PREMIUM FRAMEWORK

CASE SUMMARY · DELIVERY TRACK RECORD

HEALTHCARE · ACUTE CARE · PRE-BUILD DECISION ASSURANCE

Before customizing its HRIS, the hospital needed to know whether its scheduling rules were even buildable.

A Canadian acute-care hospital was about to commit customization spend against undocumented, union-complex scheduling rules. The real process was mapped, the workforce rules reconciled, readiness tested — and leadership got a validated basis to decide what was safe to build.

CLIENT **A Canadian acute-care hospital (anonymized)**	ROLE **Project Manager / lead business analyst**	ENGAGEMENT IN NUMBERS **20+ interviews · 3–4 workshops · 100+ requirements · 6 deliverables**
ENGAGEMENT MODEL **Independent requirements and change-readiness analysis — pre-build advisory**	DURATION **~4 months · analysis to recommendations**	PROGRAM SCALE **20+ departments · six employment types · stakeholders: HR, payroll, clinical leadership, department managers, union representatives**

01 The mandate

The hospital wanted staff scheduling integrated with its commercial HRIS payroll platform. But the rules that would drive that integration lived on paper — master-rotation, availability, and assignment sheets — across six employment types and multiple bargaining units, with leave, sick, and disability entitlements never documented end to end. Customizing against those rules as they stood meant automating errors at payroll scale: incorrect pay, union grievances, rework, and a failed implementation discovered only after the money was spent.

The engagement existed to take that risk off the table before commitment: map the real scheduling process, reconcile the rules across the workforce, test organizational readiness, and give leadership a validated basis to decide what to build, what to fix first, and what had to be true before a build could safely start.

02 The delivery context

Payroll is where bad rules become real money

Every pay period for the entire hospital workforce flows through these rules. An integration that faithfully automates an undocumented or disputed rule does not fail quietly — it surfaces as incorrect pay, grievances from multiple bargaining units, and an HR and finance cleanup costing far more than the analysis that would have prevented it.

Six employment types, one set of rules to reconcile

Full-time, part-time, contract, unionized, non-unionized, and volunteer staff each carried different entitlements and scheduling realities, administered by people who knew their corner of the process and no one else's. Until

those were reconciled into a single specification, nobody could say what the system should do — which is exactly the state in which customizations fail.

03 How the engagement was run

Led the elicitation across every workforce group

Personally facilitated 20+ stakeholder interviews and one-on-one discussions and three to four structured workshops and brainstorming sessions across all six employment types, management, HR, payroll, and clinical leadership — and kept the bargaining units briefed throughout, so the requirements baseline would hold on the floor rather than unravel at the first grievance.

Reconciled the rules into a buildable baseline

Ran gap, variance, and matrix analysis against the three families of manual artifacts — master rotation, availability, and assignment sheets — reconciling 100+ functional and business requirements spanning leave, sick, disability, and shift-rule entitlements, and making the distance between today's process and a buildable target state explicit before any vendor work was commissioned.

Framed the decision for leadership

Assessed adoption readiness with socio-technical frameworks, graded change options by information, value, and power, and closed with a recommendation package to senior management: the validated scope, the implementation risks, and the conditions required before build.

04 Outcome

The hospital avoided entering customization with undocumented rules, unresolved stakeholder assumptions, and unclear adoption risk. Leadership gained sufficient confidence to proceed with a defined scope and understood implementation risks: a validated baseline of 100+ requirements, built from 20+ interviews and facilitated workshops across a hospital of 20+ departments, with the gap analysis and change-readiness view delivered before implementation expenditure was incurred. The named deliverables below were handed to senior management as the decision package.

KEY DELIVERABLES	WHAT IT GAVE LEADERSHIP
Functional Requirements Specification	**What the integration must do — validated**
Business Requirements Specification	**The workforce rules, reconciled across six employment types**
Gap Analysis Report + Variance Analysis Matrix	**The distance from today's manual process, in scope terms**
Change-Readiness Assessment + change options	**Whether the organization could adopt it, and how**
Executive Recommendation Package (incl. high-level project plan)	**The decision: scope, risk, conditions before build**

OUTCOME POSTURE

Leadership got a validated decision foundation before committing customization spend.

The principal implementation risk identified and addressed: automating undocumented, union-disputed rules at payroll scale — incorrect pay, grievances, rework, and a failed build discovered after funds were committed.

05 What this demonstrates

De-risked the build decision.

Leadership received a defined customization scope on validated rules instead of assumptions, before implementation expenditure was incurred.

OFFERED TODAY AS: ADVISORY & DECISION ASSURANCE

Led requirements under union complexity.

Elicited and held the requirements baseline across six employment types and multiple bargaining units, keeping unions briefed so it survived the floor.

OFFERED TODAY AS: BUSINESS ANALYSIS

Reconciled conflicting rules into one buildable baseline.

Brought conflicting scheduling and entitlement rules from three families of manual artifacts into a single specification used for implementation planning.

OFFERED TODAY AS: REQUIREMENTS GOVERNANCE

Evidenced adoption readiness.

Tested organizational readiness with socio-technical frameworks and gave leadership change options graded by information, value, and power.

OFFERED TODAY AS: CHANGE STRATEGY

Packaged the executive decision.

Closed with a recommendation to senior management — validated scope, implementation risk, and the conditions required before build.

OFFERED TODAY AS: EXECUTIVE DECISION SUPPORT

SOURCE ARTIFACTS AND DISCLOSURE

Anonymized for the healthcare context: the hospital, vendor product, and commercial terms are withheld. Figures represent conservative counts derived from engagement artifacts and closeout documentation; the engagement scope was analysis and recommendation, and build outcomes are not part of this record. Drawn from the requirements and gap-analysis deliverables and the closeout report held by the practice.

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