FRONT LINES

Issue One 2007

The Magazine for Manitoba Nurses by the Manitoba Nurses' Union

Long-Term Care

A Specialty Apart

Manitoba Nurses' Union

ALWAYS CARING • ALWAYS A NURSE

Labour 101: Union Information – In a class by itself

Your Employer's Rights to Your Medical Information

Dues Refund Application – It's that time of year again

Front Lines is published six times a year by the Manitoba Nurses' Union. The MNU was founded in 1975. Today it remains an active member-driven organization dedicated to meeting the needs of its members. Approximately 11,000 nurses province-wide belong to the MNU. That's 97% of unionized nurses in Manitoba.

"To Care for Nurses is to Care for Patients"

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Front Lines

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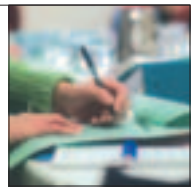

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President's Message

What's Wrong With Long-Term Care?

MNU President,
Maureen Hancharyk

There is a lot wrong with Long-Term Care in Manitoba according to the nurses who work in facilities throughout our province. Since last year's AGM we have spoken with most of our Long-Term Care nurses across Manitoba either through independent research, focus groups or mail-in survey. The response from nurses was overwhelming. We received more than 700 responses to our mail-in survey, spoke to more than 500 nurses through telephone surveys conducted by an independent research company and met with nurses throughout the province. We also held a 75-person focus group at last fall's labour school.

The results of our research have been documented and have been developed into a report which will be presented to the Minister of Health. We began an aggressive lobbying campaign following the AGM. Meetings were held with the Minister of Health and a number of senior government representatives throughout the summer and fall to press for improvements to the Long-Term Care system in Manitoba.

A joint union/government/employer committee has been established to look at the staffing guidelines with a view to recommending changes. The guidelines currently in use were established in 1973. Since those guidelines were first introduced there have been dramatic changes in Long-Term Care. Nurses now care for patients who may require one-to-one care while still being responsible for 75 and, in some cases, 100 patients on a shift. A nurse in a personal care home may be caring for patients with Alzheimer's disease, post-operative patients, frail elderly and palliative care patients. Nurses report that violence has greatly increased and is exacerbated by the fact that residents with varying conditions are placed together. Putting young disabled patients, together with the elderly, the demented, and the wanderers is not only difficult for nurses to manage, but it creates an unhealthy and potentially dangerous environment for residents. Both nurses and residents become the victims of assault.

As one nurse said in her survey response "Our residents come here to live – not to die." That comment reflects the frustration many of our members feel with their current role in the delivery of care in our current system. Long-Term Care residents are in what will probably be their final home.

President's Message

What's Wrong With Long-Term Care? Continued...

They are dependent upon us for their well being and happiness. Imagine the humiliation of lying in a soiled diaper until someone can change you. Imagine having to get up at 5 a.m. for an 8 a.m. breakfast because there are not enough staff to get everyone ready if they are woken at a more reasonable time. We receive reports of patients being forced to wait far too long for pain medication because a nurse is trying to give meds to 75 patients. How tragic that after so many years of being productive members of our society, our elderly are repaid by being warehoused in these conditions.

Initial reading of the data we have gathered clearly demonstrates that there is a serious problem in our Long-Term Care system. Inadequate staffing and inadequate supplies are critical issues. The lack of supplies is especially critical in private facilities. Nurses told us that they spend an inordinate amount of time trying to get fundamental supplies such as gloves from employers. Nurses report having to hide gloves to ensure that they will have them for procedures that can spread disease. Universal precautions should be fundamental to all facilities, yet some employers refuse to adequately protect staff and residents.

A fact that clearly emerges from the surveys and discussions with Long-Term Care nurses is that they want things to improve not only for themselves as care deliverers, but especially for their patients. Nurses in Long-Term Care are deeply concerned and care greatly for the sick, elderly and disabled in their care.

The MNU is committed to continue aggressively lobbying government to improve conditions in our Long-Term Care facilities. We are, so far, encouraged by their willingness to work with us to deal with this issue. MNU members will be kept informed of any and all progress on this issue.

Long-Term Care
A Specialty Apart

The goal of Long-Term Care: To give Elderly and those who are not able to look after themselves a "Home" in which they receive holistic care.

They should receive complete healthcare that meets all of their needs to stay healthy, physically, mentally, and Spiritually. This should not be a facility in which physically and mentally burned out staff are the only ones available to give them care.

Written by
Kathy Chute, R.N.

Staff in Long-Term Care have struggled for many years to give professional, time-appropriate care to an ever-aging, ever-debilitating, increasingly demented, increasingly acute, sector of our population without receiving increased staffing levels to do the work that is essential for the well-being of the Residents. Over the years we have found the population in care homes are increasing in numbers of clients who need more physical care done for them. In the 1970s the average age of a resident was 73; that age has increased to 85. The Residents now have decreased mobility causing an increased number of elderly who are unsteady and prone to falling as well as increasing the need for wheel-chairs and the need for extra care. When I first started in Long-Term Care, as a direct caregiver in 1979, there were more clients who could do some of their own care to meet their physical and psychological needs. As time has gone on and our population lives longer due to better medical care and stay in their homes longer due to improved homecare programs, the needs that are essential to be met by the people around them have increased. The Residents in care homes are in their 90s or even live to 100 and beyond, their children are older and find it challenging to come and visit or to do things to help their parents. With family members working out of their homes more and having increased levels of other community involvement this leaves more of the care needs falling on the shoulders of the staff that work in Long-Term Care facilities. Family members are also more medically informed and need more staff time to help them sort out concerns and questions about the care of their loved ones. There are more new policies being developed to help maintain safety for Residents and staff, putting a heavier paperwork workload on staff.

Long-Term Care has become a multi-dimensional profession in which nurses need to be trained in all areas. Some of these areas include acute diagnoses, caring for Residents with some form of dementia, care plan implementation to keep Residents active and thus healthier, integration of Residents with physical and mental challenges, new policy implementation to keep up with standards, medications that are appropriate for elderly, interpersonal relationships with many different personalities that are set and unchangeable, and superior organizational skills. Long-term care Nurses do all of these tasks without new equipment, sufficient staff, sufficient supplies, and proper medical support staff.

A Resident returning within 24 hours to a personal care home from hip surgery for a broken hip needs constant monitoring for complications. A nurse looking after medications, treatments, personal care, and keeping 10 other Residents with some form of dementia settled so as not to harm themselves or others has a very difficult time to do all of these tasks in a time efficient manner.

The fact that an elderly person with an infection knows they feel unwell but can't tell staff their symptoms due to the fact that the infection has affected their mental functioning puts the onus on staff to notice the changes in the resident and call upon their knowledge of signs and symptoms. Is this a general decrease in functioning due to aging, a chest infection, a urinary tract infection, an eye infection, elderly onset diabetes, congestive heart failure, or any other of the myriad diagnoses that afflict the elderly? A doctor does not visit the personal care home every day, trusting that the nursing staff will be able to assess the Residents and call the Doctor when an acute crisis happens. The Doctors do visit on a weekly or bi-weekly basis and assess the Residents with medical problems but the Nurses must assess which Residents need to be seen prior to this visit and put them on the list to be seen along with an explanation of why. After the Doctor does his rounds and leaves orders for 5-30 Residents, Nurses then have to process the orders, inform the pharmacy of changes, inform the families of changes, inform other staff of changes, make appointments, make sure the care plans are up-to-date, and keep the Residents aware of the Doctor's orders so they remain involved in their care. An elderly person needs Nurses to keep them informed because they are not as medically informed as younger patients that have access to medical information. We are the eyes and ears of the medical staff along with being the ward clerks, and personal informants for families and Residents.

Nurses in personal care homes are frequently called upon to give meds to 25-38 residents on a med pass. When giving medications the guidelines say medications should be given within one half hour of the time they are ordered for but when giving out medications to this many residents it can take up to two and one half hours on a regular basis so we know we are not meeting the guidelines. Residents with physical and mental disabilities are not able to take their medications quickly and the nurse needs to have time and patience to be successful in helping the Resident maintain

their medication regime. With all the illnesses that can occur for Residents on a regular basis, the nurse is frequently approached by other staff to make decisions on problems, thus the nurse's attention is not fully on the medication pass and this creates a situation that can cause medication errors and affecting the safety of the Residents.

Without staff to do the extra work, all of the needs of our clients are not being met. Nurses' time is being taken up trying to keep up with the policies, family concerns, paperwork and organizing increasing workloads. Nurses do not have as much time to do direct care and do their physical assessments that are needed to observe the changes in Resident physical and mental health. We are unable to catch acute problems as early and mental health deterioration that causes care problems. This leaves our Residents at risk for prolonged illnesses that contribute to increased needs for medication and hospitalization, for decreased personal care, and for abusing staff while Resident care is being done because they no longer understand what is happening due to their decreased mental functioning. Staff are unable to take the time to spend with each Resident every day that would help the Resident feel like an integral part of their environment and maintain their mental health.

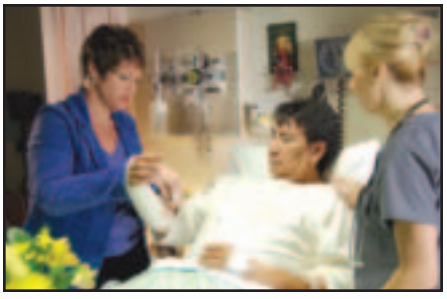
This does not only contribute to negative impact on the client, it also contributes to physical and mental burnout of staff. As staff members become burned out it affects the level of care that is given and the strain on healthcare increases due to the fact that the clients are sent to acute care facilities more often and the staff need more healthcare.

Long-Term Care Facilities and Staff have long been thought of and treated as the "second cousins" of the healthcare system. Last in the list of Facilities that need updating, last in the list of Staff that need to be informed, last in the list of Facilities that need the guidelines changed. Long-Term Care has become "A Specialty Apart" and needs changes that will help the healthcare system function more efficiently with more educated staff to do the essential work of this specialty.

The Staffing guidelines for Long-Term Care were developed in the 1970s, when the care given to a Level III Resident and a Level IV Resident was close to the same amount of work. As the amount of care needed for each of these levels has increased, the guidelines which determine the actual Resident's level has not changed. Each year as the levels are assessed, the same, outdated guidelines are used, which no longer accurately describe the amount of time and care needed for each Resident at any level.

As times have changed and the level of care for the Residents in personal care has increased the time to re-evaluate the tool used to assess residents and increase the level of staffing to Long-Term Care facilities has come. A re-evaluation and Policy update would benefit this area of healthcare in many ways. Staff would have time to assess and implement new policies that are instituted on a regular basis, and they would have time to help the Residents stay healthy physically and mentally. In the long run, these changes would help our Elderly live comfortably and happily in a caring "home" environment. Staff would be able to perform physically safe and personally fulfilling jobs, and provide more effective care. Residents would remain healthier in their own "home" with less staff and less medication, due to reduced physical and mental stress. As a result, W.C.B. claims, and acute care and mental health care costs would decrease. Our Elderly have supported "Healthcare for all" throughout their lives, and it is time for that healthcare system, that they now rely on, to give them all the support they need to live the last chapter of their lives in a comfortable, caring, supportive environment.

Public reaction to the television advertising we did during the holiday season was very positive. The ads reminded the public that nurses continue to provide care 24 hours a day throughout the season. Provincial office received a number of calls from the public and nurses supporting the campaign. MNU Vice President Sandi Mowat is shown providing technical advice during the shoot.



BEHIND THE SCENES

LABOUR 101

Irene Giesbrecht – Director of Negotiations, Manitoba Nurses' Union

The course covered labour's history, including specifically MNU's history, labour terminology, importance of solidarity, legal and constitutional requirements, and MNU's objectives including the major activities to achieve those objectives.

This course in basic unionism is designed for members who are very new to the Union or for those who have not been active in the Union. The course covered labour's history, including specifically MNU's history, labour terminology, importance of solidarity, legal and constitutional requirements, and MNU's objectives including the major activities to achieve those objectives.

It will equip new members or previously inactive members with the tools to be active, knowledgeable participants in their Union.

25 students took part in this class, of which the majority were first-timers to Labour School and most had not been activists. There was also a healthy mix of new members (recent grads) and more seasoned nurses. The interest in the history of the Union was a pleasant surprise. Often we hear the nurses of today are only interested in what is happening currently, not years ago. However, in this case, there was genuine interest in where we came from. The students believed that one can learn from the past and that the nurses of today must celebrate the MNU victories over the past 35 years.

One afternoon, we had a brainstorming session on practical ideas to assist in increasing union involvement and increasing attendance at local meetings. This was met with enthusiastic response!

The students listed many ideas which they believe would encourage more involvement and excitement in the Union. The students believe they can make a difference and were eager to tackle the challenges. Many indicated they would personally strive for elected office or assist the already elected in any union related activities.

The concluding part of the class was on solidarity and the importance of it. The students learned that solidarity is more than a word, it is a commitment. A commitment to be there when your sister or brother needs you. To be there when things are not going so well, as well as when they are.

The following question arose: Can solidarity alone resolve all workplace issues? Of course not. But unless we present a unified front and confront them, our chances of success are greatly reduced. We must fight to preserve jobs and benefits at all costs. Those that came before us fought hard to attain these jobs, rights and benefits. We are the custodians of their work. So, we must put self-interest aside and concentrate on the greater whole. Make the Union's issues your issues.

The class was very interested in the 1919 Winnipeg General Strike video and the solidarity evident at the time. As well, the MNU 1991 Strike Video evoked strong feelings of admiration for the solidarity evident on those nurses' picket lines in frosty January 1991.

This class was stimulating and a pleasure to facilitate.

The Duty to Accommodate

EMPLOYER'S RIGHT TO MEDICAL INFORMATION

Key Points to Remember:

Glenda Doerkson
MNU Labour Relations Officer

1. By virtue of the employer/employee relationship the employer has the right to seek confirmation of illness whether or not there is any wording in the Collective Agreement concerning the provision of medical notes or certificates. The key is that the employer is only entitled to medical information to sufficiently answer the question as to whether or not the individual should be away from work and nothing more. This concept comes from the principle that an employer can only intrude upon the privacy of an employee if it has a legitimate business purpose tied to the employer/employee relationship which justifies the intrusion.
2. Broadly speaking, there are three circumstances under which an employer is entitled to medical information about an employee:
   a) To verify that time away from the workplace was due to illness
   b) To prove eligibility conditions are satisfied for disability benefits (including sickness benefits)
   c) To facilitate accommodation of a disability
3. The employer is entitled to a general statement as to the nature of the illness from the doctor but the doctor is not required to provide a specific diagnosis. For example, the doctor should say "stress related leave" and not "patient suffers from depression with suicidal ideation".
4. The employer is entitled to know whether a treatment plan has been prescribed by the doctor and whether the patient is following it.
5. The employer is entitled to ask and be advised as to the doctor's prognosis for assessing when the employee may return to work.
6. Where it is contemplated that the employee may have some restrictions on return to work, either temporarily or permanently, then the duty to accommodate requires the employee to disclose medical information in order to allow the employer to assess the employee's ability to assume job duties or to allow the employer to modify job duties to accommodate any ongoing disability.
7. When an employer receives medical information about an employee there is an implied obligation that the employer shares that information with only those on a "need to know basis".
8. The Union's role in the duty to accommodate process may require it to get involved in the provision and sharing of the employee's medical information to determine such questions as extent of disability, length of disability, restriction on job duties, etc.
9. There is no duty on the employee to submit to an independent medical examination or a medical examination with the "company doctor" unless it is in the Collective Agreement. (Note: Article 3701 of the MNU Collective agreement allows the Employer to require a medical examination at the employer's expense.)
10. The employee should never let the employer have direct access to their doctor/health practitioner in writing or by telephone. The Union can be of assistance to the employee in channeling the appropriate questions to the doctor and asking for a report.
11. Whether or not the employer is using an outside consultant to manage its sick program, the information that the employee must require is the same.
12. If, however, the sick leave is being paid by an insurance carrier, there may be provisions in the insurance contract that require greater disclosure to the insurance carrier. Be aware, however, that the insurance carrier does not obtain the employee's consent to provide all of that extra information back to the employer.
13. As to who pays for the medical certificate, look to the Collective Agreement. If there is nothing in the Collective Agreement then at common law the employee probably has to pay for the certificate. Unions should try to negotiate something into their Collective Agreements requiring the employer to pay when it seeks a medical certificate. (Note: MNU members are responsible for costs related to obtaining a medical certificate.)
14. An employer who demands that a particular employee provide sickness notes or medical certificates "for all future absences from work" may be discriminating against the employee and/or imposing discipline without just cause.

MNU thanks Garth H. Smorang, Q.C. of Myers Weinberg L.L.P. for allowing us to print these notes from his presentation at the Mel Myers Labour Conference entitled *Employers Who Like to Play Doctor: Protecting Worker's Health Information.*

Preparing to Bargain

The Provincial Collective Bargaining Committee met in November of 2006 to begin preparations for Central Table Bargaining which will begin later this year.

The committee met for two days during which they reported on the conditions in their regions and worksites and the status of nurses' union bargaining throughout the country. The committee also received reports on settlements of other unions in the healthcare field.

In discussing strategy for the upcoming round of bargaining PCBC, Chair Maureen Hancharyk told members of the committee that each set of negotiations is unique and, as such, strategy must often be modified as the process unfolds.

"We know that the next round of bargaining will be very challenging. They all are. The environment in which we will be negotiating this fall will include, possibly, a newly elected government and an ever-worsening nursing shortage. These factors will greatly affect our strategy at the table," she said.

"Each time at the table is completely unique. The only thing that remains consistent is the support of our members. It is because of that unwavering support that we have achieved 45% in wages and benefits in the past two rounds of bargaining."

The committee began it's work several months ago by studying the collective agreement to ensure they know each and every article and the strengths and weaknesses of the collective agreement.

Research for Bargaining

Over the next few months, members will be extensively researched in terms of their bargaining priorities. In addition to local and regional meetings to put forward bargaining priorities, members will receive individual mail-in surveys to put forward their ideas. An independent research company will also conduct a phone survey of a significant percentage of our members. Labour Relations Staff will also meet to put forward any issues they see through working on a day-to-day basis with the collective agreement. Their expertise will play a significant part in the development of proposals.

A Bargaining Conference will be held June 20th in Winnipeg. Presidents from each Local/Worksite will attend as well as Board members and PCBC.

The PCBC is scheduled to meet in February, 2007 to continue the process of preparing to bargain.

PCBC Members are:

Assiniboine – Karen Taylor
Burntwood/Nor Man/Churchill – Darlene Jackson
Parkland – Donna Prokopowich
Central – Cynthia Hunter
Eastman – Renate McGowan
Interlake – Kathy Nicholson
St. Boniface – Deborah Mintz
Misericordia/Riverview – Karen Terlinski
Brandon – Wanda Zolinski
Wpg Long Term/Community Care – Madeline Graham
Grace/Victoria – Kim Swanson
Concordia/Seven Oaks – Mary Lakatos
Health Sciences Centre – Lana Penner

Pension & Benefits Corner

Bob Romphf, Labour Relations Officer – Benefits

SICK LEAVE OF ABSENCE (LOAs)

MNU members often go on Leaves of Absence (LOAs) and forget to make arrangements for paying their Benefit Premiums while on various leaves. It is imperative members arrange for payment with their Human Resources Office prior to taking the leave.

The following information from HEBP outlines this. If there are questions, do not hesitate to contact your H.R. Department or HEBP at 1-888-842-4233.

Maintaining HEBP D&R Coverage During a Sick Leave of Absence

A member on an unpaid, sick leave of absence (LOA) must pre-pay Disability and Rehabilitation (D&R) premiums for the entire 119-day Elimination Period, and may pre-pay premiums to maintain coverage for up to one year.

The terms of the D&R Plan require that D&R coverage be maintained during the entire 119-day Elimination Period while on sick LOA. If D&R premiums are not paid, D&R coverage will terminate and the member will not be entitled to D&R Benefits.

During a paid, sick LOA, D&R premiums are paid through payroll deductions when sick pay is issued. If all sick hours are used, pre-payment of D&R premiums must be made for the remaining portion of the 119-day Elimination Period.

Premiums for the D&R Plan are currently 2.3% of a member's gross basic earnings. To maintain D&R coverage while on an unpaid sick LOA, the member is responsible for the 2.3%.

If a member is unable to pay the full amount of premiums in advance, post-dated monthly cheques, made payable to "HEBP D&R Trust Fund" will be accepted. Employers are to forward the cheques to HEBP along with the completed LOA forms which have been signed and dated by the member and the employer representative. The forms are available in the Forms section of the HEPP/HEBP website at www.hepp.mb.ca, or by calling the HEPP/HEBP office at the numbers listed at the end of ths article.

The Member's Responsibilities Prior to and During a Sick Leave of Absence

- Notify the employer immediately regarding a sick LOA and obtain approval for the LOA.
- Meet the employer to discuss the terms and conditions of pre-paying D&R premiums during the sick LOA.
- Review the Benefits Plan Pre-payment Instructions and Forms booklet with the employer.
- Complete and sign the LOA forms and ensure that the Employer Representative signs the forms.
- Ensure that D&R premiums are paid throughout the entire Elimination Period. Arrange pre-payment of premiums if there are insufficient sick hours to cover the entire 119-day Elimination Period.
- Post-dated monthly cheques will be accepted if a member is unable to pay the full amount of premiums in advance, but the decision to pre-pay must be made when applying for a sick LOA, not after the leave has commenced.

For more information about maintaining D&R coverage and paying premiums during a sick LOA, contact your employer or an HEPP/HEBP Benefits Administrator at 942-6591 or toll-free at 1-888-842-4233 (outside Winnipeg).

P&B – 2006 Review

Retirement in a Nutshell Seminar

The 2006 Retirement in a Nutshell Series across the province was a huge success and we got tremendous feedback from members. I would like to thank all the local/regional contact members who helped and all the support staff at the Provincial Office who enabled us to deliver this program.

Benefit Basics Seminar

The new Benefit Basics Seminar started off well this fall with many Locals/Regions taking advantage of this new program. The Seminar provides orientation and information on key aspects of the HEPP Pension Plan, HEBP Disability, Life, Dental, and Health Plans. The program also covers the Provincial EAP, MNU LEAP Plan and Federal Benefits. All Locals/Regions who have not taken advantage of this Seminar are encouraged to do so by calling Bob Romphf at the Provincial Office.

The Brandon Mini-Labour School

The Brandon Region holds a Mini-Labour School every year and this year the school was focused on Benefits and Retirement with information focused on both younger and older nurses. We produced a four module program including Benefit Basics, Retirement in a Nutshell, Introduction to Financial Planning with Brian Cottom CFP as well as Conflict Resolution and Reducing Stress in Your Workplace with Melody Foster RPN and counselor for the EAP Program. Member feedback was very positive and a big thanks to Val Wotton, Cathy Jensen and all the Brandon and Assiniboine members who participated.

Update On Disability And Rehab

Most members are aware the disability plan changed from the old LTD plan to the new Disability and Rehab Plan in 2002. Since that time the big focus of the plan is on early intervention and rehab. This change has enabled the plan to be substantially more successful in helping members return to work as well as putting the plan in a more stable financial position. If you go on disability you should expect to be contacted for initial assessment and development of a rehab plan very quickly.

Looking Out to 2007

Members are well aware that 2007 is a bargaining year – with pension inflation protection (COLA'S); employer financial participation in Group Health; employer paid D&R; along with much-needed improvements, as the emerging issues. Obviously, these are subject to overall member priorities and discussion with PCBC. It should be an interesting year.

ACROSS

British Columbia

WILL PRIVATE "ER" WORSEN CONDITIONS?

Nurses in British Columbia are concerned a plan to establish a private for-profit "emergency room" in the centre of Vancouver will make problems at the city's existing hospital emergency wards even worse. The for-profit scheme by the False Creek Surgical Centre threatens to draw nurses and doctors away from already understaffed hospital emergency wards, while patients who are found to need hospitalization will be forced onto the doorsteps of hospital emergency wards anyway.

"This plan is causing our members real concerns," says Debra McPherson, president of the BC Nurses' Union. "Quite apart from any violations of the Canada Health Act, to open and advertise a private for-profit emergency room poses real problems to the quality of care patients may expect to receive."

McPherson says "there are vacant nursing positions in hospitals throughout the Lower Mainland. By hiring nurses to its own ER, the False Creek Surgical Centre is going to exacerbate the staff shortages. For most patients who need service in an emergency room, this scheme can only make the situation worse."

McPherson says the solution is to provide more appropriate long-term care and community care for seniors, and expand capacity in the public system through community health centres that are open 24/7, staffed by doctors, nurses, and other heath care providers.
(source: http://www.bcnu.org)

Alberta

SMITH RE-ELECTED AS UNA PRESIDENT

Heather Smith was re-elected provincial President of the United Nurses of Alberta at the nurses' unions convention in Edmonton. Chandra Clarke, a nurse from the Edmonton Grey Nuns Hospital, was also nominated for President.

"I'm honoured to continue representing nurses," Heather Smith said when the results were announced. "Our members are confident in their union as we face a trying time for nursing," she said. "The shortage of nurses, the workload, stress and extra hours working is taking a toll on our nurses. And we are going to work through our union to try to solve these serious problems"

In her speech to the members, Ms. Smith noted that the upcoming provincial negotiations will have to directly confront the issues of the shortage, retaining and recruiting nurses. "We have to solve these problems, and we will," she said.

Nearly 700 nurses, observers and voting delegates were at the convention held at the Agricom in Edmonton.

Saskatchewan

NURSES' REPORT TO COMBAT SHORTAGES

The Saskatchewan Union of Nurses (SUN) is in the midst of a campaign to bring attention to the ongoing shortage of nurses which is crippling the province's healthcare system. Presenting evidence from nurses is a major part of the strategy. "Recruiting more nurses to Saskatchewan is only half of the battle. We need to retain the wealth of knowledge and experience we have in our nurses," points out Rosalee Longmoore, SUN President. "Who better to ask than the nurses themselves? So, we went to our members and asked them what their concerns were and what they would recommend to keep them here in Saskatchewan."

Throughout November, SUN has presented the Minister with information concerning the vacancies in the province, issues the nurses face on a daily basis, and what the nurses believe will keep them working in Saskatchewan. "SUN wants to make sure the Minister of Health is aware of the barriers and solutions to nursing retention and recruitment. At the beginning of November we provided the Minister with the comments, concerns and solutions from our members working in the Emergency Departments in the province," said Longmoore. "Today's presentation focused on the intensive care (ICU), critical care (CCU) and surgical departments."

Nurses are the single largest group of health providers in Saskatchewan and they play a critical role. "We need to rebuild our degraded professional practice environments, we need to say to nurses "We respect and value what you do, and we want you to stay". We need to translate those words into action and commitment, supported by a major financial investment," commented SUN President. SUN remains committed to working cooperatively with all stake-holders, including governments, employers, nursing colleges, patients and the public, to ensure that the health needs of our population are met.

CANADA

Information and issues from across the country

Ontario

NURSING HOMES SETTLEMENT REACHED

The new three-year agreement for Ontario Nurses' Association (ONA) nursing home members includes an increase of 10.75% and some health and welfare benefit, premium and vacation improvements. The agreement covers approximately 1,200 registered nurses who work in nursing homes in the province.

"ONA focused its negotiation efforts on the issues our members told us are their priorities," said Linda Haslam-Stroud, RN, ONA President. "Member research revealed that wages and benefits improvements were priorities, and we are pleased that a contract could be negotiated with representatives from the province's nursing home sector."

Further details of the agreement were discussed with ONA Local Coordinators and Bargaining Unit Presidents in Toronto on November 3, and ONA members held ratification votes during the week of November 6.

ONA nursing home members voted overwhelmingly to ratify the agreement.

New Brunswick

NBNU CAMPAIGN PROMOTES NURSING

To help educate potential nurses and the public about the rewards of becoming a nurse, the New Brunswick Nurses Union (NBNU) has launched a major media and information campaign. Its purpose is to communicate the positive attributes that keep New Brunswick's 6,200 NBNU members on the front lines of healthcare every day.

The campaign's slogan, "Choose a Career in Caring. Choose a Career in Nursing", reflects the reality that anyone wanting to make a positive contribution to the community should consider becoming a nurse.

"It's no secret that the nursing profession is under pressure from declining numbers and major recruitment and retention challenges," says Marilyn Quinn, president of the NBNU.

"Within 10 years, 49% of our nurses will be eligible for retirement. The NBNU is committed to ensuring that New Brunswickers don't suffer the effects of the shortage of nurses in the near and distant future."

Traditionally, most nurses come into the profession thanks to the advice or mentoring of a relative or close friend. The NBNU wants to provide that insight and support to everyone. "Our members know that nurses continue to be one of the most important professions which keep our province's citizens healthy, and that becoming a nurse is one of the most satisfying life choices a person can make," says Quinn.

The NBNU will be using TV and newspaper ads, a promotional video and a new section of its website to support the campaign. The video, along with other material, will be circulated to New Brunswick high schools, educational institutions and other strategic locations.

"We want New Brunswickers to understand that being a nurse is a challenging and rewarding career option," declares Quinn.

Nova Scotia

N.S. USING PRIVATIZATION SCARE TACTICS

The Nova Scotia Nurses' Union (NSNU) is outraged by statements made by the Minister of Health, Chris D'Entremont, who once again raised the issue of privatization of healthcare. The Health Minister says he's drafting a white paper on the delivery of healthcare in the province and is again raising the possibility of more privatization.

The NSNU maintains that the last thing Nova Scotia's taxpayers need is another study on the topic. "I could not believe my ears when I heard his comments. What about the Romanow report and those recommendations? Clearly the Minister is forgetting that Canadians said they cannot afford a private health care system," says Janet Hazelton, President of the NSNU.

The NSNU also contends that the timing of the Minister's comments is highly suspect considering that a province-wide healthcare strike is looming.

Hazelton says that every time there is a crisis in healthcare, this government starts talking about instituting more user-pay fees, creating a public panic. What she would like to see the government do is use the current healthcare resources more efficiently, better utilize health human resources, and put an end to this on-going, and threatening debate.

"The large majority of the stakeholders have already spoken and the message was loud and clear – we do not want an American-style system. It is extremely discouraging that we are talking about this yet again when we should be focused on the bigger picture. We should fix what we now have but not on the backs of our population's sick."

Continued...

ACROSS CANADA

Information and issues from across the country

Prince Edward Island

NURSES RATIFY COLLECTIVE AGREEMENT

Over 800 Island Nurses turned out on Thursday, September 21st, to vote on the tentative contract. 64% voted in favour of the new deal.

Nurses will receive a wage increase of 8.75% over three years, putting them on par with all nurses in Atlantic Canada. Maternity/parental leave top-up benefits have been introduced. The new contract also provides for compensation for perceptorship/mentorship when a Senior Nurse partners with a new nurse to assist them in becoming comfortable in their new profession. For the first time, the Union's contract language includes the new Nurse Practitioners.

Union President, Margaret Duffy stated "It was with guarded optimism that we counted the votes as they arrived at the Union Office last night."

Approximately 200 nurses crowded into the Dutch Inn last Monday evening to voice their discontent over the tentative agreement. Senior Nurses lined up to express their frustration with their working conditions. "We clearly heard that nurses do not feel appreciated for the amount of work they undertake on a daily basis due to the nursing shortage," stated nurse leader, Margaret Duffy.

The Nurses Union's negotiating team had recommended acceptance of the new contract to its members. "We are hopeful that improvements to benefits and wages will assist in recruiting new nurses to the province and this will hopefully ease the heavy workload of the nurses in the system." stated Duffy.

The new contract will be retroactive to April 1, 2005 and effective to March 31, 2008.

Newfoundland and Labrador

TENTATIVE AGREEMENT REACHED

The Newfoundland and Labrador Nurses' Union (NLNU) reached a tentative agreement with government recently. "After many long months of negotiations, we are pleased to have reached a tentative agreement," says Debbie Forward, NLNU President. "It has been a long, arduous process and we are pleased to have made improvements in our contract. Our negotiating team worked very hard to achieve a successful conclusion to this round of bargaining."

Under the terms of this tentative agreement, the premiums paid to nurses for evening, night and weekend shifts will be increased for the first time in over a decade. Both the night and evening premiums will be increased to 72¢/hour (currently 33¢/hour), and weekend premiums will be increased to $1.25/hour (currently 28¢/hour), effective June 30, 2008.

"Increasing premiums has been among our members' top priorities for a number of years now," says Forward. "We have been the lowest in the country for many years and this increase is a positive step forward. The increase during a period of wage restraint is particularly satisfying."

The tentative agreement also includes a commitment to commence a healthy work-place pilot project. The project will involve government, the NLNU and an employer to explore solutions for creating a healthy workplace and reducing nurse absenteeism in a single work unit. "We have maintained our position that creating healthy workplaces is a proactive solution for reducing nurse absenteeism," says Forward. "This pilot project enables us to identify causes and implement solutions that will keep nurses healthy. We are hopeful that this pilot project will be successful and that we will be able to expand it to other worksites."

In addition to the premium increases and the commitment to a healthy workplace pilot project, the tentative agreement also includes:

- A 0-3-3% wage increase, with 0% retroactive to July 1, 2005; 3% effective July 1, 2006; and 3% effective July 1, 2007;
- A reduction in sick leave for new nurses, to 1 day per month, effective December 1, 2006;
- A lump sum investment of $325,000 in the Educational Leave Fund;
- A commitment to a new classification system;
- Improved language on flexible schedules;
- Contract to expire June 30, 2008.

"During this round of negotiations, I believe that both the NLNU and Government have had to make some compromises. I am pleased with the improvements gained in this contract and will be recommending this agreement be accepted by our members," concludes Forward.

VICTORY DOES NOT ALWAYS MEAN REINSTATMENT

Allan Rosky, Labour Relations Officer – Grievance & Arbitration

A nurse nearing retirement was initially suspended, and shortly thereafter terminated for violating an employer policy which specified that employees were not to accept "gifts" from their patients. Although a nurse/patient relationship had existed between the nurse and the applicable patient at one point in time, such relationship had ceased to exist several years earlier when the nurse was reassigned to a new position with the employer. The nurse was a long service employee with an excellent work record and no previous history of discipline on her personnel file. In due course, a grievance was filed by the nurse alleging termination without just cause.

The grievance eventually proceeded to arbitration. However, on the day set for the arbitration hearing, counsel acting on behalf of the employer requested to meet privately with union representatives prior to commencement of the arbitration hearing to try and resolve the issue(s) in dispute. While the discussions between the employer and the union took place, the arbitration board sat and waited. The understanding was that if the parties were unable to resolve the grievance through discussion, the arbitration hearing would then commence, albeit a few hours late.

A settlement was eventually reached through discussion between the parties and the arbitration board was asked to issue an award as consented to by the parties. The hearing as a result was a short one.

There is no doubt that the position of the nurse was significantly improved as a result of the grievance filed by the Union on her behalf. For example, all reference to the suspension and termination of the nurse were removed from the employer's records. Since the nurse had been contemplating retirement for some time prior to the date of her termination, she agreed to voluntarily retire from her position as a nurse and the employer's records were amended to reflect same. This, in itself, was a victory for the nurse. She did not want to end her career with a termination on her record. Although the Union in this case was prepared to arbitrate the grievance if the attempt to settle failed, it is important to understand that a win at arbitration cannot be guaranteed. There is a significant difference between a nurse voluntarily retiring from her position and being forceably removed, against her wishes, from the position. In addition, the employer in this case agreed to pay the nurse a considerable sum of money (in excess of $30,000) designated as a "severance payment" for her many years of service. Such payment could have been lost if the termination of her employment had been upheld at arbitration.

All in all, the nurse and the Union achieved a considerable victory by grieving and being prepared to push the grievance to arbitration if necessary.

All in all, the nurse and the Union achieved a considerable victory by grieving and being prepared to push the grievance to arbitration if necessary. It was especially significant in this case because at the time the nurse was terminated, the employer was not prepared to do any of the things that it was later forced to do.

Many grievances such as this one are resolved prior to the arbitration hearing. Sometimes settlements are not reached until the "11th hour" (the eve of, or morning of, the arbitration hearing).

Workplace Safety and Health

Your Right to Refuse Dangerous Work

Workplace safety and health is everyone's concern and everyone's right.
You can refuse dangerous work and your right to do so is protected by law.

HAZARDS IN THE WORKPLACE

At any time in your working life, you may encounter work involving safety and health risks that are not normal for the job. Hazards and dangerous situations should immediately be reported to your supervisor in order to prevent an injury or illness. In most cases, the situation is resolved by eliminating the hazard. If the situation is not rectified, you can exercise your right to refuse work.

WHAT IS THE RIGHT TO REFUSE?

Under the law, (Manitoba's Workplace Safety and Health Act), you can refuse any task that you have reasonable grounds to believe is dangerous to your safety and health or the safety and health of others. (The work refusal is initiated by the worker.)

> *Section 43(1) of the Act states: "A worker may refuse to work or do particular work at a workplace if he or she believes on reasonable grounds that the work constitutes a danger to his or her safety or health or to the safety or health of another worker or another person."*

Remember... you may not be disciplined for exercising your right to refuse in good faith, and you are entitled to the same wages and benefits that you would have received had the refusal not taken place. Your employer may also re-assign you temporarily to alternate work while the situation is being remedied. Stay at your workplace for your normal working hours unless your employer gives you permission to leave.

WHAT IS DANGEROUS WORK?

"Dangerous" work generally means work involving safety and health risks that are not normal for the job.

WHAT ARE THE STEPS INVOLVED?

STEP 1

Report immediately to your supervisor, or to any other person in charge at the workplace, giving your reasons for refusing to work. At this point, the refusing worker and supervisor must attempt to resolve the concern.

If the employer resolves the matter to your satisfaction, go back to work. If you still believe the work is dangerous...

STEP 2

If the supervisor and worker cannot resolve the refusal, the worker co-chairperson of the safety and health committee, or a committee member who represents workers (or a worker representative, if there is no committee), must be asked to help for the purpose of inspecting the workplace.

If the dangerous condition is not remedied after the inspection...

STEP 3

Any of the persons present during the inspection in STEP 2 may notify a safety and health officer of the refusal to work and the reasons for it. The safety and health officer will investigate the matter and decide whether the job situation or task the worker has refused constitutes a danger to the safety or health of the worker or any other worker or person at the workplace.

The officer will provide a written decision to the refusing worker, each co-chairperson, or the representative, and the employer. Anyone directly affected by an officer's decision may appeal it to the Director of the Workplace Safety and Health Division. The Director will make a decision about the appeal, and provide written reasons. The decision of the Director may be appealed to the Manitoba Labour Board.

SAFE WORK

S SPOT THE HAZARD
A ASSESS THE RISK
F FIND A SAFER WAY
E EVERYDAY

Providing a safe workplace is the responsibility of each and every one of us.

Manitoba Nurses' Union
ALWAYS CARING • ALWAYS A NURSE

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for the 2006/2007 Term

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Sandra Mowat, Vice-President
Fern Beasse, Secretary Treasurer

Betty Loewen
Janice McDonald
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Madeleine Graham, Winnipeg Long-Term/Comm. Care Region

Bluma Levine, Winnipeg Long-Term/Comm. Care Region

ARE YOU ELIGIBLE FOR A DUES REFUND?

You may qualify for a refund of the PROVINCIAL PORTION of MNU dues deducted by your employer, if you paid MNU dues at two or more facilities/ employers during 2006. Union dues consist of two components, the PROVINCIAL and Local dues portions. Only the PROVINCIAL portion of MNU dues is refundable.

PROVINCIAL DUES are:
$22.00 per pay period X 26 pay periods = $572.00.

LOCAL DUES, depending upon the Local, range from:
$1.00 to $8.00 per pay period X 26 pay periods.
This amount is NOT refundable.

Example:

You have been deducted $24.77 in union dues in one pay period ($22.00 Provincial portion and $2.77 Local portion – the Local portion is NOT reundable). The Local portion is sent from MNU Provincial Office to your Local treasurer. **If you are paying MNU dues at two or more facilities/employers and exceed $572.00 in Provincial dues, please apply for a refund by January 31, 2007.**

Applying for a refund:

It is your responsibility to apply for a dues refund.

Requests must be **received** in our office **no later than January 31, 2007**.

Applications received **after** this date will **not be eligible**.

Refunds will be issued by mid-April 2007 or earlier.

Apply to Manitoba Nurses' Union:
301-275 Broadway, Winnipeg Manitoba R3C 4M6;
Or apply online: www.nursesunion.mb.ca;
Or apply by email: mnu@mts.net

When applying for a dues refund, indicate your name/ or name change, current address, phone number, nursing registration licence, SIN, and the amount of MNU dues deducted by each employer.

Home Care and Community Health (Public Health) Nurses; please state your office address.

Please Note:

To ensure that your application is received in our office by the deadline, we suggest your request be sent by **registered or certified mail**.

All members receiving a dues refund in 2007 will be issued a T-4A in 2008.

Manitoba Nurses' Union Dues Reimbursement Request

Name/or Name Change: _____

Current Address: _____
(Street)

_____
(City/Town) (Postal Code) (Phone Number)

Nursing Registration/Licence Number _____ Social Insurance Number _____

Places of Employment	MNU Worksite/Local #	Full Time/Part Time	Casual	Total Dues Deducted
1.				
2.				
3.				
4.				
5.				