United Nurses of Alberta

NewsBulletin

Lots of excitement at UNA provincial meeting

UNA's record-sized meeting of over 750 nurses had some exciting moments. Here Canadian Federation of Nurses Unions President Linda Sila revs up delegates during her speech.

More photos and reports on the UNA AGM inside.

Seasons Greetings

Wishing you and your family all the best, now and in the New Year!

NOV | DEC 2008
VOLUME 32 • NUMBER 5

Published by the United Nurses of Alberta six times a year for our members

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Message from the President

Heather Smith

Where is democracy in Alberta?

Days ago the Alberta Government announced the members of the Alberta Health Services (AHS) Board, what I referred to as "BOB"- the big ole board. When the health regions are dissolved next April, AHS will officially become the employer for 90% of the nurses in Aberta.

There has been some controversy in the media because two of the 15 member Board appointed by Ron Liepert (and approved by Premier Stelmach) are not even residents of Alberta. Jim Clifford lives in New Jersey and Andreas Laupacis lives in Toronto. I do not accept that Alberta, with over three million people, does not have 15 Albertans with the ability to run the Alberta Health Board.

The Board is top-heavy with corporate and business people. Questions of conflict of interest have also arisen regarding Tony Franceschini, President and CEO of Stantec Inc. In 2007 Stantec received $14 million in Alberta government contracts and has worked on three large hospital construction projects (Mazankowski Heart Institute, Royal Alexandra Hospital and Peace Country Regional Health Centre).

When the Board was announced on November 20th a reporter asked me if I was surprised by the business/corporate focus of the individuals appointed by the government. I replied I was disappointed but not surprised. It has been clear that Premier Stelmach appointed Mr. Liepert to Health & Wellness with a pre-determined plan. A plan never discussed with Albertans (not a word during the March election) which our government intends to force upon Albertans.

Mr. Liepert is quoted as saying "We're going to do things different in Alberta than we've done in the past". Varying sources have also credited Mr. Liepert with outright declaring he is not going to make the same mistake as the former Health & Wellness Minister, Iris Evans, during the "Third Way" debate. The full picture of health care changes will not be shared with Albertans, it will be trickled out bit by bit.

Mr. Stelmach has no intention of giving Albertans an opportunity to analyze, debate or oppose the changes planned to health care in this province. While Minister Liepert is the public face of the plan, Albertan's need to know that it isn't just Mr. Liepert.

Recently 2nd Vice President Jane Sustrik met with a back-bench Conservative MLA who gave the same response as Mr.Liepert. "Plans for health care will be implemented incrementally. We are not going to give the public a target like the last Minister did.,"

What will happen to our local hospital? What corporate ventures or private insurance schemes lurk within the plan that must not be shared with Albertans?

Don't just ask Mr. Liepert, ask Mr. Stelmach and your own MLA (if he/she is Conservative) as well. They are all part of a deliberate plan to deny public scrutiny and debate – the cornerstones of democracy – about the single most important social program we have – public health care.

Where is democracy in Alberta? I believe it left March 3rd.

Heather Smith
President, UNA

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Over 750 UNA members at largest provincial AGM ever

Over 750 UNA members packed the Shaw Conference hall in Edmonton for UNA's 31st provincial Annual General meeting October 28-30. The nurses at the meeting were, of course, taking care of the usual business, electing new provincial executive board members, approving a budget and adjusting the constitution. There were also several guest speakers and special presentations, including a surprise one by President Heather Smith who did a hilarious impersonation of U.S. candidate Sarah Palin.

In her President's address, Heather Smith talked about the year past and noted that "we did have a provincial election on March 3. What didn't happen, during the election, was any discussion of massive restructuring of health care in our province," she said.

"What did happen, right after the election, without any notice and any consultation, was massive restructuring of health care. Starting with the elimination of the regional government boards, then the CEOs, and who knows what next?" Heather Smith said.

"There's a lot of speculation as to what Mr. Liepert is growing in his laboratory. Medical savings accounts? Patient-focussed funding? That is nothing more than an invitation for private delivery."

"We celebrated International Nurses Day with an event at the Legislature and we provided every MLA with UNA's Nursing Care Plan for Nursing," Heather Smith noted. The Plan of course outlined a strategy for reducing the nursing shortage.

"Also, almost up there with the miraculous is Health Minister Ron Liepert solved the nursing shortage," she told the meeting. "He didn't have to go recruiting. He didn't have to increase the number of students, although he promises to do so. All he had to do was that if every part-time and casual employee worked just one more shift, there's no shortage at all." She went on to satirically note: "I don't know why we didn't think of that."

2008 UNA AGM Framing our future together

Guest speakers tackle, energy, environment and inter-generational stress

Alberta Federation of Labour President Gil McGowan asked nurses to stand up if they had family in the oil and gas energy industry in the province, and nearly everyone at the AGM stood up. "By government's own estimates we're going to get $2 billion less in oil royalties under the new royalty regime." McGowan said it's a "sweetheart deal" for the oil companies. There are 53 major oil sands projects on the go at the same time which has "overheated" the Alberta economy. Big screen visuals showed how many major new pipelines are being built to export raw bitumen and possible Alberta jobs.

Ricardo Acuna, executive director of the Parkland Institute talked about some of the environmental impacts of the tar sands. Alberta, he pointed out, has about 10 per cent of the country's people, but produces about 33 per cent of the greenhouse gases. Canada has the second highest emissions in the world. He also noted that industries, including oil and gas produce about 70 per cent of the greenhouse gas emissions in the province. If all Albertans completely eliminated their "carbon footprint" that would only cut emissions by 30 per cent, he said. Finally, he noted that many in Alberta talk about a trade-off between the economy and the environment, but Ricardo noted: "There is NO economy without the environment."

Linda Silas, president of the Canadian Federation of Nurses Unions said nurses are affected by the economic uncertainty in the country. "We should be asking ourselves: I'm a nurse, does this really affect me?" she said. Nurses' number one issue is health care and patient care both of which certainly can be affected by the economy, she explained. Nurses must pay attention to economic policy, she explained. "It's ok to run a deficit to save our communities," she pointed out. "We have to save jobs." She also noted that tax breaks to business should be tied to growth in Canadian jobs and producing local, Canadian products.

Dr. Charl Els gave a highly-informative talk on addiction. Els explained that we need "a non-punitive approach recognizing addiction as a bona fide, relapsing disease that is amenable to treatment. ... Punishing symptoms while treating the disease denies [addicted] nurses a full acknowledgement of their illness," he said. Dr. Els captures much of his talk in an article starting on page nine in this issue.

Canadian Federation of Nurses Unions President gave a rousing talk and got delegates dancing in the hall.

UNA President Heather Smith shared some fun with her impersonation of U.S. vice presidential candidate Sarah Palin.

New UNA Executive Board members elected

New members were elected to the provincial Executive Board at the UNA Annual General Meeting.

Karen Kuprys and Bev Lawrence were both newly elected as North Central District representatives. Keith Lang and Christina Doktor were re-elected to new terms representing NCD.

Diane McInroy was newly elected and Sandra Zak, and Wanda Zimmerman were re-elected as representatives from Central District.

Blanche Hitchcow was elected and returns to the Board and Joanne Rhodes and Lois Taylor were re-elected to represent South Central District.

John Terry was re-elected to represent South District.

The provincial President and Secretary Treasurer terms also came up this year and both Heather Smith and Secretary Treasurer Karen Craik were acclaimed.

UNA Provincial Executive Board

October 2008

President
Heather Smith

Vice-President
Bev Dick

2nd Vice-President
Jane Sustrik

Secretary/ Treasurer
Karen Craik

North District Representatives
Roxann Dreger
Susan Gallivan

North Central District Representatives
Beryl Scott
Terri Barr
Judy Moar
Beverley Lawrence
Keith Lang
Teresa Caldwell
Karen Kuprys
Christina Doktor

Central District Representatives
Sandra Zak
Dianne McInroy
Wanda Zimmerman

South Central District Representatives
Denise Palmer
Blanche Hitchcow
Daphne Wallace
Joanne Rhodes
Lois Taylor
Tanice Olson

South District Representatives
Maxine Braun
John Terry

Below: In keeping with the Hallowe'en theme, the Executive Officers showed a special "rock video". They nearly brought the house down with their lip-synced version of the Twisted Sister song: "We're not going to take it!"

At least one possible "little future nurse" showed up to the AGM.

Below: Heather Smith visited with Marie Corns, President of the High River Local and her delegation of nurses at the meeting.

More Alberta Health Changes

Liepert appoints corporate-style board

On November 20th, the government announced it was appointing a former drug company rep who lives in New Jersey, along with a range of private business people to run the province's Alberta Health Services Board.

"We used to have elected hospital boards. We even had elected members on the Health Region Boards until the Conservatives stopped that," noted UNA President Heather Smith.

"Now we have an appointed board of corporate directors. There are no nurses, or front-line health workers. There aren't even any regular Albertans who are the patients in our health system. We are dismayed by the corporate appearance of this Board," she said.

The 13 appointed members include a developer, an accountant, an engineer, a stockbroker and a couple of oil and gas executives, including an Imperial Oil/Exxon Mobil Vice President.

Jim Clifford from New Jersey is a former head of CommonHealth, a group of healthcare marketing companies in the eastern U.S.

"Why does the board need to include a health care corporate "branding" consultant from New Jersey?" asked Eggen. "Minister Liepert needs to reveal his plan so the public can evaluate what this all is leading to."

Alberta Health Services Board adopts "silo" structure

Alberta Health Services recently announced some details on its new administrative structure. The organizational chart --with many overlays-- reveals some important assumptions behind the structure.

Instead of organizing along geographic lines, as the health regions had done to facilitate a local coordination of services, the new structure is a "vertical slicing" of services. For example the largest hospitals, University of Alberta, Foothills, Childrens and the "Cancer Corridor" are grouped in "Tertiary Specialized Acute Care" under Senior Vice President Deb Gordon.

The other large urban hospitals, the Royal Alex, Grey Nuns and Misericordia in Edmonton and the Peter Lougheed and Rockyview in Calgary, are in "Core Urban Acute Care" under Senior Vice President Brenda Huband.

"Urban Hospitals" under David Diamond has the other "regional" hospitals: Lethbridge, Medicine Hat, Grande Prairie, Red Deer and Fort McMurray.

Most of the other health facilities in the province are wrapped up in "Continuum of Care: Community and Rural" under Chief Operating Officer Pam Whitnack. This includes all the other "rural" hospitals which are bundled in with primary care, public health, addictions and mental health, community care, senior health and living options and emergency medical services (ambulances).

Putting all rural hospitals in the same department as long-term care and community health care could be an important signal of the government's plans.

UNA on multi-dose syringe use

On October 27th, the Alberta government announced it would be testing 2,700 former patients of the High Prairie Health Centre, after nurses identified that multi-dose syringe use was not a best practice and discontinued it. A flurry of news coverage followed a major provincial news conference announcing the testing. The media reports may have unduly raised public fears about the risk.

The risk of contamination or infection from a multi-dose syringe on an IV line is extremely small, as has been reported by numerous medical opinions in the media. The province's Chief Medical Officer of Health Dr. Gerry Predy said the practice was probably common up until about 2000.

UNA made a public statement about the low level of risk involved and the much greater risks to patients from other circumstances, especially inadequate staffing.

Some nurses and media reports misinterpreted UNA's position on syringe safety. UNA did not suggest nurses should use anything less than the safest possible syringe practice, or that it was acceptable to do so. In fact, UNA asked all nurses to report any use that does not meet this new higher standard protocol. A core tenet of the nurses' union has been our Professional Responsibility process that encourages nurses to bring forward any concerns about patient safety.

UNA had noted that using multi-dose syringes has likely been the practice in other Alberta facilities. Dr. Gerry Predy, the Chief Medical Officer for the province also made this observation. Subsequently five sites were identified in Saskatchewan where multi-dose syringes were still being used. Saskatchewan's chief medical health officer, Dr. Moira McKinnon, said the risk of infections was "extremely low" and she was not recommending that people be tested. In Alberta, the government later announced it would only be testing 1,381 patients.

Addiction Awareness Week

Addicted nurses: character flaw or illness?

How to help addicted nurses

How do we help nurses caught up in addiction? United Nurses of Alberta and the College and Association of Registered Nurses of Alberta (CARNA) have an on-going dialogue on the topic.

In its latest magazine CARNA published an article, the Facts, responding to a NewsBulletin piece on the topic of how to assist or deal with nurses struggling with addiction.

UNA has communicated to CARNA that nurses are well aware that the mandate of CARNA is protecting public safety. UNA's concern is that nurses should be fairly treated in the fulfillment of that mandate. The Health Professions Act provides an Alternative Complaint Resolution (ACR) process for handling complaints against nurses. CARNA notes that ACR cannot be used in any case of public safety. However, as public safety is CARNA's mandate and every case is by definition a public safety issue, CARNA ensures that ACR will rarely or never be used and nurses will not have recourse to a less public process.

UNA also notes that although CARNA emphasizes they do not sanction nurses for an illness, it is clear from their published position that nurses are disciplined and subject to sanction for displaying symptoms of an illness.

UNA maintains that according to best evidence practices, CARNA should make use of the Alternative Complaint Resolution but so far CARNA is declining to do so.

Edmonton psychiatrist and addiction specialist Dr. Charl Els, spoke at the UNA Annual General Meeting in Edmonton in October. Much of the information he presented is published here starting on page nine. Els says: "The current approach (and the exclusion of ACR) to addictive disorders actively discourages reporting by colleagues – acknowledged to be the primary source of reporting. Nurses know the right thing to do, but are often unable to do so as a result of a broken system failing to accommodate some chronic diseases. Are nurses treating each other as they would treat the patients in their care? This may be a source of great moral distress for the nursing profession."

Correction:

In the October 2008 NewsBulletin the article Treat Addictions as an illness incorrectly stated: "CARNA has also taken all 104 complaints against nurses in 2006/2007 to full public hearing rather than making use of the Alternative Complaints Resolution (ACR) process which protects the nurses' privacy."

This was incorrect and we apologize for the error.

CARNA has pointed out that only 16 of the 104 complaints received in 2006/7 involved substance abuse (6.5%). Four of the 16 were handled under Section118 and 12 were investigated and eventually referred to hearings.

Of the full total of 104 complaints:

- nine were on-going investigations at the end of that membership year,
- 45 were referred to hearings that actually took place or were pending at the end of the membership year,
- 46 were dismissed by the complaints director, withdrawn by the complainant or resolved by the complaints director,
- four were handled under Section 118 (incapacity with workplace not affected).

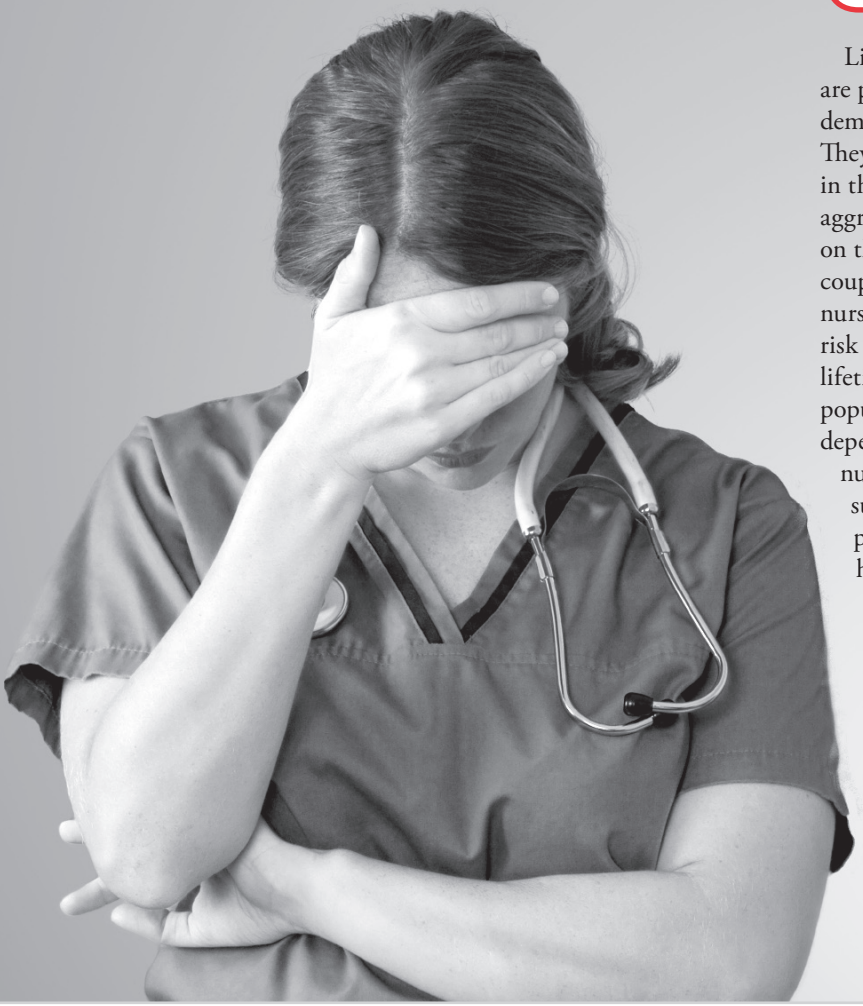
Healthcare under the Influence

Charl Els, Addiction Psychiatrist, Medical Review Officer.

In Alberta, the nursing profession is facing a unique challenge. Nurses are highly valued for their contributions to the demanding healthcare system but they are not invincible, and certainly not immune to chronic diseases. Like other members of society, nurses may develop mental illness and/or addiction and, similar to their physician counterparts, those working in Critical Care, Emergency Departments, and Psychiatry may be more prone to developing the potentially disabling condition of addiction.

Most global authorities recognize addiction as a bona fide chronic and relapsing medical condition that results from the prolonged effects of drugs on the brain, and it is classified as such in the DSM IV-TR and World Health Organization's ICD. Embedded in this condition are biological, psychological, social, and spiritual aspects, as captured in the biopsychosocial model of disease. Addiction typically manifests as continued use despite harm, tolerance, withdrawal, loss of control over use, and/or substantial amounts of time spent related to substance use. This disorder is prevalent, potentially lethal if left untreated, and the evidence for safe and effective treatments is robust. Addiction is considered at least as treatable as other chronic medical conditions like hypertension, diabetes, and arthritis.

Dr. Charl Els gave a much-appreciated talk on addiction at the UNA AGM. To give more nurses access to this information, Dr. Els prepared this special piece for the NewsBulletin.



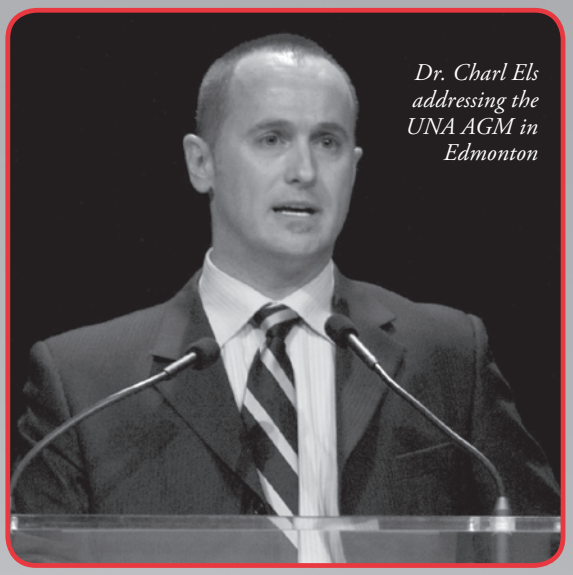
Like in many other parts of the world, Albertan nurses are part of an aging workforce, exposed to significant demands, overtime, shift work, and labor shortages. They have high rates of exposure to assault and injury in the line of their work, and peer-to-peer (horizontal) aggression may be the consequence of unrealistic demands on the profession. As a result of these and other stresses, coupled with access to addictive drugs in their work, nurses with a predisposition to addiction may be at greater risk of developing substance-related disorders. Overall lifetime prevalence rate of alcohol abuse for the general population is estimated at 13.5%, and for drug abuse and dependence at 6.2%. The prevalence of addiction among nurses is estimated to be similar, or even higher in some subgroups, and the evidence suggests that the general population addiction rates in Alberta are among the highest in Canada.

Signals of diversion of addictive drugs in the workplace are mostly not difficult to identify. These include: Early arrival to work, late departure, working on "off-days", excessive wasting of addictive drugs, regularly signing out large quantities of drugs, volunteering to give medications to other nurses' patients, taking frequent bathroom breaks, patients reporting unrelieved pain despite adequate treatment orders, and discrepancies in documentation of controlled drugs. However, moving from symptoms to effective intervention is more problematic.

What is the role of regulatory bodies the College and Association of Registered Nurses of Alberta and others? Section 3 of the Health Professions Act suggests that the College MUST carry out its activities and govern its regulated members in a manner that protects and serves the public interest; must establish, maintain and enforce standards for registration and of continuing competence and standards of practice of the regulated profession; and must establish, maintain, and enforce a code of ethics. In order to achieve this, the HPA allows for at least three mechanisms for regulatory bodies to directly intervene in cases of addiction and impairment in the health professions. If the association believes a member may be incapacitated, Section 118 provides the authority to direct a member to submit to an examination and, if necessary, to obtain treatment. When a formal complaint about a registered nurse is filed, it may be directed to a confidential Alternative Complaints Resolution (ACR) process or it may proceed directly to a formal investigation. Based on the available evidence, the College and Association of Registered Nurses of Alberta (CARNA) restricts all interventions with Alberta nurses with addictive disorders to formal investigations which, with sufficient evidence, conclude with public hearings on the behaviours expressed as a consequence of the disease process. In other words, the confidential ACT process is not currently accessed for nurses with addictions. Using a public disciplinary hearing, but precluding nurses from the option of an ACR, is not considered evidence-based and raises serious questions. Does our system's failure to acknowledge (and accommodate) the link between the disease and symptoms potentially constitute a contravention of the human rights of its members?

Using a public disciplinary hearing, but precluding nurses from the option of an ACR, is not considered evidence-based and raises serious questions.

Nurses generally believe that chemically-dependent colleagues can and should be helped. But can we reasonably expect our nurses to self-report or report addicted peers knowing full well that they have limited access to the interventions their physician peers have access to, and that they are currently precluded from confidential processes? A disciplinary approach propagates the negative prevailing stigma and social attitudes to those with addictions. The evidence suggests that nurses who believe reporting will lead to punitive consequences are more reluctant to make a formal report about a nurse peer. Addicted nurses may



Dr. Charl Els addressing the UNA AGM in Edmonton

fear that they will be humiliated, punished, and exposed to measures that are widely viewed as not contributing to rehabilitation, and this negatively impacts the course of the disease. It can be reasonably foreseen that this could reinforce attempts to conceal the disease and lead to delays in access to treatment. Facing this reality, addicted nurses may simply choose to leave the profession, perpetuating existing workforce shortages. The current status quo of a disciplinary approach in Alberta, coupled with inadequate access to longitudinal aftercare and routine and affordable toxicological monitoring, may be responsible for under-identification of addiction, increased severity of the disease process when identified, higher risk of complications, higher relapse rates, and under-treated nurses attempting a return to work. The net effect is one of potentially placing both public safety, and the health of nurses, at substantial risk.

CARNA, in fulfilling its "College" (regulatory) role, investigates and responds to all formal complaints of professional misconduct regarding registered nurses. But, it appears that only a fraction of the anticipated number of addicted nurses is identified, all of whom are formally investigated as a consequence of behaviour related to the disease of addiction. The current approach (and the exclusion of ACR) to addictive disorders actively discourages reporting by colleagues – acknowledged to be the primary source of reporting. Nurses know the right thing to do, but are often unable to do so as a result of a broken system failing to accommodate some chronic diseases. Are nurses treating each other as they would treat the patients in their care? This may be a source of great moral distress for the nursing profession.

Can an ACR really serve as a viable option, as a part of a greater menu of options? There is evidence indicating that alternative approaches (e.g. those employed by other nursing regulatory bodies in Canada) result in more nurses with active licenses, fewer nurses with criminal convictions, and more persons employed in nursing without any evidence of differences in addiction relapse rates.

The positive effect of earlier identification and improved and evidence-based interventions are two fold: risks to

public safety are decreased, and the nurse's chance of successful recovery is increased. It was made evident to the author that CARNA is mandated to ensure safe nursing care is provided (the regulatory role), but that it does not consider itself responsible for the health and well being of membership (which would be generally considered an "Association" role). The "College" (regulatory) role of CARNA is generally clearly understood but in the context of impaired nurses, the "Association" role of CARNA appears to be less clear. The real questions are, does any regulatory body have the right to unilaterally prohibit access to a legitimate and legal process that has been proven to be safe and beneficial? What is the role of the Association in this regard?

Most recovered nurses can return to their jobs to provide safe and competent care. The current body of evidence is supportive of the suggestion that an ACR may well be ideally suited to protect the public, fulfill the Association's duty to accommodate its members, and at the same time successfully facilitate access to rehabilitation for the nurse suffering from a chronic disease. For a few pennies per nurse per day (which may be found through reducing the number of costly Formal Hearings), this can be achieved. However, the current policy of precluding ACR access does not appear to be aligned with scientific evidence. These observations may suggest that our current systems do not fully comprehend the implications of the disease of addiction. The current policy and practices potentially place public safety at risk.

Improvements in the existing process are an urgent priority, and necessary to ensure public safety and to protect the rights of our valued partners in health: the registered nurse. The demand for excellence in intervention and long-term support for successful outcomes warrant the following recommendations:

1. Addiction is a chronic, relapsing, potentially lethal (if untreated) disease, and should be approached as such. Adopting a process that endorses addiction as an illness reduces stigma, and increases self-reporting and identification of addiction issues by peers. The focus should be on treatment and recovery, and education to this extent should be widely promoted.
2. The current regulatory approach to impaired nurses is not aligned with the best evidence. Human rights', legal, and ethical considerations of the current status quo of precluding access to ACR's by CARNA should be investigated.
3. The "Association" role (as opposed to the regulatory mandate) of CARNA has to be explored in the context of the approach to addicted nurses. This may include consideration of the ethical duty to facilitate early identification, access to evidence-based interventions, supportive environments, and ongoing aftercare, as these are effective measures for allowing a humane and successful return to the workforce.
4. Initiatives to educate the profession on addiction, and to de-stigmatize this disorder needs to be undertaken, in order to sufficiently protect the public and the profession.

Disclaimer: The opinions expressed in this manuscript do not necessarily reflect the opinions of any of the bodies the author is affiliated with. References: Available on Request.

BC College pushes for consensual resolution for nurses with addictions

The College of Registered Nurses of British Columbia has taken a much different position on appropriate handling of addictions cases. The following is an extract of a piece by Laurel Brunke, Executive Director, from the College's October 2008 magazine. It is worth noting that BC had a much higher reporting of addictions problems than CARNA has.

Nurses who shouldn't be practising because of issues related to competence, ethics, mental health or addiction are removed from practice more quickly through the consensual complaint resolution process than they would be if a formal disciplinary hearing was held.

Out of 149 complaints formally investigated by the College in 2007, 61 related to addictions and/or mental health problems. This is not an insignificant number of registered nurses with these problems, albeit a very small percentage of the College's 40,000 registrants. Changes proposed to the Health Professions Act last spring would have required the College to publish all the details of a consent agreement with a registrant whose ability to practise nursing was impaired as a result of a physical or mental ailment, emotional disturbance or substance abuse. This was of significant concern to us as we did not believe that such a requirement would support these registrants to get the help they need or support their recovery.

CRNBC worked collaboratively with other B.C. health regulatory bodies to bring these concerns forward to the Minister of Health. The Minister heard these concerns and amendments were passed to address them. These amendments provide for information to be withheld from the public notification, if the registrant voluntarily admits to one of these conditions, and if the information would identify the registrant or personal health information of the registrant respecting the condition. Clearly, government does not believe that exposing these registrants to the public eye increases the safety of the public or serves as a warning or deterrent to other professionals.

UNA seeks to bring LPNs into direct nursing care bargaining units

UNA is asking the Labour Relations Board to rule that nurses should NOT be artificially divided

After many requests from Licensed Practical Nurses (LPNs), UNA has made a number of applications to the Alberta Labour Relations Board seeking to bring LPNs into the same bargaining units as Registered Nurses and Registered Psychiatric Nurses. UNA has decided to take this significant step with the support of UNA Locals and members.

Cara Johnston was a bit surprised to hear her name called from the podium at the AGM. There was a big round of applause when Heather Smith introduced her specially to the meeting as the first Licensed Practical Nurse to become a UNA Local president. Carla says her Local #406 at Agecare LTC in Calgary has both RNs and LPNs and it works well. "RNs and LPNs do virtually the same thing," she says. Cara says she has learned a great deal since she helped bring UNA in to her workplace. But it wasn't easy and there was a lot to learn. She said Tanice Olson her District Representative had been a huge support.

UNA has made the applications for determination for the LPNs at Extendicare Holyrood, Good Samaritan Centre Millwoods, Millwoods Shepherds Care, Red Deer Nursing Home, and Mannville Health Centre. If the Labour Relations Board accepts the applications, UNA will represent these LPNs and would negotiate salary and collective agreements for the LPNs.

The LPNs would not have exactly the same contract as RNs, or exactly the same wages. Like most collective agreements, UNA's contracts include different classifications for different nursing roles. But once in the same bargaining unit, LPNs, RNs and RPNs would all be bargaining together.

"All across this province LPNs and RNs work closely side-by-side doing very similar work. Yet we are forced to bargain our contracts separately, and get very different terms and provisions. It is time to recognize the united role nurses play in providing care to Albertans" says Heather Smith.

Over twenty years ago the Alberta Labour Relations Board set four functional bargaining units in the province's health sector. In 2001, Bill 27 set those units in law.

The four bargaining units that health employees are unionized in are:

- Direct Nursing Care or Nursing Instruction
- Auxiliary Nursing Care
- Paramedical Professional or Technical Services
- General Support Services

The Auxiliary group historically has included LPNs, registered nursing assistants, nursing aides and orderlies.

"LPNs and RNs share a significant number of skills. They are recognized professional nurses, able to practice independently. We believe they should be in the same bargaining unit as RN's and RPN's. Many LPNs are asking about joining our union, so we are asking the Alberta Labour Relations Board to make a ruling," says UNA Director of Labour Relations David Harrigan.

The key legal element in the determination on whether LPNs and RNs should be in the same bargaining unit is the actual work they do, David Harrigan says.

""This makes it clear that legally the LPNs and RNs should be in the same bargaining unit in direct nursing care," he says.

> *The basis of these unit descriptions is job function. The Board's assignment of an employee to a bargaining unit depends on the person's actual function, not upon occupational title."*
>
> *– LRB Information Bulletin #10*

The increasing scope of practise of LPNs makes the nature of their work far closer to that of RNs than of the other employees in the auxiliary nursing category.

Changing nursing practise of LPNs

The Licensed Practical Nurse title was created in 1989. Before that they were called Registered Nursing Assistants, and even earlier Nursing Aides. Over time the qualification requirement for LPNs has increased significantly. In 1995, the mandatory qualification for registration included courses in Physical Assessment, Medication Administration and Infusion Therapy.

At one time nursing aides really did work in an auxiliary capacity. In recent years, the roles of LPNs and RNs have become increasingly similar, with LPNs undertaking many of the direct nursing tasks that were previously only performed by RNs, such as administering medications.

The scope of practise for LPNs is regulated under a professional body and by the Health Professions Act, just as are Registered Nurses and Registered Psychiatric Nurses.

"We're trying to recognize that LPNs have an increased scope of practise. Let's face reality. The days when LPNs were assistants to nurses are no longer here. They are fully autonomous professionals," notes David Harrigan.

LPNs who are performing many of the same functions as RNs are questioning the level of disparity and valuation of LPNs' work and the lower salaries. Many RNs and LPNs believe the LRB ruling that keeps the two groups who work side by side in very similar jobs, in separate bargaining units is no longer appropriate.

In Manitoba and Nova Scotia RNs and LPNs are largely in the same union. UNA also does represent LPNs with some long-term care employers.

RAISING THE ALARM

A small OH&S victory for the Drayton Valley Community Health Unit

Nurses and other employees at the Drayton Valley Community Health Unit wondered why there were no smoke detectors in their building. They raised the issue and requested six smoke detectors be installed in various areas. The Occupation Health and Safety Committee looked at the concerns and the request was supported by all the union members and the management members of the Committee.

They recommended the Board purchase detectors, but the proposal was refused by upper management. Using the Occupational Health and Safety provisions in the provincial collective agreement, the Local took the issue to the Chief Executive Officer of the (then) David Thompson Health Region.

They got their meeting with the CEO designate within the 21-day timeframe stipulated by the agreement. This level of management noted they had probably spent more on salaries for the meeting, than it would have cost to install the smoke detectors. A decision came later that installation would go ahead.

Bernadette Bredin, President of Local #97 said the members were pleased with the improvement in safety in their facility. The OH&S process got the job done for them.

LAPP CEO reports at UNA provincial meeting

The CEO of the Local Authorities Pension Plan (LAPP) gave a short address to the UNA Annual General Meeting in Edmonton at the end of October. Although LAPP has taken a hit with the upheaval in the markets, Ron Liteplo reassured nurses their pension is safe.

"We are a young, strong, growing pension plan with a positive cash flow. What we are experiencing right now is uncomfortable, but we believe our investments in good companies, our skilled investment managers and our fully diversified portfolio will combine to see us through," Liteplo says in a statement.

"LAPP has suffered a reduction in value, on paper, as a result of the financial crisis. We started the year with $15.6 billion dollars, and that value has dropped to around $14.1 billion. We note that this reduction in value is "on paper", because gains and losses are only realized when an asset is sold. Eventually, when markets return to normal, we expect that the value of our assets will rise again.

"I do not believe we have "hit the bottom" yet," Ron Liteplo says. "This crisis is unlike anything we have seen in the past few decades, so we don't know when or how it will bottom out. I believe we will see some fundamental changes to the economy when this is all over – less growth, less leverage, and far more caution in the markets. The days of high year-over-year growth could well be gone, replaced by low expectations and a more sceptical and cautious banking system. For LAPP, we are now projecting lower investment returns and the need for higher contributions in the years to come."

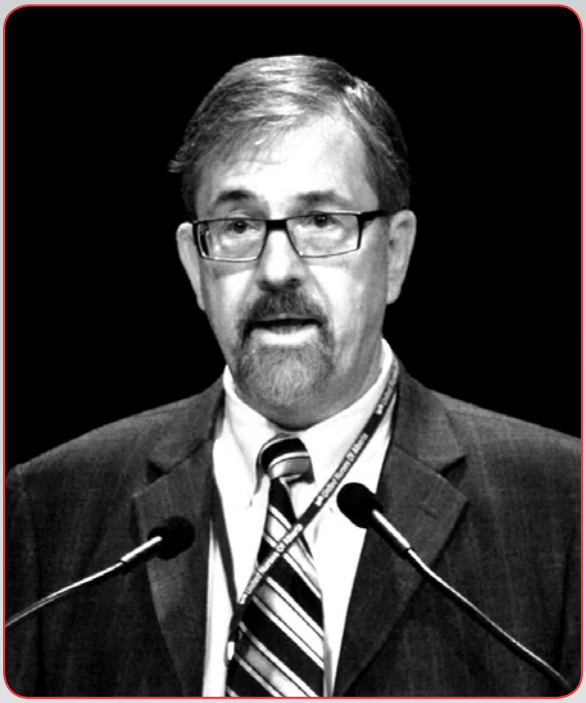
Pension contributions going up 1.57% in January

The Local Authorities Pension Plan Board of Trustees decided in July that it had to increase contribution rates. Contributions will increase on January 1, 2009 by a total of 1.57% of pensionable salary.

The increase is spread over both the Employee and the Employer. For example, if you are currently earning $75,000/year your monthly contribution will increase from $494.36 to $546.52. Your employer's contribution will increase from $556.87 to $609.02.

LAPP said advice from the plan's actuary was that the rates must be increased to maintain the plan's long-term funding security. Members living longer, investment market turmoil and other factors lead to the increase.

For more information: www.lapp.ab.ca



plan for your future

Warm welcome for new Filipino nurses

Innovative integration of IENs

When a flight with new nurses from the Philippines arrived at the Edmonton International Airport recently it was quite the scene. There was a big Welcome banner and a whole welcoming committee there to meet the newly arriving "Internationally Educated Nurses" or IENs.

> *"It was wonderful to see this extraordinarily warm and thoughtful welcome that can help them get a good start in Canada."*
>
> *Local #301 President BettyAnn Emery*

"What a heartwarming sight the group was!" says Local #301 President BettyAnn Emery.

She said the new nurses were greeted with warm smiles, hugs and laughter.

"We are desperate to get these nurses here, we really need them. They do have a big challenge ahead, with lots to learn to get up to speed," BettyAnn Emery says. "It was wonderful to see this extraordinarily warm and thoughtful welcome that can help them get a good start in Canada."

The wonderful welcoming committee it turns out, are Edmonton nurses, some of them members of BettyAnn's Local at the University of Alberta Hospital. They are with the Filipino Nurses' Association in Alberta and they are volunteering to help new Filipino nurses adjust.

"We try to make life easier for them coming to a new community," says Elena Lardizabal, who is Vice President of the Filipino Nurses in Edmonton. Elena retired not too long ago from a lengthy career in intensive care, neuro surgery and several other units at the U of A Hospital. Like many other "retirees", she still picks up shifts. Elena remembers how difficult it was when she first came to Canada many years ago. "There was no support like this," she says. "We want to help with their integration and help them settle in."

Elena says they don't overdo the big welcome at the airport. The nurses have been on an almost continuous 16 hour flight from Manila and really appreciate getting to a place where they can comfortably rest.

The Filipino Nurses Association approached Capital Health about helping out and have an arrangement to billet the new nurses for up to 45 days, and Capital Health picks up the costs. The month-and-a-half gives the IENs a chance to get on their feet and find a place to live, but some still stay on as boarders with their host family. The Filipino nurses also assist Capital Health with orientation for the new arrivals.

Rebecca Aizenman and Mel Teghtmeyer from Friends of Medicare address the memorial.

UNA President Heather Smith presents a brick from the old Calgary General building to Diane Lantz, president of UNA Local #1 at the Peter Lougheed Centre. They are holding up a poster of photos showing the explosion and crumbling demolition of the General Buildings in 1998.

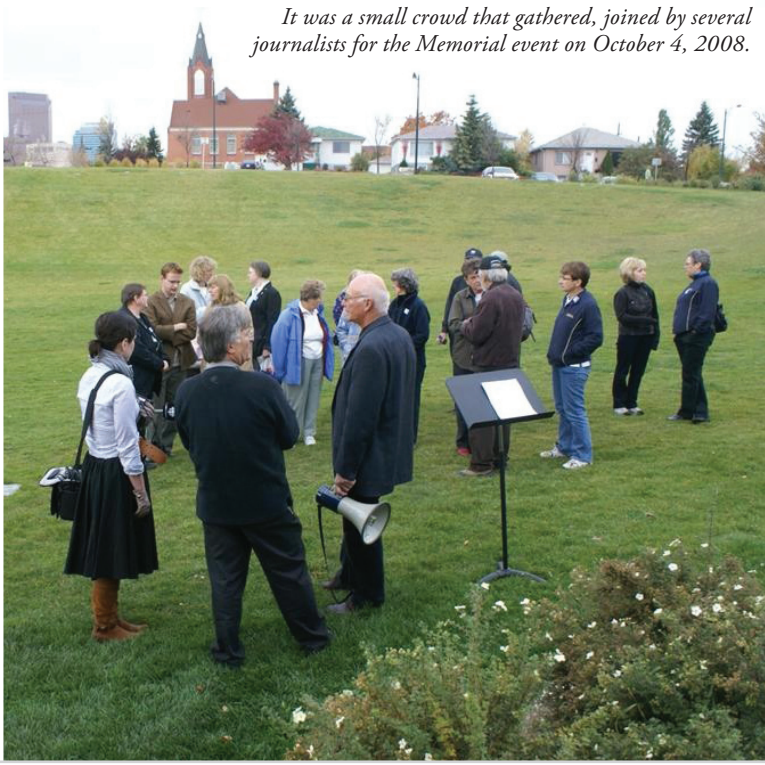
Special memorial marks 10th Anniversary of destruction of Calgary General.

"It was 10 years ago on a sunny Sunday, October 4th, 1998, that the General Hospital, an important icon of the Calgary skyline, was demolished," Ted Woynillowicz of Friends of Medicare in Calgary told the small crowd who'd gathered for the Memorial ceremony for the Calgary General, this October.

Woynillowicz went on to explain some of the consequences of the closure: "During the irrational cost cutting of the 90's, closures of hospitals occurred in many communities across Canada but the demise of the General was significantly different from those of other hospitals... First, the General was the largest hospital in North America to be shut down and have its equipment, staff, and patients integrated into the remaining hospitals. Secondly, it left Calgary as the only large city in Canada without an emergency department in the downtown core."

Mrs. Mairi Matheson, the last chair of the board of the General was not able to come to the memorial event but sent a message: "As you know I fought along with all the courageous souls that wanted to "Keep the General" and I shall always be grateful to those who then and now fight for quality healthcare for our citizens."

The Calgary General Hospital had a long history in the community. It opened its doors on November of 1890 with 8 beds in a two-story frame house. 20 years later (1910) a new Calgary General opened here on the banks of the Bow River in what was to be its permanent site. In the 1950s a new core building, nurses residence and school of nursing opened. By 1977 the capacity reached 960 beds with the opening of the Centennial Wing, including Canada's first forensic psychiatric unit in any general hospital.



It was a small crowd that gathered, joined by several journalists for the Memorial event on October 4, 2008.

National Report says for-profit health clinics are eroding our health system

89 suspected violations of Canada Health Act

In October Health Coalitions across Canada released a ground-breaking report investigating 130 for-profit surgical, MRI/CT and "boutique" physician clinics. Researchers found evidence to suspect 89 possible violations in 5 provinces of the Canada Health Act's requirement for equal access to hospital and physician care and prohibition on extra-billing patients. The report reveals a new phenomenon of a for-profit health industry that has emerged significantly over the last five years, and the first forays of U.S. private health companies into Canada.

Friends of Medicare Executive Director David Eggen

In Alberta the new Copeman Clinic in Calgary was one of several for-profit health services documented in the report. "The study shoots a big hole into the mythology of "choice" and "taking pressure off the public system" that private medicine advocates like to talk about. How many of us can "choose" to pay 13 to 20 thousand dollars for knee surgery?" said David Eggen of Friends of Medicare in Alberta.

Report author, Natalie Mehra, Director of the Ontario Health Coalition called upon the federal government to live up to its responsibility to protect Canadians from extra-billing and two-tier health care:

"We found evidence that for-profit clinics are eroding the fairness and equality of Canada's health system that is supposed to provide access to necessary hospital and physician services based on need, not wealth. A significant proportion of for-profit surgical and diagnostic clinics are billing provincial health plans and also charging extra fees to patients to maximize their revenues and profits," she explained. "The charges are unaffordable for all but the wealthiest Canadians. Clinics told us they charge $13,000 - $20,000 or more for knee surgery, $1,200 - $2,000 or more for cataract surgery, and hundreds to thousands of dollars for MRIs."

"For-profit clinics are also taking specialists, health professionals and operating room nurses out of local public hospitals to serve less urgent patients, often for extra fees. Despite claims about reducing wait times, we found direct evidence that poaching staff out of local hospitals by for-profit clinics worsened shortages in local hospitals forcing the hospitals to reduce MRI hours. We found evidence of staff poaching out of local hospitals by for-profit clinics in Nova Scotia, Quebec, British Columbia, Ontario and Manitoba."

"Ironically, while some provinces are considering introducing for-profit clinics for the first time, we found that three provinces – Alberta, Ontario and Manitoba, under governments of varying political stripes -- all have rolled back their experiments with for-profit MRI/CT clinics or surgical clinics, opting instead to build capacity in the public non-profit health system where access is improved on an equitable basis. In Ontario and Manitoba, the for-profit cancer and cataract surgery clinics revealed direct evidence of higher costs per treatment than non-profit clinics. This should serve as a warning to provinces like Quebec, New Brunswick, Nova Scotia, Saskatchewan and British Columbia where more for-profit privatization of health care is being considered."

"We found that the for-profit clinics overwhelmingly locate in large urban centres where there are more wealthy people to buy their health care procedures, raising concerns about worsening access in rural areas," she added.

"This report should serve as a wake up call and a call to action. The federal government is required, by law, to ensure that patients are not exploited by extra-billing or two-tier health care. In turn, our provincial governments have failed to set up adequate regulatory and enforcement regimes to protect patients. The evidence is clear that the for-profit health care industry is undermining equal and fair access to health care for all Canadians by taking resources out of the public health system, by selling two-tier access and by levying extra charges on patients.

The full report in English and a French summary are available at www.ontariohealthcoalition.ca or www.healthcoalition.ca

Nursing News

New Brunswick nurses moving to strike vote

At press time the New Brunswick Nurses Union (NBNU) had decided to proceed to a strike vote on their provincial contract negotiations.

"The bottom line is that Government is not willing to address working conditions by improving compensation for nurses working shifts and weekends. This is a question of respect," said Marilyn Quinn.

"Too many nurses are working short-handed every shift they work. Overtime and double shifts are a daily occurrence. It's beginning to take a toll on our nurses. How long can nurses go on working a 12-hour shift, go home and sleep four hours, and then return to work for another 12 hours?" said Ms. Quinn.

The government said it had offered 11.5 per cent on salaries and was willing to move on other items.

Liepert delays Lethbridge Extendicare closure

Health minister Ron Liepert announced in November he would delay the closure of Extendicare in Lethbridge – a full nursing home with 120 residents. The plan had been to close the last full care nursing home in Lethbridge next July. Significant public pressure from family members and Friends of Medicare may have forced Liepert to delay. Health spokespeople said they were waiting for a new designated assisted living residence to be built which would take up to two years.

Public Interest Alberta looking for help keeping pressure on Long-term Care

Public Interest Alberta is looking for people to help keep up pressure on the government to stop privatization and improve quality of long-term care. PIA's Seniors Task Force has met with the Premier and three different Ministers of Seniors. But Bill Moore-Kilgannon says it is vital that all Members of the Legislature hear directly from their constituents about these issues. This is why we are setting up our "MLA Teams" to make sure all politicians are made aware of the on-going issues in seniors care and that we keep the heat up for them to invest in our public care system.

These teams will meet with their MLAs three or four times per year, so it will not involve too much of your time. To sign up for one of these teams, please visit www.teams.pialberta.org or call PIA at (780) 420-0471.

UNA's Silvie Montier awarded national rescue honour

UNA Labour Relations Officer Silvie Montier recently travelled to St. John's, Newfoundland where she was presented with Canada's Outstanding Search and Rescue Achievement Award. Silvie Montier is a founding member of the Canadian Search & Disaster Dogs Association, or CASDDA. As a volunteer dog trainer, Montier has assisted in several rescue missions, both home and abroad. Silvie began training dogs when she was 11. Training rescue dogs and taking them into disaster situations has become her passion. She has travelled with her dogs, and husband Richard Lee to many disaster situations, including last year to the site of an earthquake in southern Peru that claimed 500 lives. While it is important to find any survivors and rescue them, Silvie points out it is also extremely important for family members to find the bodies of victims. "As long as the body is not pulled out of there, they always have the hope," she told the Edmonton Journal for a special feature story on her award.

LRO Silvie Montier with Canada's Outstanding Search and Rescue Achievement Award.

Bait and switch staffing plan

Can a nurse picking up an extra or casual shift turn around and go home again if it turns out to be on a different unit than advertised? UNA is considering how nurses should respond to this situation which some nurses consider to be a "bait and switch" staffing scheme. Managers or supervisors call nurses in for a shift on a particular unit, but then when the nurse arrives, he or she is told to report to another, far-more-difficult-to-staff, unit.

Any nurse who walks away from a shift after arriving on the property could face serious repercussions. They could face a complaint with their professional college for abandoning patients, or they could face discipline from their employer.

Nurses offered a shift on a particular unit should ask again to double check that it is clear which unit is involved. If the unit is later switched to a far more difficult, heavier load, or less palatable unit, the nurse should ask questions to find out if a "bait and switch" scheme is being used. If there is clear evidence of "bait and switch" the nurse should alert their Local executive members, or their Labour Relations officer to this practice.

Many nurses would likely be reluctant to accept further extra shifts, if they believe the units are being switched under false pretences.

Pharmacists avert strike at Rexall

Pharmacists and Pharmacy Technicians who undertake specialized services for organ transplant, HIV/AIDS and pediatric outpatients, nearly were forced into a strike situation by their employer, Darryl Katz owner of Rexall group. After taking a unanimous strike vote the 30 pharmacy staff re-entered negotiations and reached a tentative agreement. The small group of pharmacy workers are members of the Health Sciences Association of Alberta and they were quite prepared to take on the drug giant Rexall.

Secretary Treasurer Karen Craik poses with the WORKUS tent. The display was set up at the AGM. The WORKUS is a story-collecting, story-telling 'mobile-installation' that is travelling around Alberta. Happy worker images on outside of the WORKUS contrast with the stories inside, which expose the hidden epidemic of workplace related illnesses and chronic ailments. The WORKUS is a program of the Alberta Workers' Health Centre.

Nurse samaritan...

UNA recently took a phone call from Peggy Kemp, who really wanted to thank a nurse who helped her and her mother.

"It was like a miracle. I almost imagine he appeared in a puff of smoke," Peggy says about the nurse who came to the aid of her mother at a Safeway in Edmonton on October 25.

Peggy and her 85-year old mother were going shopping on the windiest day Edmonton has seen in years. One of the powerful gusts blew the older woman right down and knocked her out.

Peggy said she panicked. Her mother was on the ground, with her eyes open but completely unresponsive and immobile. "I thought she was dead."

Peggy screamed for help and dialed 911.

"This fellow came running up, so calm and wonderful," she reports. "I didn't even know he was a nurse. He just calmly took charge and focused on my mother. He was so nice to her."

Peggy called UNA Provincial Office because she says she completely missed thanking this nurse. "I feel so bad, I never even had a chance to thank him. Please tell him thanks for me."

An ambulance took Peggy and her mother to the University of Alberta Emergency. "The nurses there were just amazing. They are my heroes right now. One even got my mother a sandwich, because she was starving, she hadn't eaten for hours. All this while they had many other serious cases coming through."

Peggy's mother is alright. She had a concussion and lost a couple of hours of memory, but is back functioning fine. Peggy herself is greatly relieved and appreciative of the nurses who helped.

Apology Act cuts possible liability

This fall, Alberta followed Ontario's lead by passing an amendment to the Evidence Act that allows individuals and organizations to offer an apology without fear of it being used against them in court. The change should help reduce a culture of secrecy in health care and allow a more human interaction with patients when mistakes happen. The logic is that admitting a problem and apologizing keeps the nurse patient relationship stronger and helps move on.

Holiday Office Closure

Please be advised both the UNA offices will close at 1200 hours Wednesday, December 24 and will re-open at 0830 hours on Monday, January 5, 2009.

Nurses are advocates

for our patients, for public health care for ALL Albertans

Stella Chorney, RN could have retired long ago, but she's still caring for patients. It's what she loves to do.

Stella Chorney from Fort Saskatchewan got her picture taken with the lovely Miss Elizabeth Milligan-Coyle, but she also appears with her daughter, Brenda Venesia on the cover of this year's UNA Nurses' Planner which is included with this issue.

Publications Mail Agreement #40064422