**OPPORTUNITY AND BENEFITS PLANNING REPORT**


# THE COUNTY OF LAMBTON
# STAFF SCHEDULING MODERNIZATION PROJECT

**DECEMBER 31, 2021**

CONSULTING
TRAINING
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SERVICES-CONSEILS
FORMATION

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# 1 EXECUTIVE SUMMARY

Lambton County Homes (LCH) has three LTC homes: North Lambton Lodge, The Marshall Gowland Manor and The Lambton Meadowview Villa totaling 339 beds and 450 staff. LCH is experiencing ongoing and chronic challenges such as critical health human resource shortages, increased absenteeism, complex labor issues and employee dissatisfaction with scheduling. These problems are all too common in the long-term sector. All job groups have been affected particularly in the dietary, housekeeping, and clinical (nursing) areas. In the context of the pandemic, these issues have been amplified. Resident and staff safety are a key considerations and time is of the essence.

Despite best efforts to increase recruitment and hiring, critical scheduling and resourcing issues remain. Given the urgency of the current state, both a plan and actions to transform the environment are of high value to the County. Short-, medium- and long-term gains will be realized by advancing the maturity of the scheduling ecosystem and committing to formal change management to involve all stakeholders. The plan, design and implementation considers the long-term vision for LCH to establish a leading practice scheduling environment. The focus of this initiative is to improve staff experience, increase human resource utilization efficiency and develop strategic workforce planning capacity.

LCH has reached out to Workforce Edge Consulting and Training to provide strategic scheduling the vehicle modernization and transformative change. Through the initial discovery and consultation with LCH, the following issues were identified.

**Critical Issues**

- Increase surge demand and staffing needs during the COVID-19 pandemic and need for rest time for staff is imperative;
- Inability to consistently staff homes to the safest staffing levels our residents deserve;
- Increased overtime and subsequent exhaustion of care providers;
- Spike in absenteeism during outbreaks;
- Lack of key data collection to inform strategic and proactive scheduling;
- Ongoing schedule issues driving union disputes;
- Inability to collect data required for reporting staffing status;
- Limited strategic resources in scheduling with a limited ability to align cost with WF plan
- Schedules lack equity, weekend coverage an ongoing problem;
- Requirements for new scheduling software configuration need to be anchored in leading practice and standard scheduling processes not yet designed;
- Low quality in current schedules such a single shift on or off are contributing to employee burn out;
- Low FTE positions and limited availability for full time work is driving away part time staff;
- Part time staff work all of the weekends causing low staff engagement and inequity amongst staff;
- Scheduling services are only available on weekdays leaving a evenings and weekends underserved;

- Clinical staff are responsible for evening and weekend scheduling creating lack of consistency, increased collective agreement breaches and pulling valuable clinical leadership away from residents and front line employees.

# 2 Staff Scheduling Modernization – Phase 1 Rapid Response – Analysis and Design

## 2.1 Objectives

1. Scheduling leadership inclusive of scheduling practices advice and core business processes to meet immediate needs;
2. Daily coaching and support for the scheduling staff and those involved to meet the needs for a defined period;
3. Support the modification of three staff schedules/rotations to increase quality and operability, whilst simultaneously helping to accommodate single site and cohort restrictions.

## 2.2 Key Deliverables

1. **Discovery** assessment to determine opportunities to leverage, and identify the immediate needs for process improvement;

2. **Rapid revision of up to five business processes** (to be identified during Discovery) to meet the immediate needs of Lambton County (one home)

3. **Updated rotations** for Personal Support Worker, Dietary and Housekeeping for one home increasing part time FTE to cover gaps

4. **Management and/or support** the schedulers on a per-diem basis, to enable cleaner data collection, creative scheduling tactics to fill shifts and , implement change

# 3 Phase 2 Design, Engagement, Implementation and Sustainment

## 3.1 Objectives

1. To create and implement a staff engagement plan for all three homes that ensures transparency, collaboration and a positive team experience while maximizing the speed and adoption of change;
2. To maintain or improve resident care and outcomes for all three homes by ensuring adequate staffing levels are consistently maintained for all homes, departments, and units;
3. To improve the employee experience for staff and management by providing predictable work schedules that meet the 5 Collective Agreements obligations, support work life balance, appropriate fatigue management, and minimize the stress of working short-staffed;
4. To minimize financial waste and to enhance quality through optimizing the use of relief staffing which allows a higher percentage of vacant shifts to be filled at straight time; and
5. To create a scheduling service and ecosystem that is based on strategic workforce analysis that will achieve our heath human resource planning goals; and
6. Better prepare us to respond to environmental variations such as surge events, staffing model or funding changes

## 3.2 Key Deliverables

1. Change Engagement and Support
2. Strategic Scheduling Support
3. Rotation and Relief Optimization
4. Design of Processes and Procedures
5. Training, Implementation and Sustainability

# 4 Benefits to Full Implementation

| KPI | WFE Workforce Deployment Maturity Model Implementation | Types of Benefits Realized |
|---|---|---|
| **Patient Care** | Baseline coverage maintained each day on a master rotation | Reduction in number of uncovered shifts<br>Reduction in overtime and/or Agency cost |
| | Master rotations have high quality and are created with consideration of fatigue management | Reduction in absenteeism<br>Reduction in clinical errors due to fatigue<br>Reduction in turnover and associated training and orientation costs |
| | Advance booking of relief shifts as far in advance as possible | Reduction in number of uncovered shifts<br>Reduction in overtime and/or Agency cost<br>Reduction in clinical errors due to clinical staff working short-staffed |
| | Appropriately sized relief workforce including an appropriate number of regular and casual positions | Reduction in number of uncovered shifts<br>Reduction in overtime and/or Agency cost<br>Reduction in training/orientation costs for casual employees by maintaining appropriately sized relief pool |
| | Maintaining a ration of approximately 70% full time staff where possible | Continuity of care for patients, who are more comfortable expressing care needs to staff they come to know |
| **Employee Experience** | Not having to work short-staffed and having relief shifts filled | Increase in employee retention and decrease in training/orientation of new staff<br>Reduction in clinical errors due to overworked clinical staff |
| | Schedule predictability through a repeating master rotation | Increase in employee retention and decrease in training/orientation of new staff |
| | Equity with one's peers by having less desirable shifts be fairly distributed among employees | Increase in employee retention and decrease in training/orientation of new staff |
| | Master rotations have high quality and are created with consideration of fatigue management | Increase in employee retention and decrease in training/orientation of new staff<br>Reduction in clinical errors due to overworked clinical staff |
| | Employees have input into development of master rotations when changes are required | Reduction in cost of labour relations activities and after-the-fact cost to address employee concerns<br>Increase in employee retention and decrease in training/orientation of new staff |
| | | |

| KPI | WFE Workforce Deployment Maturity Model Implementation | Types of Benefits Realized |
|---|---|---|
| **Labour Relations** | Collective Agreement provisions for master rotations met | Decreased cost of resolving grievances |
| | Collective Agreement provisions for staff scheduling met | Decreased cost of resolving grievances |
| | Unions and employees appropriately engaged in changes to employee rotations | Reduction in cost of labour relations activities and after-the-fact cost to address union concerns<br>Reduced risk of public relations issues to be managed, and associated costs<br>Positive working relationship with unions is maintained |
| | Bargaining priorities consider implications of provisions on employee experience and work-life balance | Ensure that employee work-life balance is not affected by scheduling or rotation rules |
| | | |
| **Cost Savings** | Staffing model includes appropriate number of regular relief positions so that predictable relief needs are covered by regular staff | Reduction in number of uncovered shifts<br>Reduction in overtime/Agency costs<br>Reduction in employee turnover and associated training & orientation costs |
| | Appropriately sized casual employee pools to minimize risk of overtime | Reduction in number of uncovered shifts<br>Reduction in overtime/Agency costs<br>Reduction in casual employee turnover and associated training & orientation costs |
| | Advance booking of relief where need is known in advance | Reduction in number of uncovered shifts<br>Reduction in overtime/Agency costs<br>Reduction in clinical errors due to clinical staff working short-staffed |
| | Relief mobility amongst clusters of units where similar skills are required | Reduction in cost of relief staffing<br>Increased satisfaction of employees |
| | Creation of a management model and culture where a relief employee is a valued team member and a desirable career path, and not just an entry-level position | Reduction in cost of relief staffing<br>Increased satisfaction of employees<br>Increased retention in relief lines and decreased turnover and associated training/orientation costs<br>Improved patient care through having experienced relief nurses and other clinical staff |

## Summary

Many of the benefits of implementation for this project relate to a reduction in overtime costs and a reduction in training and orientation cost for new staff. After analysis in savings in merely two of these areas is expected to meet or exceed the $405,000 identified in the Municipal Modernization Program Phase Two Expression of Interest and be closer to $500,000 in actual savings.

**Employee Training and Orientation:**

On-boarding of new staff in the nursing department costs approximately $3,000 per staff member. A reduction in onboarding requirements by 50% would result in a savings of $75,000 over the first 12 months after implementation.

Although we do anticipate a reduction of 50% in both these areas, the changes could be somewhat less due to transition and/or increases in funding to support the Provinces 'Four hours of Care" recommendations.

# 5 WFE Similar Engagements

Workforce Edge is a highly specialized Canadian organization focused entirely on workforce planning, scheduling, and deployment in healthcare. This is an emotive area for staff and very time consuming for operational leaders. Especially in a pandemic world and the complexities of sustaining the delivery of health services, we need to leverage all of the predictability we can. Doing so can have significantly advance joy @work for care providers, give time back to busy clinical and operational leaders, and provide for safer staffing to care for patients and their families.

Within the global healthcare sector, Workforce Edge has distinguished itself with a niche focus on sustaining healthcare service delivery through co-creating scheduling processes that are consistent and equitable for staff, delivering strong stable schedules that balance operational needs and staff preferences, and creating strategies to more effectively manage relief needs and fill shifts faster.

**APPENDIX A**

**2021 LTC OT January 1, to July 31, 2021**

| | January | To February | February | To March | March | April | May | June | to July | July | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | |
| 009 OVERTIME @ .5 | 31,944.56 | 54,071.31 | 22,126.75 | 60,462.63 | 6,391.32 | 41,385.79 | 23,614.60 | 10,184.18 | 158,359.58 | 22,712.38 | **158,359.58** |
| 010 OVERTIME @ 1.0 | 130.08 | 706.50 | 576.42 | 706.50 | - | - | - | 24.05 | 954.35 | 223.80 | **954.35** |
| 012 OVERTIME @ 1.5 | 41,516.30 | 64,710.21 | 23,193.91 | 70,220.12 | 5,509.91 | 40,775.68 | 23,259.61 | 8,170.76 | 169,400.18 | 26,974.01 | **169,400.18** |
| 020 BANKED - 1.0 | 3,796.91 | 6,593.12 | 2,796.21 | 9,339.44 | 2,746.32 | 2,682.12 | 2,177.64 | 3,912.81 | 20,947.49 | 2,835.48 | **20,947.49** |
| 022 BANKED OT - 1.5 | 6,880.84 | 13,826.57 | 6,945.73 | 17,836.68 | 4,010.11 | 7,240.94 | 4,194.62 | 4,825.16 | 39,446.88 | 5,349.48 | **39,446.88** |
| 122 COVID19 - OVT @ 1.5 | 3,901.12 | 7,101.89 | 3,200.77 | 7,890.74 | 788.85 | 5,364.67 | 4,577.28 | 2,293.65 | 26,607.63 | 6,481.29 | **26,607.63** |
| 124 COVID19 - BANK OVT @ 1.0 | 5,710.17 | 8,320.66 | 2,610.49 | 10,582.82 | 2,262.16 | 548.94 | 197.88 | - | 11,706.67 | 377.03 | **11,706.67** |
| 125 COVID19 - BANK OVT@1.5 | 2,936.96 | 5,155.30 | 2,218.34 | 7,432.79 | 2,277.49 | 1,739.92 | 481.37 | 853.38 | 10,637.32 | 129.86 | **10,637.32** |
| **Total** | **96,816.94** | **160,485.56** | **63,668.62** | **184,471.72** | **23,986.16** | **99,738.06** | **58,503.00** | **30,263.99** | **438,060.10** | **65,083.33** | **438,060.10** |