ONA - Local 100 Newsletter

Representing Members: Canadian Blood Services, Chelsey Park, Elmwood, Extendicare, LHSC (Allied & RN), Meadowpark and Middlesex Terrace

March 2015

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March 23 @ 7:30 p.m.
LOCAL General Meeting:

Budget and Policy review for approval

And a visit from Linda Haslam Stroud, Provincial President Violence Campaign

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Local Co-ordinator Report - Jill Ross

The mark of a New Year begins the work of setting the budget and reviewing the policies for the upcoming year.

However, the work begins much earlier than that, because as the LC, I have to submit by September 30th an education plan for the Local each year. As 2014, was an election year, we needed to take into consideration the election of new local executive, bargaining unit executive members or ward reps to ensure that we have an education plan to meet their needs. We look at trends to see if other education is required to get everyone up to speed. An example would be the increasing problems with mental illness or substance abuse among ONA members and increasing knowledge around these issues is required so we can effectively represent our members.

As it turns out, the results of the election did not see any new local executive members but a new VP of Health and Safety at the LHSC Nursing BU representing the UH site. So all the education we had planned strategically is not required at this time.

In November, as LC, I send out a form to the local executive to identify needs for their Bargaining Unit which can impact the budget. For instance, any Nursing Week or Medical Radiation Therapist events; increase in grievances or changes in the Labour Relations relationship between the Bargaining Units and their employers; attendance at Provincial Meetings or members attending the yearly Health and Safety Caucus in Stratford. The Bargaining Unit Leaders are required to submit that document to me by early January, and then a budget committee meets and develops a preliminary budget based on the requests to take forward to the Local Executive Meeting held every January.

The results of that budget review goes forward to the General Membership meeting for approval by the end of March as per the ONA Constitution.

The budget for the year is a strategic budget based on the revenue coming in from membership for 2015. We have to submit a balanced budget for approval by the membership based on the coming years anticipated revenue. That revenue is received from Central monthly based on the number of members within the Local. For the purpose of setting the budget, we use the membership numbers we have at the end of the previous year. So for 2015, we use the final numbers from December 2014.

That anticipated revenue can change as it did last year as we took on 40 members from the LHSC Educators and LHSC hired a number of nurses over the last year. It can also change if we lose members through lay off or retirements. So when we show the members at the general membership meetings the budget in March, the revenue may be different than the actual amounts we show you at the December meeting.

Just as you do at home in setting your budgets, you anticipate the best you can but something unexpected may come up that you did not budget for or costs were higher than anticipated. That happens with us as well so the budget we show you at every general membership meeting, may be over in some areas but we have come in way under in other areas.

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We report the variances at every general membership meeting. In my experience, at the end of the year, we come in under budget. At our preliminary budget meeting for the coming year, we look at the previous budget and look at items that we over estimated and those that clearly were not enough and adjust those amounts.

As required by the ONA organization, our local financial policies are based on the Provincial Financial Guide. We are required to have a yearly audit done and submitted to ONA Central by the end of March. Our audit is done by Collins Barrow which is a prominent accounting firm in London. Our audits have been clean with never any suggestion of irregularities and in fact, the auditor is required to submit a document along with the audit report confirming that nothing was found to lead them to believe that any suggestion of fraudulent practices were evident after reviewing our budget along with our local policies. ONA Central reviews our audits with a fine tooth comb plus they review our monthly statements. Monthly we have a process where the entire local executive has to review all the statements and send an email response to the treasurer and myself stating they have reviewed the documents and any questions arising our dealt with.

I explained that the budget we set is based on the anticipated revenue for the coming year. That budget does not take into account the monies saved from previous years. The statements that we provide you do indicate the current financial picture for the local. We have the anticipated revenue from our 2015 membership dues from ONA Central and our local dues levy. We do have some GIC's, low risk investments and some revenue remaining from previous years that we refer to as our contingency fund. In this current climate, we need to be prepared for anything. The March membership meeting is also the time the membership provides input and approves policies followed by the executive. Policies are a work in progress and based on issues that may have come up over the previous year, the local executive amend policies to match the trends or to provide greater clarity.

Provincially, many locals report an increasingly challenging labour relations environment. Local 100 is no different and no bargaining unit is spared. Grievances are not being resolved and many, many go on to arbitration. There is increasing concern about the potential for layoffs as the hospital has to trim their budgets. Twice in the last 6 months, the bargaining unit was prepared to pull me from my assignment to work through the Ebola issues and again with the issues on mental health. The employer stepped in and paid for my time but the world of health and safety is just as challenging and fluid as the labour relations world and there may again be time in the future that the bargaining unit needs to free me up to do what we need to do to advocate for our members safety. We do our best to anticipate the needs for the coming year at our budget day but who knew last January that Ebola would be front and centre. For those reasons, we need to maintain those contingency funds.

Last year we promised to review the local levy this year and we are prepared to have that discussion and take direction from the membership. At the executive table we are becoming increasingly hesitant to make a change based on the current climate but we promised a discussion and we will have that discussion at the March meeting.

There has been a concern come forward about the time of day for the general membership meetings. Concern was expressed that 1930 is not a reasonable time as it does not allow maximum numbers of members to attend. Our meetings have always been held at 1930 for longer than the time I have been at the Local. We have checked in with members who attend the meetings regularly to see if 1930 still works and no one has ever asked for a change. If the majority of members at the meeting in March want a change then we can discuss a more convenient time that meets the majority of the memberships needs.

Thank you to the members that walked the picket line with the CCAC's. They very much appreciated the support that we provided in terms of Tim Cards etc. Each Local was asked to provide $2000.00 to the CCAC strike fund. We were prepared to do that then the strike ended. However, the end of the month was challenging for many when those bills came in so we did submit a cheque to be dispersed to our CCAC members.

I am off to the Provincial Coordinator's meeting today and will have a report back at the membership meeting. See you at the end of the month.

CBS Report: Carol Lobodinzski, BUP

Hello everyone, this will be a short note as a lot of issues are pending. Our upcoming LMM will be devoted to scheduling issues and the DCA initiative implementation which we were expecting but not this soon. Many staff have concerns about seniority and the number of hours that RN's will get once CBS has completed the 3 sessions of training of our phlebotomists to DCA's. These DCA's will be doing the screening which was done by the RN. We hope to have a clearer picture following this meeting. I have arranged to have a meeting at each site- London, Windsor and Sarnia to communicate this information and listen to concerns from members. Check your bulletin boards for dates.

Platelet program has changed it's days and quotas and will now be running Monday, Wednesday, Thursday, Friday and Saturday collecting 6 units each day. For now there will not be collecting on Tuesdays.

Chelsey Park Report: Dianne Popp, BUP

Finally it is looking a little more like summer will come this year! With that comes the summer vacation request sheet. The quota for last year was 1 RN/shift only could be off at any given time. The summer schedule is to be posted by May 1. Please keep your eye out for it and let me know if it isn't posted.

With the change to our contract, I am working on getting scheduled Union/Management meetings quarterly. I am looking for someone to attend these meetings with me. The PRC forms are also discussed at these meetings. We will be discussing at our next meeting, how the time owing bank is going to work. You will be allowed to carry up to 2 days of time owing from times you have had to stay [paid at time and ½] to complete your assignment. You will still have to get this TO approved as before.

Watch for your back pay coming in one of the next pay periods. It has to be paid out by April 4. Make sure you check that it was calculated correctly as Extendicare has a long history of inaccuracies. The hourly rate should be changed on the March 13 pay run and the next raise will come on the 1st full pay run in July.

Please continue to fill out the PRC forms- they are to be completed whenever you feel you have a unsafe work assignment. Please let management know you are completing one-this can be done by leaving a message on the answering machine/ talking to the NOS's or the DRC.

According to the contract, PT & casual staff should be giving your availability to the Employer in writing, for the next 6 weeks, 2 weeks prior to the posting of the schedule. [Article 15:20]

Local Issues ratification vote will be held in April if needed. A copy of our new collective agreement [CA] will be coming in the next few months. Remember this next CA expires June 30, 2016.

Interested in attending a LTC dinner? Please let me know.

Come out to our next Local meeting March 23 were Local Policies/Local budget will be reviewed.

Remember, do not meet with management without union representation. You do have the right to ask what the meeting is about prior to attending [from our newest CA]. If you have an inappropriate encounter with management, please document it and let me know.

LHSC Allied Report: Janice Bell, BUP

I wish that I had better news to share on the negotiations front, but we're still waiting for an Arbitrator. For what it's worth, Phil has offered for the Union to meet with an Arbitrator, based on his/her availability, on a weekend or evening if it means moving up the date. The question is, whether the Employer is willing to do the same!

On February 20, we held our most recent Labour Management meeting, with Scott, Kim Kirk and myself representing the Union and a bit of a change up for the Employer. With Andrew Pearson now on paternity leave, Lisa Haalstra, Krista Morrison, Kim Paton, Lesley and Nissa represented the Employer. There were three issues addressed, but as none of them have been totally resolved at the time of writing this newsletter, we will naturally have to delay sharing the outcome until there is a resolution.

On January 29, United Way held its Annual Labour Appreciation Awards Night for London and Middlesex, at the Goodwill Industries building on Horton Street. By now, all of you are probably aware that Allison Walker won one of those awards presented that evening. Each recipient was introduced individually with a small bio, listing their contributions that made them the worthiest recipient for this award. Allison proved to not only be an outstanding fundraiser for the United Way campaign within LHSC, but we see Allison to have always been a strong advocate for the LRCP Pediatric Program, volunteer for the "Dinner at Our House" program at Ronald McDonald House and volunteer Camp Counselor at Camp Trillium, to mention only a few of her contributions. This award is particularly noteworthy, as Allison was the only recipient out of all LHSC's unionized employees!

On March 2, the "Cuts for Cancer" event, a free wig program for cancer patients, was held in the LRCP Level 1 Atrium. Radiation Therapist and participant Julie Downes organized the event, signing a cheque for the funds raised made payable to the Canadian Cancer Society for a whopping $6,278.00. Now that's a fundraiser! In addition to some participants from other departments within the LRCP, there were many volunteers donating their locks from Radiation Therapy. They included Allison Camera, Julie Downes, Janelle Krug, Kathryne Lee, Meghan McCormick, Helen Simovic, Allison Walker, Julaine Matthews, Brittany Medd, and Jessica Rankin. Thanks of course go to the many hair stylists who donated their time, not only to clip the donated hair, but also to restyle the remaining tresses into works of art.

Finally, on February 20th, we gave our best wishes to Sue Kudirka R.N., as she retired after 28 years of dedicated service in the LRCP. During that time, Sue worked closely with the Radiation Department through her services in Patient Review. Her absence will be dearly felt, but we welcome Marg Vallee R.N., who has already seamlessly stepped into her shoes.

LHSC-VH (RN) Report: James Murray, BUP

The new fiscal year is fast approaching and the hospital is again asking the front lines to bear the brunt of budget reductions. Depending on whom you speak to, the reductions range from 1 to 1.7%.

There isn't any fat left to trim on the front lines, we're now cutting into the meat, and it's going to seriously impact our ability to provide safe, quality patient care!

Occupational Health and Wellness (the name seems a bit ironic now) has decided to change their model of care from a medical based model to a rehab model. That is to say they will lay off 5 Occupational Health Nurses, effective spring 2105, replace them with rehab adjudicators, and eliminate a few more RN positions as they have retired from or left the organization, and replace them with RPN's. We anticipate the organization won't realize savings from the layoffs and skill mix /model changes, we expect the savings will be realized when the rehab consultants begin denying claims for short term disability (sick time), and forcing Nurses to return to work before they are ready. Similar models have been established in other institutions, with detrimental results for the members. The

Union is very concerned with the employer's actions. Long service Nurses are no longer valued for the work they did. Now, more than ever, it is very important that you engage the services of the Union prior to any dealings with Occupational Health. The Union has filed grievances regarding these changes.

Despite the budget reductions across programs, Medicine and Mental Health have decided to increase their senior leadership ranks by creating two additional director positions, and spend hundreds of thousands of dollars on a Toyota Production System. Meanwhile, funding approval for a second Clinical Educator is turned down for the Medicine Program at UH, a program that struggles daily with a disproportionate novice to senior nurse ratios!

Another program impacted by budget reductions is Surgery, OR service reductions of 75% over two weeks in March are forcing Nurses to utilize their vacation or lieu time, or face the prospect of a layoff. The employer has yet to provide the Union with the information required under the Collective Agreement in regard to layoffs, but we anticipate that hundreds of Nurses will be impacted by this dubious cost saving measure, let alone the hundreds if not thousands of patients who have been waiting for surgeries that must now be rescheduled. The employer has been put on notice by the Union that the process they have implemented to meet these staff reductions is in violation of the Collective Agreement, and we expect that many grievances will result because of it. If you have been impacted by the service reductions please call the office asap.

Reminder: Physio benefits for VH Nurses are unlimited. If you are a VH Nurse and have had a physio claim denied, please resubmit to Manulife, and call the Union Office. This unlimited benefit predates the certification UH, and as per Arbitrator McNamee's decision of July 2014, was not awarded to UH Nurses upon certification in 2102.

Negotiations for the new Local Agreement wrapped up last year, and the Arbitration Hearing was completed in late February. I'm hoping we have a decision by early summer. You will be noticed as soon as we receive the decision.

Grievances numbers continue to increase with the number of grievances last year (approx. 70) exceeding the previous years record numbers. When you compare our grievance numbers with other Locals across the province, who have several hundred grievances on their books, our numbers seem small, but historically for LHSC, our current number is unprecedented. It appears as if the employer has made a conscious decision to not settle any disputes without going to arbitration. Fortunately we continue to be successful at achieving awards or settlements that meet the needs of our members. I can't say that the employers current labour relations strategy is cost effective for them, when they continue to pay a very expensive Bay Street Toronto Law Firm to represent them at each of these grievance arbitrations. I may be just a Nurse, but even I can see that wasting thousands of dollars on lawyers fees, just to be told that you are going to pay that Nurse the 3.75 hrs. of OT that she's entitled to, does not make financial sense. We recently received Minutes of Settlement (MOS) that included the phrase "the hospital agrees comply with article 14.01(a) of the Collective Agreement." This is a big victory for all FT Nurses who agree to work on their scheduled day off, on the pretext of receiving OT, and are then told they will be paid straight time, because; they made a switch during that pay period which reduced their hours below 75, they took a Personal Emergency Leave during the pay period, or an unpaid LOA. As a FT Nurse, article 14.01(a) states, a nurse who is required to work on her or his scheduled day off shall receive overtime premium of one and one-half (1½) times her or his regular straight time hourly rate except on a paid holiday the nurse shall receive two (2) times her or his straight time hourly rate.

The Union has filed a complaint of unfair labour practices against the hospital with the Ontario Labour Board for interfering with the Unions ability to represent our members. This decision was not made lightly, but only after

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serious consideration of the employer's refusal to implement a mediated settlement. We expect to have further information on this matter that we will share with members at the March 23 General Meeting.

LHSC (RN) Attendance and HR&E Report: Kathy Burgess-VH & Margaret VanPuymbroeck-UH, VP's

Over the past several months we have seen an increase in AEM's report dealing with harassment in the workplace. As your ONA Human Right and Equities and Attendance Management VP for UH and VH we are committed to providing you with the information you need to determine if your rights as an employee have been violated. Under the Ontario Human Rights Code, s. 7(2) every person who is an employee has a right to freedom from harassment in the workplace because of sex by his or her employer or agent of the employer or by another employee. The Ontario Human Rights Code definition of s.10 "harassment" means engaging in a course of vexatious comment or conduct that is known or ought reasonably to be known to be unwelcome. Some elements of Harassment under the Ontario Human Rights Code are as follows. In order to successfully prove that an employee has been harassed, contrary to the Human Rights Code, the employee must prove that there was a course of comment or conduct and the comment or conduct was vexatious. The comment or conduct was known to be unwelcome and objectively should have been known to be unwelcome. At times employees are unsure if the conduct meets the definition of harassment. If you find yourself in a situation which could classify you as a victim of work place harassment take the time to write down your narrative and contact the Local 100 office ASAP.

Many Nurses at LHSC continue to be counseled for attendance as they move through the Attendance Management Program. The rolling calendar which does not acknowledge good attendance but captures sick time is causing many nurses to meet to discuss attendance with leadership. The employer is looking at employees with either Culpable or Non Culpable absenteeism. Culpable Absenteeism: If an employee has been absent without medical or other justification. The employer can treat the conduct as culpable and impose discipline and the just cause standard is applied. Innocent Absenteeism: An absence that is due to factors beyond the employee's control such as illness or injury, or a disability as defined in the Ontario Human Rights Code. Under these circumstances the employee is not blameworthy therefore disciplinary action is inappropriate

What is a Disability?

Ontario Human Rights Code definition: Physical, developmental disability, learning disability. A dysfunction in understanding or using symbols or spoken language. A Mental disorder or an injury/disability for which benefits were claimed or received under WSIB.

As your HR&E and Attendance Management VP's we encourage our members to ensure proper documentation from their Health Care Provider to support the claim of a disability. Our employer must be able to demonstrate that the absence is excessive relative to some object. The six step program at LHSC is the employer's way of qualifying what is excessive absenteeism. Where these elements are met, arbitrators have upheld discharge for poor attendance but only where the employer can show it tried unsuccessfully to accommodate the employee up to the point of undue hardship. The employee and ONA must raise the issue of accommodation to trigger the employer's duty to accommodate. We urge our members to be diligent in obtaining proper documentation to support their absence. Employers have the right to monitor attendance. As a matter of fairness the employer must put the employee on notice that her employment is in jeopardy. The employer must ensure they have turned its mind to accommodation and has obtained all of the available information. The requirement to give notice is generally why employers provide non-disciplinary counselling letters at every stage of the AMP. Letters typically identify the sta-

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tus of the employee in the program and discuss ways to assist in improving attendance. The letters often end with a statement stating if the attendance does not improve it may result in termination appointment. Arbitrators have ruled that these letters are non-disciplinary even if the letter threatens termination; and therefore cannot be challenged through the just cause provisions of the collective agreement. Employers are obliged to warn employees about the prospect of job loss in cases of innocent absenteeism. Letters are generally not grievable. This doesn't mean that termination of employment is not grievable.

LHSC (RN) OH Report: Jill Ross-VH/Alan Warrington, VP's

Jill Ross's Report

Violence

For the first time since I have been involved in Health and Safety at LHSC, in the month of November the number of staff reporting incidents of workplace violence has surpassed the number of musculoskeletal injuries. That means the number one reported adverse events was workplace violence. Nurses were the majority of those impacted followed by security.

This unfortunately fits the trend ONA is seeing provincially. At the Biennial Convention in November, ONA was given direction that we need to mount a campaign to push the healthcare sector to put measures and procedures in place to protect our members. Most of the discussion was around the mental health facilities and in fact, charges have been laid by the Ministry of Labour at two facilities recently and ONA is pushing for charges to be laid at a third facility. I cautioned ONA to not just limit the campaign to mental health sites because at LHSC, the number of incidents occurring on the medical units equals the number on the mental health units.

I am worried. I went through page after page of AEMS for the month of November. Many many times no violence risk assessment was done though the patients had been confused and agitated but no assessment was done until an event occurred. More worrisome to me and I may be completely off the wall here, but in the actions taken to prevent further harm, a risk assessment was done and the patient was now identified as the potential for violence and staff were to approach with caution. What does that mean? I worry that once the patient has been identified as having the potential for violence, magically that behaviour goes away. No other action is required to protect us. Very few reports mentioned violence training! Nowhere did it mention that the violence training provided does not meet the needs of staff based on what we are seeing in the AEMS. Is more education needed on dealing with patients with substance abuse? Does staff need training on working with the elderly with dementia? Is there a different approach to those patients that will be more calming? I am not sure the answer is bringing a cast of thousands in to assist with personal care. I don't work on medicine but forcing care on someone with security and more nurses to assist would seem to me to lead to more agitation. Is there something else we need to incorporate into the care plan? I don't know. I need your help!

The Ministry of Labour has been in several times recently. One visit was related to a call about lack of response to an affiliate's behaviour. What was important in that visit, the message was clear from the MOL- that once the employer is aware of the hazard and in this case bad behaviour, the employer needs to review our violence policy and program and see if it meets the needs of that specific unit based on current state. What that means for the rest of us, if a new health hazard is identified or a trend is identified, and then the employer needs to go back and review the current violence policy and program. That includes the education program that is in place to see if it currently meets the needs of staff. Are staffs leaving the education with the tools they need to keep them safe?
What is a consideration, is the entry point for many new grads is the medicine units such as the acute care of the elderly units. Having spoken to new grads, they receive no violence training through their schooling. I am not clear if clinical placements increased their knowledge on dealing with the elderly with cognitive problems. In that case

based on what the MOL states, the employer is responsible to ensure they have that skill and knowledge to do their work safely. If the school is not doing it then that becomes our responsibility.

I spoke with a fairly new grad that suffered an injury while orientating to mental health as part of the Nursing Resource Team. She told me she was comfortable on the inpatient unit but had no idea about the potential risk to her in the PICU (the intensive care area for caring for the mentally ill during their acute phase). That is not acceptable and she was put in harm's way. That could have been a career ending event for her.

The issue of care of the mentally ill needs to become a provincial campaign. I am not an expert on care of these patients but I do know that the restructuring of mental health care has decreased the number of available beds and putting a lot of stress on the acute care hospitals to manage the shortfall on inadequate budgets. Our staff in the emergency departments and on the inpatient units are struggling with the increased volumes of patients requiring admission and the lack of other facilities to care for the patients that cannot be discharged back to their homes. This is a provincial problem requiring a provincial strategy. Through the reporting system of AEMS and the Professional Responsibility Workload Forms, we as a union can support a provincial plan because we have the stories to tell.

Though the majority of AEMS are related to patient care, there does seem to be an increase of verbal abuse by patient's families and visitors. There is a policy on abuse by families and visitors but I am not sure it is currently meeting our needs either. AEMS reports indicate where some visitors or family members have been escorted off the property due to their inability to follow a code of conduct and I am glad to see that. But there is a process and there is a responsibility of your leaders to address behaviours that can't help but impact the quality of care their family member gets. There is patient advocacy and then there is abuse and it is the abuse we need to nip in the bud. Please continue to complete AEMS and provide as much detail as you can. The more reporting leads to a better chance of identifying a trend and a hazard that needs addressed.

Ebola

The hospital has been more than responsive to the ministry directives that come out often on a Friday evening at 1600hrs. The most recent directive reduces from 11 to 3 or 4, the number of facilities who will care for the patients with Ebola. LHSC as you will note from Laurie Gould's most recent update, remains one of those 3-4 sites. Though we have not seen a case in Ontario there have been suspect cases and their care is exactly the same as carrying for a confirmed case until the diagnosis is confirmed either way.

The units that will be impacted are the emergency departments and the intensive care units at both sites. One of the first directives from the MOHLTC, based on ONA's involvement is the requirement for not only training but constant drilling and testing. The donning and doffing is a challenge and no one is proficient or can remain proficient without the repeated drills.

The challenge though is the demand for supplies provincially. As a result the donning and doffing training used type suits but not the fluid resistant suits required to care for an Ebola patient. The donning and doffing procedure did not change based on the suits supplied for training but those training suits became quite limp due to overuse and staff report that despite the amount of training they contaminate themselves always due to the conditions of the suits. We recognize that gap for people. It is hard to feel competent when you can't get to where you need to be to prevent self-contamination. I am trying to work out a plan to address that gap. Just know, there is a supply in different sizes of the appropriate suits but Occ Health is manning the supply. The required units have a few in their Ebola kits but the rest of the supply is kept in Occ Health. No need to worry about how to access on shift and weekends, as once a code Ebola is announced (and not overhead) a whole group of people are notified

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immediately and no care is provided until the team is in. That team includes the keepers of the equipment.

It is very important to understand, that no one goes into a room with a suspect or confirmed case if they do not have the appropriate PPE, have not been trained and tested and are competent in their skill. Some staff are not able to handle the required PPE for medical reasons and that is okay. You just need to speak to Occ Health and they will ensure the appropriate documentation is there to accommodate your need.

Again, we don't have the ability to refuse to care for an Ebola patient- but we do have the ability to refuse to care for that patient until the required PPE is available and training, testing and drilling has been provided to ensure competence.

Food and Drink

I am sure the word is out that again we received MOL orders around food and drink. I have been present for every visit of the MOL where orders were written or leaders were spoken to about their responsibility to ensure compliance. The pressure is on to ensure compliance and it has been for some time. The wind has shifted now to the requirement of workers to follow the health and safety policies of the employer and the requirements of the ACT. The employer has proven to the MOL that staffs have been educated about the food and drink regulation, now the inspectors are looking to the workers to be compliant. The only reason why the most recent incident did not result in a fine to the worker as the inspector could not know with absolute certainty, it was that worker's drink. If they could have, they would have issued a **fine up to $1000.00 to be paid by the worker.**

As a result, I have been involved in a number of food and drink assessments with the health and safety analysts in a number of areas. The guidelines are pretty clear for us to follow in identifying a fluid safe area. I need to be very clear, that I expect leaders are asking me to attend the assessment as I am an ONA member and the co-chair of the JHSC. ONA did not write this piece of legislation. I did not write this piece of legislation nor did the employer. The provincial legislature writes the legislation that is the Occupational Health and Safety Act. The ACT is changed or new sections are added based on monumental events that have occurred. The West Ray mine disaster lead to the development of the Occupational Health and Safety Act. The healthcare regulation around needle safety was written in response to healthcare workers contracting hepatitis and HIV/Aids related to needle sticks. The Violence legislation came after the Lori Dupont murder.

We all get the inconvenience of this section of the ACT, but it is there for our protection from the invisible killers out there such as infectious agents, hazardous drugs and chemicals. It is clear that if you can eliminate the hazards of exposure to chemicals, drugs and infectious agents then food and drink safe area would be identified. In many patient care areas, we are not able to identify safe areas. Some areas, the area is just so overpopulated with staff and patients we could not be guaranteed a breach would occur as it is so dependent on so many people being compliant to safe practices.

There is a new food and drink policy coming out in January and it is very tight in terms of directions for safe areas and practices. We are pretty close to losing the ability to have any fluids outside of staff lounges due to the number of MOL orders. So please whether you agree or not agree, follow the policy.

If you can find the little Green book- Occupational Health and Safety Act (available on every unit) turn to page 445 - section 32. Section29 (2) requires potable drinking water on every floor where work is regularly performed and within 100 meters of where work is regularly performed.

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Your leaders are required to ensure staff gets their breaks in order to take fluids. If you need a drink, I am hearing that you can ask someone to cover for a couple of minutes so you can run and get a quick drink.

Alan Warrington's Report

My name is **Alan Warrington**, an ICU staff nurse with 15 years' experience (7.5 here at LHSC-UH), and I am proud to be your elected VP-OH & S (UH). I have been a LHSC JHSC worker representative since December 2013 and worked closely with Jill Ross and our dedicated ONA JHSC representatives to pursue safety initiatives affecting our members, specifically, and LHSC staff broadly.

I want to extend many thanks to Ron Bouwman for his contributions to the JHSC as he has recently stepped down; wishing you well in all your future endeavours.

We have had a full agenda at the main meeting since the fall, with much dialogue surrounding **Ebola preparations, Mental Health area increased violence incidents, and the reconvening of our workplace violence subcommittee.**

The MOL has been monitoring, and assigning orders, to ensure progress is made with implementing of controls to these hazardous situations for our members. We devoted the entire October meeting to Ebola and the January meeting to Mental Health; with full revision of policy and procedures, respectively. We continue to review all AEMS related to worker injuries and put recommendations forward to protect our staff/members.

Gowns: The level 2 gowns are available and should be on your units now. If not, ask your leadership why.

Food & Drink: MOL is beginning their bi-weekly blitzes and members are advised that fines are likely to be given if food & drink in patient care areas are found. These fines may be levied at the individual worker and leadership too.

Musculoskeletal Disorders (MSDs): We are seeing an increase to injuries and many different areas, in addition to those we see with the HUGO WOWs (Workplace on wheels). Please ensure that you are completing AEMS and contacting Occupational Health.

Anaesthetic Gases: A comprehensive review of anaesthetic gas use at LHSC is underway. If your area uses such gases, we would love to hear from you. Areas that may use gases, possibly very infrequently, that might not show up could be: burns, a dental clinic, research laboratories or physician specific use. We want to ensure that the list is complete. Email or text me, see below!

North American Occupational Safety and Health Week (NAOSH)
May 3- 9, 2015
"Make Safety a Habit for Your Career"

Nomination deadline for awards: **March 27th, 2015**
On LHSC's Intranet Site: https://intra.lhsc.on.ca/priv/ohss/naosh.htm

Please feel free to contact me at: awarrington.ona@gmail.com or phone/text me at: **226-919-9139**

LHSC (RN) Professional Practice Report: James Gibbons - UH/Colleen Roefs-VH, VP's

James Gibbons Report

Nursing Workloads remain problematic for our members due to ongoing budget cuts across the healthcare system. This has placed increase demands on our nurses, which includes:

- The reduction of RN staff
- The reduction of support staff
- Increase non-nursing responsibilities
- Lack of supplies and equipment
- Working in an over census environments

This all has a direct impact on patient safety, but also the safety of our nurses.

Patients

Research has showed every patient added to a nurse's workload was associated with a 7% increase in hospital deaths after common surgery. BCNU published a paper "Nursing Workload and Patient Safety" and some of the data was concerning. In Canada medical errors affect 158,000 Canadians annually; it's estimated that 60,000 of these problems could have been prevented. Every year, some 700 Canadians die from a preventable adverse drug event. It also showed that 1.1 million added hospital days at a cost of $750 million dollars due to medical errors. Inadequate staffing = poor patient outcomes.

Nurses

Nurses are constantly placed in situations where they find themselves rushing to complete tasks and duties. We need to take the time to properly assess the situation, and *only* proceed when it is safe to do so. You should not be subjecting yourself to injury! However studies have shown that nurses are twice as likely to be absent due to illness or injury compared to other occupations. Studies have also shown that healthcare workers experience work related musculoskeletal disorders (MSD's) at a rate that's nearly seven times the national average. Information from the workplace insurance board data (May 2014), showed that health care workers had the most MSD's, Workplace Violence, and Exposures compared to manufacturing, construction and mining. Other reports indicate that nurses are more likely to be attacked at work than prison guards or police officers. This has to change!

PRC Process

Nurses are encouraged to complete the ONA Professional Responsibility Workload Report Form (PRC) when you feel you are not meeting your CNO standards or practice guidelines. In doing so, the form becomes a mechanism to identify and address the quality client care issues, thereby fulfilling the College of Nurses of Ontario (CNO) standards. The form can also be a mechanism to address staff safety, equipment failures or lack of supplies, identifying and improving unsatisfactory working environments/conditions. The form puts the onus on the em-

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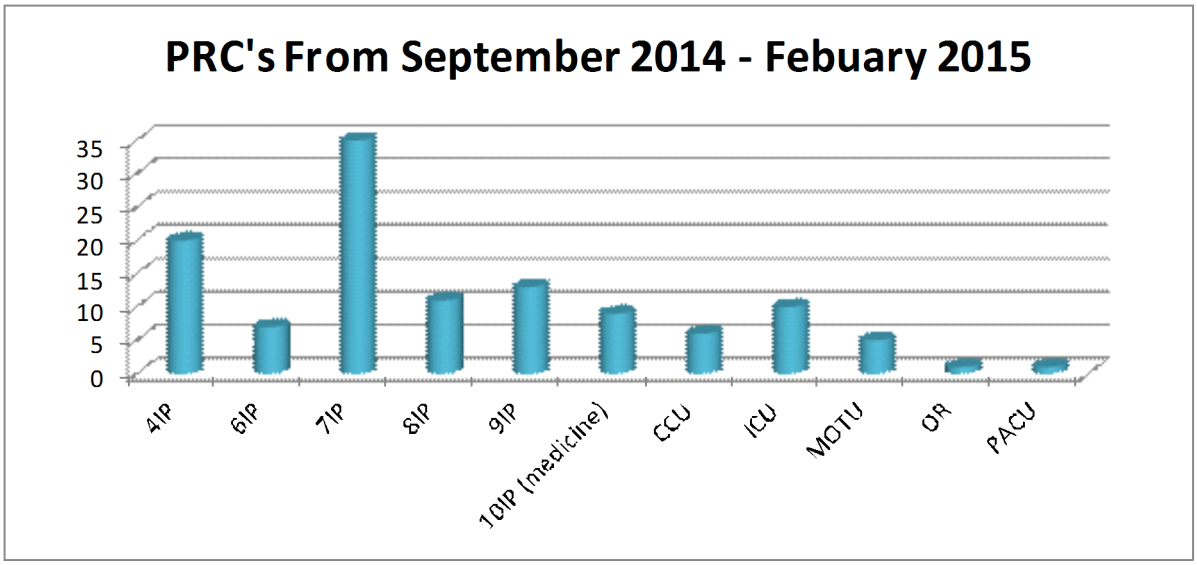
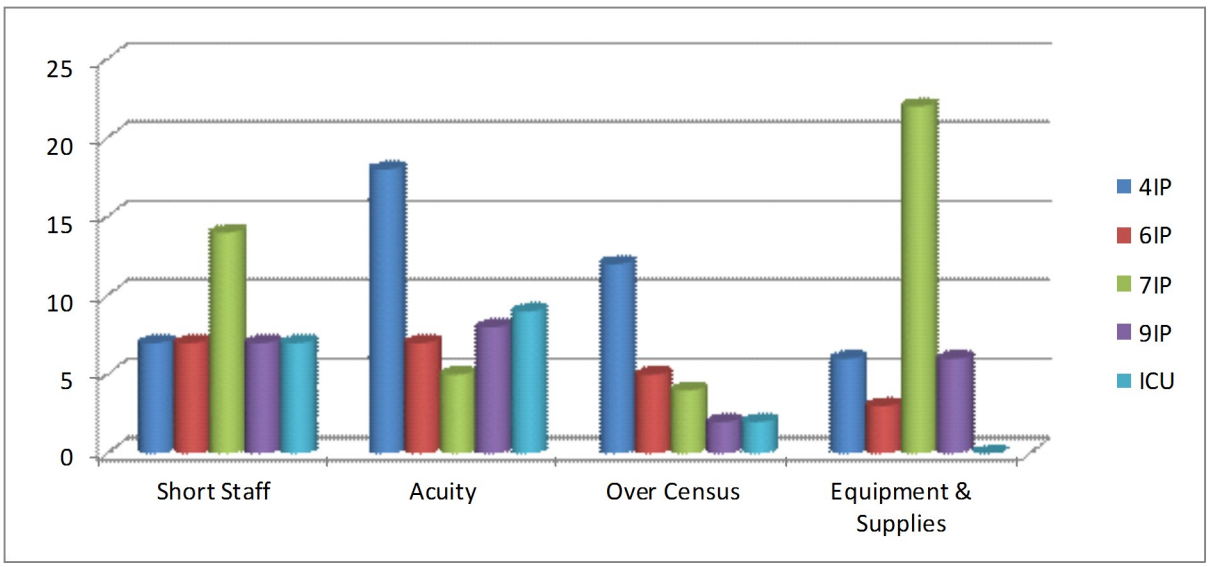
ployer to address the issues. And lastly, the form serves as a mechanism for improving communication and cooperation from both parties.

If you require help completing the forms, please contact me 226-919-8827 or by email james71lesley76@gmail.com

PRC Reports - UH





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Colleen Roefs Report

PRC work continues with the areas of PACU and PCCU, heating up, AMH seems to have calmed with the last PRC January 12 and some good work happening in Acute Medicine at VH with the implementation of a 24/7 resource nurse providing in the moment education to novice learners. Feedback has been positive to this point with wrinkles being ironed out as we go along.

I will be resuming my travelling lunch and learns and will be coming to AMH, OBCU, and CEPS in the near future.

As always, the FIRST thing to do when you have a workload issue is to call your first in charge, charge nurse, coordinator, AHC and alert them to the issue that is arising. Solving in the moment is always preferable but when that fails please proceed to the PRC process. I suspect that sometimes nurses have trouble initiating the conversation, for whatever reason, with their leadership when struggling with workloads. Please, slow it down, make the call and consider using the following tool to guide your conversation with your leader and be prepared to defend your position---you know what you speak of, it is your reality and **you are the expert**:

- **S**--situation--describe the situation that is causing you concern for your practice standards
- **B**--background--give some background about the patient—(i.e. increasing needs, behaviours)
- **A**–action--what action you feel will help you to meet practice standards or organization policy
- **R**–response--the answer you get to your request

If the response you receive is a no to your request, please ask why or why not? If no help can be elicited from the conversation please proceed to a PRC.

This is where, as a bargaining unit we have added a new and collaborative step to the PRC process; When there is a workload issue unresolved the new direction is to theme the issues and suggest solutions at a meeting with unit leadership/union leadership and most importantly the members that have submitted the workload concerns to find a home grown solution.

Failing resolution the issues are elevated to HAC.

As always, please contact me in whatever method is most comfortable for you--roefs@rogers.com, call or text to 226-926-5971

LHSC (RN) RTW and Accommodations Report: Jill Bischop-VH/Kathy Payne-UH, VP's

As we move forward in 2015 we will see many changes to the face of Occupational Health. We have many concerns with the way our nurses will be supported during illness and injury and nurses return to work reintegration programs. The only way we can support you and work toward a successful, healthy plan tailored specifically to your individual medical needs, is early notification to our ONA office. We will respond in a timely manner. As you approach a pre-planned surgery or at the onset of an illness or injury, start the process. Trust us, we are here.

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Documentation

Physio – We are sometimes encourage to take advantage of on-site physio. Sounds Convenient? For part time nurses without benefits this might be the answer—for full time nurses who are cautious and do not want to reach their cap of benefits, or on the off chance they need this support again, we do understand. Choosing a clinic is a personal choice. This should be around your treating person of choice, the hours of the clinic and your location to the clinic. As a nurse receiving treatment, it is important and is your right as a client, to receive written reports and updates of your ongoing restrictions. Always keep copies for your file. My understanding that in house physio are reluctant to complete Disability Status Forms, or Functional Ability Forms. Often verbal updates are supplied to the occupational health dept. Their college does support written documentation. This practice needs to be stopped. Please push the envelope----insist on copies of documentation. This is your medical information.

LHSC RN Vacation Accrual/Entitlement Chart

ONA	3 week vacation 112.5 hours	4 week vacation 150 hours	5 week vacation 187.5 hours	6 week vacation 225 hours	7 week vacation 262.5 hours
Service Date/Hours Vacation hours accrual per pay (FT) – on paystub every two weeks	After 1 year 2014/1500 4.33	After 3 years 2012/4500 5.77	After 11 years 2004/16500 7.21	After 20 years 1995/30000 8.65	After 25 years 1990/37500 10.09

ONA Local 100 ANNUAL Meeting Notice

Ontario Nurses' Association

[March 23, 2015]

[at 7:30 P.M.]

Lamplighter Inn, Regency Room

591 Wellington Road

1. **Call to order at 1930 hours. Report on attendance.**
2. **Adoption of agenda.**
3. **Reading and adoption of the last general membership meeting minutes.**
4. **Business arising from the last bargaining unit meeting.**
5. **Treasurer's report.**
6. **New Business: a. Local Budget Presentation/Review/Approval b. Local Policies Review/Approval**
7. **Local Coordinator's Report: Linda Haslam Stroud discussing Violence Campaign and other updates**
8. **Report from Bargaining Units: Canadian Blood Services, Chelsey Park, Elmwood, Extendicare, LHSC (Allied and Nursing), Meadowpark and Middlesex Terrace**
9. **Adjournment**

We have sent this meeting notice and documentation to Local 100 members personal email addresses. If you did not receive one, please call the Local 100 office @ 519-667-0937 or email: local100@skynet.ca with your email address and a package will be emailed to you.