



From the **PRESIDENT** Linda Haslam-Stroud, RN

Health care challenges...and some good news

Recent weeks have been eventful ones in Ontario health care. ONA has done its best to be on top of all the issues.

As the final year of the provincial government's term begins, talk about achievements and shortcomings are heating up. The McGuinty government is making a number of claims in the health care field, including the assertion that it has added over 4,000 nursing jobs, sharply increased medical school enrolment and taken measures to ensure that more doctors, including foreign-trained ones, are practicing right now in Ontario.

Although it is true that there are more nurses in Ontario and the government has funded new initiatives, the majority of nurses on the front lines have not experienced significant improvements in their working conditions. As I have said many times before, the promise of 8,000 new nurses over the course of this government's first term is an inadequate response to the looming RN

crisis, but achieving it would at least be a start. Are we on course to make this happen?

More doctors mean good things for patients. But a crisis has wracked as many as 19 emergency rooms in Ontario hospitals, putting ERs on the brink of collapse. The government has responded by promising an additional \$142 million in new resources. We will wait and see how these monies impact nurses' working conditions and patient care. Certainly we welcome the promise to increase the role of nurse practitioners in emergency rooms.

Meanwhile, the government's long-term care legislation, while containing positive measures, does not do enough to guarantee either patient care or the safety of health care professionals. Guaranteed minimum hours of care, including care by a registered nurse, are essential.

There is good news on the long-term care front as well, specifically a tentative agreement in the central homes sector – one negotiated at the bargaining table. A good deal that doesn't have to wait for arbi-

tration is always something nurses welcome.

In this case, we have achieved impressive wage increases of 11.25 per cent over three years, benefit improvements (including an improved vision care package as well as up to \$750 coverage of a range of paramedical services) and provisions to bolster full-time work in nursing homes. Please read the details of the deal beginning on this page.

Settlement reached in nursing homes

The following are details of a new collective agreement, subject to ratification, in the central nursing homes group. Assuming its approval by members, the new contract will be in effect from July, 2006 until June 30, 2009. This report was prepared by Beverly Mathers.

Background to the deal

The negotiations proceeded as follows:

- Team election process occurred from January – March 2006.
- Orientation was held from May 15 to May 19, 2006.
- The Memorandum of Conditions for Joint Bargaining was signed on June 5, 2006. This round of bargaining had 126 nursing homes participating in the process.
- There were 8 days of negotiations, from September 25 through 29 and then October 16 through 18, 2006. A settlement was reached on the evening of October 18, 2006.
- The Sector Meeting was held on November 3, 2006.
- Ratification meetings were scheduled in the individual homes during the week of November 6, 2006.
- Announcement of the ratification results is set for November 21, 2006.

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Multiple emergencies at Grand River

At Grand River Hospital in Kitchener, “emergency” has recently become an adjective describing more than the function of the ER. At the beginning of October the emergency room at this hospital was reportedly within hours of closing (plans were afoot to maintain services only at one site in the south-western Ontario city – St. Mary’s Hospital), a development that ONA Local 139 Coordinator Elaine Reed said would have created a situation in which “people would die,” as complicated cases arrived at a facility without the means to treat them. But last-ditch efforts allowed Health Minister George Smitherman to announce that the Grand River ER would stay open.

Supervisor Tom Closson, armed with extraordinary powers including those of dismissal over the Board and Chief Executive Officer Dennis Egan, was assigned the task of developing a viable “action plan” for the institution over the longer term. Smitherman reportedly stated that he was displeased with the

performance of hospital management.

Indeed, Grand River’s problems extend beyond the ER. Like similar institutions throughout the province, it faces problems arising from its deficit, some \$8 million – and more pointedly, from the government’s insistence that its budget deficit be cleaned up as soon as possible. In September, following what nurses and other health care advocates regard as an all-too-familiar pattern in Ontario, the hospital announced plans to slash a maximum of 50 jobs (some 17 of these registered nurses) and eliminate 18 beds in order to get a handle on its financial situation.

Cutbacks will not affect the surgical unit, says Reed, but Grand River surgery is in trouble. Elaine Reed claimed that 37 nurses (25 RNs plus 12 registered practical nurses) have left the surgical program “over the last year [or] year and a half,” due to frustration over a lack of supplies, inadequate staffing and an unhealthy work environment. “They’re leaving because of the working conditions, though they don’t tell Human Resources that because they don’t want to burn their bridges,” observed Reed. “Morale is terrible.” Among other challenges, nurses in the facility find them-

selves cutting up towels to make face cloths and putting in overtime in order to do their charting on computers that are in short supply – and thus needed by other professionals in the hospital.

On October 5, ONA took the rare step of calling for an external independent assessment committee to look into the situation at Grand River surgery and recommend solutions after, according to a statement from the union, “close to two years of unsuccessful attempts to convince management to fulfil their obligations to fix the staff and supply shortages.”

As ONA President Linda Haslam-Stroud noted, “nurses have a professional obligation to provide safe patient care. Heavy workloads and inadequate support in the surgical unit at Grand River make this a near-impossible task. It would be irresponsible of our members and our union not to speak up about this issue, to remain quiet and complicit in a process that puts patients at risk. We believe there is no choice but to call for an independent assessment,” observed Haslam-Stroud. Such committees normally hold a hearing within 14 days of their composition.

Organizing in the GTA

Joint organizing campaigns involving ONA, OPSEU, SEIU and CUPE continue at two large facilities: Trillium Health Centre in Mississauga and Markham-Stouffville Hospital. Readers will recall that out of the four health care unions’ joint response in early 2006 to the government’s Local Health Integration Network initiative, a plan arose to join forces in unionizing new workplaces.

According to Jamie Tataryn, the ONA lead on the Trillium drive, this is bearing fruit in Mississauga where a “dedicated and committed” internal organizing committee has helped ONA make significant strides in convincing nurses to sign cards indicating they want the Ontario Labour Relations Board (OLRB) to hold a repre-

sentation vote. According to Tataryn, cooperation among the unions (with OPSEU signing up paramedics at the facility and SEIU enlisting clerical staff) has meant “strength in numbers;” collaboration “boosts the presence of the union side in the campaign,” and has helped get the message out.

The unions coordinated a leafleting session and a drop-in, information evening, the latter on October 3. On its own, ONA also held a phone bank on October 24 where volunteers called members of this potential bargaining unit of 1500 nurses, answering their questions and discussing their workplace issues.

Meanwhile at Markham-Stouffville, lead Stacey Papernick hopes in the weeks ahead to consolidate that facility’s internal organizing committee. According to Papernick, “We need to uncover the RN leaders in the workplace, determine who

is pro-union (or can be moved to be pro-union) and once we have this information, assist those presently active in the committee to recruit others across the facility’s 20 units.” At this hospital, OPSEU and CUPE make up the other parts of a three-pronged drive. Ads taken out in local newspapers by the union coalition have helped spark interest among workers employed in the York Region facility.

Tataryn and Papernick agree they are both confronting employers serious about preventing unionization. In the Markham-Stouffville case, this has meant a “strategic and continuous” counter-campaign by the hospital that has included disrupting the distribution of ONA materials and the encouragement of hospital-wide e-mails authored by anti-union RNs. Tataryn said, in the case of his drive, that the employer is “nervous,” and has also impeded union access to potential members.

Defending public care and contracting out...at the same time



Rallying in Toronto against privatization

The Minister of Health and Long-Term Care told the Economic Club of Toronto recently that the public health care system that Canadians “cherish” in under “a very real, very tangible threat...We have to start fighting” to protect it, George Smitherman argued before a crowd that at the very least recognizes the competitive advantage that a single-payer system gives Canadian businesses over those U.S. enterprises funding expensive insurance plans.

Organizations that defend not-for-profit care were hardly dismayed by Minister Smitherman's identification of the privatization threat. The Ontario Health Coalition (OHC), even praised him for his description of the situation. What worries groups like the OHC are practices that undermine the speechmaking.

Notable on this front are the recent business activities of the human resources enterprise Med-Emerg International,

stepping in to “save” emergency rooms in several hospitals on the brink of closing for want of staff. University Hospital in London, for example, last December contracted out positions in its emergency department; according to city-wide ER chief Dr. Gary Joubert, the facility will continue to require Med-Emerg's services until at least July of 2007, when the hospital will be able to reassume control of staffing. In October, Joubert told local media that University Hospital was engaged in a recruiting process.

At Grand River Hospital in Kitchener, Med-Emerg was also involved in the ticking-clock rescue of emergency services. Defenders of the measure, generally described as a band-aid solution necessary to keep services running while more comprehensive solutions are found, deny it has anything whatsoever to do with privatization.

But the latest saga in the Med-Emerg story undoubtedly takes things a step closer. The company's six-month contract at Cambridge Memorial goes beyond the

provision of a few doctors; the company, in the person of interim chief of Emergency Medicine James Ducharme, is running the ER. Hospital CEO Julia Dumanian has assigned Dr. Ducharme the task of turning the department around, recruiting staff and ultimately finding a new department head. In a statement announcing and defending the deal with Med-Emerg, Dumanian, without a hint of irony, praised Dr. Ducharme's “interest in innovative health care models.”

In the opinion of the OHC's Natalie Mehra, “for-profit emergency department administration is privatization. It siphons hospital care budgets away to profits.” Indeed, it has been estimated that Med-Emerg is collecting an additional ten per cent on top of whatever fees the hospital would have paid its ER doctors.

As for Minister Smitherman, he told CBC radio that he was uncomfortable with Cambridge Memorial's decision and has apparently suggested to other Ontario hospitals that they not follow the precedent.

Mehra countered, proposing that the government provide a similar service “by creating a public, non-profit initiative to help out hospitals that are having difficulty finding staff.”

Back at Grand River, ONA Local 139 Coordinator Elaine Reed reports that at her facility, the hospital's use of Med-Emerg is nothing new. And while critics have noted that Med-Emerg's fees inflate costs when hospitals should be directly hiring doctors, Reed makes the telling point that direct recruitment can be just as costly when, in a market favourable to physicians, some emergency rooms top up doctors fees from an average \$170.00 per hour to, say, \$230.00, in order to lure them on board – or keep them. In short, competition between agencies can mean higher costs, not greater efficiencies. And fewer health professionals for those communities that don't pay extra.

ONA-nursing homes

The full text version is available on the Members Section of the ONA website at www.ona.org. Please follow the links to the settlement after the commencement of the Sector Meeting on November 3, 2006.

ONA Team Members included the following:

Region 1 - Leah Payette, Central Care Corporation, Versa Care Thunder Bay

Region 2 - Bernadette Lamourie, Extencicare, Laurier Manor, Team Chair

Region 3 - Victoria Thomas, Extencicare Managed, Tendercare Living Centre

Region 4 - Marie Haase, Extencicare, St. Catharines

Region 5 - Sandra Kravets, Brouillette Manor

Team Members, Ex Officio, included:

Linda Haslam-Stroud, President, ONA
Lesley Bell, Chief Executive Officer, ONA

ONA Staff Members who contributed to the process were:

Beverly Mathers, Project Manager,
Spokesperson

Valerie MacDonald, Project Lead

Dan Anderson, Chief Negotiator

Ina Caissey, LRO, NDST, Nursing Homes Lead

Colleen Ionson, LRO, WDST

Liz Dewar, LRO, EDST

Mark Miller, LRO, SDST

Highlights of the Settlement

As in past rounds of bargaining, the team was directed in its bargaining priorities by the results of the membership research survey conducted in the fall of 2005. The following presents the highlights of bargaining by tiers as identified by the nursing homes members.

Tier 1: Wages – parity, premiums (shift, w/e, on call, responsibility), per cent in lieu

The new collective agreement will expire on June 30, 2009.

The same percentage differential will be maintained for other classifications of RNs.

Registered Nurse	Current	July 1/06	Jan 1/07	July 1/07	Jan 1/08	July 1/08	Jan 1/09
Start	\$22.49	\$22.88	\$23.28	\$23.69	\$24.11	\$24.53	\$25.02
1 Year	\$23.49	\$23.90	\$24.32	\$24.74	\$25.18	\$25.62	\$26.13
2 Year	\$24.28	\$24.70	\$25.14	\$25.58	\$26.02	\$26.48	\$27.01
3 Year	\$25.60	\$26.05	\$26.50	\$26.97	\$27.44	\$27.92	\$28.48
4 Year	\$26.66	\$27.13	\$27.60	\$28.08	\$28.58	\$29.08	\$29.66
5 Year	\$27.98	\$28.47	\$28.97	\$29.47	\$29.99	\$30.52	\$31.13
6 Year	\$29.24	\$29.75	\$30.27	\$30.80	\$31.34	\$31.89	\$32.53
7 Year	\$31.76	\$32.32	\$32.88	\$33.46	\$34.04	\$34.64	\$35.33
8 Year	\$34.39	\$35.00	\$35.60	\$36.23	\$36.86	\$37.51	\$38.26

Pay rates for the Valley Manor Registered Practical Nurses as well as the claim for recent related experience remain outstanding issues between the parties. If the parties are unable to resolve these issues they will be referred to Arbitrator Shime sixty days after ratification.

The new wage rates represent increases of 1.75 per cent on July 1, 2006, January 1, 2007, July 1, 2007, January 1, 2008, July 1, 2008 and 2 per cent on January 1, 2009. When these increases are compounded over the term of the collective agreement, the raises equal 11.25 per cent.

Retroactivity will be paid within four full pay periods (approximately eight weeks) of the date of ratification (November 20, 2006). It will be on the basis of hours paid. Retroactive pay will be paid on a separate cheque where the existing payroll system allows. Where the existing payroll system does not allow for such separate cheque, the Home may pay retroactivity as part of the regular pay. In such circumstances, the Home undertakes that the rate of income tax on the retroactivity will not change unless the retroactive pay changes the employee's annual tax bracket. Former employees will be contacted at their last known address on record with the home within 30 days of November 20, 2006. These employees will then have 60 days from the date of the notice to claim such retroactivity and, if they fail to make a claim within the 60-day period, their claim will be deemed to be abandoned.

Weekend Premium will be increased to fifty-five cents (\$0.55) per hour effective January 1, 2007, for RNs only and for RPNs the weekend premium will be fifteen cents (\$0.15) per hour.

Tier 2: Workload/staffing – unsafe

workload, nurse/resident ratio

The staffing letters of understanding were renewed during this round of bargaining. New participants will be added to the Appendix of Data. The Professional Responsibility clause was negotiated to apply to RNs at Valley Manor.

Tier 3: Health and welfare benefits, retirement package

The team was successful in negotiating some new benefit provisions effective January 1, 2007:

Vision care will be increased to a minimum \$160 every 24 months.

The drug plan will require generic substitution for drugs covered by the plan unless otherwise prescribed by the employee's doctor.

The Plan will include a paramedical coverage bank to a maximum of \$750/insured person/year for the following services: Osteopath, Chiropractor, Podiatrist or Chiropodist, Naturopath or Homeopath, Audiologist, Physiotherapist, Psychologist, Speech Therapist, Acupuncturist, Massage Therapist and Ophthalmologist or Optometrist from paramedical providers who are licensed or registered in the province of Canada in which the services are provided.

The cost of dental benefits will now be 50/50 cost shared in all homes with a one year lag in the ODA. The dental plan shall provide for fluoride treatments only for persons under the age of 18 years and dental recall on a nine-month basis for persons 18 years and older.

A new provision will provide coverage for members who wish to keep working past age 65. Effective December 12, 2006, benefit coverage with some reductions will continue and at age 70 all benefits are converted to the

settlement reached

percentage-in-lieu.

The Registered Retirement Savings Plan (RRSP) language was updated to explicitly cover those members working beyond age 69 who can no longer contribute by legislation to RRSPs. The language ensures their contributions are directed into a mutual fund plan.

We were also successful in negotiating an option to move the RRSP contributions into the Nursing Homes and Related Industries Pension Plan founded by SEIU and now co-trusted by CUPE and CAW. The language first provides the plan information in order to do a feasibility actuarial review of ONA members, prior to ONA receiving approval to join the plan. ONA will also be reviewing the plan to determine if joining would be in the members' best interests. If ONA is approved, then ONA would need to determine changeover dates, discuss those dates with the employers, and notify ONA nursing homes membership. Details of the plan were provided to membership at the November 3 sector meeting.

Tier 4: Leave issues, job security – vacations, personal leave days

The automatic termination date for members on WSIB or illness absences was changed to 36 months and only then if there is no reasonable likelihood the employee will return to work within the foreseeable future.

Bereavement Leave was improved to five continuous calendar days without loss of pay upon the death of an employee's spouse, child or stepchild.

For the calculation of Pregnancy/Parental top-up, the percentage in lieu of benefits will now be included in the regular weekly earnings for those members who commence leave after November 20, 2006.

Effective at the commencement of the 2007 vacation year, vacation pay will be paid at the current rate of pay provided an employee who is regularly scheduled seventy-five (75) hours on a bi-weekly basis does not work less than 1500 hours in the vacation year. If the member works less than 1500 hours in the vacation year, they will receive vacation pay as a percentage of gross earnings in accordance with Article 13.02.

The five-week vacation entitlement was decreased to those with fifteen years except

for employees who are currently enjoying an earlier five-week entitlement.

Tier 5: Sick leave, part-time issues, per cent in lieu, scheduling shift issues (job share)

The language stating that the normal retirement age is 65 years of age will be deleted effective December 12, 2006.

The collective agreement provisions for the first two weeks of sick leave were modified. The first three days will now be self-insured by all homes thereby removing the need to complete paperwork for an insurance company for up to three days of illness; however, the collective agreement now contains language for the homes to receive limited information regarding the absence. Some homes will continue their practice of self-insuring the entire first two weeks of an illness.

The collective agreement now contains enabling language for Job Sharing and Time Sharing. Job sharing shall be interpreted to mean two employees sharing one full-time job (10 shifts bi-weekly). Time sharing shall be interpreted to mean two employees sharing one full line (14 shifts bi-weekly). Bargaining Unit President and Labour Relations Officers will now be able to negotiate scheduling language at individual homes that desire such scheduling variations.

Tier 6: Education issues, working conditions and safety; permanent full-time positions.

The parties agreed that in an effort to maximize full-time employment opportunities, the local parties may agree to a "four-on, two-off" innovative schedule of 7.5-hour tours. While these schedules are less than the normal 75 biweekly hours, they will be considered full-time positions. These schedules will require local language to alter the normal weekends off work because they involve the scheduling of full and part weekends over a six-week rotation.

The Health and Safety language has been improved. Bargaining Unit members on the Joint Health and Safety Committee will now be entitled to the Incident/Accident Report Form required in S.51, S.52 and S.53 of the Occupational Health and Safety Act making them better able to perform their duties under the Act. Language was also negotiated to provide that the Joint Health and Safety

Committee will discuss and may recommend appropriate measures to promote health and safety in workplaces, including, but not limited to, musculo-skeletal injury prevention; needle-stick injury prevention; personal protective equipment; and training designed to ensure competency under the Act for those persons with supervisory responsibilities. ONA was also successful in negotiating specific language in collective agreements to prevent and manage Violence in the Workplace. This now provides ONA members with an avenue to handle verbal abuse in the workplace.

The team was also able to negotiate language around interruptions and/or missed meal breaks. The new language provides that in the event that a meal period is interrupted, requiring an employee to attend to a work-related problem, the balance of the unused meal period will be taken within two hours of the interruption. If the employee is unable to reschedule such time, she shall be paid time and one-half her regular straight time hourly rate for all time worked in excess of her normal daily hours, in accordance with Article 16.01.

Tier 7: Respect, better representation, RN role and scope

The collective agreement now includes new language providing members of the grievance committee with a brief period of time during the day to fulfill their duties as committee members with permission from their immediate supervisor.

The collective agreement was modified to provide a longer period of time prior to the referral of a grievance to arbitration. The parties did not want this provision to delay the arbitration process but rather to provide an opportunity for the parties to resolve grievances prior to arbitration.

Tier 8: Quality of working life, miscellaneous issues

The definition of casual part-time employee was clarified to ensure that casual employees are part-time employees for all terms and conditions of the collective agreement and secondly, that they are employees who do not work regular schedules but are on a call-in basis.

LTC legislation: Improving a troubled sector or just tinkering?

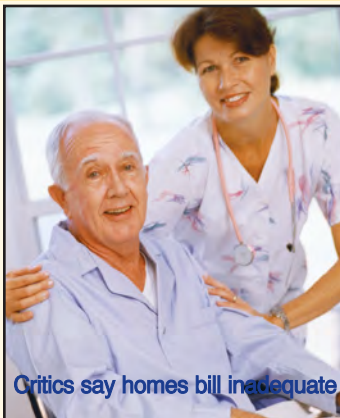
As he introduced in the legislature Bill 140, the Long-Term Care Homes Act, George Smitherman did what he does best: put an Ontario Liberal project in the most positive and progressive light possible. Anticipating, no doubt, that critics would charge him with doing little more than consolidating existing pieces of law into one and then avoiding strict standards that might alleviate the living conditions of many homes residents mired in poverty, the Minister of Health attempted to head opposition members off at the pass with some rhetorical flourish.

Recognizing that the bill would indeed replace three different statutes already in place, Smitherman added, "...but it will do oh so much more than that." And who could object to his plea about the moral debt society owes the aged? "Surely we have an obligation to ensure that we all, regardless...of our station in life, are able to live our declining years without feeling that society no longer cares or has passed us by." The Minister's stated intention was nothing short of revolutionary: to transform "facilities" into "homes" when it comes to those 618 institutional settings in Ontario where our elderly dwell.

So what was the substance of the legislation unveiled at Queen's Park on October 3?

Bill 140: defended and criticized

The government is touting a range of measures and practices that the legislation enshrines, such as a patients' Bill of Rights, obligatory programs to deal with abuse and neglect, mandatory residents' councils as a means to ensure at least an avenue through which elderly men and women can express views about their own treatment and care, and a "rigorous" review of the licence-granting process for operators, including the power to revoke



Critics say homes bill inadequate

in cases of non-compliance. Central to the legislation, in the government's view, is protection for staff, residents and volunteers reporting cases of neglect and abuse.

But neither immediate reactions to the legislation nor those informed by weeks of reflection and review of the fine print have been especially positive – especially where health care unions and advocates of improved Medicare are concerned. As anticipated, critics have charged that Bill 140 does little more than tidy up the array of legislation governing long-term care, much of it brought in by the Liberals in recent years. But their real quarrel with this legislative exercise, reasonable in itself, is that it enshrines much that is inadequate.

ONA, along with the Ontario Public Service Employees Union (OPSEU) and the Service Employees International Union (SEIU) were quick to note that the legislation fails to mandate levels of care per resident. Unions call for 3.5 hours of care per resident per day as an absolute minimum, essential to ensure seniors are getting basic attention. ONA is somewhat more detailed in this regard, insisting that of this total, at least 35 minutes should be furnished by a registered nurse. As the association noted in its Patients Matter document on the province's nursing shortage, "This is far from standard practice in the sector." The situation will not be helped by a bill that simply requires one RN to be on site and

on duty at all times.

The Registered Nurses Association of Ontario (RNAO), though generally enthusiastic about the legislation, also criticized its failure to set care minimums.

Not-for-profit gain little

Nor were patient advocates especially excited about the legislation's lukewarm support for the not-for-profit sector. It is no secret that the most troubling stories in elder neglect arise in centres where extracting a profit (always boosted by public dollars) is the priority. Groups like the Ontario Health Coalition called for legislation that would ensure "all new capacity...be built in public and non-profit homes. Operators that transfer their licences must transfer them to public or non-profit ownership only." Bill 140, despite coming from a government planning to run for re-election next fall as guardians of public health care, offers little on this front.

ONA government relations officer Lawrence Walter and LTC specialist Shalom Schachter, for their part, remain unimpressed with the much-touted whistleblower provisions. "The proposed protection does not create any new protections. It doesn't go as far as the federal legislation," which reinstates "discharged whistleblowers until the employer proves just cause," they write in a preliminary analysis of the bill. Significantly, they argue that the "prohibition of retaliation doesn't apply to retaliation against employees who speak to the media." So much for journalistic exposés as tools for outing negligent home operators.

Walter and Schachter also take issue with the absence of any guarantee that the Ministry will employ a sufficient number of inspection staff to properly meet obligations under the Act. That is to say, a government can on paper oblige homes to meet a demanding gamut of requirements. But if enforcement is under-funded, it is unclear how facilities

can be compelled to improve the level of care they offer.

As for patient rights, Walter and Schachter also assert that the bill details no limits to the "chemical restraints" that may figure in a resident's care plan, thus quarrelling with the government assertion that this bill contains effective safeguards to limit the ways in which the physical integrity of residents can be compromised.

Time left to fix this project?

Residents of LTC centres, still getting their two baths a week (one with a washcloth, often enough) in the post-Bill 140 era, might be forgiven for wondering what exactly all the fuss was about... unless, critics of the legislation assert, the government holds full public hearings and seriously pays attention. According to the

Minister, in the run-up to this bill, his parliamentary assistant Monique Smith travelled the province "and heard from administrators and residents, from countless different members of Ontario's long-term-care community about their views on how to improve the system." It is not clear that she listened to front-line workers, however. At this writing, that might still change.

ONA Biennial at the Royal York, week of Nov. 20

Our keynote speaker will be Stephen Lewis, until recently the United Nations Special Envoy for HIV/AIDS in Africa. There will be an opportunity for those attending to show solidarity with others by donating warm clothing, toys and blankets to the Redwood Centre, a 33-bed emergency shelter for women and children fleeing abuse. Education sessions on labour relations and conflict resolution will be offered on November 24.

Visit www.ona.org for more information on the Biennial.

Identifying health and safety shortcomings

On September 11 ONA charged that Ontario's health care employers are failing to live up to all their responsibilities under the Occupational Health and Safety Act, putting members at risk on the job.

The union took the issue to where ultimate responsibility for workplace health and safety resides, addressing a letter to agency administrators and human resource directors. In the note, ONA bemoans the state of health and safety in the sector by citing an unidentified hospital CEO to the effect that "health care is 20 years behind industry" – words reportedly expressed at a recent Health and Safety Action Group meeting. The letter reminds administrators that the Occupational Health and Safety Act "requires an employer to identify hazards, protect workers and to consult the joint health and safety committee..." Almost one year after Lori Dupont was stabbed to death at her Windsor workplace, violence remains a key health and safety area in which the union finds many employer policies wanting. ONA suggests that agencies engage the Ontario Safety Association for Community and Health Care, along with their Joint Health and Safety Committee (JHSC), to develop a "comprehensive program that includes training for all workers." Finally, in the context of respiratory protection, ONA reiterates its demand for N95 devices to be made available to workers in proximity to patients with respiratory symptoms during a pandemic and those suffering from airborne illnesses.

Days after the ONA initiative, the provincial government announced a new permanent health and safety advisory committee in the health care sector. Six union representatives, including ONA President Linda Haslam-Stroud, will sit on the committee. Helping convince employers to adhere to policy already in place might be the body's first task.

Hamilton reneges on commitment to public health nurses

On October 18 ONA took the city of Hamilton to task for preferring lawyers' fees to meeting its financial obligations to public health nurses. Last April the city was ordered to pay ONA members for extra hours worked but is taking the case to a judicial review in November instead.

"Despite a very clear decision handed down by the arbitrator, which ordered that nurses be paid overtime, the city of Hamilton continues to prefer to pay legal fees than to pay its Public Health nurses," said ONA President Linda Haslam-Stroud.

"Public Health Nurses work throughout the community to promote health for Hamiltonians of all ages. They are the front-line defence against infectious diseases, such as influenza, HIV and sexually transmitted diseases. They work to prevent injuries, and chronic diseases such as cancer and heart disease," she continued.

"They also work to provide a healthy start for children. Public Health Nurses are integral to the health and safety of the residents of Hamilton, many of whom are more vulnerable because they are new immigrants or struggle with poverty. The treatment by city officials of these dedicated professionals is outrageous," added Haslam-Stroud. "The city has used intimidation and scare tactics against the nurses, threatening to lay off nurses and close services that many of those most in need rely on."

The dispute began in 2005, when ONA Local 50 negotiated a new collective agreement with the municipality. ONA nurses agreed to the city's proposal regarding overtime pay for full and part-time staff. However, since the June 2005 ratification the employer has refused to abide by the language that it tabled and agreed to.

"ONA believes it would be much more sensible and a better use of resources for the city to abide by the arbitration agreement, rather than using taxpayers' money to take public health nurses to a Judicial Review and – as they have threatened – to the Supreme Court," concluded Haslam-Stroud.

ONA counsel awarded Law Society medal



Elizabeth McIntyre, an advocate for union rights and senior legal counsel with ONA, joined seven other lawyers this past September as a 2006 recipient of the Law Society medal. The award recognizes outstanding contribution to the legal profession.

ONA Chief Executive Officer Lesley Bell noted that "Liz has played many roles within ONA during her outstanding career. She

has represented the professional interests of our members at the College of Nurses while defending them on allegations of professional misconduct and incapacity." She added that one of the highest compliments members give McIntyre is that the latter "understands the unique role of the nurse," without being one herself. "This illustrates her empathy and insight into the predominantly female profession which suffers from gender bias and limited scope of practice."

Bell observed that McIntyre did stellar work for nurses during those very stressful days of the SARS crisis in Toronto. She played a key role in the preparation of ONA's submission to the SARS inquiry led by Justice Campbell, as she did more recently when the union told the Ontario government to change its Local Health Integration Network (LHIN) plan.

McIntyre had this to say about her career: "While in law school, a fortuitous summer job placement at ONA directed and focused me, irrevocably, toward social justice and professional and employment issues affecting the nursing profession...and health professionals in general. My most significant accomplishment has been working with my colleagues to help these men and women achieve justice individually and as a group to gain increasing recognition of the very significant contribution they continue to make to our health care system, often under difficult conditions. Much work remains to be done."

Bluewater censure extended for fifth year

In October the ONA Board of Directors extended its censure of Bluewater Health for a fifth consecutive year, despite crediting the Sarnia hospital's new vice-president of programs Patty Chapman with helping to alleviate some of the long-running problems at the facility.

According to Linda Haslam-Stroud, nurses are still "devastated" with front-line workloads and believe that staffing levels are insufficient to ensure quality patient care. The union does acknowledge that the hospital is paying more attention to the resolution of grievances, such that "a dim light at the end of the tunnel" might be in sight in this long-festering Sarnia dispute. But for the time being ONA will continue to recommend to nurses that they not accept employment in this agency on the shores of Lake Huron. ONA members also remain concerned about staff cuts in Bluewater's palliative care unit. A proposal to eliminate the unit in the summer of 2005 provoked massive union and community mobilization and the plan was subsequently rescinded.

CEO David Vigar recently cited the need to eliminate Bluewater's 2005 deficit of \$14 million as the reason for ongoing staffing shortfalls. Vigar noted in the October 14 Sarnia Observer that financial difficulties continue to plague the facility.

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