Hello Uzoma,

Thank you again for being supportive and listening to the concerns my colleagues and I have regarding patient safety and care at the Grace Emergency. Our ER was struggling before the pandemic and with the pandemic it has reached a breaking point. Like HSC and St B we are in no way ready for a third wave of the pandemic. It is almost impossible to retain highly trained nurses as they are getting burned out as faster and faster rates. We have had multiple meetings with management at the start of 2021 to address our concerns about staffing, nurse to patient ratios, and infection control concerns.

The outcome of these meetings is to create 3 LPN positions within ER for positions that were not getting filled by RN's. These were not additional rotations added to existing vacancies, these were vacancies that had already remained unfilled. A lot of the things we are asked to tackle are well above our experience and job descriptions as Registered Nurses and Health Care Aides.

I cannot say thank you enough for reaching out and being willing to listen to the concerns of myself and my colleagues. A lot of us are dealing with an overwhelming amount of moral injury not just from what we have seen due to the pandemic but the lack of support from management to allow us to do our jobs to the fullest and provide safe, effective and compassionate patient care. I have stayed at the Grace because there was a deep culture of compassion, support and community amongst my colleagues and management at the time. I work with some of the most incredible nurses, health care aids and physicians this city has to offer but consolidation has taken a toll. The transition from community ER to tertiary has been incredibly difficult and we have suffered from a lack of direction or foresight as well as critical lack of funding. We are a growing tertiary centre that is being made to stretch a very thin community hospital budget and unfortunately management is towing the line.

Due to the Grace's unique position as third tertiary centre in Winnipeg we have no found our footing as far as what our "specialty" is. HSC has neuro, trauma, womens health, mental health and dialysis. St B has cardiac care, womens health, mental health and dialysis. The Grace on the other hand has become a dumping ground for anything that does not definitively fall into those criteria. I hear EMS say that we are the "Shortness of Breath", "Weakness" centre. I am unsure whether this is official. Unfortunately in the time of a global pandemic with a respiratory virus this means we see EVERYONE and unfortunately our patients are older with multiple co-occurring health conditions. The support we received to deal with covid and the onslaught of respiratory patients was to have cardiology technicians do EKGs overnight instead of Respiratory and more Respiratory Therapists hired to deal with ventilators.

Due to the physical constraints of being a previous community hospital we have a finite amount of inpatient beds, 10-11 ICU beds and 31 ER beds. We run out of inpatient beds quickly and every day have patients held in the ER as a result. To make room our ER was designed with "care zones" A, B and D for each low, mid and high acuity. The care zones were originally intended for patients who are stable, ambulatory and waiting for diagnostic results, maybe

getting IV fluids while sitting in a chair and then discharge under 24hrs from ED. (please see https://www.youtube.com/watch?v=CgdjxPEN2-E a tour of the department after it was built). Unfortunately, this is a very small number of our patients and the care zones are now for patients waiting for admission to low acuity beds who need occupational therapy, physiotherapy, home care and possibly paneling for PCH. We have 80 year old's and older sitting in recliners or stretcher in these care zones with no privacy, limited access to toilets and no call bells for up to a week while waiting for low acuity beds. Our second longest holds are mental health. Our mental health patients have been known to wait up to 4 days for beds at our mental health centres, sitting in chairs and sleeping in stretchers in care zones with no privacy. Patients waiting for admission to medicine units in the hospital can also wait in these areas, waits reaching 50hrs are not uncommon.

Our other slapdash holding area is triage bay. Originally this area was intended as a hallway to the triage nurses pods for EMS to line up while they register and get patients triaged. There were 4 curtained areas for recliner chairs or stretchers for discharged patients needing stretcher service to get home. Now this area has become a mixed-use location with a mix of EMS offloaded patients waiting to be seen, patients with treatment in progress but not yet admitted to the hospital and admitted patients. All patient who are stable enough not to require high oxygen needs or a cardiac monitor. Usually, these patients are not ambulatory and require an enormous amount of care by health care aids and nurses alike. In the times of covid or flu the four curtained spots are used for patient on respiratory precautions (droplet/contact) while the hallway are patients who do not require droplet precautions but may need contact. When someone's covid test comes back negative and if they are no longer symptomatic, they are brought to triage bay to wait for admission. Spots have been made in the triage bay/ EMS offload hallway by nurses during the 2019/2020 flu season as our hospital was overwhelmed. We made spots temporarily and hung letters on the walls to demarcate where patients were. During that flu season those spots became permanent and added to our computerized system. They can range from A-J with some spots doubled up for a total of 14 hallway spots and 4 curtained spots numbers 1-4. Last winter there was no designated nurse for this area so we pushed to have a nurse responsible for these patients. We have 2 triage nurses on days, plus pod C which became "flow, waiting room reassessments and triage bay/hallway nurse". When covid hit we were approved funding for an additional nurse that we had approached management for during 2019 that was initially intended to be a dedicated Resuscitation Nurse who would float around the department until there was a code blue and that nurse would be the primary nurse for the code blue patient. Instead that nurse became triage bay nurse. Triage bay nurse would be the nurse taking care of all the patients in the hallway/ curtained spots while pod C would do reassessments for patients waiting to be seen and create flow in the department to get waiting room patients into rooms to receive assessments by physicians and move patients waiting for admission out to the hallway, as well as be the second nurse to respond to code blues. Prior to covid the addition of 2 nurses was not nearly enough, they have added 1 more since but we don't have enough staff to fill these spots. Our numbers for patients in the department have steadily been climbing since consolidation. Although we have a new department it was designed with our old numbers in mind when we were a community hospital and the same staff numbers. 60+ patients in the department is the norm when our old baseline

was 35-40. We regularly see numbers comparable to St B ER and do with less. Our poor nurse and health care aid to patient ratios are causing us to neglect our patients, not due to lack of care or compassion but due to lack of hands to care for these patients. There are many days I wish I could duplicate myself 4 or 5 times to make sure all of my patients get the care they need. Missed meds, rushed and skipped assessments, delayed hygiene, falls, bed sores, are daily occurrences. Code blues and seizures in the triage hallway are common because nurses are stretched so thin they are unable to monitor patient condition close enough to catch when a patient is declining. More code whites due to our mental health patients having no privacy or dignity for days. Patients missing meals because we run out of sandwiches. Little to no hot meals supplied for patients who are waiting in the department for days. Our patients are suffering instead of getting the help that they deserve!

With the covid 19 pandemic, trends that began during consolidation and the 2019/2020 flu season were compounded. At the start of the pandemic our numbers dropped off significantly which was also seen across all hospitals as patients were too scared to seek care. During the second wave we had a large influx of covid patients as well as our non-covid patients many now seeking care for chronic conditions exacerbated by lack of treatment during the first wave of the pandemic. Our patients are more acute and more complicated. Covid also has made patient flow incredibly challenging for our department. We outsource or rapid covid swabs to HSC at present and receive our results slower than other sites as they are only sent to HSC in batches a few times a day. If a swab is done at 5pm we do not receive results till 8am the next day meaning that patient has to remain isolated overnight in a treatment room, blocking our ability to see new patients. Patient also must get a swab results back before they are admitted to a medicine, surgical, low acuity or mental health bed, thus delaying treatment and transfer further. Our hospital treats swabbed patients differently as well. We keep all swabbed patients, symptomatic or not on covid isolation until they receive a negative result. This means that if you are being admitted for a kidney infection and have no covid19 risk factors you are placed on covid isolation after being swabbed and held in the ER until your swab is back. On nights this creates a gridlock in the department and on days it is still often a **4-12hr delay**.

Right now in our department it is not so much a lack of isolation beds for covid 19 patients, it's a lack of beds for all of our other patients. The community is very sick. We are seeing more acutely sick diabetics, patients in congestive heart failure, horrible skin infections, sepsis, and missed strokes and so many patients who are elderly and failing to cope at home on their own. Our system is so overburdened right now that a third wave of the pandemic will absolutely cripple us. The moral injury suffered by our staff over the past few years and intensified over the last year of the covid pandemic has caused the majority of our highly trained senior staff to quit. It's almost a given at this point that when you get trained on cardiac monitored patient care that you will burn out in a few months and quit. It is rare to see a nurse that lasts longer than 5 years at the Grace at the best of times but the majority of staff is not making it past a year. The ones who have made it to triage or resus prior to covid are all leaving. According to our Staff Experience Survey close to 50% of our staff are actively looking for positions elsewhere. Many of us want to stay but we can't continue to man a sinking ship.

Management has known about the majority of these issues as soon as the new department opened and little has been done to prevent the catastrophe that we are dealing with now. We have been told there is no funding and there is nothing we can do to change things. We have many Brian Sinclair's in our department regularly and no one cares except the nurses and health care aids. We shout to our managers for someone to do what is right for our patients and we are told nothing can be done. We document our Rl6's for our critical incidents and injuries and near misses. We fill out heavy workload forms, we have talked to our unions and still nothing. It feels like war time nursing with a war that was born out of political negligence not out of a true catastrophe! It is a humanitarian crisis that has been fabricated by a government who has cut funding to our healthcare system and does not care about its people. Our patients are dying from governmental neglect on all systems and what we are seeing at the Grace and other emergencies is result of that neglect. The PC government cut ICU beds and inpatient beds with consolidation and we were struggling to stay afloat with those cuts long before the pandemic hit. During the 2019 flu season I watched an ICU doctor and our ER doctor debate which patient out of 2 would die sooner and how long they could last without a ventilator while they waited for another patient to get extubated to free up the last remaining ventilator in the city. Our hospital system was so stretched after consolidation it was unprepared for the yearly flu season and somehow it is expected to cope with covid 19. We have also been dealing with an enormous mental health and addictions crisis prior to covid that has also only worsened. Our communities are crying out for help and we don't have enough support to care for them.

Now to address the third wave of covid. Our ICU's filled up faster than the second wave. There was less staff to pull from other departments to work as extenders. ICU staff is burnt out and also leaving their jobs. This is felt directly in the emergency department as we house any patients that cannot be transferred to the ICU right away due to bed shortages. Before they opened the flex beds at the Grace we had ~5 or 6 ICU patients in our department. They opened the felx beds for covid patients and within days they were full. These patients are much younger and will require extended visits compared to the second wave where patients were much older and unfortunately succumbed to covid faster. We are in for a rough few months and the sad thing is this could have been prevented by waiting to open our province until the majority of people had their vaccinations.

Thank you so much for listening to our concerns. For many of us it has felt like we have been shouting to the void for years already. We are a very beat up and broken staff but we stay because we care for our patients with all our hearts and so desperately just want to keep them safe and healthy.

Please see below for how our department breakdown as far as nursing coverage and patient acuity:

<u>Grace Emergency</u>:
Triage 2 Nurses plus 'c nurse' (1 triage nurse on nights + "c" nurse)- C will help with hallway and waiting room patients so an unlimited patient assignment.

Resus Nurse 0 Nurse
High Acuity 1:3.5+ (plus care zone which could stretch patient assignment to 1:7)
Mid Acuity 1:4.5
Care B: 1:6+
Low Acuity 1:4+
Care zone pt (can house 6 safely during covid, double prior to covid)
Triage Bay/Hallway 1: unlimited patients (we have now added "overbaseline" nurses to this area but can rarely staff those positions)
HCA/clerks: 7
Resus 1: **21%** RN's pulled (during a code blue this is how many nurses are pulled off of the floor)
Resus 2: **43 %** RN's pulled

St. B Emergency

Triage 3 Nurses
Resus Nurse 1 Nurse
High Acuity 1: 3.14
Mid Acuity 1:4
Low Acuity/RAZ 7 beds 2 nurses
Obs areas: 1:6
HCA/clerks: 9
Resus 1: 11% RN's pulled
Resus 2: 29% RN's pulled

HSC Emergency

Triage 3 Nurses + 1 Resus/Resource Nurse
Offload/Resus Nurse 1
High Acuity 1: 3.5 patients + 2 Resus Nurse support
Mid Acuity 1:4 +1 Resus Nurse Support
Low Acuity variable due to MLA WR
1:3.5 to 1:6 (if 10 pt in WR). + 1 Resus Nurse Support
Obs areas: 1: 4.75 + 2 Resus Nurse Support
*offsite 8 bed holding area (LAA) staffed by 2 nurses scews ratio. Usually 1:5 or 1:6
HCA/clerks: 15
8 Resus Nurses with assigned float areas