup> This will also allow for improved communication and between staff and MRP when giving report on the patient. There was also concern that proper orientation around the telephone triage process had not taken place for new hires as well as onboarded staff.

#### The IAC Recommends:

1. The employer will explore the development and implementation of a standardized phone triage tool that will assist staff in the assessment of pregnant women over the phone.
2. The employer will provide education to all staff in the implementation and utilization of this tool.
3. There will be a policy and procedure development surrounding the use of telephone triaging and when implemented a policy and procedure regarding the new tool.
4. New hires will have review of this education in orientation but formal training to commence after 6-month period of working in the FBU.
5. The employer will implementation of a standardized tool such as SBAR for the FBU staff to utilize while giving telephone report to the MRP whether that be OBGYN, GPOB or midwife. Each staff will receive formal training surrounding the use of this tool. This will enhance effective, precise communication.
6. The employer will work collaboratively with Champlain Maternal Newborn Regional Program to develop an Obstetrical Triage Tool that will be utilized in the assessment of antenatal patients. There will be mandatory education surrounding the implementation of this tool with annual review.

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<sup>54</sup> ONA Brief Volume II PRWRF's.

<sup>55</sup> IAC Hearing Day 2, February 1, 20024.

<sup>56</sup> British Columbia Obstetric Triage Acuity Scale Guidance, September 2021.

## SBAR report to clinician about a clinical obstetric situation

# S

### Situation

I am calling about (woman's name): \_\_\_\_\_ Ward: \_\_\_\_\_ Hosp No: \_\_\_\_\_

The problem I am calling about is: \_\_\_\_\_

I have just made an assessment:

The vital signs are: Blood pressure \_\_\_\_ / \_\_\_\_ Pulse \_\_\_\_ Respirations \_\_\_\_ SPO<sub>2</sub> \_\_\_\_ % Temperature \_\_\_\_ °C

I am concerned about:

**Blood pressure** because it is:  
systolic over 160  
diastolic over 100  
systolic less than 90

**Pulse** because it is:  
over 120  
less than 40

**Respirations** because they are:  
less than 10  
over 30

The woman is having oxygen at  
\_\_\_\_ l/min

**Maternal temperature** because it is: \_\_\_\_ °C

**Maternal serum lactate** because it is: \_\_\_\_ mmol/l

**Urine output** because it is:  
less than 100mls over the last 4 hours  
significantly proteinuric (+++)

**Haemorrhage:**  
Antepartum  
Postpartum

**Fetal wellbeing:**  
Pathological CTG

**FBS Result: pH** \_\_\_\_  
Time sample taken: \_\_\_\_ hrs

Obstetric Early Warning Chart Score:

# B

### Background (tick relevant sections)

The woman is:

Primiparous Multiparous Grand multiparous  
Gestation: \_\_\_\_ wks Singleton Multiple  
Previous Caesarean section or uterine surgery

**Fetal wellbeing**

Abdominal palpation:  
Fundal height: \_\_\_\_ cms Presentation: \_\_\_\_\_ Fifts palpable: \_\_\_\_ FH rate: \_\_\_\_ bpm  
CTG: Normal Suspicious Pathological

**Antenatal**

A/N problem (details): \_\_\_\_\_

**Labour**

Spontaneous onset Induced  
IUGR Pre eclampsia Reduced Fetal movements Diabetes APH  
Syntocinon  
Most recent vaginal examination: Time \_\_\_\_ hrs  
Cervical dilatation: \_\_\_\_ cms Station of presenting part: \_\_\_\_ Position: \_\_\_\_\_  
Membranes intact Meconium stained liquor Fresh red loss PV  
Third stage complete Retained placenta

**Postnatal**

Delivery date: \_\_\_\_\_ Delivery time: \_\_\_\_ hrs  
Type of delivery: \_\_\_\_\_ Perineal trauma: \_\_\_\_\_  
Blood loss: \_\_\_\_ mls Syntocinon infusion  
Fundus: High Atonic Uterus tender Abdominal/perineal wound oozing

Treatment given / in progress: \_\_\_\_\_

# A

### Assessment

I think the problem is: \_\_\_\_\_

I am not sure what the problem is but the woman is deteriorating and we need to do something

# R

### Recommendation

Request:

Please come to see the woman immediately  
I think delivering needs to be expedited  
I think the woman needs to be transferred to delivery suite  
I would like advice please

Reported to: \_\_\_\_\_ Response: \_\_\_\_\_

Person completing form (name): \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

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## 8. Safety and Security

Throughout the IAC hearing<sup>58</sup> and presented in ONA's briefs<sup>59</sup>, the IAC panel was presented with issues of staff working alone while caring for patients. The only means of communication nurses has been a portable phone if they left the nursing station. It was shared with the IAC Panel that these phones at times were unreliable.

At present, Winchester District Memorial Hospital is in the process of implementing "screamers" as a security measure for staff based upon request. The IAC Panel shared example other organizations utilize as communication devices such as the use of Vocera.<sup>60</sup>

The FBU is not a secured unit as evidenced by the hospital video tour of the unit presented on Day One of the IAC Hearing.<sup>61</sup> There is no infant abduction device system in place and no security guards employed by the hospital. There is a code yellow policy that mentions child abduction but not a specific "Code Amber" procedure, if there was an infant abduction.

In ONA's Brief it was mentioned that security cameras had been installed on the FBU following a staff meeting which took place in January 2022 between the previous FBU manager and the CNE<sup>62</sup>. It is remains unclear as to the purpose of the video cameras and who is monitoring this video footage.

### The IAC Panel Recommendations:

1. The Employer will explore the utilization of Vocera's as a communication/safety device for staff that are working.
2. The implementation and use of "screamers" to all staff members working alone not just issued if requested. Education to be provided to staff regarding the use of this device.
3. The development and implementation of a Working Alone policy and procedure.
4. The employer will re-evaluate the intended purpose of security cameras on the FBU and determine who is monitoring them, determine how long the videos are kept within the hospital.
5. The Hospital will re-evaluate the positioning of the security cameras on the FBU unit so that no laboring woman is on video in a vulnerable position during the birthing process.
6. Review and communicate the corporate policy and procedure for electronic recording and how it relates to the privacy act.

### Safety

7. Implement a specific Code Amber policy specific for infant abduction.
8. There will be communication and education provided to all staff related to new policies, and procedures, and medical directives.

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<sup>58</sup> IAC Hearing Day 1 January 29, 2024.

<sup>59</sup> ONA Brief Volume II PRWRF's.

<sup>60</sup> Friend, T. H., Jennings, S. J., Copenhaver, M. S. & Levine, W. C. (2017). Implementation of the Vocera communication system in quaternary perioperative environment. *Journal of Medical Systems*, 41 (1), 1-6.

<sup>61</sup> IAC Hearing Day 1 January 29, 2024.

<sup>62</sup> ONA Brief Volume I, ONA Brief Volume III PRWRF's.



## 9. Equipment

Functioning equipment is an essential and important resource for nurse's ongoing assessment of patient's current condition and status. Proper equipment can lend itself to the quality and safe treatment plan for the health care team regarding a patient's medical needs. This becomes especially prudent in the FBU where electronic fetal monitors assist the nurse in determining the wellbeing and status for an unborn child.<sup>63</sup> Electronic fetal monitors also assess how a mother's uterus is responding to labor in gauging the length and strength of contractions. Having the appropriate amount of functional equipment for the number of patients is essential for positive patient outcomes without the delay of care related to insufficient equipment.

Having the appropriate equipment readily available in the appropriate location will assist in the delay of life saving treatment. Day 1 of the IAC hearing<sup>64</sup> the panel heard that on the postpartum unit there is not a Neonatal Resuscitation Cart. If there is a Code Pink that has been called on the postpartum unit, the FBU staff if able, will bring the Neonatal Resuscitation Cart to the postpartum unit. If they are not available, then it is relied upon for the Code Pink designates to collect and bring the cart, thus delaying lifesaving care or appropriate treatment.<sup>65</sup>

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

1. The purchase a Neonatal Resuscitation Cart with all appropriate Neonatal Resuscitation supplies immediately to be placed on the Post Partum Unit.
2. Biomedical services to do monthly equipment checks of all Panda's, Infant warmers, and Electronic Fetal Monitors.
3. A thorough review of all Electronic Fetal Monitors to ensure they are in working condition. If they are sent out for repair, then they are to be replaced with a loaner until the original is returned.
4. A thorough review to ensure Neonatal Resuscitation Posters are posted and visible in each birthing room, OR theatre, postpartum assessment room and the ER gyne room where during unit closures or emergency situations infant deliveries may take place.
5. Each birthing room or assessment room equipped with Electronic Fetal Monitor, IV pole with IV pump and epidural pump.
6. Dedicated Neonatal IV pump with micro-dosing capabilities for the administration of IV fluid and medication in the event of an a at risk and/or unstable neonate.
7. A review of all the phones in patient's rooms. These phones should have the capability to access the main switchboard to facilitate the call of Code Pink on overhead paging system.
8. Staff will be invited to be involved in the discussion surrounding capital equipment purchase for the FBU.

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<sup>63</sup> ONA Brief Volume III PRWRF's.

<sup>64</sup> IAC Hearing January 29, 2024.

<sup>65</sup> IAC Hearing January 29, 2004.

## 10. Policies and Procedures

Perinatal nurses strive to provide excellence in care. Perinatal nursing standards reflect current evidence and aim to assist both novice and experienced nurses to execute their role as they provide care to childbearing persons and their families. Policies, procedures, and core competencies are the foundation of quality and safe patient care and drive nursing practice.

Correspondence was sent to Winchester District Memorial Hospital requesting information about policies and procedures July 23, 2023. The Hospital responded by including information about policies and procedures in their submission brief on January 8, 2024.<sup>66</sup>

The Ontario Nurses Association shared numerous PRWRFs that included the need for revised policies and procedures and recommendations for new policies and procedures.<sup>67</sup> On January 19, 2024, the IAC Panel requested additional information regarding policies, procedures, and medical directives from the Hospital of which they shared. This information provided by Winchester District Memorial Hospital was shared with ONA on January 29, 2024. Winchester District Memorial Hospital also included information regarding policies and procedures in their presentation on Day 1 of the IAC Hearing.<sup>68</sup>

The Ontario Nurses Association identified several policies and procedures during their presentation on Day 2 of the IAC Hearing. The IAC Panel requested the Association to provide this detailed list to both the Panel and the Hospital. There were several new policies and procedures identified and the Winchester District Memorial Hospital provided an updated list of progress in terms of policies and procedures in development and/or near completion.<sup>69</sup>

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

1. Within three (3) months of the IAC Report submission, both the Ontario Nurses Association and the Winchester District Memorial Hospital meet to review and prioritize the policies, procedures and medical directives that are required for the Family Birthing Unit.
2. Family Birthing Unit RNs provide input and feedback to all policies, procedures, and medical directives.
3. Benchmark with the Champlain Maternal Newborn Regional Program in developing and/or revising policies, procedures, and medical directives and/or implement their existing policies, procedures and medical directives ensuring they meet Winchester District Memorial Hospitals guidelines.
4. Winchester District Memorial Hospital's policies, procedures and medical directives are reviewed during orientation with new staff to ensure best practices, policies and procedures are always followed.
5. Policies, procedures, and medical directives be a standing agenda item on the Family Birthing Unit Care Team meetings and the Maternal Child Care Team meetings.

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<sup>66</sup> Winchester District Memorial Hospital Brief January 8, 2024.

<sup>67</sup> ONA Brief Volume II

<sup>68</sup> Winchester District Memorial Hospital Presentation January 29<sup>th</sup>, 2024.

<sup>69</sup> Winchester District Memorial Hospital Policy and Procedure Update Feb 2, 2024.

## 11. Use of Verbal Orders

Rural maternity care is often characterized by maternity care teams led by family physicians, nurses, and midwives. In some communities, they are the only ones providing maternity care, and in other cases backup is provided by general surgeons, GP-anaesthetists, obstetrician-gynaecologists, and/or family physicians with surgical training.<sup>70</sup> In communities with a surgical service the needs of women are more effectively met locally. In these communities, the majority (> 75% depending on provider model) of women give birth locally and the outcomes are good. WDMH is supported by Obstetricians, GPOB as well as midwifery. Rurality and the provider model of care must be considered but patient care and patient safety must not be compromised. Professional staff are accountable for ensuring that their practice and conduct meets legislative requirements and competency standards for their profession.

Medication orders conveyed verbally by telephone or in person are prone to errors. Problems can arise if a medication order is miscommunicated, misheard, or incorrectly transcribed. The Institute for Safe Medication Practice (ISMP) Canada encourages the use of written orders, including electronic orders, to prevent medication errors.<sup>71</sup>

Within a Public Hospital, prescriptions, procedures, treatments, medications, or interventions require a direct patient order or medical director authorized by a provider. In cases where ordering authority is limited, providers must comply with the standards of their respective Regulatory Colleges. Orders are required when.<sup>72</sup>

- A procedure falls within the one of the controlled acts authorized to the Regulated Health Care Professional (RHCP) who will carry out the order, when that RHCP does not have the authority to independently decide to perform/initiate the procedure.
- It is a requirement of the Public Hospitals Act, Healing Arts Radiation Protection Act, or other legislation governing patient care. There is an organization policy or Provider plan of care, which outlines that an order is required for a specific treatment/intervention.

The College of Physicians and Surgeons of Ontario (CPSO) set out expectations for the professional conduct of physicians practising in Ontario. Physicians **must** ensure that<sup>73</sup>:

- the care provided through delegation is documented in accordance with the College's [Medical Records Documentation](#) policy, including that each entry in the medical record is identifiable and clearly conveys who made the entry and performed the act;
- it is clear who the authorizing physician(s) are (e.g., the name(s) of the authorizing physician(s) are captured in the medical record); and
- verbal direct orders are documented in the patient's medical record by the recipient of the direct order and are reviewed or confirmed at the earliest opportunity by the delegating physician.

The College of Nurses of Ontario Practice Standard/Scope of Practice (2023)<sup>74</sup> describes a direct order is client-specific regarding an activity. It may be written or verbal (oral). Verbal orders must only be used in

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<sup>70</sup> Rural Maternity Care. SOGC Joint Position Paper. Retrieved: [Rural Maternity Care \(jogc.com\)](http://jogc.com).

<sup>71</sup> Hospital Medication Safety Self Assessment (MSSA) Retrieved: [Introduction | ISMP Canada MSSA \(ismp-canada.org\)](http://ismp-canada.org).

<sup>72</sup> O.Reg 965 (Hospital Management) – Public Hospitals Act.

<sup>73</sup> Delegation of Controlled Acts. CPSO. Retrieved: [CPSO - Delegation of Controlled Acts](http://cpso.org).

<sup>74</sup> College of Nurses of Ontario. Practice Standard. Retrieved: [49041-scope-of-practice.pdf \(cno.org\)](http://cno.org).

emergency situations or when the prescriber is unable to document the order, such as in the operating room.

Throughout the IAC hearing as well as identified in both ONA and WDMH's brief(s) and numerous PRWRF's the panel was made aware that the use of verbal orders is common practice at WDMH. While attempts have been made as provided by WDMH in the form of a memo to physicians the practice remains.

ISMP Canada has published several bulletins describing medication errors associated with telephone and other types of verbal orders. Various contributing factors have been identified, including sound-alike drug or patient names, similar-sounding numbers, a practitioner's use of unfamiliar terminology or acronyms with multiple meanings, background noise and other factors affecting reception clarity, workflow disruptions, and caregivers' lack of familiarity with individual patients and their needs.<sup>75</sup>

The communication, entry and management of patient care orders is an interprofessional team responsibility requiring ongoing assessment in response to changes in patient status and care needs. One reason for the use of verbal orders is the absence of the physician in the healthcare organization, especially in non-working hours, thus causing a lack of access and lack of attention to the patient care data. Therefore, information technology, especially CPOE, can reduce the number of verbal orders and the errors. Moreover, with the rapid growth of mobile-based information systems, the ability to design and develop information systems is much more flexible compared to traditional information systems. Mobile-based information systems will give users more mobility and the use of these systems will provide the ability to collect; analyze and store detailed information of verbal orders, in a more updated and effective form<sup>76</sup>. WDMH has recently implemented EPIC an integrated electronic patient information system which provides Computer Provider Order Entry (CPOE).

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

1. All patient orders will be entered electronically into the health information system using CPOE or during a planned or unplanned downtime written on WDMH approved order forms by the provider.
2. Verbal orders are intended to support patient care during a bedside procedure, in an emergency, or other situation where barriers to placing the order in the electronic medical record is not in the patient's best interest.
3. Telephone orders will be taken only when it is not possible for the prescribers to place the order themselves. This includes situations where the provider does not have computer access or is being paged directly about a clinical situation that is time sensitive requiring a new order, and where a delay in accessing the patient record is not in the patient's best interest.
4. Verbal/telephone orders require the prescriber to co-sign the order immediately upon accessing the patient record.
5. Complete a "readback" process for all verbal/telephone orders. The receiving clinician will read or repeat back any orders provided to ensure clear understanding. The prescriber will listen and confirm that the "readback" is accurate.
6. Enter telephone orders into the electronic medical record with the prescriber still on the phone to clarify any system messages/suggestions that arise.

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<sup>75</sup> Hospital Medication Safety Self Assessment (MSSA) Retrieved: [Introduction | ISMP Canada MSSA \(ismp-canada.org\)](#).

<sup>76</sup> Verbal Orders in Medicine: Challenges; Problems and Solutions. JOJ Nursing and Health Care.

7. Develop a process for monitoring the number of verbal orders with supporting evidence that is reviewed by the Chief of Staff with recommendations and education to providers if deemed appropriate.

## **12. Professional Responsibility Workload Report Forms (PRWRF)**

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

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

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

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

The 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 problems; and provides a process and forum for RNs to make recommendations to the employer to address the issues. The PRWRF promotes a problem-solving approach by means of facilitating discussion with, and requiring a written response from, the Manager. Once the employer has been made aware of the Professional Responsibility and Workload Issue(s), it is the administrative nurses' accountability to their own CNO Standards to advocate for and pursue resolution.<sup>77</sup>

The FBU RN staff began raising professional responsibility and workload issues in January 2021 by submitting PRWRFs to report their concerns of insufficient, unsafe staffing levels, an inappropriate skill mix and inadequate orientation. The RNs reported their concerns for safe quality patient care to nursing leadership, the clinical manager (CM), and Vice President, Clinical Services & Chief Nursing Executive (CNE).<sup>78</sup>

Prior to January 2022, the Hospital-Association Committee (HAC) met every two months unless

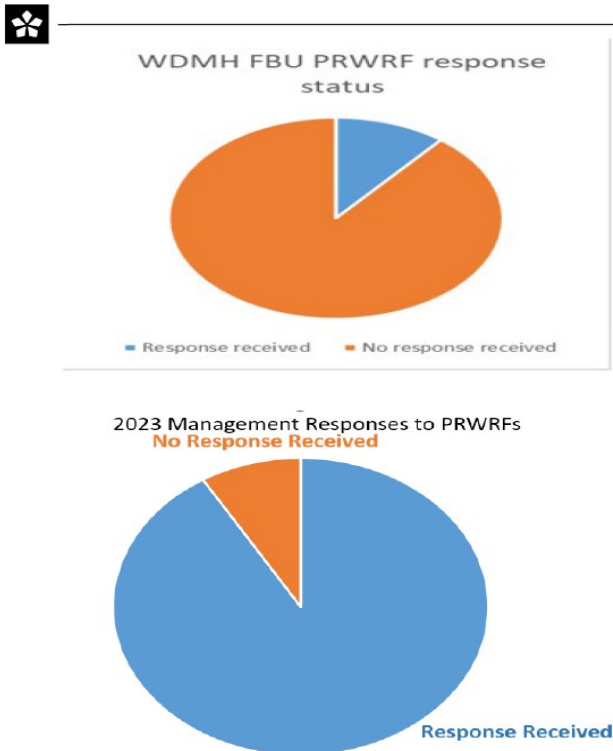
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<sup>77</sup> ONA Brief Volume I p. 6-9 January 8, 2024.

<sup>78</sup> ONA Brief Volume I p. 6-9 January 8, 2024.

otherwise agreed and required under Article 8.01 (a) (iv) of the collective agreement. The last HAC meeting took place on January 27, 2022, and a timeline of prior and subsequent events is listed below.

None of the PRWRFs submitted in 2021 received a manager response and no meetings between the manager and the RNs occurred as per the collective agreement. The RNs report that since the current clinical manager has been in the position (September 16, 2022) she has been more responsive to meeting with members following a PRWRF submission, as outlined in the diagram below, however the identified workload and professional practice issues are unresolved and ongoing.<sup>79</sup>



Nurses have reported ongoing issues with insufficient RN staffing, an inappropriate skill mix for patient population, their inability to meet CNO and perinatal nursing standards and hospital policies and procedures, as well as insufficient education, orientation, and mentorship for all staff.

The Employer has not followed the Article 8 process, and a grievance was filed for this violation. The Union is grieving that the Employer has violated the Collective Agreement, Articles 1, B, in not meeting with the Union to discuss issues at HAC as outlined in article C.2 and 6.03 and in not meeting to discuss Professional Workload forms as per article C.6 and 8.

A Letter forwarding the unresolved issues to the IAC was submitted by the Union to the (IAC) Chairperson on May 24, 2023. As indicated in the Union’s Letter of Referral, ONA respectfully requests that the IAC assess the nursing practice and workload concerns put before them from the perspective of being able to provide safe, ethical, competent, and professional quality patient care in a quality practice

<sup>79</sup> ONA Presentation Day Two of the IAC Hearing p. 5.

setting according to relevant professional and specialty standards, and supporting research and literature, including the following CNO Practice Standards and Guidelines:

- Code of Conduct, 2023 (Exhibit 8)
- Scope of Practice July 1, 2023 (Exhibit 22)
- Therapeutic Nurse-Client Relationship Revised 2006, 2019 (Exhibit 23)
- Confidentiality and Privacy – Personal Health Information, 2019 (Exhibit 24)
- Documentation Revised 2008, 2019 (Exhibit 25)
- Medication Revised 2008, 2019 (Exhibit 26)
- Consent, 2017 (Exhibit 27) <sup>80</sup>

**The IAC Panel Recommends:**

1. RNs in the Family Birthing Unit at Winchester District Memorial Hospital continue to document their concerns on the Professional Responsibility Workload Report Form, in alignment with the Collective Agreement.
2. The Hospital and the local Association work together to improve the Professional Responsibility Workload (PRW) process with the goal of implementing a collaborative approach to resolving workload concerns. This will include commitment on both sides to follow the steps in the collective agreement including timelines established in this process.
3. RNs in the Family Birthing Unit initially communicate their patient care concerns to the Clinical Manager to give management the opportunity to resolve the matter and facilitate decisions that will support safe, quality patient care.
4. Management continues to review and respond in a timely manner to the PRWRF in writing as per the Collective Agreement and engage in dialogue with the nurse(s) about the complaint with the goal to resolve the immediate issue and move toward a long-term resolution, if required.
  - a. The manager continues to respond within 10 days as per the Collective Agreement utilizing the OHA/ONA PRWRF tool.
  - b. The manager is to use the 10-day window to discuss the workload complaint with the nurse(s) involved, with an ONA representative present, if desired, to understand the concerns and to seek resolution.
  - c. Unresolved complaints will be presented at the Hospital Association Meeting as per the Collective Agreement with the intent to identify themes and work together on resolutions.
  - d. The Clinical Manager provides the Chief Nursing Executive (CNE) with a Workload Complaint Summary Report, monthly for the next six months, to include the number of PRWRFs completed, the workload issue documented, and any developing themes of concern.
  - e. The CNE to support the Clinical Manager to develop corrective action plans and to support the Clinical Manager and the nurses to resolve issues in a timely and effective manner.

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<sup>80</sup> ONA Brief Volume I p. 13-14 January 8, 2024.

### 13. Hospital Association Committee (HAC)

The intent of the Hospital Association (HAC) meetings is to provide a forum for both the Association and the Hospital to engage in meaningful dialogue about issues including workload and to seek common resolutions.

The Hospital-Association Committee (HAC) at Winchester District Memorial Hospital is scheduled to meet bi-monthly, in accordance with Articles 6.03 and 8.01 however both parties agree to meet monthly for discussions to achieve joint resolutions for multiple PRWRFs.

The HAC is the forum for discussing issues related to workload and practice raised by ONA members and to allow both parties to propose solutions or ideas for resolution; however, over the last two years very little resolution or progress has been achieved.

The Union presents scenarios, identifies root causes, such as a lack of staff, and the Employer's response has been that staffing is a non-starter issue, referencing the shortage of RNs is a provincial issue. They have taken the position and informed ONA that there is no possibility of improving staffing or adding more RN positions.

#### 6.03 Hospital-Association Committee<sup>81</sup>

- (a) There shall be a Hospital-Association Committee comprised of representatives of the Hospital, one of whom shall be the Chief Nursing Executive or nursing designate and of the Union, one of whom shall be the Bargaining Unit President or designate. The number of representatives is set out in the Appendix of Local Provisions and the membership of the Committee may be expanded by mutual agreement.
- (b) The Committee shall meet every two (2) months unless otherwise agreed and as required under Article 8.01 (a) (iv). The duties of chair and secretary shall alternate between the parties. Where possible, agenda items will be exchanged in writing at least five (5) calendar days prior to the meeting. A record shall be maintained of matters referred to the Committee and the recommended disposition, if any, unless agreed to the contrary. Copies of the record shall be provided to Committee members.
- (c) The purpose of the Committee includes:
  - i) Promoting and providing effective and meaningful communication of information and ideas, including but not limited to workload measurement tools and the promotion of best practices. Such communication may include discussion of nursing workload measurement and patient acuity systems. The Hospital will provide, upon request, information on workload measurement systems applicable to nursing currently used by the Hospital, and evaluations completed by the Hospital of such systems.

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<sup>81</sup> 20230331\_HospCentralAgreementF [37429] p. 7 Expires March 2023.



- ii) Reviewing professional responsibility complaints with a view to identifying trends and sharing organizational successes and solutions, making joint recommendations on matters of concern including the quality and quantity of nursing care and discussing the development and implementation of quality initiatives.
- iii) Making joint recommendations to the Chief Nursing Executive; on matters of concern regarding recurring workload issues including the development of staffing guidelines, the use of agency nurses and use of overtime.
- iv) Dealing with complaints referred to it in accordance with the provisions of Article 8, Professional Responsibility.
- v) Discussing and reviewing matters relating to orientation and in-service programs.
- vi) Promote the creation of full-time positions for nurses and discuss the effect of such changes on the employment status of the nurses.

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

- (d) The Hospital agrees to pay for time spent during regular working hours for representatives of the Union attending at such meetings. Where a committee representative designated by the Union attends Committee meetings outside of their regularly scheduled hours, they will be paid for all time spent in attendance at such meetings at their regular straight time hourly rate of pay. Such payment shall be limited to two (2) Committee representatives per meeting.

**The IAC Panel Recommends:**

1. The HAC meetings continue with the intent to follow the process and intent outlined in Article 6.03 of the Collective Agreement.
2. All parties in attendance at the HAC, treat one another in a professional, respectful manner and through dialogue seek to find common solutions to identified concerns.
3. The following format for HAC be adopted.
  - a. Meetings to be Chaired on an alternating basis by ONA and the Hospital.
  - b. Minutes continue to be taken by ONA and the Hospital, alternating monthly and circulated within one week to all members of the Committee.
  - c. The agenda be circulated 5 days prior to the meeting to give all parties ample opportunity to add any issues/items required by either party.
  - d. The CNE/Directors/Clinical Managers continue to attend meetings when related to workload.
  - e. When agreement on an issue(s) is achieved, the agreement be put in writing, reviewed, and signed by all parties to ensure that all agree and sign off on joint decisions.

- f. That a separate meeting be called to deal with workload concerns that are escalating in a particular unit so that trends can be identified, and corrective action put in place in a timely and effective manner.

## **SECTION IV: CONCLUSION AND SUMMARY OF RECOMMENDATIONS**

### **4.1 Conclusion**

Article 8.01 of the Collective Agreement between the Ontario Nurses' Association and the Winchester District Memorial Hospital Family Birthing Unit, the Independent Assessment Committee to specifically address the issue of whether RNs are being requested to perform more work than is consistent with safe and quality patient care.

The IAC Panel completed a thorough analysis, which included an in-depth review of information received prior to and during the IAC Hearings held January 30<sup>th</sup>, February 1<sup>st</sup>, and 2<sup>nd</sup>, 2024 in relation to the literature relating to perinatal and neonatal care, consideration of factors impacting the WDMH Family Birthing Unit practice environment, and integration of the Panel's cumulative practice, knowledge, experience and expertise. There are one hundred and eleven (111) recommendations.

### **4.2 Summary of Recommendations**

#### **Role of the Team Leader**

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

1. The Team Leader must be supported in their leadership role by the Clinical Manager as evidenced by daily status exchange/touch points. These exchanges will review potential issues such as staffing, patient flow and assign appropriate escalation if required.
2. The Team Leader role will be reviewed to ensure their hours of work align with needs of the unit. The role is currently scheduled from 0700-1500 hours Monday to Friday. Planned inductions as well as planned Caesarean sections are scheduled Monday to Friday. The hospital is encouraged to engage in a robust review and documentation of team leader standard work and align hours to acuity and activity of the unit. Consider shifting to a Monday to Friday 0830—1630 model to incorporate day ahead planning for assignments and procedures as well as availability on the unit when several deliveries occur.
3. The Team Leader role will be replaced for all scheduled and unscheduled absences.
4. A Charge Nurse will be designated in the absence of the team lead. This includes weekends and statutory holidays. This assignment will be compensated as per the ONA collective agreement.
5. The Team Leader will develop a standard work document that is shared with FBU staff. Standard work documents increase understanding of the role, improve communication within the team and enhance patient safety.
6. A Charge Nurse roles and responsibility description/document will be devised with input from FBU staff.
7. The Team Leader and Clinical Manager will identify specific RNs to place in the Charge Nurse role in the absence of the team leader. Education, including the use of standard work tool will be provided to ensure charge nurses understand the role and accountabilities associated with the role.
8. RNs assuming the Charge Nurse role will be offered four buddied shifts.

9. The Team Leader and designated Charge Nurses are encouraged to participate in leadership development opportunities that are available. Opportunities may be available through the Champlain, Maternal, Newborn Regional Committee. Staff are encouraged to utilize the hospital's education policy for reimbursement.
10. Update Team Leader job description to reflect accountabilities.

### **Flexible Staffing Model**

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

1. Planned Caesarean sections are scheduled by the operating room clerk when requested. Coupled with scheduled outpatient procedures, each week based on planned heavy workload additional resources are requested. This request for heavy workload will be filled with an RN. The RN with an increased scope of practice can be deployed to either Labor and Delivery or Postpartum to provide the assistance that is required. This flexibility ensures that staff can adapt to changing demands.

2. The Hospital will review all patient activity through the Family Birthing Unit Care Team meeting to identify trends, issues, and scheduling opportunities. This review will maximize scheduling and ensure appropriate resource allocation for scheduled activity. This activity should include but not limited to:

- Scheduling of outpatient procedures
- Types of patients being scheduled for outpatient appointments.
- Triage visits (not scheduled) change in status.
- Most Responsible Provider Activity – Consider provider scorecards.
- Scheduled Inductions – Use of Induction tool – Medically Indicated
- Scheduled Caesarean Sections.

3. The results of the patient activity review will be shared with the Clinical Manager and Team Leader for program planning. The results will be shared with staff to promote transparency and trust.

4. Quality and Performance indicators specific to FBU are to be shared at huddles and staff meetings. Regularly reviewing data, involving multidisciplinary teams, and collaboration with stakeholders will enhance obstetrical care across the program.

### **Role of the Ward Clerk**

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

1. A review of the Ward Clerk job description, roles, and responsibilities as it pertains to the FBU within three months following the IAC Report submission Consider the following roles and responsibilities during the review.

- (a) Answering of the phones, assisting in the booking of outpatient appointments
- (b) Assisting with transfer paperwork if needed.

(c) Assisting in the FBU when needed to assist FBU with administrative duties.

2. Increase the ward clerk hours from 2 hours per day to 4 hours per day.

3. The employer will explore the resources available within the hospital to assist the clerical team with the assembly of FBU health teaching packages and educational information pamphlet restocking

### **Role of the Care Coordinator**

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

1. The Care Coordinator Job description is shared with all members of the FBU team to promote understanding of the role.
2. The Care Coordinator should huddle within FBU utilizing a status exchange tool (similar to the Team Leader tool) to review potential issues, appropriate escalation as well as planning and accountability assigned for follow up. This should be completed at regular designated intervals during times of high volume, high acuity to ensure that staff are supported.
3. The Care Coordinator, upon review of the organization's staffing and acuity needs will have the authorization to call in staff as needed. This will proactively address FBU and hospital staffing issues.
4. The Care Coordinator will contribute to managerial written responses to the PRWRFs when the issues raised by the RNs occur on their shift, in accordance with the collective agreement timelines.
5. The Care Coordinator should attend skills days provided by the organization to increase understanding of the FBU acuity and activity. This learning will be beneficial if called upon for support.

### **Role of the Clinical Scholar**

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

1. Clinical Scholar Funding was available from June 1, 2023-March 31, 2024. The hospital will reapply for this funding if extended into fiscal year 2024/2025.
2. The Clinical Scholar within FBU will capture baseline metrics of the support that has been provided (understanding this role was implemented for a short period of time) such as number of nurses supported, hours required for support as well as successes and areas of opportunity. These performance metrics will demonstrate the need for increased funding as well as any improvements that may enhance the program.

## **Model of Care**

### **The IAC Panel recommends:**

1. Complete an environmental scan to explore the possibility of geographically locating both the Labor and Delivery and Postpartum units in the same space. Sharing the space provides an opportunity to gain supportive efficiencies based on patient care needs within the unit.
2. Consider in the shared space a coordinated care team approach which focuses on an interprofessional collaboration. In this approach every patient is assigned a most responsible nurse during each shift. Most responsible nurse is an RN or RPN depending on patient acuity and is the person ultimately responsible for the direct care the patient receives<sup>82</sup>.
3. Optimize scope of practice to provide role clarity between RN's and RPN's. Clear understanding of each team members scope of practice encourages coordinated work. This will build internal flexibility within the program.
4. Provide education to staff regarding role clarity and scope of practice. This will enhance key understanding and promote collaboration.
5. Explore enhanced clinical supports such as clinical scholars to provide education and at the elbow support for team members.
6. Explore external resources such as Public Health to provide discharge support.
7. If implemented, monitor staff and patient satisfaction indicators to demonstrate improvement.
8. Monitoring and reviewing staffing levels in FBU is crucial to ensure safe and effective care. Closely monitor volumes of births by provider each fiscal quarter to ensure staffing levels are appropriate. This proactive approach will inform hospital budget requests for enhancements if required.
9. In supporting the Model of Care, Professional Staff and Midwifery staff are held accountable to their credentialing and privileges as set out by the hospital. Organizational policies such as Code of Conduct, availability, and standard response times if off site must be adhered to. Failure to do so should be escalated as per hospital policy.

## **Leadership and Communication**

### **Professional Practice Advisory Committee (PPAC)**

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

1. A standing agenda item for each meeting be related specifically to Nursing Practice related issues.
2. The PPAC Terms of Reference be finalized within three (3) months of the submission of this report.
3. Meetings be held monthly.

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<sup>82</sup> Michael Garron Hospital Toronto, Ontario, Canada. Advisory Board interviews and Analysis.

4. Consider adding a Human Resources representative to membership.

### **Family Birthing Unit Care Team Meetings and Maternal Child Care Team Meetings**

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

1. Family Birthing Unit Care Team meetings continue monthly to address policies, procedures, medical directives, evidence-based practice, and other relevant issues.
2. Maternal Child Care Team meetings to be held monthly. There should be an established meeting time, so it becomes familiar with options for in person or virtual attendance.
3. The agenda should be circulated one (1) week prior to the meeting to all staff in the department with a call for agenda items to be discussed.
4. An updated agenda should be circulated 5 days prior to the meeting to ensure informed participation.
5. Minutes will be distributed to all staff.

### **Huddles and Staff Rounding**

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

1. The CNE participates in staff rounding monthly to foster collaboration and trust with the Family Birthing Unit staff effective immediately.
2. Implement huddles with the Manager/Team Leader daily utilizing a status exchange tool<sup>83</sup> to review potential issues of the day, appropriate escalation as well as planning and accountability assigned for follow up effective immediately.
3. Manager to round daily checking with the Team Leader or delegate to understand patient flow, staffing or other concerns effective immediately.
4. Manager is encouraged to share her schedule with the Team Leader or delegate to facilitate communication and accessibility if needed effective immediately.

### **Orientation**

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

1. The employer will conduct a thorough review of the current orientation program in collaboration with the Champlain Maternal Newborn Regional Program.
2. The employer will implement and maintain a structured, consistent orientation program, that will include all methods of adult learning to promote success for the learners.
3. The employer will establish and maintain a thorough orientation program with a minimum of one week in class theory education provided by a designated clinical educator who has Perinatal

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<sup>83</sup> Cambridge Memorial Hospital ED Daily Status Sheet Exchange Tool.

background and knowledge. The educator will provide didactic lectures and discussion, in person interaction, and hands on skill training.

4. The orientation program will be extended to twelve (12) weeks specific to the unit above the corporate orientation.
5. The employer will ensure all RN's that are in a mentorship role are offered and supported by mentorship training such as the Canadian Nurse Educators Institute Preceptor Training Program.
6. Evaluation of the new hire will be scheduled for every four (4) weeks to consist of the manager, mentor and clinical educator (if one exists).
7. The mentee's orientation will not be decreased in length unless it has been agreed upon by all parties.
8. The employer will implement and utilize the Champlain Maternal Competency check list as part of their standard orientation for new hires. This will allow for standardized, and an organized measure of progress.
9. The employer will explore the collaboration with community partners to access, share and utilize their resources to assist in the continued learning needs of their staff.
10. When a new hire is with their mentor for their required shift it should be discussed at morning huddle the absence of completion of any core competencies not yet achieved. This will allow for greater opportunity and exposure for the new hire to take advantage of even if not with their mentor.
11. Prior to onboarding of a new hire off the orientation program, it will be mandatory they have Fetal Health Surveillance and Neonatal Resuscitation as it was stated in the hearing by clinical manager, Winchester District Memorial Hospital has in house instructors to complete this.
12. The employer will continue to support ongoing education opportunities for staff. This will include the exploration of community partners to bring specialized education opportunities to Winchester District Memorial Hospital; e.g. STABLE, ACORN or MORE OB programs.
13. The employer will arrange and facilitate monthly on-going skills days for staff to attend. These skills days will also be available to ER staff, Care Coordinators, Midwives, GPOB, Obstetricians, Anesthesiologist. This will allow for continued success amongst team members that may be called upon to help the FBU.
14. The employer will initiate paid education in Obstetric Triage. Once new hires have been onboarded and unit specific competencies achieved, new staff will have the opportunity to add this to their skill mix, approximately at the 6-month mark.
15. All new staff will have training and access to birth registration procedures during in class training.

### **Professional Development**

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

1. The Clinical Manager, Team Leader, and/or Clinical Scholar discuss with nurses/staff members asking them to identify professional educational opportunities that would enhance and benefit their learning as part of an annual learning needs assessment.



2. To improve access to professional development activities, develop a process of scheduling nurses and backfilling if necessary to attend educational sessions.
3. Encourage nurses to participate in the PPDP provided by CMNRP. This could be coordinated with the Team Lead and Clinical Scholar to promote continuous learning and ongoing professional development.
4. Implement simulation of mock drills such as Mock Code Pink and responding to Obstetrical Emergencies immediately. This will support improved team function and increase understanding of defined roles and responsibilities in an emergent situation.
5. All staff must adhere to the organization's Code of Conduct policy. Education must be provided to all staff including professional staff to ensure compliance. Embedded within the policy is an escalation process when behaviour does not meet the policy standard.
6. Explore possibility of participating in programs to reduce obstetrical risk such as Salus Global More OB or reviewing the PROMPT program<sup>84</sup>. This is an evidence based multi-professional training package for obstetric emergencies. It is associated with direct improvements in outcomes for mothers and babies through improvement in knowledge, clinical skills, and human factors. Retrieved: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8532559/>. WDMH is encouraged to explore sharing costs with other hospitals within the region.
7. Conduct an annual educational needs assessment to determine educational needs and planning for the following year.

### **Family Birthing Unit Outpatient Visits**

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

1. Develop an outpatient schedule to book all outpatient visits both antenatal and postpartum at regular scheduled intervals to anticipate the need for additional staff to provide this care.
2. Develop a plan to transition to the Outpatient Lab Services to conduct newborn bilirubin tests.

### **Obstetrical Triage Tool**

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

1. The employer will explore the development and implementation of a standardized phone triage tool that will assist staff in the assessment of pregnant women over the phone.
2. The employer will provide education to all staff in the implementation and utilization of this tool.
3. There will be a policy and procedure development surrounding the use of telephone triaging and when implemented a policy and procedure regarding the new tool.
4. New hires will have review of this education in orientation but formal training to commence after 6-month period of working in the FBU.

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<sup>84</sup> PROMPT Wales project: national scaling of an evidence-based intervention to improve safety and training in maternity. Retrieved: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8532559/>

5. The employer will implementation of a standardized tool such as SBAR for the FBU staff to utilize while giving telephone report to the MRP whether that be OBGYN, GPOB or midwife. Each staff will receive formal training surrounding the use of this tool. This will enhance effective, precise communication.
6. The employer will work collaboratively with Champlain Maternal Newborn Regional Program to develop an Obstetrical Triage Tool that will be utilized in the assessment of antenatal patients. There will be mandatory education surrounding the implementation of this tool with annual review.

## **Safety and Security**

### **The IAC Panel Recommendations:**

1. The Employer will explore the utilization of Vocera's as a communication/safety device for staff that are working.
2. The implementation and use of "screamers" to all staff members working alone not just issued if requested. Education to be provided to staff regarding the use of this device.
3. The development and implementation of a Working Alone policy and procedure.
4. The employer will re-evaluate the intended purpose of security cameras on the FBU and determine who is monitoring them, determine how long the videos are kept within the hospital.
5. The Hospital will re-evaluate the positioning of the security cameras on the FBU unit so that no laboring woman is on video in a vulnerable position during the birthing process.
6. Review and communicate the corporate policy and procedure for electronic recording and how it relates to the privacy act.

## **Safety**

7. Implement a specific Code Amber policy specific for infant abduction.
8. There will be communication and education provided to all staff related to new policies, and procedures, and medical directives.

## **Equipment**

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

1. The purchase a Neonatal Resuscitation Cart with all appropriate Neonatal Resuscitation supplies immediately to be placed on the Post Partum Unit.
2. Biomedical services to do monthly equipment checks of all Panda's, Infant warmers and Electronic Fetal Monitors.
3. A thorough review of all Electronic Fetal Monitors to ensure they are in working condition. If they are sent out for repair then they are to be replaced with a loaner until the original is returned.
4. A thorough review to ensure Neonatal Resuscitation Posters are posted and visible in each birthing room, OR theatre, postpartum assessment room and the ER gyne room where during unit closures or emergency situations infant deliveries may take place.
5. Each birthing room or assessment room equipped with Electronic Fetal Monitor, IV pole with IV pump and epidural pump.

6. Dedicated Neonatal IV pump with micro-dosing capabilities for the administration of IV fluid and medication in the event of an a at risk and/or unstable neonate.
7. A review of all the phones in patient's rooms. These phones should have the capability to access the main switchboard to facilitate the call of Code Pink on overhead paging system.
8. Staff will be invited to be involved in the discussion surrounding capital equipment purchase for the FBU.

## **Policies and Procedures**

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

1. Within three (3) months of the IAC Report submission, both the Ontario Nurses Association and the Winchester District Memorial Hospital meet to review and prioritize the policies, procedures and medical directives that are required for the Family Birthing Unit.
2. Family Birthing Unit RNs provide input and feedback to all policies, procedures, and medical directives.
3. Benchmark with the Champlain Maternal Newborn Regional Program in developing and/or revising policies, procedures, and medical directives and/or implement their existing policies, procedures and medical directives ensuring they meet Winchester District Memorial Hospitals guidelines.
4. Winchester District Memorial Hospital's policies, procedures and medical directives are reviewed during orientation with new staff to ensure best practices, policies and procedures are always followed.
5. Policies, procedures, and medical directives be a standing agenda item on the Family Birthing Unit Care Team meetings and the Maternal Child Care Team meetings.

## **Use of Verbal Orders**

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

1. All patient orders will be entered electronically into the health information system using CPOE or during a planned or unplanned downtime written on WDMH approved order forms by the provider.
2. Verbal orders are intended to support patient care during a bedside procedure, in an emergency, or other situation where barriers to placing the order in the electronic medical record is not in the patient's best interest.
3. Telephone orders will be taken only when it is not possible for the prescribers to place the order themselves. This includes situations where the provider does not have computer access or is being paged directly about a clinical situation that is time sensitive requiring a new order, and where a delay in accessing the patient record is not in the patient's best interest.
4. Verbal/telephone orders require the prescriber to co-sign the order immediately upon accessing the patient record.
5. Complete a "readback" process for all verbal/telephone orders. The receiving clinician will read or repeat back any orders provided to ensure clear understanding. The prescriber will listen and confirm that the "readback" is accurate.
6. Enter telephone orders into the electronic medical record with the prescriber still on the phone to clarify any system messages/suggestions that arise.

7. Develop a process for monitoring the number of verbal orders with supporting evidence that is reviewed by the Chief of Staff with recommendations and education to providers if deemed appropriate.

### **Professional Responsibility Workload Response Forms (PRWRF)**

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

1. RNs in the Family Birthing Unit at Winchester District Memorial Hospital continue to document their concerns on the Professional Responsibility Workload Report Form, in alignment with the Collective Agreement.
2. The Hospital and the local Association work together to improve the Professional Responsibility Workload (PRW) process with the goal of implementing a collaborative approach to resolving workload concerns. This will include commitment on both sides to follow the steps in the collective agreement including timelines established in this process.
3. RNs in the Family Birthing Unit initially communicate their patient care concerns to the Clinical Manager to give management the opportunity to resolve the matter and facilitate decisions that will support safe, quality patient care.
4. Management continues to review and respond in a timely manner to the PRWRF in writing as per the Collective Agreement and engage in dialogue with the nurse(s) about the complaint with the goal to resolve the immediate issue and move toward a long-term resolution, if required.
  - a. The manager continues to respond within 10 days as per the Collective Agreement utilizing the OHA/ONA PRWRF tool.
  - b. The manager is to use the 10-day window to discuss the workload complaint with the nurse(s) involved, with an ONA representative present, if desired, to understand the concerns and to seek resolution.
  - c. Unresolved complaints will be presented at the Hospital Association Meeting as per the Collective Agreement with the intent to identify themes and work together on resolutions.
  - d. The Clinical Manager provides the Chief Nursing Executive (CNE) with a Workload Complaint Summary Report, monthly for the next six months, to include the number of PRWRFs completed, the workload issue documented, and any developing themes of concern.
  - e. The CNE to support the Clinical Manager to develop corrective action plans and to support the Clinical Manager and the nurses to resolve issues in a timely and effective manner.

### **Hospital Association Committee**

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

1. The HAC meetings continue with the intent to follow the process and intent outlined in Article 6.03 of the Collective Agreement.
2. All parties in attendance at the HAC, treat one another in a professional, respectful manner and through dialogue seek to find common solutions to identified concerns.

3. The following format for HAC be adopted.
  - a) Meetings to be Chaired on an alternating basis by ONA and the Hospital.
  - b) Minutes continue to be taken by ONA and the Hospital, alternating monthly and circulated within one week to all members of the Committee.
  - c) The agenda be circulated 5 days prior to the meeting to give all parties ample opportunity to add any issues/items required by either party.
  - d) The CNE/Directors/Clinical Managers continue to attend meetings when related to workload.
  - e) When agreement on an issue(s) is achieved, the agreement be put in writing, reviewed, and signed by all parties to ensure that all agree and sign off on joint decisions.
  - f) That a separate meeting be called to deal with workload concerns that are escalating in a particular unit so that trends can be identified, and corrective action put in place in a timely and effective manner.

## SECTION V: APPENDICES

*Appendix 1: Article 8.01: Professional Responsibility*



20201210\_IAC  
Guidelines and Chair

*Appendix 2: Hospital Nominee*

Begin forwarded message:

From: Lynn Harnden <[lharnden@ehlaw.ca](mailto:lharnden@ehlaw.ca)>

Date: May 29, 2023 at 11:16:20 AM EDT

To: [drothwell9@gmail.com](mailto:drothwell9@gmail.com)

Cc: "Andrea Cashman RN, BScN, M.Ed. Counselling" <[andreas@ona.org](mailto:andreas@ona.org)>, Michelle Blouin <[mblouin@wdmh.on.ca](mailto:mblouin@wdmh.on.ca)>, Maureen Taylor-Greenly <[MTaylor@wdmh.on.ca](mailto:MTaylor@wdmh.on.ca)>, Michelle Gélinas <[mgelinas@ehlaw.ca](mailto:mgelinas@ehlaw.ca)>, [stephaniepearsall3@gmail.com](mailto:stephaniepearsall3@gmail.com)

Subject: RE: Advancing Professional Responsibility Issues in the Obstetrics Unit to an IAC - ONA GEL File #202104666 - Winchester District Memorial Hospital

Donna:







Further to my email of May 18, 2023, I would advise that the Hospital's Nominee will be Stephanie Pearsall rather than Susan Kwolek. Stephanie's contact information is as follows:

Stephanie Pearsall BScN, MST

[stephaniepearsall3@gmail.com](mailto:stephaniepearsall3@gmail.com)

Can you please advise when you plan to schedule a hearing date into the issues?

Lynn

|   |   |
|---|---|
| <br>EMOND HARNDEN<br>  | EMOND HARNDEN LLP <small>scj per/pai</small>  |
|   | <b>LYNN HARNDEN</b> (he/him)  |
|   | Lawyer   Avocat   |
|   | <a href="#">707 rue Bank St., Ottawa, ON K1S 3V1</a>  |
|   |  613-940-2731                                |
|   |  613-791-4453                                |
|   |  <a href="tel:613-563-8001">613-563-8001</a> |

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From: Lynn Harnden <[lharnden@ehlaw.ca](mailto:lharnden@ehlaw.ca)>



## Ontario Nurses' Association

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

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

May 5, 2023,

SENT VIA EMAIL

Donna Rothwell, RN BScN MN Stantec Consultants, Principal 56 Carriage Road  
St. Catharine's, ON L2P 1T1 Home: 905-687-3980  
Cell: 647-801-1589  
Email: drothwell9@gmail.com

Dear Ms. Rothwell,

**RE: Naming ONA Nominee for the Independent Assessment Committee (IAC) – Winchester District Memorial Hospital – Obstetrics Unit - ONA GEL File #202104666**

---

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

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

The attached letter provides the Association's nominee - name and contact information. The Employer has been requested to share their nominee's information within the timeframes as set out in the Collective Agreement, by May 13, 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:

Lynn Stranges, RN, BScN  
Phone: 905-394-1604  
Email: [strangeslynn@gmail.com](mailto:strangeslynn@gmail.com)



Donna Rothwell May 5, 2023

Page 2

Re: Professional Responsibility Complaint IAC at Winchester District Memorial Hospital

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Yours truly,



**ONTARIO NURSES' ASSOCIATION**

Andrea Cashman RN, BScN, M.Ed. Counselling  
Professional Practice Specialist

C: Stacey De Jong, ONA Bargaining Unit President Mary Lou  
White, ONA Local Coordinator  
Cindy Drouin, Professional Responsibility Representative  
Abbygail McIntosh, ONA Local Vice President  
Marc Page, ONA Servicing LRO  
Maureen Taylor-Greenly, Interim Chief Nursing Executive  
David McCoy, Director, Ontario Hospital Association  
Jackie Kehoe-Donaldson, ONA Manager Professional Practice  
Lorrie Daniels, ONA Manager Professional Services Learning and Development Lynn  
Stranges, ONA Nominee



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

April 13, 2023

**SENT VIA EMAIL**

Maureen Taylor-Greenly Interim  
Chief Nursing Executive  
Winchester District Memorial Hospital  
566 Louise Street  
Winchester, ON K0C 2K0

Dear Ms. Taylor-Greenly,

Re: Advancing Professional Responsibility Issues in the Obstetrics Unit to an Independent Assessment Committee (IAC) – ONA GEL File #202104666

---

This letter is in follow up to previous discussions at the PRC/Hospital Association meetings and earlier communication advancing the professional practice and workload issues in the Unit/ Program at Organization to the Independent Assessment Committee and is in accordance with Article 8.01(a) v) of the Hospital/Ontario Nurses' Association (ONA) collective agreement.

As previously stated, the Registered Nurses (RNs) working in the Obstetrics Unit at Winchester District Memorial Hospital have consistently identified serious practice and workload concerns, and have documented that the current practice, patient care and workload environment does not allow them to meet College of Nurses of Ontario (CNO) standards; and they believe they are being asked to perform more work than is consistent with proper patient care. Effective support has not been provided to respond to patient acuity and volumes, fluctuating workloads, fluctuating staffing, and professional practice issues.

Please be advised that in accordance with the Hospital/Ontario Nurses' Association (ONA) collective agreement, Donna Rothwell has accepted the nomination to Chair the Independent Assessment Committee (IAC). This has occurred in consultation with David McCoy, Director, Employee Relations Services, Ontario Hospital Association (OHA).

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

Chair name and contact information is:

Donna Rothwell, RN BScN  
MN Stantec Consultants,  
Principal 56 Carriage Road  
St. Catharines, ON L2P  
1T1 Residence: 905-687-  
3980  
Cell: 647-801-1589  
Email: drothwell9@gmail.com

Please provide the name and contact information for your nominee to the Chairperson, Donna Rothwell, and copy the Association, in accordance with the timeframes as set out in the Collective Agreement and the referral letter of April 4, 2023.

Yours truly,

**ONTARIO NURSES' ASSOCIATION**



Andrea Cashman RN, BScN, M.Ed. Counselling  
Professional Practice Specialist

- C: Mary Lou White, ONA Local Coordinator  
Stacey De Jong, ONA Bargaining Unit President  
Cindy Drouin, ONA Bargaining Unit Practice  
Representative Marc Page, ONA Servicing LRO  
Erin Ariss, ONA Provincial President  
Elect Andrea Kay, ONA CEO  
Lorrie Daniels, ONA Manager, Professional Services Learning and  
Development Jackie Kehoe-Donaldson, ONA Manager, Professional  
Practice  
Cholly Boland, Organization President and  
CEO Shannon Horsburgh, Unit Manager  
Michelle Blouin, Vice-President, Corporate & Information Management Services, and  
Chief Financial Officer  
Angela Preocanin, ONA First Vice-President  
Bernadette Robinson, ONA Regional VP, Region 2 and Interim ONA Provincial  
President Mark Miller, ONA Regional Manager  
Donna Rothwell, IAC Chairperson  
David McCoy, OHA Director, Employee Relation Services,
-



Hospital Collective  
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## IAC Guidelines



20201210\_IAC  
Guidelines and Chair

## IAC Procedural Guidelines



APPENDIX 8 -  
Procedural Guideline

## Email confirmation to Nominee



Nominee For  
Collingwood Genera

## **Independent Assessment Committee for Winchester Hospital**

**Data Request on July 23, 2023, with request for information no later than Monday January 8, 2024, by noon hour 1200 hrs.**

- 1) Patient Information for the Labor and Delivery Unit for the past three fiscal years April 1, 2020, to March 31, 2021; April 1, 2021, to March 31, 2022; and April 1, 2022, to March 31, 2023**
  
- 2) Unit Organization/Functioning**
  - a) Structural drawing of the Labor and Delivery Unit.
  - b) Description of how the Labor and Delivery unit is organized.
  - c) Organizational Chart for Nursing Labor and Delivery
  - d) Job Descriptions for Team Leader/Charge Nurse, Registered Nurse, Registered Practical Nurse, Nurse Practitioner, Advanced Practice Nurse, Nurses Educators, Professional Practice Leaders any other registered staff including all allied health professionals; Does Team Leader/Charge Nurse have a patient assignment?
  - e) Admission Guidelines
  - f) Criteria for admission to Labor and Delivery
  - g) Staff assignment sheets
  - h) Number of times staff pulled to work in another department.
  - i) Orientation Program for RNs, including number of weeks with a preceptor/buddy.
  - j) On going newborn training that is offered in orientation and what is offered on an ongoing basis
  - k) Description of how RNs are prepared to work in Labor and Delivery
  - l) Support roles, such as, but not limited to Personal Support Worker, Ward Clerk/Clerical Assistant
  - m) Copy of a typical chart format/template
  - n) Charting guidelines and/or policies
  - o) Describe the process that is in place until the team arrives if newborn has unfavourable outcome, who is responsible with no nursery nurse.
  - p) Describe the layout/process of the unit to provide newborn care until the team arrives.
  - q) Describe the process in place to support labour and delivery when RN is transferring a patient out if post partum is staffed with 1 RPN.
  - r) Changes or initiatives that have impacted Labor and Delivery in the last three years.
    - I. External issues that impact patient flow
    - II. Major process changes, model of care changes, technology implementations, special projects in the unit
  
- 3) Staffing Data for fiscal 2021-2022, 2022-2023, 2023-2024 (April 1<sup>st</sup> to March 31<sup>st</sup>)**
  - a) Budgeted Full-time Equivalents (FTEs) for all staff categories in Labor and Delivery
  - b) Total paid hours in FTEs 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 2023-2024
- e) Sick-time, overtime in FTEs for RN's and comparison over last three fiscal years
- f) Copy of ads for past and current RN positions
- g) Current RN vacancy rate
- h) Turnover rate for RNs
- i) Novice to Expert Experience Profile – number of RNs with ED experience (under 1 year, 2 years, 3 to 5 years, 5 to 10 years, 10 to 15 years, 15 to 20 years, greater than 20 years)
- j) Number of nursing staff on modified work or have permanent accommodations.
- k) Copy of local collective agreement
- l) Master schedule: copy of the posted schedules for RNs for the past year and a copy of daily assignment sheets for the past year.
- 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,
- p) If utilized by the Labor and Delivery: the size and utilization of a department or organizational float pool.
- q) Number of short, staffed shifts for RN/RPN/ward clerk/PSW/housekeeping.

**4) Budget and Performance Indicators for the past three fiscal years 2021-2022, 2022-2023, 2023-2024 (April 1<sup>st</sup> to March 31<sup>st</sup>)**

- a) Total planned and expended budgeted for Labor and Delivery: Staffing and Equipment and Supplies

**5) Quality of Care Performance Indicators**

- a) Patient Satisfaction Results in Labor and Delivery 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 Labor and Delivery for the past three years
- d) Number and type of staff injury in Labor and Delivery for the past three years
- e) Number of Medication incidents in the past three years
- f) Winchester Hospital's violence prevention program and the number of violent incidents in the last two years
- g) Number of patients falls in 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 during the past three years.
- j) Number of vaginal deliveries
- k) Number of C – sections
- l) Number of inductions (unsure if these occur either misoprostol or oxytocin)
- m) Midwifery deliveries
- n) Most recent BORN KPI's

- 6) **Hospital Association Committee (HAC) Agendas and Minutes from 2021, 2022 and 2023 and any other Agendas and Minutes of meetings regarding workload** complaints in Labor and Delivery
- 7) **Med/Surg Staff Meeting Minutes for 2021, 2022 and 2023**
- 8) **Media Articles**
  - a) All media articles since 2021

# Independent Assessment Committee Hearing

## Ontario Nurses' Association (ONA) and Winchester District Memorial Hospital

### Agenda

**Tuesday January 30, 2024**

|               |  |
|---------------|--|
| 08:00 – 08:30 | <i>Independent Assessment Committee Meeting (Committee Members only)</i>   |
| 08:30 – 08:45 | Welcome and Introductions  |
| 08:45 – 10:00 | Tour of the Winchester District Memorial Hospital L&D via Zoom<br>Follow-up Questions<br><b>Note: The tour needs to involve representatives from ONA and the Hospital</b>  |
| 10:00 – 10:15 | Break  |
| <b>10:15</b>  | <b>Commencement of Hearing</b>   |
| 10:15 – 10:30 | • Introduction and Review of Proceedings by Chairperson  |
| 10:30 – 12:30 | • Ontario Nurses' Association Submission Presentation <b>(1.5 hrs)</b><br>♦ Response to questions of clarification by: <b>(0.5 hrs)</b><br>· Independent Assessment Committee<br>· Winchester District Memorial Hospital |
| 12:30 -13:30  | Lunch  |
| 13:30 – 15:30 | • Winchester District Memorial Hospital Submission Presentation <b>(1.5 hrs)</b><br>♦ Response to questions of clarification by: <b>(0.5 hrs)</b><br>· Independent Assessment Committee<br>· Ontario Nurses' Association |
| 15:30 – 15:45 | • Review of Process for Thursday Feb 1 <sup>st</sup> , 2024, and Friday Feb 2 <sup>nd</sup> , 2024<br>by IAC Chairperson   |
| 15:45         | Adjournment of Hearing   |



# **Independent Assessment Committee Hearing**

**Ontario Nurses' Association / Winchester District Memorial  
Hospital**

## **Agenda**

**Wednesday February 1<sup>st</sup>, 2024**

08:00 – 16:00

*Both parties work on developing their responses to the presentations held on Tuesday January 30<sup>th</sup>, 2024, in preparation for Thursday Feb 1<sup>st</sup>, 2024*

# Independent Assessment Committee Hearing

## Ontario Nurses' Association / Winchester District Memorial Hospital

### Agenda

Thursday February 1<sup>st</sup>, 2024

|               |  |
|---------------|--|
| 07:30 – 08:30 | <i>Independent Assessment Committee Meeting (Committee members only)</i>   |
| 08:30         | Continuation of Hearing  |
| 08:30 – 11:30 | <ul style="list-style-type: none"><li>● Winchester District Memorial Hospital Response to Ontario Nurses' Association Submission<br/><b>(2 hours maximum to present)</b><ul style="list-style-type: none"><li>◆ Response to questions from <b>(1 hour for questions)</b><ul style="list-style-type: none"><li>· Independent Assessment Committee</li><li>· Ontario Nurses Association</li></ul></li><li>◆ Discussion</li></ul></li></ul>                     |
| 11:30 – 12:30 | Lunch Break  |
| 12:30 – 15:30 | <ul style="list-style-type: none"><li>● Ontario Nurses' Association Response to Hospital Submission<ul style="list-style-type: none"><li>◆ Response to questions from Winchester District Memorial Hospital<br/><b>(2 hours maximum to present)</b><ul style="list-style-type: none"><li>· Independent Assessment Committee <b>(1 hour for questions)</b></li><li>· Winchester District Memorial Hospital</li></ul></li><li>◆ Discussion</li></ul></li></ul> |
| 15:30 – 15:45 | <ul style="list-style-type: none"><li>● Review of Process for Friday February 2<sup>nd</sup>, 2024, by Chairperson</li></ul>   |
| 15:45         | Adjournment of Hearing   |
| 16:00 – 20:30 | <i>Independent Assessment Committee Meeting (Committee members only)</i>   |

*Note: The timing of the agenda is 'fluid'. If the Winchester District Memorial Hospital Response submission/discussion is concluded before lunch, we will proceed with the ONA Response submission/discussion before the lunch break. If the ONA Response submission/discussion concludes before 15:30, the Hearing will adjourn. The Hearing will adjourn at 16:00 at the latest.*

# Independent Assessment Committee Hearing

## Ontario Nurses' Association / Winchester District Memorial Hospital

### Agenda

Friday, February 2<sup>nd</sup>, 2024

|               |  |
|---------------|--|
| 08:30         | Continuation of Hearing  |
| 08:30 – 12:30 | <ul style="list-style-type: none"><li>• Questions to both ONA and Winchester District Memorial Hospital<ul style="list-style-type: none"><li>• <b>Labor and Delivery nurses have opportunity to present their issues/stories. This will be time limited.</b></li></ul></li></ul> |
| 12:30 – 13:00 | • Closing Remarks and Discussion of Next Steps by Chairperson  |
| <b>13:00</b>  | <b>Closure of Hearing</b>  |
| 13:00 – 15:00 | <i>Independent Assessment Committee Meeting (Committee members only)</i>   |

*Note: The timing of the agenda is 'fluid'. If the Collingwood General and Marine Hospital Response submission/discussion is concluded before lunch, we will proceed with the ONA Response submission/discussion before the lunch break. If the ONA Response submission/discussion concludes before 15:30, the Hearing will adjourn. The Hearing will adjourn at 16:00 at the latest.*

*Appendix 6: Attendee List*

**IAC Panel**

Donna Rothwell – IAC Chair

Lynn Stranges – ONA Nominee

Stephanie Pearsall – WDMH Nominee

**ONA**

Tanya Beattie

Stacy De Jong

Cindy Drouin

Tanya Beatie

Danielle Richard

Jackie Kehoe-Donaldson

Marc Page

Angela Preocanin

Sheila Begin

Abbygail McIntosh

Lori Harreman

Jenn Merkley

Erin Ariss and

Kim Taylor

DJ Sanderson

Terry McArthur

Erin Ariss

Angela Preocanin

**WDMH**

Janie Desroches

Michelle Blouin

Shannon Horsburgh

Veronica Blanco Sanches