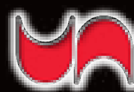
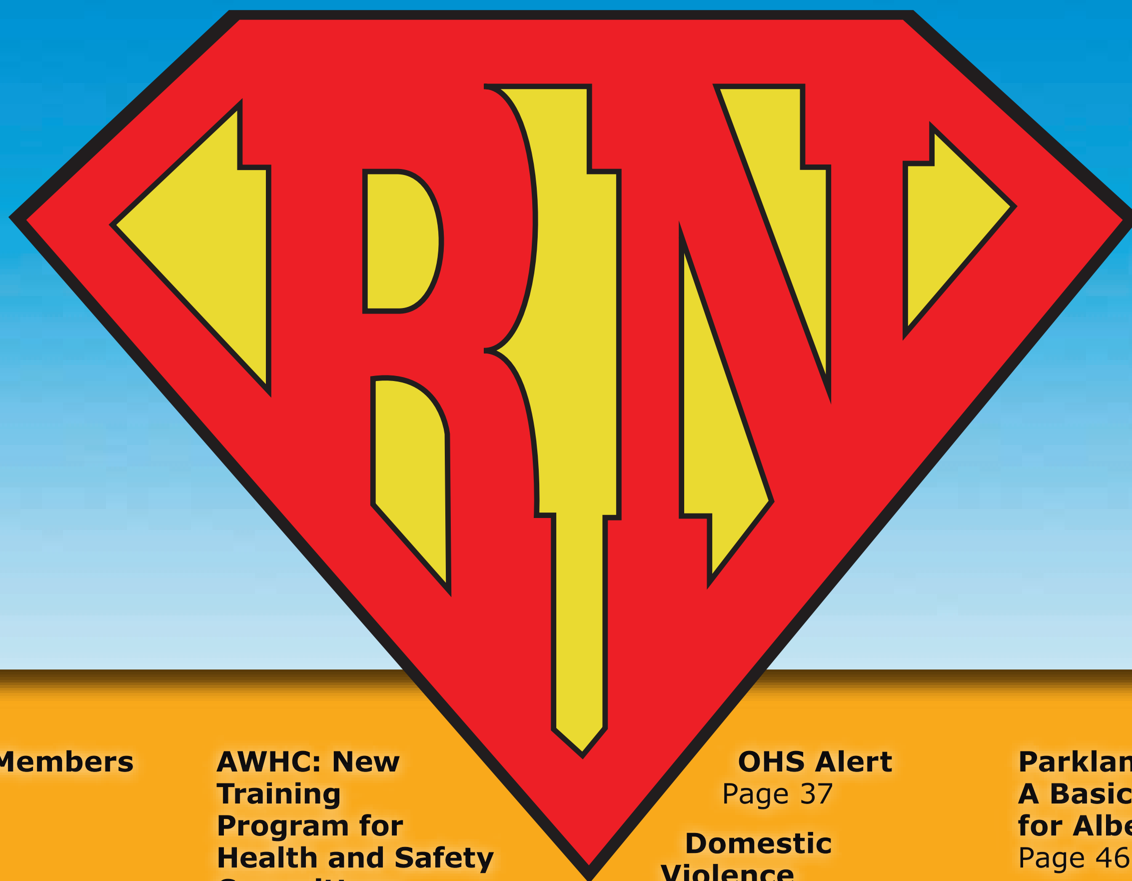
Spring 2020

NewsLetter



United Nurses of Alberta



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For the Latest Contract Interpretation Discussion Check out the FirstClass Contract Issues Conference Through UNANet!!!

What is UNANet?

UNANet is an online system that provides digital access to all that is the United Nurses of Alberta. The two major components of the the system are **FirstClass** and the **Data Management System**, commonly referred to as DMS. Benefits of each include…

FirstClass:

- Get your own UNA Email Address! FirstClass provides you with a union email address, _____@una.ab.ca. UNA email is private, has excellent SPAM and email virus protection, and comes with direct access to computer education and support personnel for troubleshooting inquiries. Communication with your Local Executive, LRO, UNA Staff, Executive Officers, and other UNANet users is always secure; they never pass through the Employer's email servers (or Telus' or Shaw's) and remain contained within the UNANet service.
- Gain access to up to the minute news, information & discussion through various folders and Conferences including Negotiations, Member Resources, News, Local 115 Membership, PRC, OH&S and much more. The Conferences are much like an email chat room where members can participate in discussion with nurses from around the province and post questions which are responded to by experienced UNA staff. For example, inquiries about the collective agreement can be posted in the "Contract Issues" Conference which is monitored and responded to by Labour Relations staff who are UNA's experts in contract interpretation.

Data Management System (DMS):

- Access and update your on-file personal information, file Expense Claims, view Union pay stubs, T4's, personally submitted PRC and OH&S forms, job postings, and dates for upcoming workshops like the popular "Know Your Rights" and "Dealing with Abuse".
- Download our App for your handheld device by searching "UNA" in the App Store which not only provides you direct access to DMS, but also to the Collective Agreement, your UNA membership card, and which you can use to register directly for workshops and events.

Activate your account today: http://una.ab.ca/unanet

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Heroes

By Sheldon Vogt,
Local 115 Executive Secretary,
United Nurses of Alberta

"I think a hero is an ordinary individual who finds strength to persevere and endure in spite of overwhelming obstacles." – Superman

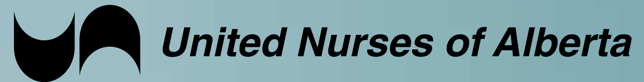
The above image was first shared on Twitter April 22nd by a comic book store out of Barcelona, Spain, and has since gone viral in the wake of the caronavirus pandemic. Besides the overarching unease of a crowded hospital hallway free of social-distancing, maskless crime fighters and protectors of the galaxy serving as an immediate public health hazard, and that one nurse who I'm sure would say is "clean"while strolling the hallway wearing gloves, is appreciation, respect, and recognition of real heroes, at a time the world desperately needs them most.

While the sentiment of this image is welcomed, our current situation reminds us of all the times we've begged for more staff, more resources, better equipment, and safer working environments long before the current pandemic. We warned of situations that that fell outside of what was seen as "normal" and expressed concerns surrounding our system's ability to respond. Through all of this we were met with trained tactful administrative gobbledy-goop, empty promises, and stubborn opposition, far removed from the day-to-day experience lived by working nurses everywhere.

We've worked tirelessly 365 days a year, 24 hours a day for generations. It's time for those expressing their gratitude to help us advocate for conditions that allow us to provide for people the way that they deserve rather than the way the budget allows. It's time for our leaders who currently speak our praises to put up or shut up. We are the heroes and we've been here from the beginning.

Sheldon Vogt

Executive Secretary Local 115
United Nurses of Alberta



RN RPN

www.una.ab.ca facebook.com/unitednurses twitter.com/unitednurses

April 28

DAY OF MOURNING

for those injured or killed on the job

YOU ARE INVITED TO A ZOOM WEBINAR EVENT

TUESDAY, APRIL 28TH, 2020 AT NOON

ZOOM WEBINAR ID: 986 737 453

+1 587 328 1099

to join: https://zoom.us/j/986737453

CALGARY & DISTRICT LABOUR COUNCIL
#321, 3132-26 ST. NE CALGARY, AB T1Y 6Z1

Alberta seniors deserve better now & moving forward

Seniors in Continuing Care facilities now count for over half of all COVID-19 deaths in Alberta (29 of 46). As of April 13th, the number of those who tested positive in continuing care facilities was 199 and rising. There is no data yet available as to how many workers who provide care to seniors have tested positive.

For decades, FOM and seniors' advocates have been sounding the alarm over issues in our seniors' care system. We have repeatedly called on governments to get profits out of seniors' care, and to enact patient-staff ratios to address unsustainable workloads which lead to burnout for the staff, and which degrade the quality of care and attention that seniors receive. We have called for an end to the increasing privatization of seniors' care abetted by government grant programs that subsidize the building of privately owned and operated supportive living facilities. But despite our calls, we have instead seen a drop in funding such that staff are tasked with not only personal care, but housekeeping duties. This is not only an egregious misuse of much needed care staff, but now in light of COVID-19, it poses the possibility of cross contamination. We have seen a race to the bottom when it comes to providing quality care for seniors, and an ever increasing offloading of costs and care to seniors and their families.

"We are weeks into this pandemic and it is becoming more evident by the day that the chickens have come home to roost when it comes to the crisis in our seniors' care," indicates Sandra Azocar, Executive Director of Friends of Medicare. "For too long, our governments have largely ignored the way that we have been caring for our most vulnerable. What we are seeing now was decades in the making."

As of April 16th, workers in long-term care and designated supportive living sites will only be allowed to work in one location. Facilities have up until April 23rd to ensure that this measure is in place. Until now, the majority of care staff have been required to move from one care site to another, as they are unable to make ends meet with the number of hours they are given in each facility. Most have multiple jobs that they move between in long-term care homes, hospitals, home care and other places, but now, staff are being instructed to choose just one part-time job with no income replacement, all while taking on personal risk to continue to help all of us through this pandemic.

"Homes already operate with severe shortages of staff, which means many seniors go without the care they need. With COVID-19, the pressures have only increased, and we are seeing the consequences in black and white," states Azocar. "The conditions of work are the conditions of care for residents and their families."

To support residents and staff in Alberta's continuing care system and to curb the spread of COVID-19, Friends of Medicare is urgently calling for the following measures from our provincial government:

- All staff must be immediately provided with personal protective equipment (PPE) in accordance with the precautionary principle, including N95 masks for those exposed to residents with suspected or confirmed COVID-19 infection. In addition, all homes must be provided with necessary support to provide training to staff in the use of PPE immediately.
- Given that seniors' facilities will not be able to rely on residents' families and/or paid companions to fill the existing staffing gaps that have been exacerbated by this pandemic, the provincial government must support the workforce to be able to work full-time whenever possible.
- Staffing levels must be put in place so that seniors receive the care they need, and where gaps in staffing and care levels exist, the most robust possible recruitment of appropriately trained staff must be implemented as per existing regulations.
- Provincial government resources and policy must be immediately provided to improve wages and conditions for staff, and to support the stabilization of the workforce and recruitment efforts with the provision that all operators (public, not-for-profit, and for-profit alike) be obliged to expend these funds on direct care staffing.
- All seniors' care facilities must be legally bound to minimum staffing levels established in relation to experts' assessments of the levels required to ensure equality care.
- Regular, unannounced inspection must be implemented to ensure compliance with high standards of care and safety and current health orders by the CMOH.

Even when this pandemic is lifted, and the brunt of the threat of COVID-19 has passed, the toll that it has taken on our seniors should serve as a harrowing reminder of the failure of our seniors' care system. It will not be enough for us to return to normal, because in Alberta, our continuing care system's normal is woefully flawed. For seniors now and for years to come, we have a responsibility to do better.

Alberta
Seniors
Deserve
Better

COVID-19 INFORMATION

HELP PREVENT THE SPREAD

Prevention starts with awareness. Be informed on how you can protect yourself and others from COVID-19.

- Now mandatory to self-isolate for 10 days if you're feeling sick
- Now mandatory to self isolate for 14 days if you're returning from international travel, or in close contact with people confirmed to have COVID-19
- Stay home – if you must leave your home, maintain physical distancing of 2 metres
- Wash your hands frequently for at least 20 seconds
- Cover coughs and sneezes
- Avoid touching your face

Stay informed on how you can help prevent the spread.

alberta.ca/covid19

March 31, 2020

PREVENT THE SPREAD OF CORONAVIRUS

You can help prevent the spread of COVID-19 in Alberta. Prevention starts with awareness.

- Practice physical distancing
- Self-isolate if you're feeling sick
- Wash your hands frequently
- Cover coughs and sneezes
- Avoid touching your face
- Do not travel outside of Canada

PRACTICE PHYSICAL DISTANCING

All Albertans have a responsibility to help prevent the spread of COVID-19. Take steps to protect yourself and others:

- Limit the number of times you leave your home
- Stay at least 2 meters away from others when you go out for groceries, medical trips, and other essential needs
- Have groceries or other items delivered if possible
- If you go outside for fresh air maintain 2 meters distance from others
- Avoid overcrowding in elevators and other enclosed spaces
- Wash your hands after touching communal surfaces such as handrails, handles
- Postpone family visits, friend gatherings, and group outings, especially if household or family members are senior citizens or have high-risk medical conditions
- Do not gather with other people if you have a fever or a cough, even if symptoms appear to be mild.
- Obey all mandatory self-isolation requirements and mass gathering restrictions now in place in Alberta.

Legally enforceable public health measures are in place to limit the time Albertans spend in contact with each other. Anyone violating these restrictions is now subject to fines.

MONITOR YOUR SYMPTOMS

COVID-19 symptoms are similar to influenza and other respiratory illnesses. Symptoms can include:

- cough
- fever
- shortness of breath
- runny nose
- sore throat

If you have any of these symptoms stay home and self-isolate; do not go to an ER or medical clinic. **Call Health Link at 8-1-1 for more information**. Services are available in 240 languages.

SELF ISOLATE

You are legally required to self-isolate for:

- **14 days** if you returned from international travel or are a close contact of a person with COVID-19
- **10 days** if you have a cough, fever, shortness of breath, runny nose, or sore throat that is not related to a pre-existing illness or health condition

If you are self-isolating:

- Stay home — do not go to work, social events or any other public areas or community settings
- Avoid close contact with other people, including household members but especially seniors and people with chronic conditions or compromised immune systems
- Do not use public transportation or ride sharing
- Do not go for walks in public places. This includes children in mandatory self-isolation.
- If you go outside, you must remain on private property not accessible by others.
- If you live in an apartment building or high-rise, you must stay inside and cannot use the elevators or stairwells. If your balcony is private and at least 2 metres away from other balconies, you may use your balcony to get fresh air.

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POSITION STATEMENT

MARCH 23, 2020

Safety Is Not Negotiable
Pandemic Preparedness – the Coronavirus 2019 (COVID-19)

> *The point is not who is right and who is wrong about airborne transmission. The point is not science but safety. Scientific knowledge changes constantly. Yesterday's scientific dogma is today's discarded fable. When it comes to worker safety in hospitals, we should not be driven by the scientific dogma of yesterday or even the scientific dogma of today. We should be driven by the precautionary principle that reasonable steps to reduce risk should not await scientific certainty. Until this precautionary principle is fully recognized, mandated and enforced in Ontario's hospitals, workers will continue to be at risk.*
>
> **Justice Campbell, Chair of the SARS Commission**

POSITION

New evidence and information on COVID-19 is emerging daily, and CFNU's recommendations remain based on emerging science and Occupational Health and Safety principles, including the precautionary principle; in particular, as it applies to nurses using their professional clinical judgment[1] when performing a point-of-care risk assessment[2]. As well, the occupational health and safety principle of the hierarchy of controls applies. It starts with eliminating the hazard when possible. When that cannot be accomplished, a combination of engineering and administrative controls, combined with personal protective equipment, must be applied. The system is called a hierarchy because you must apply each level in the order that they fall in the list; a systematic comprehensive approach must be taken to reducing hazards; a hierarchy of controls cannot be applied in a piecemeal fashion.

Examples of engineering controls: plexiglas barriers; negative pressure rooms; private rooms with private toilet and patient sink; HEPA filters; an appropriate supply of and accessibility to PPE; designated hand washing sinks for HCW use.

Examples of administrative controls: training on the employer's pandemic plan; active screening protocols; respiratory protection program; enhanced environmental cleaning; application of precautions (droplet, contact, airborne); safe patient transportation policies; training, testing and drilling; education, surveillance and auditing practices; visitor restriction policies; policies on PPE; policies on supply of PPE.

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[1] Professional judgement: knowledge, skills, reasoning and education.

[2] Point-of-care risk assessment: a risk assessment undertaken by the HCW prior to any interaction with the patient to determine the risk based on, for example, the client symptoms, the specific task, or the environment and the related potential for exposure, in order to determine the appropriate personal protective equipment (PPE) to protect themselves and their patients, and prevent and control the spread of infectious viruses in acute care, long-term care and the community.

Source: U.S. Centers for Disease Control and Prevention (CDC)

As promised, our Network of Occupational Health & Safety (OH&S) experts have reviewed and revised CFNU's position on COVID-19 as of March 23, 2020, in light of the declaration of a pandemic by the World Health Organization and the spread of the virus throughout Canada.

It is the position of the Canadian Federation of Nurses Unions (CFNU) that, in the event of an outbreak of any new respiratory virus, we acknowledge that the best respiratory protection for health care workers at risk is a fit-tested N95 or greater respirator (e.g., powered air-purifying respirator (PAPR), given emerging science and the precautionary principle.

- All nurses and frontline health care workers at risk in their area of work (based on an organizational infectious disease risk assessment) with the potential for exposure, and/or who are caring for a suspected or confirmed 2019 novel coronavirus patient, should be provided, fitted for and have access to a NIOSH-approved N95 or greater respirator (e.g., powered air-purifying respirator (PAPR)), and trained, tested and drilled to safely don and doff it by the employer.
- The CFNU recognizes the critical importance of the point-of-care risk assessment (PCRA), an activity that is based on the individual nurses' professional judgment (i.e., knowledge, skills, reasoning and education). All nurses and frontline health care workers at risk in their area of work are required to perform a point-of-care risk assessment. If a nurse feels the protective equipment they have been provided is inadequate, given the patient acuity, environment or other factors, they should be able to access a higher level of PPE.
- At a minimum, as required of and by employers, all employees must also be equipped with personal protective equipment for contact and droplets precautions for suspected, presumed or confirmed cases of COVID-19, including gloves, eye protection (face shield and goggles), isolation gowns and surgical/procedural masks, for which they must also be trained and drilled in safe use.
- Airborne precautions and the use of respirators N95 or higher must be mandated at all times in clinical areas considered aerosol-generating medical procedures 'hot

spots' (e.g.: intensive care units (ICU), emergency rooms, operating rooms, post-anaesthetic care units and trauma centres) that are managing COVID-19 patients.

Point-Of-Care Risk Assessment (PCRA)

Given the amount of uncertainty around COVID-19 and the current threat to health care workers across Canada, the Canadian Federation of Nurses Unions (CFNU) recognizes the critical importance of the point-of-care risk assessment (PCRA), an activity that is based on the individual nurses' professional judgment (i.e., knowledge, skills, reasoning and education). Underlying the PCRA is the principle that individual health care workers are best positioned to determine the appropriate personal protective equipment (PPE) required based on the situation and their interactions with an individual patient. They do so by evaluating the likelihood of exposure to themselves or others based on a specific task, environment, conditions, interaction or patient. Among the factors that should be considered in the PCRA are: the potential for contamination of skin or clothing; exposure to blood, body fluids or respiratory secretions; the potential for inhaling contaminated air; the patient's ability or willingness to comply with infection control practices (e.g., wearing a mask); whether care requires very close contact; what engineering and administration controls are in place; and whether the patient could require an aerosol-generating medical procedure at any point and/or is in an aerosol-generating hot spot" (e.g.: intensive care units, emergency rooms, operating rooms, post-anesthetic care units and trauma centres) that are managing COVID-19 patients. Personal protective equipment should be selected based on the potential for exposure in order to minimize the risk of exposure to HCWs, a specific patient or other patients in the environment.

Screening and Triage

For those workers involved in triage and screening and testing for COVID-19, ideally a floor-to-ceiling plexiglas barrier with speaker phone would eliminate worker exposure to the hazard if there was no further direct contact with a patient required. However, if the barrier is not in place and direct contact is required, other administrative and engineering controls such as disposable equipment, signage procedures, training, separate examination rooms and waiting area should be in place before direct contact with the patient, and workers must be equipped with the PPE described above, trained and drilled in its use. Patients should be provided with surgical masks as a source control to be donned before entering the health care environment. Further, it is evident that for the direct care/treatment of presumed and confirmed cases, engineering controls are insufficient to prevent exposure.

Nasopharyngeal Swab

For those engaged in taking a nasopharyngeal swab for obtaining specimens for testing from patients with known or suspected cases of COVID-19: HCWs must perform a PCRA to determine the level of risk. Some factors to consider are the patient's respiratory secretions, the frequency and severity of coughing, any breathing difficulties and whether there is a fever. If the PCRA indicates the need for respiratory protection, a fit-tested N95 respirator as a minimum must be worn.

Designation of aerosol-generating medical procedures hot spots

- All workers in so-called 'hot spots' where there could be aerosol-generating medical procedures (AGMP) (e.g.: intensive care units, emergency rooms, operating rooms, post-anaesthetic care units, negative pressure rooms, single-patient rooms used to isolate patients in absence of negative pressure rooms, and trauma centres) that are managing COVID-19 patients should wear at least N95 respirators or greater (e.g., powered air-purifying respirator (PAPR)) at all times; head and foot protection; eye protection (e.g., face shield that covers the sides of the face); gloves; impermeable gowns, or at least fluid-resistance gowns, as they may suddenly be required to undertake an AGMP (e.g., intubation) and thus may risk exposure to the virus.
- Having zones of the hospital dedicated to patients with presumed or confirmed cases of COVID-19, as is taking place in other jurisdictions, would also be useful; workers in these zones would be required to wear at least N95 respirator masks.

Precautionary Principle and OH&S Law

A recent legal opinion posted by a leading Canadian law firm Osler, Hoskins & Harcourt LLP recommends employers "benchmark to current best practices" and follow "appropriate precautionary measures": *"Where there is conflicting evidence as to whether a certain precautionary measure is required or not, hospitals should adopt the elevated precautionary measure(s). Hospitals should be cognizant that it will be the hospital that will be legally liable for any failures to protect patients and staff from harm, even if hospitals have relied on federal, provincial or municipal government directives in establishing its own plans, policies and procedures."*[3]

This legal opinion makes it clear that health care employers must respect nurses' professional judgement as expressed through the PCRA to determine when and where to use PPEs and to determine under what circumstances the level of PPE needs to be increased. The CFNU is clear that the clinical judgement of our members – as expressed through the PCRA – should prevail.

Employers' responsibilities are clearly laid out in provincial OH&S law: employers must work with joint OH&S committees on their pandemic plans, protocols and measures; provide training, testing and drilling for all employees on health and safety measures; establish a respiratory protection plan and provide fit-testing for N95 respirators to all employees who may need them as based on their areas of work or potential work responsibilities; and employers are also responsible for making PPE readily accessible and available to health care teams so they can do their jobs safely.

Several jurisdictions in Canada have established surgical masks as part of the precautions to be used with suspected and actual COVID-19 patients, when not involved in AGMPs. The CFNU rejects the 'blanket' rules currently in place which treat the safety of health care

[3] https://www.osler.com/en/resources/governance/2020/coronavirus-covid-19-lessons-learned-from-sars-a-guide-for-hospitals-and-employers

workers as an afterthought and fail to respect their professional judgement in undertaking a PCRA.

It is our position that a pan-Canadian approach to emergency preparedness must incorporate the precautionary principle so that all nurses and health care workers across Canada have the same access to health and safety in their workplaces, including the same standard for personal protective equipment (PPE) and pandemic planning. If the precautionary principle is not instituted throughout the health care system, which includes long-term care facilities, nurses and other health care workers could readily become vectors spreading the disease to each other and their patients and families. Further, it is crucial for effective infection control and health and safety strategies that a hierarchy of controls (engineering, administrative and at the worker level) be developed and implemented throughout the organization, in conjunction with joint health & safety committees that include direct care providers (including nurses) and their unions.

If AT ANY TIME you feel that your employer is not following the OH&S laws and principles as outlined above, please contact your union immediately.

The above position draws on international guidance on infection prevention and control in health care settings from the U.S. Centers for Disease Control and Prevention (CDC), the EU European Centre for Disease Prevention and Control (ECDC), and similar guidance in the UK and Australia. For more information, visit CFNU's website for information on international infection control and prevention guidance, and the current science related to COVID-19, including how it spreads and the efficacy of personal protective equipment.

Nurses are expected to be prepared, 24 hours a day, to face any number of health emergencies. The ability to respond quickly and efficiently to emergencies is fundamental to the nursing profession. However, rapid response requires the support of many parts of the health care system. It requires emergency preparedness planning, proper administrative and engineering controls, the support of the administrators of the health system, as well as the government to ensure the necessary protocols, measures, procedures, training and protective equipment that take into consideration risk and the precautionary principle.

For workers, we recognize the critical importance of the point-of-care risk assessment and that individual health care workers, using their knowledge, skills, judgement and education, are best positioned to determine the appropriate PPE required based on their interaction with an individual patient in a particular environment.

Questions or concerns? If you have any questions or concerns, please speak with your union or a member of your Joint Occupational Health & Safety committee.

EMPLOYER'S CHECKLIST

- Consult the Joint Occupational Health & Safety Committee on all measures, procedures and training with respect to COVID-19.
- Review and update existing institutional pandemic plans, developed in conjunction with the joint OH&S committees, to ensure they include staffing, communication, education and training for staff with respect to pandemic preparedness plans and the health risks of the current emergency and/or pandemic situation.
- Ensure that workers have ready access to PPE, are regularly trained and fit-tested for the N95 respirator (at least biennially or in accordance with personnel changes) and regularly drilled in any potential hazards, including the reason for and use of protective equipment such as the N95 respirator and powered air-purifying respirator (PAPR), if available, how to don and doff all equipment, and all safety protocols.
- It is essential to ensure that health care providers are fully trained, tested and drilled in the care provisions/protocols required during a pandemic, including conducting a point-of-care risk assessment before each interaction with a patient and/or the patient's environment to evaluate the likelihood of exposure to contact, droplet and/or aerosols in care procedures, equipment and treatment settings to determine the appropriate safe work practices.
- Conduct a comprehensive organizational risk assessment, including determining all points of potential entry (and how to restrict them using prominent signage and limiting access) and other points of potential exposure for workers (e.g., screening, triage, isolation rooms).
- Implement changes in policies, procedures, equipment and the environment to eliminate or minimize identified risks in accordance with a hierarchy of controls approach to hazards.
- Have in place relevant travel screening and worksite/unit exposure controls. Ensure that sufficient protective measures and equipment are in place for all screening locations at all entry points.
- Have in place suitable structural barriers (e.g., ceiling-to-floor plexiglas barriers at triage and registration), disposable equipment, separate examination rooms and waiting area.
  - Have an adequate supply of appropriate N95 respirators, gloves, impermeable gowns or at least fluid-resistant gowns, head protection, face shield and foot protection as well as PAPR (for aerosol-generating medical procedures, e.g. intubation) and full body protection on hand.
- Have airborne infection isolation rooms (negative pressure rooms) available and prepared for immediate occupancy whenever possible.
- All workers operating in aerosol-generating medical procedure hot spots must wear N95 respirators, or preferably higher, at all times (e.g.: intensive care units, emergency rooms, operating rooms, post-anaesthetic care units, and trauma centres) that are managing COVID-19 patients.
- When a suspected patient is identified, implement isolation measures in a negative pressure room for those with symptoms and move patient immediately to this room, separate from other patients, with access to a dedicated washroom or commode, and ensure that only trained and properly equipped personnel (with appropriate PPE) are assigned as care providers and to enter these rooms.
- Create dedicated teams of clinicians who are protected with and trained, tested and drilled in the use of proper personal protective equipment for COVID-19, including teams trained in the use of N95 respirators and PAPR, if available (for aerosol-generating procedures), donning and doffing protocols, who can care for both suspected and confirmed cases of COVID-19.

- Ensure sufficient staffing is available to supplement nurses and other health workers who need to care for patients in isolation, and schedule work in a manner that allows for multiple rest periods and recovery periods, as well as implement systems for monitoring fatigue.
- Implement surge capacity protocols as needed.
- Implement cleaning protocols requiring, at a minimum, fit-tested N95, face shield, gloves, gown, head and foot protection, and waste disposal protocols. Use disposable equipment whenever possible; non-disposable equipment should be dedicated to the patient.

NURSE'S CHECKLIST

- Comply with existing workplace infection control policies and procedures.
- Stay home when you are ill.
- Update your N95 respirator fit testing and wear an N95 respirator if there could be any risk of exposure to COVID-19.
- Use required droplet, contact and additional airborne precautions such as (but not limited to): gloves, goggles, impermeable or at least fluid-resistant gowns, face shields, respirators, powered air-purifying respirators (PAPR) when available (for aerosol-generating medical procedures, e.g., intubation).
- Conduct a point-of-care risk assessment employing your professional judgement before each interaction with an affected patient and/or the patient's environment to evaluate the risk of exposure to contact and/or contaminated air in care procedures, equipment and treatment settings; at any time during this risk assessment nurses may request an increase in PPE.
- If you have any health conditions of concern when caring for COVID-19 presumed or confirmed cases, please consult your health care provider.
- Avoid touching your eyes, nose and mouth with hands to prevent self-contamination; clean hands before contact with any part of the body.
- Avoid contact between contaminated gloves/hands and equipment and the face, skin or clothing when removing PPE.
- Familiarize yourself with your collective agreement and legislation with respect to pandemic preparedness, occupational health and safety (OH&S) and the right to refuse dangerous work.
- **STOP if you do not have the required personal protective equipment or properly fitted respiratory protection, and/or have not been trained, drilled and tested in its care, use and limitations, and speak with your manager or supervisor; document the situation and copy your union and Joint OH&S Committee representative.**
- **REPORT any health and safety concerns, including gaps in adequate protocols and procedures and/or communications, access to PPE, fit-testing and/or training or other health and safety concerns to your manager or supervisor, copying your Joint OH&S Committee and your union.**

UNSUPPORTED?

SHORT STAFFED?

EXHAUSTED?

ALL OF THE ABOVE!

HELP US CHANGE THAT! FILL OUT OUR OUTLOOK ON NURSING SURVEY AT: NURSESUNIONS.CA/OUTLOOK

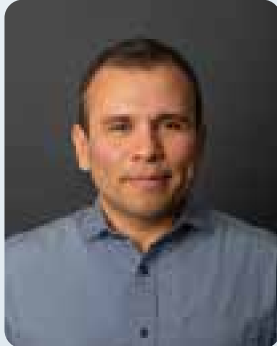
Please take 20 minutes to help your fellow nurses

To achieve the change we want – the change we need – it takes hard data. Help us produce an accurate picture of what's happening in your workplace so we can finally get politicians to LISTEN.

New Training Program for Health and Safety Committees and Health and Safety Representatives

By Jared Matsunaga-Turnbull,
Executive Director,
Alberta Workers' Health Centre

Jared Matsunaga-Turnbull


Mario Téllez

Workers in Alberta have 4 basic workplace health and safety rights:

- The Right to Know about the dangers of our jobs and how we are protected
- The Right to Participate in activities affecting our health and safety
- The Right to Refuse dangerous work
- The Right to Be Free from Reprisal for using our health and safety rights

In 2018, the previous provincial government made long overdue changes to Alberta's Occupational Health and Safety Act, which strengthened these 4 basic rights.

For the first time, Joint Work Site Health and Safety Committees (HSCs) and Health and Safety Representatives (HS Reps) became mandatory in Alberta, similar to other provinces. This means that while some Alberta workplaces have had HSCs for years, it is new for many workplaces, and new for many workers who now play an important role participating in making their workplaces safer and healthier. To add to the confusion, in December the government changed their interpretation of when organizations need an HSC or HS Rep.

Mario Téllez, project coordinator for the Alberta Workers' Health Centre's HSC/HS Rep Training Program, says that this newness and confusion presents an opportunity to educate people on what the legislation means for HSCs or HS Reps. "We really see it as a chance to educate workers and all committee members on their legal responsibilities, and especially to empower them with the tools to make their committees more effective."

"Workers are the ones doing the job. We generally know what the problems are and have good ideas on how to fix things," Mario continues. "We need to be able to meaningfully participate in health and safety, and being involved on the HSC or as the HS Rep is a good way to do that."

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In 2019, the Alberta Workers' Health Centre (AWHC) became an Approved Training Agency, designated by the Alberta Government to deliver the specific training that is mandatory (and employer-paid) for HSC co-chairs and HS Reps. We feel the 8 hour course is also useful for other committee members and union reps.

As with all of our programming, we take a worker-focused approach, an approach that is possible because of the support we receive from unionized workers in the province who are affiliated to the Alberta Federation of Labour. Our HSC/HS Rep Training Program was developed and is being delivered thanks to the AFL and additional financial support from UNA.

Mario says that his goal is not just to highlight minimum standards for compliance with the law. "My hope is that everyone who takes our course will feel better equipped to help make their workplaces safer."

If you sit on your Health and Safety Committee, or are just interested in learning more, plan to attend one of our courses. Our schedule and additional information can be found on our website:
www.workershealthcentre.ca/hsc-hs-training

The Alberta Workers' Health Centre (AWHC) is a registered not-for-profit charity. We have a small but dedicated staff are that take direction from a volunteer Board of Directors made up of working people from across the province.

We believe that every worker is entitled to a safe and healthy workplace, and we support all workers, both unionized and non-unionized, who need assistance to make their workplaces healthier and safer. We provide worker-focused education and resources for organizations, young workers, newcomers and health and safety activists. Through our outreach programming and research, we come into contact with thousands of working people every year, enabling us to make recommendations for policy change that will make peoples' working lives safer and healthier.

Information, Education and Empowerment for Workers:
www.workershealthcentre.ca
1-888-729-4879

Employer must indicate denial of vacation requests in writing

Article 17.03 of the UNA Provincial Collective Agreement states that all vacation earned during one vacation year shall be taken during the next following vacation year at a mutually agreeable time.

At most UNA sites, the employer must inform the employee of approval or denial of their requests on the vacation planner by April 30.

Under Article 17.03 (b) (ii) the Employer must indicate approval or denial of the vacation request in writing within 14 days of the request.

In addition, it is management's job to find a replacement. The vacation planner is intended to assist the Employer with that task. So Employees should not be required to find their own replacement in order to have their vacation approved.

If there is a delay in the approval beyond the deadline, or if the employer says it is pending, the employee should consider their vacation denied and initiate a grievance immediately.

Grievances should be filed within 10 days (excluding weekends and named holidays) of April 30 or from the day you were informed of vacation decisions, whichever is earlier.

For more information, contact your UNA local executive or your UNA Labour Relations Advisor at 1-800-252-9394.

TWO LETTERS THAT
MAKE A VITAL DIFFERENCE
TO YOUR CARE
RN
YourRN.ca
RN
UNA
COLLEGE & ASSOCIATION
OF REGISTERED NURSES
OF ALBERTA

Member Spotlight: Connie and Kelsey Singer

By Sheldon Vogt,
Local 115 Communications Committee,
United Nurses of Alberta

Connie and Kelsey Singer are a mother-daughter Registered Nursing duo from a prestigious family nursing lineage that transcends tradition, beginning in Quebec and having roots dating back to the first World War and the care of royalty. Connie, a recently retired grandmother, exudes tenderness and cultivated warmth and kindness on Unit 52 post-partum and the nursery at Foothills Medical Centre for almost 25 years. Kelsey, a passionate personality impressed upon a proficiency in care for expecting mothers and their children, is a practiced nursing professional currently working on Unit 51 in labour and delivery. An extraordinary enthusiasm for nature serves to maintain optimal personal health, fosters a powerful sense of gratitude, and forms an unbreakable bond between these two nursing leaders. Continually striving to better the lives of individuals around them, Connie and Kelsey are proud union advocates who can be found at the gatherings of UNA advocating for better conditions and safer environments, to maximize the delivery of the highest quality of patient and family centered care.

Q: Where does the family's nursing story begin?

A: (Connie) We come from a long line of nurses, the first of which is my great aunt Vivien Tremaine who served in the first World War. The lineage continues with my mother Patricia Tremaine, mother-in-law Dorothy Singer, aunt Jeanette Tremaine, and cousins Vivien Webb and Lesley Andrew. It includes myself before trickling down to my youngest Kelsey. That makes seven nurses over three generations.

Q: What is known about great aunt Vivien?

A: (Connie) Vivien Adlard Tremaine was my mother's aunt. Her family name, Tremaine, is British in origin. Our ancestors are from Great Britain and worked as land surveyors. She was born in Montmorency Falls, Quebec but was English speaking. She was among the first group of nursing sisters to voluntarily enlist in World War I in 1914 and sailed from Quebec City with the first contingent to Great Britain. She began her journey with mandatory war training at Salisbury Plains training camp before being transported to Fort Gassion (Aire-Sur-La-Lys) close to the Seine river in northern France near the front-lines. Fort Gassion was previously a very old prison which was converted to the No. 1 Canadian casualty clearing station. The men literally lived in the trenches and the nurses were taking in the wounded right in the midst of this horrific situation. She got pretty good at what she did and developed a reputation as a strong nurse.

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Member Spotlight: Connie and Kelsey Singer

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Q: Any surviving stories of Vivien Tremaine from the war?

A: (Connie) I recently connected with a man on a forum who was trying to find the nurses who looked after his uncle, Vivan Dixon, who was a Scotsman and would've been around seventeen years old at the time. His uncle had kept a diary of his time in the war and it mentioned Vivien by name. The gentleman was from England and when we chatted he quoted me some of the things in the diary like when his uncle and his uncle's nurse Vivien were joking about the "bran pie" he had to eat to prevent constipation while on bedrest.

In October of 1915 she was summoned to care for King George V. She was promoted to matron at this time. King George V came to visit the troops on the front-lines at Flanders France. He was on horseback and apparently it was very muddy when he arrived. The troops cheered so loudly when they saw him that his horse reared up. He fell and the horse landed on him and pinned him, causing him to break his pelvis. General MacPherson, who was a surgeon, chose two nurses to care for the King, one being Viven. One would work the dayshift and the other would work the nightshift. The plan was to care for the King on the frontlines until they could secretly arrange his transport back to England. They had to keep it secret because if the enemy found out that the King was there and injured, they would try and kill him. So she looked after him for several days on the front-lines before they were transported by hospital ship back to England. Many of the hospital ships at that time were being bombed, several of them full of nurses and patients on board, but they managed to secretly get away. They got to Buckingham Palace and she stayed at least five weeks caring for His Majesty on the night shift. In a letter from Viven to her brother Trevor she wrote, "I was terribly anxious for some time till we were certain he had so serious an injury, but he was frightfully bruised, he was in a lovely old chateau in France and he stayed there till he could be moved in 5 days all the time worried of Zeppelins and German spies or something happening. I thought my hair would turn grey, you can't have any idea of the responsibility".

Q: When did she return home from the war?

A: After caring for the King she she returned to the No. 1 CCCS field hospital in France until she was transferred to Granville Canadian Special Hospital in Ramsgate, Kent, England on January 7th, 1917. This location was a requisitioned Victorian Spa Hotel on the cliff top overlooking the sea and specialized in treating shell shock, nerve, joint and bone injuries. It was shortly after that that she returned home where she did some supervisory work at what they call the port nurseries which were located in Halifax, Montreal, and St. John. These places received women, children, and babies that were being transported away from the war to keep them safe. Over 15,000 women came through the ports to escape the war in Europe. She would welcome these women, children, and babies into Canada and make sure they were safe, healthy, and got to a safe home. Canadian families took these women in and helped them integrate into Canada and to be safe until the war was over. That's the one connection I see between Kelsey, Vivien and I is that we've all helped young mothers and their babies. After the war she was awarded with the Royal Red Cross medal, the Mons Star, and the Royal Victorian Medal. You can actually find the medals she received and the connection to the Canadian Red Cross seaboard nurseries online.

Q: Did King George V ever reach out to her afterwards?

A: (Connie) He did. He came and presented the medals to her in Canada. He also gave her a private gift. It was a necklace that eventually made it to my mom. It's really lovely.

Q: What was her training like being so close in time to Florence Nightingale?

A: (Connie) I remember two readings about the expected duties of nurses back in the late 1800's. One was the Florence Nightingale Pledge and the other a description of the duties of a trained nurse in those times. I imagine Vivien's training in the early 1900's would be very similar, ie; very strict in nature, upholding a philosophy of selflessness to provide the best possible care, and extremely hard work. Slightly before her time nurses were expected to sharpen the doctor's quill pens, maintain the fireplaces, wash linens, clean rooms and fill the kerosene lamps, while balancing all the medical work. My mother trained at a catholic hospital in Montreal and her instructors were catholic sisters. They worked 6 days a week, only being allowed to attend church on Sunday, and starched the nursing supervisor uniforms as part of their duties. I watched my mom do shift work. She actually worked with some of the holocaust survivors at the Jewish General in Montreal. Florence Nightingale was woven within everything the nurses did from my great aunt Vivien to my mother, and her ethics continue with nurses to this very day.

Q: It would appear there's a family calling to nursing...

A: (Connie) The history certainly has had an impact. My mom really encouraged me into nursing. She did a lot of what they called "specialling" back then which was private nursing. She always said to me that nursing was a respectable job and a good long term career. She said it would be hard and that I'd hate shift work but that I'd do well with it.

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Member Spotlight: Connie and Kelsey Singer

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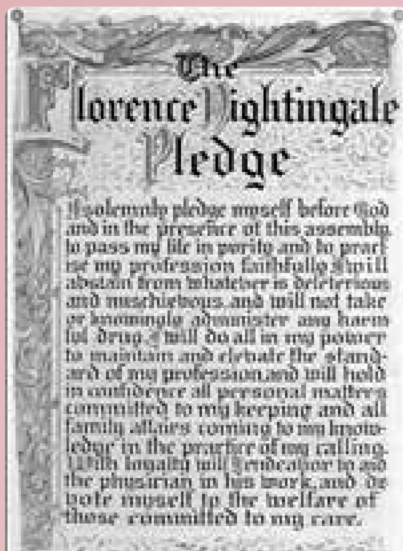
A: (Kelsey) Both my grandmas were nurses. Both of my parent's mothers and my own mom. I felt like it just ran in my blood. Like it was instantly part of me.



The Florence Nightingale Pledge

I solemnly pledge myself before God and in the presence of this assembly, to pass my life in purity and to practise my profession faithfully. I will abstain from whatever is deleterious and mischievous, and will not take or knowingly administer any harmful drug. I will do all in my power to maintain and elevate the standard of my profession, and will hold in confidence all personal matters committed to my keeping and all family affairs coming to my knowledge in the practice of my calling. With loyalty will I endeavor to aid the physician in his work, and devote myself to the welfare of those committed to my care.

Q: Tell me about your nursing education?

A: (Connie) I was born in Montreal and lived a good portion of my life there until young adulthood. Right out of high school I pursued a nursing education at John Abbot College in Sainte-Anne-de-Bellevue in Quebec. It was called CEGEP which stands for collège d'enseignement général et professionnel, which means general and vocational college. It was a two year diploma program plus an extra year which was the equivalent of a university year. I trained at seven different hospitals in Montreal in a number of different areas. My first rotation was in geriatrics at a veterans hospital. We were taught to have an immense amount of respect for these men because they had been through mustard gas and all sorts of terrible things. As we got into our second year we did pediatrics and obstetrics, and surgery later in the third year. The bonus to the entire situation was that me education was free. We only had to pay for our uniforms.

(Kelsey) I pursued nursing through Mount Royal University right out of high school. It was still a college but nursing was the first degree they offered and I attended the very first year the degree program was offered. My education was not free.

Q: Where was your first job as a Registered Nurse?

A: (Kelsey) From nursing school I started as a grad nurse in children's palliative care working at the Rotary Flames House. I started there as a health care aide, then got a job as a grad nurse, before writing and passing my CRNE and becoming an RN. It was a very challenging job to deal with the loss of children.

(Connie) My first job was in Ontario in the health centre of the Ontario Correctional Institute. The job was six months duration via a program called the Ontario Career Actions Program.

Corrections was a very eye opening experience. Following that I jumped into a full-time position at the Mississauga General Hospital in the premature newborn nursery.

Q: What brought the family from Quebec to Alberta?

A: (Connie) It was a romantic choice. I met my future husband Lee in Calgary. We carried a long distance relationship for a year then I took the plunge moving out west. The search for a new nursing job was easy. I had two offers in one day! One at the Alberta Children's Hospital and other other in the NICU at Foothills. Pediatrics won me over. After seven years at the ACH I ventured over to a new position in postpartum at the Foothills Hospital, staying there for nearly twenty-five years to retirement.

Q: Where did the interest come from in caring for babies?

A: (Connie) At that time it was what was available but my mother had a little bit of obstetrical experience which kind of trickled down to me. I always had an interest in pediatrics so I chose to work at the Children's and I loved it. I worked there for seven years. Alberta Children's at that time had clusters which were designated to different age groups and specialities. My first years there were very informative years in terms of learning and picking up new skills. Later as my family came along, I decided to go into obstetrics and started working at Foothills and ended up staying on Unit 52 in the post-partum and nursery area for almost twenty-five years.

A: (Kelsey) My mom was in postpartum at Foothills and I always had a relationship with the post-partum nurses. They kind of felt like family to me. So I applied and got a job in labour and delivery on Unit 51 at Foothills and have been there ever since.

Q: Tell me about the nursing world of obstetrics at Foothills…

A: (Kelsey) Obstetrics is the umbrella term that covers our three main units including antepartum, labour and delivery, and post partum. We are the level 1 trauma centre which means we have to accommodate the highest acuity patients from all over central and southern Alberta.

We take anyone who is high risk and under 32 weeks gestation. Although the job is often filled with joy and excitement, we also see some very challenging things and care for very sick mothers and babies. Unit 51 is our labour and delivery unit, which also has two operating rooms for both booked and emergency c-sections/procedures. We see young babies anywhere from 24 weeks and up. Unit

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Member Spotlight: Connie and Kelsey Singer

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51 also houses two high risk beds specifically for patients that, prior to or after delivery, are in need of more extensive medical monitoring, like in instances of pre-eclampsia, HELLP syndrome, postpartum hemorrhage, or following a hysterectomy or other incase procedures. Previously we were only taking patients anywhere from 20 weeks and above in gestation. We have recently expanded to include 12-20 weeks if they're cases we feel we can manage. Our antepartum unit is where I say we try and keep people pregnant. We also have private rooms available where we may care for early pregnancy losses and see them through postpartum as well. We take a lot patients who are pregnant with significant medical issues such as placental previa, organ failure and other life threatening diseases, premature rupture of membranes, gestational hypertension and diabetic management, major fetal anomalies, antepartum hemorrhages and much more. Some patients are admitted for a short period of time and others are there until they deliver. One of the typical ones we keep until delivery are monoamniotic-monochorionic twins, often referred to as mono mono twins. They share one placenta but have two separate umbilical cords and there is a huge risk of cord entanglement. Our job is to monitor them and their babies. If we have to deliver them early, we do it for their and their child's safety otherwise we try and keep them pregnant as long as we can.

Q: Are midwives commonplace at Foothills?

A: (Kelsey) Yes and they can be very helpful. They will consult the OB/GYN team quickly when they need to. Most patients who choose to have a midwife do so with the intention of giving birth at home or at a birthing station, for example, to have a water birth. It's important for birthing mothers to understand that natural births can and do take place in the hospital. It's important that everyone involved understands the risks with giving birth and have a plan to address complications, should they arise, by seeking help at a medical facility as early as possible. We're dealing with the most important transition in a human being's life and want to do everything we can to prevent a traumatizing experience. It's important people are well informed with evidence-based information so they can make the best decision for them and their families.

(Connie) It has been interesting to see the evolution of midwifery organizations in Calgary and how they integrate with community and in hospital experiences. We have been drawing on the well established practices of other nations and integrating this knowledge into the local needs and cultures practices of our community. Midwifery is growing in our community and will likely present new challenges as society changes or situations and resources change.

Q: What is the best analogy you've heard to describe the physical experience of giving birth?

A: (Connie) Early on in my career an older nurse told me that being in labour is like playing four quarters of a football game without a break, in terms of energy and output. Then at the end, you deliver the football.

(Kelsey) People often use the comparison of delivering a baby to that of passing kidney stones yet I've heard people say kidney stones are worse.

Q: What's the average length of stay on the post-partum unit after delivery?

A: (Kelsey) A typical stay is two nights after a c-section free of complications. After a vaginal birth it's one night.

A: (Connie) Back in the 80's it was three days for a vaginal birth and five days for c-section.

Q: How do nurses help vulnerable birthing mothers and those experiencing domestic violence?

A: (Kelsey) It is part of our nursing responsibilities to ask the birthing mother if they live in a safe place and are the victim of any domestic violence. It's on our admission form as well. We ask the patient when they are alone and we do it every chance we get. They'll hear it five or six times and it's important because sometimes it takes thirty times for someone to reach out for help. It's one of the things I wish we had more opportunity to address.

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Member Spotlight: Connie and Kelsey Singer

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Q: What's the follow up process after a birthing mother and their baby are discharged?

A: (Kelsey) We confirm all contact information then postpartum does the follows through. There's always someone that goes to the home the following day to make sure everything is going well. People are discharged so quickly from hospital that they may not have established successful breastfeeding yet.

(Connie) We complete a public health referral form for every patient. A public health nurse would then see them at home within twenty-four hours of being discharged from hospital. They assess for things like jaundice, postpartum depression, and to ensure breastfeeding is going well. Those are some of the important aspects of the home assessment.

Q: What are some challenges you face working in an urban centre with such a diverse population?

A: (Kelsey) We have a very diverse patient population full of different cultures. Assessing for domestic violence situations can be particularly challenging when communicating in other languages. It's really difficult when people talk over the birthing mother or are interpreting for her. It can be hard to deal with when your intuition is telling you one thing but you don't know if what we're being told is what the patient is actually saying. Culture also plays a role in the care requested by family. We've seen situations where family's have pursued desperate aggressive resuscitative treatment based on the baby's gender. We see situations where families decide the life of the child based on congenital health issues. We see people in same family relationships who continue to have children despite the known risks of congenital issues. We even see prison inmates. It may not make sense to us but it doesn't affect how we treat anyone. We cuddle baby. That's all we do. Leaving work at work is not always easy. It's vital that nurses take time to look after themselves when they get home.

(Connie) Every city has its unique set of situations and challengers. It takes a lot of energy and commitment to remain aware and open minded to the constant changes in our society. Diversity, increased population, societal values and changes in health care resources all impact how we can provide effective health care. We have to stay on top of those changes and improve our abilities to prepare for change.

Q: Looking back, if you could give yourself some advice as a young nurse, what would it be?

A: (Conniex) To be more confident. Face your fears, tell yourself "I can do this", and keep learning. A nurse with confidence in their abilities fosters that confidence their patients.

A: (Kelsey) Continue to learn, grow, and try new things. Have respect for yourself as part the team. You matter!

Q: What is your favourite thing to do in Calgary and the surrounding area?

A: (Kelsey): Anything outdoors. My mom and I are hiking buddies and we thrive off of the outdoors. Nature never judges and I feel at peace when I'm outside. The fresh air, the birds chirping, and the sights put me in a comfortable place. I also volunteer for the Cochrane Humane Society fostering kittens. I also have an interest in tattoos.

A: (Connie) Our love for the outdoors is mutual and enduring. Living on an acreage just outside of Bragg Creek, next door to the Rockies provides great hiking, camping and winter sports opportunities. I am passionate about nature, photography and immersing myself in outdoor activities. These passions came mainly from family camping experiences, working as a canoe tripper at YWCA Camp Oolahwan in the beautiful Laurentians, Quebec, and two Outward Bound Canada wilderness courses. In retirement I am more active than ever enjoying back country hiking, camping and cross country skiing. I did my first 15 km Loppet this winter and remain actively engaged with the Outward Bound Canada organization. One of the greatest revelations from these pursuits has been the positive impact on my life and nursing career. They have provided me with great direction in life, improved self confidence, compassion, resilience, courage and some leadership skills.

Q: What is your favourite restaurant/book/tv show/movie/place to shop?

A: (Kelsey) The Coup. I'm a vegetarian with vegan habits. My favourite book is called The Subtle Art of Not Giving

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Member Spotlight: Connie and Kelsey Singer

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a F%&!. I My favourite old TV show is Friends and my favourite new one is Stranger Things. My favourite movie is Tarzan. I loved the music. My favourite place to shop is Lululemon.

(Connie) Swiss Chalet. Huckleberry Finn. Call the Midwives. My favourite movie is Oliver Twist. Fagan is my favourite character. My favourite place to shop is Atmosphere Sports.

Q: What is the greatest challenge Nurses face in the workplace?

A: (Kelsey) Staffing, the lack of understanding from the government and other leaders of our experiences, and the expectations that are placed on us.

(Connie) I would like to see nurses not lose what they've worked so hard to gain. They need better staffing ratios and a greater respect for what they do from leaders.

Q: Any words of advice for Nurses planning their retirement?

A: (Connie) You should start planning at least five years before your retirement date. Start crunching numbers as to what your personal needs are for your projected lifespan which is pretty good these days. Healthy people are living well into their 90s. Take full advantage of the Employer-shared RRSP contribution. Mark sure you're signed up for LAPP and the benefits plan through ARTA, both of which are recommended by UNA and are a really good fit. Invest your money when you're young because you need a portfolio for yourself to supplement your pension. Really communicate with UNA, HR and LAPP. I wish I had done the workshops like the pre-retirement workshop offered through the Calgary District Labour Council and the LAPP workshop offered by AHS.

Q: Why is the union important to you?

A: (Kelsey) My mom got me involved by taking me to the AGMs when I was a nursing student. I'm grateful for the awareness I've gained for what the union does for us, how they support us, what they offer, and for their response when I've reached out personally for support. They are nurses fighting for what they would want as nurses. It's a like a family with similar goals and desires.

(Connie) The support I felt the moment I stepped in to my first AGM was incredible. I realized how strong Heather Smith is and the executive group working with her are. They do so much to help us and their relationships with other unions are so diverse. It's everyone working together as a strong formidable force to help protect us and give us better workplaces.

Public Health Care
WE'VE GOT THIS!

Canadian Health Coalition
Coalition canadienne de la santé

For-Profit Health Care

Public health care has existed in Canada for 50 years. It guarantees access to doctor and hospital services regardless of people's ability to pay. In recent years, privatization has been creeping into our health care system. This has led to illegal billing practices, lower-quality care, unnecessary medical tests, and pressure on patients to buy medical services.

88 private clinics across Canada have been illegally billing patients.
–Ontario Health Coalition, 2017

$ For-profit clinics across the country are illegally billing patients or misleading them into thinking they have to pay for publicly-covered services.

$ For-profit diagnostic imaging centres are operating in Saskatchewan and Manitoba. Although they provide fewer images than publicly-run MRIs, governments are promoting them as “innovations” in health care delivery.

$ A doctor in British Columbia has filed a lawsuit claiming that doctors should be allowed to charge patients and the public system for the same procedures. He says there shouldn't be a cap on private fees for health care, and that doctors should be able to charge whatever the market will bear.

$ Boutique medical clinics are common in major urban settings in Canada. They often order unnecessary medical tests that can do more harm than good.

$ A for-profit plasma company has opened collection centres near vulnerable communities in Saskatchewan and New Brunswick. It pays people for their blood plasma and then sells it on the international market. The company plans to open many more centres.

$ For years, patients in Quebec were charged for things like eye drops (up to $300), inserting IUDs (up to $200), and instruments and medication for colonoscopies ($500).

The Federal Government’s Role and Responsibility

The federal government is responsible for monitoring and enforcing the *Canada Health Act*. All provinces and territories must provide medically necessary health services that are: publicly-administered, universal, comprehensive, accessible and portable. Provinces and territories must also prevent user fees and extra-billing. If the provinces don't follow these principles, the federal government can withhold funding for health care.

W healthcoalition.ca f Canadian Health Coalition @healthcoalition

Cambie Case

Ensuring equal access to health care is a core Canadian value. Our health care system is based on the principle that care should be based on need, not on the ability to pay.

Our public health care system is currently under attack through a lawsuit in British Columbia. Brian Day has filed a lawsuit challenging BC's health care law to avoid penalties for illegal billing of patients at his private, for-profit clinic, Cambie Surgeries. He claims that he wants to reduce wait times for medical services, but what he really wants is to make more profits.

The Canadian Health Coalition is monitorng this case closely and getting the word out.

Why does it matter?

This is one of the most significant constitutional cases in Canadian history. If Day wins, he'll open the floodgates to a US-style private health care system. Wealthy patients will be able to jump to the front of the line by paying for medical services, while others won't be able to afford health care.

Although this case is being heard in British Columbia, it will likely be appealed and end up in the Supreme Court of Canada.

Take action

- Sign up for updates on the case and make a donation to the BC Health Coalition's Legal Defense Fund: www.savemedicare.ca
- Share information about this important case with other public health care advocates.

W healthcoalition.ca f Canadian Health Coalition @healthcoalition

Background

Canada's Health Care System

To access federal funding for health care, the provinces must meet certain requirements. They must cover the costs of medically necessary services provided by doctors and hospitals. They must also prevent 'extra-billing' (when patients are billed on top of the amount that's billed to the public system). If the provinces allow extra-billing, the federal government can withhold part of their funding for health care.

The federal and provincial governments haven't been doing a very good job of making sure these requirements are respected. Across the country, doctors and clinics have been billing patients illegally.

The Lawsuit

In 2007, the BC Government notified several private, for-profit clinics that they intended to investigate complaints they'd received from several patients about illegal billing. In response, Day filed a lawsuit against the BC Government.

Day wants to be able to bill patients directly and bill the public system for medically-necessary services. This practice is currently illegal. Day claims that allowing extra-billing would reduce wait times for health care.

In fact, the evidence shows that allowing patients to jump the line by paying for medical services actually increases wait times in the public system. Since medical staff and equipment are limited, private clinics take precious resources away from the public system. This results in longer wait times.

Timeline

The trial began in 2016. After many procedural delays the trial is expected to end in 2019.

FactSheet

NURSE FATIGUE

WHAT IS NURSE FATIGUE?

"A subjective feeling of tiredness (experienced by nurses) that is physically and mentally penetrative. It ranges from tiredness to exhaustion, creating an unrelenting overall condition that interferes with individuals' physical and cognitive ability to function to their normal capacity. It is multidimensional in both its causes and manifestations; it is influenced by many factors: physiological (e.g., circadian rhythms), psychological (e.g., stress, alertness, sleepiness), behavioral (e.g., pattern of work, sleep habits) and environmental (e.g., work demand). Its experience involves some combination of features: physical (e.g., sleepiness) and psychological (e.g., compassion fatigue, emotional exhaustion). It may significantly interfere with functioning and may persist despite periods of rest" (Canadian Nurses Association [CNA] & Registered Nurses' Association of Ontario [RNAO], 2010, p.12).

PREVALENCE OF FATIGUE IN NURSES

- Fatigue affects all nurses, no matter where they work. Fifty-five and a half per cent of nurses always or almost always feel fatigued during work, and 80 per cent feel this way after work.
- Rates of nurse fatigue are increasing.
- Nurses reported experiencing the effects of sleep deprivation at a rate of 67.7 per cent.
- Fatigue is a factor for 26 per cent of nurses who are considering leaving the profession.
- One study reported 38 per cent of nurses making a fatigue-related near error (CNA & RNAO, 2010).

CONSEQUENCES OF NURSE FATIGUE

Patient Safety

- Fatigue-related impairments are similar to alcohol-related impairments. "Someone who has not slept for 18 hours is as impaired as someone with a 50 mg% blood alcohol level" (Canada Safety Council, 2006).
- Nurses who work a shift lasting more than 12.5 hours "are likely to make three times more errors" (Rogers et al., 2004, as cited in CNA & RNAO, 2010).
- The risk of falling asleep nearly doubles after eight hours of work (Scott et al., 2006, as cited in CNA & RNAO, 2010).

Fatigue negatively affects patients, since, by reducing health-care workers' judgment (Lyndon, 2007, as cited in CNA & RNAO, 2010), it increases the risk of errors, falls, injuries, irregular assessment, poor communication and lack of continuity in care.

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Nurse Safety

- Fatigue negatively affects nurses. It leads to moral distress; an impaired ability for self-care and coping with daily life; stress; impaired concentration and judgment; impaired work-life balance and interpersonal relationships; and falling asleep while driving home. In addition, it negatively impacts physical and mental health.

CAUSES

- Heavy workloads, staffing shortages, shift work, increased patient acuity, increased patient expectations, little time for professional development, decline in leadership, inadequate recovery time and personal factors.
- Health-care cultures that create pressure for nurses to take on extra work (e.g., "hero" culture; "doing more with less").

MYTHS

- You cannot just "sleep off" fatigue, because it stems from long-term drainage of the body's energy supply (CNA & RNAO, 2010).

SIGNS AND SYMPTOMS OF FATIGUE (CNA & RNAO, 2010)

Physical

- Yawning
- Heavy eyelids
- Eye rubbing
- Head drooping
- Inappropriate sleep onset (or "micro sleeps")
- Decreased hand-eye coordination

Mental

- Increased anxiety
- Slowed reaction time
- Decreased efficiency and performance
- Difficulty concentrating
- Lapses in attention

- Difficulty with memory
- Failure to communicate appropriately
- Failure to anticipate
- Errors of commission
- Errors of omission

Emotional

- Feeling like "living in a vacuum"
- Feeling "worn out"
- Being more quiet or withdrawn than normal
- Feeling lethargic
- Lacking motivation
- Feeling irritable or exhibiting bad-tempered behavior

THE SCIENCE OF SLEEP (HARVARD MEDICAL SCHOOL, 2008)

- Sleep has a "critical role in immune function, metabolism, memory, learning, and other vital functions."
- Our circadian rhythm is the internally controlled "body clock" that controls alertness and sleepiness. Shift work is difficult because it requires concentration and activity when the body is in the rest phase of its daily cycle.
- Chronic sleep deprivation can lead to serious diseases and is associated with a lower life expectancy.

WHAT NURSES CAN DO

Individual Level

- Get adequate rest and recreation
- Make sleep, breaks and naps a priority
- Create a work-life balance
- Eat a healthy, balanced diet
- Exercise regularly

- Decrease caffeine consumption
- Recognize when you are fatigued
- Use a buddy system to check for fatigue
- Know organizational policies
- Engage in appropriate self-care

Organizational Level

- Advocate for new or improved policies

System Level

- Advocate for systems changes, as fatigue is a multidimensional issue

TOOLS AND RESOURCES

More About Nurse Fatigue

CNA: *Nurse fatigue and patient safety*

CNA: *Code of ethics for registered nurses*

RNAO Best Practice Guidelines for Healthy Work Environments: *Preventing and mitigating nurse fatigue in health care*

Drew Dawson and Kristy McCulloch: *Managing fatigue: It's about sleep*

Harvard Healthy Sleep website

Insomnia

Marla Hardee Milling: *Shift workers: Solutions for sleep problems*

Shift work in nursing

Coping Strategies

Relaxation techniques

Strategies for shift workers

Shift work and healthy eating

Twelve tips to improve your sleep

What to do if you can't sleep

Sleep Clinics

Locations in Canada

This document has been prepared by CNA to provide information.
The information presented here does not necessarily reflect the views of the CNA Board of Directors.

Published August 2012

References:

Canada Safety Council. (2006). Is driving tired like driving drunk? Retrieved from https://canadasafetycouncil.org/node/867

Canadian Nurses Association. (2010). *Taking action on nurse fatigue*. Ottawa: Author. Retrieved from http://www2.cna-aiic.ca/CNA/documents/pdf/publications/PS112_Nurse_Fatigue_2010_e.pdf

Canadian Nurses Association & Registered Nurses' Association of Ontario. (2010). *Nurse fatigue and patient safety* [Research report]. Ottawa & Toronto: Authors. Retrieved from http://www2.cna-aiic.ca/CNA/documents/pdf/publications/Fatigue_Safety_2010_Summary_e.pdf

Harvard Medical School. (2008). Healthy Sleep. Retrieved from http://healthysleep.med.harvard.edu/healthy/matters/benefits-of-sleep

Fatigue - Worn Out and Worn Down

ALERTS

Fatigue has been defined as a subjective feeling of tiredness and exhaustion that is an unrelenting overall condition. It can significantly interfere with an individual's physical and cognitive ability to function at their normal capacity and may persist despite periods of rest.

What are the signs of fatigue?

- tiredness
- sleepiness including falling asleep against your will ("micro sleeps")
- irritability
- giddiness
- loss of appetite
- digestive problems
- increased susceptibility to illness

What are the effects of fatigue in the workplace?

Fatigue can effect and individual's physical and health which also affects their ability to provide safe patient care. In a study that looked at the effect of fatigue (hours of wakefulness) on performance researchers found that **moderate levels of fatigue produce higher levels of impairment than alcohol intoxication.**

- reduced decision making ability
- reduced productivity and performance
- reduced attention to detail
- unable to stay awake
- loss of memory or ability to recall details
- reduced reaction time
- increased workplace illness and injuries

What are the factors that contribute to fatigue in the workplace?

In a recently released study, Nurse Fatigue and Patient Safety, conducted by the Canadian Nurses Association and the Registered Nurses Association of Ontario the following were identified as the **top factors contributing to fatigue in nurses.**

- increased workload
- working short staffed
- increasing expectations from patients and families
- high levels of patient acuity
- functionally disorganized workplaces
- relentless change within the workplace

The factors list above can all be characterized as workplace organizational factors or stressors. There are **other factors** that cause fatigue which include:

- shift work
- extended work hours
- mandatory and/or "guilt" overtime

What can you do?

As part of your responsibilities as a health care professional covered by the Alberta Health Professions Act you are required to **assess your own fitness to work and to not work if you are unfit to practice**.

Therefore it is imperative that **you do not agree to work excessive hours** and you track your hours of sleep and your hours of wakefulness (psychomotor impairment at 17 hours of wakefulness equated to a .05 blood alcohol concentration and 21 hours of wakefulness was equivalent to 1.0 blood alcohol concentration).

If you are **mandated to work overtime and/or double shifts** and you do not feel that you are fit to work then you need to notify your supervisor of your concerns as soon as possible. If you are still required to work you should contact your local representative or labour relations officer.

In addition, **shift work schedule**s should be examined to reduce the impact of the disruption of circadian rhythms.

United Nurses of Alberta

DOMESTIC VIOLENCE

Just because it happens at home doesn't mean it's not hurting you at work.

Reach out to EFAP for 24-hour support.

Call 1-877-273-3134

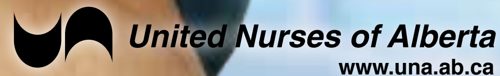
Abuse Violence Harassment

GET HELP

TAKE A STAND

TALK TO US

1.800.252.9394



Occupational Health & Safety and Staff Abuse

REPORT FORM

Immediately file this form with your Local Union. Keep a copy for your records.

Local File #: ______________________

Local #: ______________________ Employer: ______________________

Worksite (ward/unit/office): ______________________ Date & Time/Shift: ______________________

Describe the Nature of Incident ***(Do not use names of patients, clients, residents, staff or doctors)***:

____

What is the suspected hazard?: ______________________

Any injury or disease related to problem? (if known):

____

What action is required?:

____

Was the incident reported to your Supervisor?: yes ☐ no ☐

Name of Supervisor: ______________________ Date of Discussion: ______________________

Action Taken:

____

______________________ ______________________ ______________________
Name (Printed) E-Mail Phone No.

______________________ ______________________
Signature Date

United Nurses of Alberta
900-10611 98 Avenue Edmonton AB T5K 2P7 • 425-1025 (ph) • 426-2093 (fx)

This form does not replace a Workers' Compensation Form, Occupational Hazard Form or Employer Incident Form. Please file these forms where appropriate.

A Workers' Compensation Form must be filed if any injury has resulted or if there is any possibility of disease or injury which may result from the hazard.

OH&S Form • May 2009 • Kld • CEP

1st Copy - Union/OH&S Committee • Second Copy - Employee

Professional Responsibility Concern Form
(PRCF)

Electronic submission of this form is available on the UNA app (available for iOS and Android) and online at dms.una.ab.ca/forms/prc

ALL sections of this PRC MUST be completed. A PRC representative will be in contact with you within two weeks to follow-up on your PRC.
For more information on completing a PRC, go to https://una.ab.ca/memberresources/professionalresponsibility

Worksite: ______________________ Unit: ______________________

Reporter Name(s): ______________________ ☐ Individual ☐ Group

Local File#
Date Rec'd

Manager's Name & Title: ______________________

It is expected that a Manager will be notified about the PRC concern to allow the manager the opportunity to address the issue. Discuss exceptions to this requirement with your UNA PRC representative.

Manager/Manager-on-call contacted? ☐ Yes ☐ No Date __________ Time __________

Reason Manager not contacted: ______________________

Name of Manager/Supervisor contacted: ______________________

When did the incident/issue occur? Date __________ Time __________ Shift __________

REQUIRED What Patient Safety or Quality of Care Concern was Impacted by this Situation?
In other words, what is the general reason for filing this PRC. Keep this section brief.

____

____

REQUIRED Detailed Description of Situation/Issue/Concern
Do not use names of patients, residents, clients, staff, doctors, or others

____

____

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____

☐ See 2nd page (attach 2nd page if you need additional room)

Purpose

Nurses are required by the standards of their professional licensing bodies to advocate for practice environments that have the organization and human support systems, and the resources necessary for safe, competent, and ethical nursing care.

This form and the information contained in it is the property of the United Nurses of Alberta.

United Nurses of Alberta
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Calgary, Alberta T2N 3P9

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(403) 263-2908 fax
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www.una.ab.ca

RLS (or other incident report) completed? ☐ Yes ☐ No RLS/Incident Report#: __________
This form does not replace the Employers' incident reporting form/system. RLS is a voluntary reporting system. If known

Is staffing a factor for this issue? ☐ Yes ☐ No Were any medications missed/late? ☐ Yes ☐ No

Were any assessments done late? ☐ Yes ☐ No Did you miss any breaks? ☐ Yes ☐ No

REQUIRED Recommendations/Potential Solutions You Would Propose
What is needed to prevent this situation or issue from occurring again? What are the potential solutions that solve this problem?

____

____

____

Name (Printed) ______________________

Designation: ☐ RN ☐ RPN ☐ LPN ☐ Other (Specify) __________

Signature ______________________ Date PRC Submitted __________

REQUIRED Personal E-Mail ______________________ Cell ph __________
A UNA PRC representative will be in contact with you. Do not use AHS email or work phone as UNA is unable to communicate with you via work email/phone.

Mental health and self-care resources for UNA members

Having to work and provide family care and self-care during these unprecedented times can not only be stressful but can be truamtziing. United nurses of the Alberta recognizes that these events can affect our members in different ways.

There is no right or wrong way for each individual to respond to stress and trauma.

With increased pressure on nurses and health care workers during the fight against the COVID-19 pandemic in our hospitals and health care facilitties, we encourage our members to stick together, be kind, and reach out to their coworkers who might be feeling personally overwhelmed by the rapidly evolving siutation.

Resources

Toll Free Crisis Line/Distress Centres

Mental Health Helpline: 1-877-303-2642

Provincial: 211 (provides referrals for community, government and social services)

Addiction Helpline: 1-866-332-2322

Family Violence: 310-1818

Income Supports: 1-866-644-5135

Kids Help Phone: 1-800-668-6868

Further Phone Supports: myhealth.alberta.ca

Mental Health and Self-Care Websites

Mental Health Commission of Canada - Mental Health First Aid COVID-19 Self-Care & Resilience Guide: https://www.mhfa.ca/sites/default/files/mhfa_self-care-resilience-guide.pdf

Nova Scotia Nurses Union - Escape: https://www.nsnu.ca/escape

Centers for Disease Control and Prevention - Tips for Taking Care of Yourself: https://emergency.cdc.gov/coping/responders.asp

Alberta Health Services - Text4Hope: https://www.albertahealthservices.ca/topics/Page17019.aspx

Wellness Together Canada - Mental Health and Substance Use Support: https://ca.portal.gs

My Health Alberta - Warning Signs of Suicide: https://myhealth.alberta.ca/health/pages/conditions.aspx?Hwid=hw29139

Psychologists' Association of Alberta - Disaster Response Network: https://psychologistsassociation.ab.ca/about-paa/disaster-response-network/

The Future of Alberta's Oil Sands Industry

More Production, Less Capital, Fewer Jobs

Ian Hussey

LOBBY TRAINING

MAY 5TH 5 TO 7 PM

VIA ZOOM MEETING:

https://us02web.zoom.us/j/87529972684?pwd=dFY5eWpjQWlBWHpTVy9iazlDNWlDZz09

Dial: +1-587-328-1099

Meeting ID: 875 2997 2684

Password: 221564

Calgary & District Labour Council | #321, 31232-26 St. NE Calgary | 403.262.2390

A Basic Income for Alberta

Alison McIntosh and Rebecca Graff-McRae

AN AFL BLOG SERIES:

PUBLIC EDUCATION DURING A CRISIS

AN INDEPTH LOOK AT
PUBLIC EDUCATION IN ALBERTA

Alberta Federation of Labour

Thomas Baril

In Canada, nearly 1 in 5 children live below the poverty line. This leads to debilitating effects for their personal and physical and mental health, which can cause lasting damage. They are more vulnerable to issues affecting mental health, educational attainment, health and cognitive development, housing, relationships, employment, and food insecurity.

Since 2008, the Edmonton Social Planning Council, Public Interest Alberta, and the Alberta College of Social Workers have been releasing child poverty reports, which serve to inform the public on the effects of poverty, current efforts undertaken by governments to address it, and offer recommendations in which they can improve in these programs going forward.

This fACTsheet, which serves as a companion to the full report, will explore the most recent data and programs that help to reduce poverty and its effects.

Where We Are At Now

Over the last 10 years, the proportion of those living in poverty has slowly declined among all family types.

While couple families have experienced greater drops in child poverty, poverty rates have seen an increase among children from lone-parent families. While 1 in 12 children from couple families experience poverty, 1 in 2 children in lone-parent families are in poverty. This means that the benefits of improved family transfer programs are not shared equally.

Due to higher incomes on average, Alberta has a slightly lower child poverty rate compared to the national average with 1 in 6 children experiencing poverty in the province.

Indigenous Children

In Alberta, 6.5% of the general population are Indigenous – which includes First Nations, Métis, and Inuit peoples – while Indigenous children account for 11% of the entire child population. There continues to be a disparity among child poverty rates among Indigenous and non-Indigenous children as a result of decades of discrimination and intergenerational harm. On a national level, 47% of First Nations children live in poverty while the rate of poverty for non-racialized, non-recent immigrant, non-Indigenous children sits at 12%.

Due to these circumstances, they are more likely to be affected by trauma and mental health issues, low high school completion rates, poor health, unemployment, child welfare interventions, and homelessness.

Poverty rates for First Nations children, both on and off reserve, have been in decline since 2010. However, they continue to experience poverty at vastly different rates – 58% of Indigenous children living on reserve experience poverty compared to 26% of those who live off reserve.

Affordable and Accessible Child Care

Access to high quality, universally accessible, and affordable childcare is a proven method for lowering child poverty. Studies show that children in universal, low-cost child care have better physical health, developmental, and psychological conditions by age 6 to 7. Better health means children can live fuller lives, miss fewer days of school, and contribute meaningfully to the physical and mental health of our society.

Child care for a family is one of the biggest household expenses, which can be as high as 67% of their monthly income. This makes it extremely difficult for a family to afford nutritious food, housing, education, and other essentials.

The effects of universally accessible and affordable child care are especially profound when it comes to families headed by single mothers, who are among those most affected by poverty. Collaboration between the federal and provincial governments is necessary to provide a solid foundation for improving availability and affordability of child care.

Housing

Affordable housing is a necessity to prevent and combat child poverty in Alberta. The federal and provincial government, along with municipal governments throughout the province have created Housing Strategy plans to address homelessness and poverty.

The Canadian National Housing Strategy aims to decrease chronic homelessness by 50% within 10 years. As part of the National Housing Strategy, federal and provincial governments have agreed to develop a portable Canada Housing Benefit initially delivering an average of $2,500 per year to qualifying households. This proposed national benefit has the potential to significantly expand the number of households receiving direct rent subsidies.

With the change in government on the provincial level, uncertainty persists on the province's commitment to their share of affordable housing initiatives. Funding to the Rental Assistance Program will be cut by 24% along with a 3.5% reduction in operating budgets for housing management bodies like Capital Region Housing. It is unclear how vulnerable populations relying on these programs will be affected, but it is expected that their risk of eviction will increase.

Family Violence

Family violence within the home correlates with child poverty and homelessness. In 2017, nearly 60,000 children and youth in Canada were victims of police-reported family violence incidents. More than half of the children were female. A 6% increase of police-reported family violence and non-violence was observed from 2016 to 2017. The overall numbers of children who experience family violence is expected to be much greater due to under-reporting to police.

The Alberta Council of Women's Shelters identified an increase in unemployment rates for women accessing shelter services. In addition, nearly half of women and children were turned away from an emergency shelter due to capacity shortages.

Family violence has significant effects on children such as increased impulsivity, behavioural issues, decreased emotional regulation, increased risk of crime, and increased risk of family violence throughout life.

Access to Health Services

While the provincial government has introduced a series of new funding commitments in the areas of mental health and addictions, opioid response strategy, palliative care, and a new sexual assault hotline, there are also serious cuts to health services as a whole.

In the area of mental health and children, the number of hospitalizations of children related to mental health issues have been steadily increasing, which includes increased emergency room visits related to self-harm. Despite commitments to a mental health and addictions strategy, no concrete information on what the strategy will look like has been made available thus far. In turn, necessary mental health projects are being delayed, such as a proposed child and adolescent mental health centre at the Royal Alexandra Hospital.

Changes to the Alberta Seniors Drug Benefit program will end coverage for non-senior dependents, which include grandchildren being raised by their grandparents. There currently is no pharmaceutical coverage for children in Alberta. The only program that provides some coverage is the Alberta Child Health Benefit, which provides health coverage for children 18 and under in low-income families. The income thresholds for families to qualify are also very low, and those who do not qualify end up paying substantial sums of out of pocket for pharmaceuticals and other services.

A universal prescription drug coverage program would go a long way to addressing these deficiencies.

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JOINT COMMUNICATION

Multi-Employer/UNA Collective Agreement

Guidelines Regarding Booking and Cancellation of Shifts By Casual Employees and Employers

January 19, 2007

Casual Employees and Employers have expressed significant concerns with the booking and cancelling of shifts involving Casual Employees with short notice. The Multi-Employer/UNA Joint Committee recommends the following guidelines related to this issue:

The Impact

When the Employee Cancels - When a Casual Employee has booked a shift, cancelling at the last moment leaves the Employer little time to find a replacement. This could result in the unit/program operating short-staffed thereby creating additional work and stress on other Employees and impacting patient care. Alternatively, if a replacement can be found on short notice, overtime payment is often required. This may cause the unit/program to run over budget and could, in the longer term, negatively impact staffing options and patient care.

When the Employer Cancels - When an Employer books a Casual Employee for a shift as a precaution against anticipated absences or increases in workload and then cancels at the last moment when it appears the Casual Employee won't be needed, this creates problems for the Casual Employee. The Casual Employee may have missed out on other opportunities to work, they may have made arrangements to deal with personal issues such as childcare that are difficult to change or they may have cancelled or rescheduled personal life events or appointments that are important to them.

Both the above scenarios can cause a great deal of angst, distrust and negativity in the workplace.

In addition, there tends to be a spiral effect as Employers and Casual Employees may start booking multiple shifts to protect themselves against potential shift cancellations.

Application of the Collective Agreement

In the current staffing environment, Casual Employees have multiple opportunities for accepting work. Since Casual Employees can only be scheduled with their consent, there is nothing prohibiting them from changing their consent if they receive multiple requests to work the same shift.

Under the Collective Agreement (Article 30.03(a) (i)), Casual Employees can only be scheduled more than seven days in advance if they are relieving another Employee for an absence of three months or less or for a specific job.

Where the Employer cancels a shift after the Casual Employee has reported to work, the Employee is entitled to 4 hours pay at basic rate of pay.

It is not a breach of the Collective Agreement for either the Casual Employee or the Employer to cancel the shift, even on short notice, provided it occurs prior to reporting for the shift. Even though it is not a violation of the Collective Agreement, there is a significant impact for Employees, Managers and patients/residents/clients.

Joint Committee Recommendations

1. **Minimize the occurrence of shift cancellations** - The Multi-Employer/UNA Joint Committee encourages all Employees and Employers to exercise reasonable judgment and consider the impact of their decisions when faced with these scenarios. Employees and Employers are urged to only cancel a shift where a casual Employee is already booked in the event there is an unanticipated development that would change the availability of the shift or the Employee's availability for the shift.

2. **Consider alternatives** - Employers are also urged to consider the long term impact on the availability and commitment of Casual Employees in areas where shifts are routinely offered and then later cancelled. When unanticipated situations do arise, (for example the sick employee that the Casual Employee was to replace returns to work earlier than anticipated) improved coordination between various areas of the Employer may assist in ensuring that the Casual Employee is offered alternative opportunities to work rather than simply having the booked shift(s) cancelled.

3. **Communicate** - Use communication, consideration and understanding. While we encourage Employees and Employers to avoid canceling shifts, there may be times when it is absolutely necessary to cancel a shift with short notice. Please

4. communicate with the other party as far in advance as possible. Communication is the key. Please be considerate of the circumstances around the need to cancel. In the absence of effective communications Employees and Employers may question the reliability of each other. Effective communication will improve both the quality of patient care and the relationships within the workplace.

NOTE: Collective Agreement provisions for Part-time Employees are different than those applicable to casual Employees. However, the Joint Committee encourages Employees and Employers to apply the same considerations as described above when booking and cancelling additional shifts for Part-time Employees.

If you have any questions regarding these guidelines, please contact:

For the Union:

David Harrigan
Director of Labour Relations
United Nurses of Alberta
1-800-252-9394

For the Employers:

Cory Galway
Senior Negotiator
HBA Services
(403) 281-8510

Casual Employees eligible for overtime when they work beyond their scheduled shift hours

When Casual Employees are offered a shift, they should confirm the length of the shift they are being asked to work. This is important information as Casual Employees are eligible for overtime if they work beyond their scheduled shifts hours. However, Casual Employees must work a minimum of 7.75 hours to be eligible for overtime.

If a Casual if replacing a regular Employee, any hours they work beyond what the regular Employee would have worked (7.75 hrs or an extended hour shift) is deemed to be overtime and paid at 2X the basic rate of pay.

When a Casual is offered a shift that does not replace a regular Employee, they should confirm the number of hours they are booked to work. Any hours worked beyond the scheduled shift length and in excess of 7.75 hours should be paid at 2X the basic rate of pay.

If a Casual Employee is scheduled to work a 4 hour shift and is asked to stay an addition 3.75 hours (total of 7.75 hours), they are not eligible for overtime.

Make sure you claim overtime when it is appropriate. If your Employer denies your request for overtime, contact your Local Executive or Labour Relation Officer as soon as possible.

UNA
United Nurses of Alberta

Provincial Office: 780-425-1025 or 1-800-252-9394 • **Southern Alberta Regional Office:** 403-237-2377 or 1-800-661-1802 • **www.una.ca**

It's time to **recognize the critical contribution** nurses and midwives make to global health!

2020

INTERNATIONAL YEAR OF THE NURSE AND THE MIDWIFE.

#SupportNursesAndMidwives

Want to get more involved? Mark your calendar with these upcoming 2020 events!

The Calgary and District Labour Council Lobby Training: May 5th, 1700-1900 via Zoom. Learn how to lobby government to call for the creation of laws that would benefit all members of society, laws that would become the foundation of our social programs in Canada today. URL: **https://us02web.zoom.us/j/87529972684?pwd=dFY5eWpjQWlBWHpTVy9iazlDNWlDZz09**

Dial: 1-587-328-1099, Meeting ID: 875 2997 2684, Password: 221564.

Dealing with Abuse Workshop: September 30th. The "Dealing with Abuse" workshop is designed to provide participants with an understanding of the various types of workplace abuse and that abuse in any form is unacceptable. It will also encourage participants to take appropriate action if they are the targets of abuse, to provide support to co-workers who have been abused, and to provide participants with the tools to advocate for the prevention of workplace abuse. See **http://una.ab.ca/events** for more information and register through DMS or contact us at **local115exec@una.ca**.

Know Your Rights Workshop: September 1st, October 27th & December 1st. The "Know Your Rights" workshop offers new members, or members who considering becoming active in their Local, a chance to learn about their union and their rights in the workplace. During the day, participants will explore UNA's relevance to their own lives and understand the goals, philosophy, and functioning of UNA. It provides participants with the tools to protect their rights and opportunities to engage more effectively with UNA. See **http://una.ab.ca/events** for more information and register through DMS or contact us at **local115exec@una.ca**.

Local 115 Meetings: May 13th (Zoom) & June 10th. Due to the current health situation, different digital platforms are being trialed. ID numbers and passwords to attend will be emailed the week before the meeting. All members are welcome. Come and voice your work-related concerns! See reverse cover, Local 115's Facebook page **https://www.facebook.com/UnitedNursesofAlbertaLocal115/** or contact us at **local115exec@una.ca** for more information.

South Central District Meetings: June 18th & December 3rd. Locals are grouped into five geographically based districts – North, North Central, Central, South Central and South. Presidents of UNA locals attend regular District Meetings where they share information, compare challenges and develop strategies. Please contact us at **local115exec@una.ca** for more information.

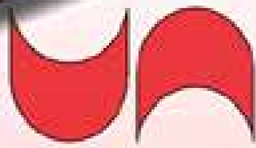
The Calgary and District Labour Council Pre-Retirement Weekend Workshop: November 28th – 29th. A pre-retirement course that deals with all the major issues those planning for retirement need to consider (e.g. goal setting, legal issues, housing, activities, changing relationships, volunteering, labour movement involvement, health and financial matters). More information can be found at **http://www.thecdlc.ca/**.

Engagement & Support Workshop: October 6th & November 24th. In this workshop, Unit/Office Representatives and Local Executive members will come together to develop their practices in membership outreach, engagement, and support. Through large and small group discussions, activities, and scenarios, participants will identify ways to improve member outreach, to overcome barriers to participation, and to engage members in their local, while gaining a better understanding of the relationship between different local positions. Participants will also identify ways to support members through workplace concerns. This workshop is designed for Unit/Office Representatives and Local Executive members only. Unit/Office Representatives, where possible, should take Know Your Rights before taking this workshop. See **http://una.ab.ca/events** for more information and register through DMS or contact us at **local115exec@una.ca**.

With the exception of the monthly Local meeting, please note that the ever-evolving pandemic situation can and may impact the above events.

Keep an eye out for our summer publication for more.

Please Post



United Nurses of Alberta

Notice of Monthly Meetings:

May 13th (Zoom) & June 10th
16:00 – 18:00

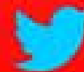
Zoom URL: https://zoom.us/j/6707812119?pwd=V1FzU3lJY2pLbXVuN0liZkpWd2g4QT09

Meeting ID: 670 781 2119 Password: 411322

403-670-9960 local115exec@una.ab.ca www.local115.wordpress.com

UnitedNursesofAlbertaLocal115

Join the Member's Only Closed Group – UNA Local 115 Foothills Medical Centre (Group)


@UNALocal115