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THE Report

Fighting for safety

by CINDY STEWART

Cindy Stewart, HSA President

The statistics are staggering.
In Canada, on average, 900 workers die at work every year. That's more than two deaths every day.

Usually, it's a number you read in the newspaper, or a story you hear on the radio on your way to work.

But for HSA members earlier this year, the story was about someone we know. It was about one of us.

Dave Bland was a vocational rehabilitation counselor at the Richmond Mental Health team for 27 years. He was killed leaving work on January 19, 2005. An advocate for his clients, he worked tirelessly and gave of himself to the troubled people he worked with. An advocate for his profession, Dave was active in bringing recreation therapists into HSA and being recognized as paramedical professionals.

We all know people like Dave. And many HSA members are people like Dave. You give of yourselves – sometimes to your own detriment. But never should any one of you be put into a position of personal risk when you are delivering the services that you do.

While we will mourn for the dead on April 28, the Day of Mourning, we have many activists in HSA who are fighting for the living.

Last year, BC's Auditor General released a report about the health of workplaces in the health care setting. Health care workers told the auditor general that they have a number of occupational health and safety concerns, but the one of particular concern for staff was their personal safety and security.

"According to focus group participants, both patients and families are becoming more aggressive, and anyone can walk freely in most areas of many facilities. Especially in the evening and on nights, staff in some departments may work alone and away from easy contact with others. For staff working in the community, safety and security is an issue when they are working alone in an office or client's home," the Auditor General's report says.

The Day of Mourning, marked annually on April 28, originated in 1984 when the Canadian Labour Congress declared a National Day of Mourning for workers killed and injured on the job.

National union organizations in other countries quickly followed suit. In the United States, a Workers' Memorial Day was established by the AFL-CIO. Today, working people around the world take time on April 28 to remember lost co-workers, friends and family while renewing their commitment to safer workplaces under the slogan "fight for the living, mourn for the dead."

And while we will mourn for the dead – we have many activists in HSA who are fighting for the living.

At HSA's annual convention this month, delegates will hear from the union's Occupational Health and Safety Committee about the heroes in our workplaces who make a difference every day – to their patients, to their clients, and to their co-workers. They are the people who are active in making your workplace a safer one – as OH&S stewards, members of joint OH&S committees and advocates for improved health and safety measures where you work.

I applaud their work and encourage you to seek out your HSA occupational health and safety stewards to join the fight for the living. R

contents

10 VIOLENCE IN THE HEALTH CARE WORKPLACE
Health workers face the highest risk: an in-depth report

NEWS

4 SHORTAGE THREATENS ACCESS TO CRITICAL HEALTH SERVICES
5 ONE IN THREE FEELS EFFECTS OF HEALTH PROFESSIONAL SHORTAGE; WHISTLE-BLOWER BILL TO PROTECT MANITOBA HEALTH WORKERS
6 STRESS AND WORKLOAD TAKING TOLL ON HEALTH PROFESSIONALS
7 SINGLE SENIORITY LIST AGREEMENTS REACHED FOR ALL HSA MEMBERS IN VCH; COMMUNITY SOCIAL SERVICES: CASUAL WORKERS' STAT PAY POLICY GRIEVANCE
31 HSA DONATES TO TSUNAMI RELIEF AND BC FOOD BANKS

DEPARTMENTS

8 BOARD OF DIRECTORS: ELECTION RESULTS
19 CONTRACT INTERPRETATION
20 ACTIVIST PROFILE: JENNY STEVENS
22 MEMBER PROFILE: GERALD YU
24 COMMITTEES: EQUALITY AND SOCIAL ACTION
26 IN MEMORIAM: DOROTHY ROY
27 FOCUS ON PENSIONS

COLUMNS

2 MESSAGE FROM THE PRESIDENT
28 EXECUTIVE DIRECTOR'S REPORT
30 ACROSS THE PROVINCE: REGION 1

THE FRONT COVER

Gerald Yu is the Fraser Health Authority's coordinator of data quality; see profile page 22. Dan Jackson photo.

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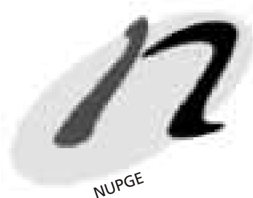
News



Shortage threatens access to critical health services

NUPGE

Without an adequate supply of skilled health science professionals to operate medical equipment, Canadians' access to critical medical imaging technologies will continue to be hampered, says Cindy Stewart, co-chair of the Canadian Health Professionals Secretariat (CHPS) and President of the Health Sciences Association of BC.

Stewart's comments follow the release of a report by the Canadian Institute for Health Information (CIHI) entitled *Medical Imaging in Canada 2004*. The report concludes that while the last decade saw an increase of more than 75 per cent in the supply of MRIs and CT scans, there has been no increase in the supply of professionals required to run the equipment.

Compounding the problem is the fact that the population of medical radiation technologists (MRTs) is aging. Between 1991 and 2001, the proportion of MRTs under the age of 35 has dropped from 47 per cent to 31 per cent.

"There is some concern that there will not be enough professionals to properly run the increased number of machines," the report concludes.

"Improving the availability of new technologies and medical imaging equipment is important, but this equipment becomes little more than a large and very expensive testament to poor management if it is allowed to stand idle because there are not enough qualified technologists to run it," said Stewart.

"It makes no sense to spend more scarce health care dollars on capital equipment when we do not have a strategy in place to ensure the skilled professionals required to operate the equipment are available now, and in the future."

In a November 2002 Ipsos-Reid poll, Canadians said that reducing wait times for diagnostic services, such as MRI and CT scans, should be the number one priority for new health care spending.

"But a serious shortage of health professionals is leaving patients without access to those critical services, jeopardizing quality care, and in fact exacerbating the waitlist problem government says it's committed to fixing," said Stewart.

The CIHI report chronicles the problem in the specific fields related to medical imaging, but the shortage of health professionals is much wider. Health professionals are intimately involved in every step of health care delivery including diagnosis, treatment and recovery, and staff shortages are reported across the spectrum.

"Canadians expect a team of highly skilled health professionals delivering timely and quality services, but those expectations will never be met unless governments address the shortages of health professionals," said Stewart.

"Governments must recognize that they can only make significant progress in reducing wait times and improving access by working with and supporting the dedicated health professionals currently working in the system and by investing in the recruitment of future health professionals."

CHPS represents more than 60,000 health professionals across the country. These are the physiotherapists, respiratory therapists, pharmacists, dietitians, lab and x-ray technologists, as well as more than 100 other highly specialized disciplines integral to the delivery of health care services.

MARILYN KOOP GRAPHIC

One in three feels effects of health professional shortage

NUPGE

One-third of all Canadians, including more than half of Atlantic Canadians, say they or a family member have been unable to get prompt access to health services within the past two years because of a shortage of health science professionals such as physiotherapists, dieticians, laboratory, x-ray and MRI technologists.

The finding is contained in a national poll conducted by Vector Research and Development for the National Union of Public and General Employees (NUPGE).

The results demonstrate that the impact of the shortage of trained health professionals extends well beyond services provided by doctors and nurses.

There is a serious shortage of health science professionals and clearly a large number of Canadians are feeling the effects of this in terms of reduced access to critical health services," says Shelley Wilson, a NUPGE national representative.

NUPGE and other unions representing health science professionals have launched advocacy campaigns to draw attention to three key issues: the serious shortage of professionals who provide essential diagnostic, clinical, rehabilitation and pharmacy services; the impact of the shortages on patient care and the actions governments can take to address the problem.

The poll also found that 67 per cent of Canadians believe the single most effective way to reduce wait times for health treatment or hospital care is to hire more health care professionals, including doctors, nurses and health science professionals.

"The poll indicates that most Canadians believe waiting times are not the result of equipment or capital shortages, inefficiency, or abuse in the system," says Wilson.

"Most Canadians understand that wait times are largely the result of a serious shortage of health professionals to run the tests, operate the sophisticated equipment, interpret results and deliver diagnoses and treatments.

The poll also found that 53 per cent of Canadians think health science professionals are overworked.

"We know that staff shortages are resulting in crushing workloads and burnout, leading to workers departing the health science professions," notes Wilson.

"Governments must understand they can only make significant progress in addressing wait times and improving patient care by recognizing that health science professionals are a critical part of the health care team and investing in the recruitment and retention strategies that will address staff shortages," she says.

"It's going to take a coordinated, collaborative approach, with governments working with the men and women who deliver these essential services, to resolve these issues before it gets any worse.

The findings in this national poll are based on telephone interviews conducted Dec. 8-16 for Vector Research and Development Inc. of Toronto. Results are considered accurate within plus or minus 2.9 percentage points, 19 times out of 20.

Whistle-blower bill to protect Manitoba health workers

NUPGE

The Manitoba government has introduced whistle-blowing legislation requiring health care workers to report any "critical incidents" that affect the care of patients.

When passed, the new law will protect workers from being disciplined or otherwise penalized for coming forward.

Health Minister Tim Sale says the Regional Health Authorities Amendment and Manitoba Evidence Amendment Act will "require the reporting of critical incidents that may happen during the provision

Continued next page

News

Continued from previous page

of health services and help health care providers participate fully and openly in an investigation of a critical incident."

The legislation will also ensure that analysis and opinions are kept confidential while at the same time ensuring that patients affected by a particular incident are fully informed about their situation and the care they are receiving.

"When health care providers share information about critical incidents, they are better able to learn from their experiences and move forward," Sale said.

"This legislation will help us develop a more open process and ensure that Manitobans continue to receive high-quality health care services."

Sale said the bill is among a series of health system improvements that have already been implemented to enhance patient safety and quality health care in Manitoba, including the creation of the Manitoba Institute for Patient Safety last year and an increase of $500,000 in the 2005 budget to further support the work of the institute.

Other initiatives that have been undertaken to improve patient safety in Manitoba include: (a) the requirement for personal care homes to develop a bill of rights to protect their more than 9,000 residents; (b) a process for internal disclosure of staff concerns, and (c) regional health authority guidelines for health services.

Stress and workload taking toll on health professionals

NUPGE

MRI technologists, physiotherapists, lab technologists and other health science professionals working in Ontario hospitals ranked stress and workload as the top issues in a recent health and safety survey conducted by the Ontario Public Service Employees' Union.

"The results are significant but not surprising", says Patty Rout, chair of OPSEU's 12,000 member Hospital Professionals Division. "This is the high cost of staff shortages. Our members are being stretched beyond their limits to make up for inadequate numbers of staff."

The OPSEU survey findings are consistent with the conclusions of several recent national reports, including the Romanow report, the Kirby report and the Health Council of Canada report.

All documented a connection between shortages and poor working conditions confronting health science professionals.

The OPSEU survey found that health science professionals are working large amounts of overtime and often skip work breaks. Poor working conditions lead to profound morale problems that affect not only today's care providers but also discourage young people from entering these disciplines.

Figures for 40 of the Ontario hospitals where OPSEU represents health science professionals show overtime costs for these employees more than doubled between 1999 and 2004, increasing by 152 per cent to nearly $4 million.

"Our work has increased and become more complex, so it's no wonder we are seeing these results," says Rout. "The question is: what are the hospitals going to do about it?"

Poor working conditions exacerbate the shortage of health science professionals and erode any progress made in improving quality patient care and reducing wait times for critical services.

"This is taking a toll on our members and it is hurting patient care. Workers who are exhausted, stressed and overburdened cannot consistently provide the quality patient care workers and patients alike expect. Our members are worried about making mistakes," says Rout.

"The hospitals have to improve wages and working conditions now to attract and keep people in our professions," added Rout.

OPSEU hospital professionals work in more than 70 acute care hospitals across Ontario. Their ranks include Pharmacists and Pharmacy Technicians, X-Ray, Lab and Ultrasound Technologists.

Single seniority list agreements reached for all HSA members in VCH

All Health Sciences Association members who work in the Vancouver Coastal Health Authority and are covered by the Paramedical Professional Bargaining Association and Nurses' Bargaining Association collective agreements will benefit from agreements reached to develop single seniority lists for each of the bargaining associations.

"This is a very significant breakthrough, as HSA has been trying for several rounds of bargaining to engage HEABC in discussion on regional seniority lists of this nature," said Ron Ohmart, HSA's Executive Director for Labour Relations.

"I am pleased that we have been able to conclude these agreements on behalf of HSA members. These agreements allow members improved access to job opportunities throughout the region," he said.

Vancouver Coastal Health Authority will be working with the affected unions to implement the single seniority lists over the next several months. Members will be given at least 150 days notice of implementation of the system. It is anticipated that the merged lists will be in effect in the early part of 2006.

The main features of the agreements are:

- equal access to regular and temporary positions – regardless of worksite
- enabling career laddering, skill development to 'trial' positions in different clinical settings
- formation of regional services
- one seniority list per bargaining association

The full text of the Memorandum of Agreement between Vancouver Coastal Health Authority and Paramedical Professional Bargaining Association and the Memorandum of Agreement between Vancouver Coastal Health Authority and Nurses' Bargaining Association are available on the HSA website at www.hsabc.org in the "collective agreements" section.

Watch future issues of The Report *for updates on lab restructuring in both VCH and Providence.*

Community social services: casual workers' stat pay policy grievance

The dispute over stat pay for casual employees will be decided by an arbitrator at a hearing set for May.

The bargaining association for unionized community social services sector workers – the Union Bargaining Association – filed a policy grievance last fall when the association learned that some casual employees are only being paid straight time instead of time and one-half for hours worked on statutory holidays, and that some employers are cancelling shifts of regular staff scheduled to work on a stat and replacing them with casual staff at the lower rate of pay.

The UBA considers this practice to be a violation of Article 30 where the parties have agreed to limit the use of casuals to backfill for sick leave, vacation, special leave or to augment during peak periods. The collective agreement prohibits employers from laying off a regular employee for the purpose of calling in a casual employee at a lesser rate of pay.

If this is happening to you, don't file a grievance but inform your steward, and keep a record.

Casual employees should keep track of all stat holidays where they are only paid straight time. Regular employees should keep track of all shifts on stat holidays that are cancelled by their employer.

Members who are on Long Term Disability (LTD) should be aware of changes regarding payment of their benefit premiums.

The Community Social Services Employers' Association (CSSEA) is advising all employees on LTD of a "one time opportunity" to enroll in a cost-sharing arrangement (50-50 split) with their employer for the payment of premiums for MSP, dental benefits and extended health benefits. This is a change from CSSEA's original position that employees on LTD are responsible for paying the full cost of their benefit premiums. The UBA filed a policy grievance last November regarding this position. R

BOARD OF DIRECTORS

Results announced for elected representatives

Elections were held this year for positions on the HSA Board of Directors representing odd-numbered regions.

Region 1: Kelly Finlayson

Finlayson

HSA members in Region 1 have re-elected Kelly Finlayson, a mammography technologist at St. Joseph's Hospital in Comox , as their representative on the HSA board of directors.

Finlayson defeated Suzanne Bennett, a youth addictions counsellor at the John Howard Society in Courtenay.

Finlayson has served on the board of directors for ten years, including as vice-president of the union since 1997. She has also served on numerous HSA committees including Resolutions, Education, Political Action, Run for the Cure and Equality and Social Action.

Finlayson will begin her next, two-year term at the conclusion of HSA's 2005 annual convention.

Region 3: Maureen Ashfield

Ashfield

Members in Region 3 have acclaimed Maureen Ashfield as their representative to HSA's Board of Directors. She was acclaimed after the January 28, 2005 deadline passed with no further nominations.

Ashfield is a Home Health Services Care Coordinator at North Shore Health.

She has been a member of HSA since 1997 and has been Chief Steward at her chapter since April 2000.

She has been a Member-at-Large in Region 3 and has served on the union's Political Action Committee, the Committee for Equality and Social Action, and the Resolutions Committee.

In her community, she has been President of the Board of Directors of her housing cooperative, secretary on her local school's Parent Advisory Council, and active in community sports and other local organizations.

Region 5: Reid Johnson

Members in Region 5 have elected Reid Johnson, a social worker at the Centre for Ability in Vancouver, as their representative on the HSA board of directors.

Johnson defeated the incumbent director, Bonnie Norquay, a recreation therapist at Vancouver Community Mental Health Services.

Johnson

Johnson served previously on the board of directors from 1997 until 2002. During his time on the board, Johnson served on numerous HSA committees including Staff Relations and Finance. He was Secretary-Treasurer of the union for three years.

Johnson will take office for a two-year term at the conclusion of HSA's 2005 annual convention.

The board of directors sincerely thanks Bonnie Norquay for her contribution to the union.

Region 7: Audrey MacMillan

Members in Region 7 have returned Audrey MacMillan as their representative on the union's Board of Directors. She was acclaimed after the January 28 deadline passed with no further nominations.

MacMillan is a registered psychiatric nurse at Chilliwack General Hospital. She has served as a chief steward and was a key activist in HSA's campaign against Patient Focused

The role of Regional Directors is to advocate on behalf of the membership and to represent members' interests.

MacMillan

Care (also known as Program Management), first at the hospital where she works and then as a member of HSA's Working Group on Multiskilling.

She is currently a member of the union's Finance and Education Committees, and has represented HSA in the Nurses' Bargaining Association.

MacMillan has served as a Regional Director since 1995.

Region 9: Jackie Spain

Members in Region 9 have returned Jackie Spain as their representative on the union's Board of Directors. She was acclaimed after the January 28 deadline passed with no further nominations.

Spain

Spain has worked as a laboratory technologist at Golden and District General Hospital for the past 25 years. She has been actively involved with HSA both as chief steward and as an Occupational Health and Safety steward since the early 1980s. Spain is presently in her sixth term as chair of HSA's Occupational Health and Safety Committee. She also serves as Chair of the Committee for Equality and Social Action.

In past years, Spain served as chair of the Education Committee and she also served for six years as a Member-at-Large for her region. This included two years as a member of the Resolutions Committee.

Spain is seconded by the Occupational Health and Safety Agency (OHSAH) as an Occupational Health and Safety Trainer. She is a co-ordinator and facilitator for the BC Federation of Labour's Occupational Health and Safety Education Project, and is 1st vice president of the East Kootenay Labour Council.

Role of Board of Directors

The Board of Directors is the elected governing body of the union when convention is not in session.

The board is composed of the President and one Regional Director from each of the 10 regions outlined in the union's constitution.

The role of Regional Directors is to advocate on behalf of the membership and to represent members' interests. Annual regional meetings, chaired by the Regional Directors, are held each fall in each of the regions to allow members opportunity to meet with the Regional Director, President and the union's senior staff.

In addition to the annual regional meetings, Regional Directors may attend chapter meetings and other HSA events in the region to enhance their understanding of issues and concerns in their region in order to be able to represent members at the regular board meetings.

Board members chair all committees of the board, including: Finance, Equality and Social Action, Education, Political Action, Occupational Health and Safety, Run for the Cure, and Elections. Board members also represent HSA as delegates to conventions, including the BC Federation of Labour, the National Union of Public and General Employees, and Canadian Labour Congress.

HSA's Regional Directors are elected to two-year terms, with elections held in odd years for directors representing members in odd-numbered regions (1,3,5,7,9) and even years for directors representing members in even-numbered regions (2,4,6,8,10). R

VIOLENCE IN THE HEALTH CARE WORKPLACE

Health care workers face highest risk

by CAROL RIVIÈRE and YUKIE KURAHASHI

It happened in a flash.

Late last year, Dave De Bruin, a psychiatric nurse, responded to a 'code white' in the emergency department at Matsqui-Sumas-Abbotsford Hospital.

What is violence?

According to BC's Occupational Health and Safety Regulation s. 4.27, **violence** means the attempted or actual exercise by a person, other than a worker, of any physical force so as to cause injury to a worker, and includes any threatening statement or behaviour which gives a worker reasonable cause to believe that he or she is at risk of injury.

"I was called because there was a person down in the ER who was being violent. When I got there, there was already a scuffle going on: the ambulance attendants and police were trying to deal with this fellow. We managed to get him subdued somewhat and put him into restraints," he said.

"I noticed that one of the restraints wasn't the correct one, so I went to get the correct restraints. As I was changing the restraints, he stopped fighting and promised the police officer he would settle down – so the officer let go of him.

"He took that opportunity to punch me in the face."

De Bruin is a tall, soft-spoken, gentle man. His friendly and reasonable problem-solving approach is an advantage at MSA Hospital, where he is HSA's chief steward as well as occupational health and safety steward.

"Usually, I'm very cautious because I don't want to get hit; you're always looking for that stuff," he said. "I'm a big guy, but so was he. He broke my nose. But what if it had been one of my colleagues? If he had hit one of the smaller staff members, she could have been gravely injured."

During the course of his work, De Bruin routinely deals with violent situations. "All violence is impossible to predict 100 per cent of the time," he said. "But we do have good ways of predicting violence. For example, most violence is repeat violence; people on certain drugs are more likely to be violent; if they're on alcohol, they're also more likely to be violent," he said.

"The next morning when I got up, my face was in a sling, I had my nose filled up with cotton, and I had to go to a specialist the next day to get my nose put back into place."

"But when we do find out about somebody who is a violent person, there is still nothing done to ensure that we're not put in the situation of being injured again."

De Bruin was angry about last year's incident, but even more concerned for his colleagues. He decided to act. "The next morning when I got up, my face was in a sling, I had my nose filled up with cotton, and I had to go to a specialist the next day to get my nose put back into place," he said.

"I thought it would be a good time to go down to my MLA's office and make him aware of what was happening.

"In fact, I walked into his office, sat

preventing workplace violence

down, and I said, 'Mr. [Barry] Penner, this is the face of nursing.'"

One fatality is too many

HSA President Cindy Stewart is concerned about disturbing levels of violence in health care workplaces.

"Health care workers have always accounted for a disproportionate number of workplace injury claims in BC – a staggering 9.4 per cent of days lost due to injury or occupational illness in 2003," she said.

"This is higher than logging, manufacturing, and transportation. In addition, health workers file about 40 per cent of violence-related WCB claims, even though we make up less than five per cent of the workforce in BC.

"Violence in health care is different from violence against workers in any other industry," she said. "Health care workers interact closely with their patients or clients and their families – often under challenging circumstances. Patients and clients may be on medication or have medical conditions that make them aggressive. They might have a history of violent behaviour. Their circumstances and recently reduced government services might make them feel angry or frustrated," she said.

In January, HSA members reacted with shock to the violent and deadly attack on fellow member David Bland, a vocational therapist with the Richmond Mental Health Services Team. According to police, a former client was waiting to ambush Bland when he walked out of an employees-only exit into the parkade. Bland was stabbed and killed.

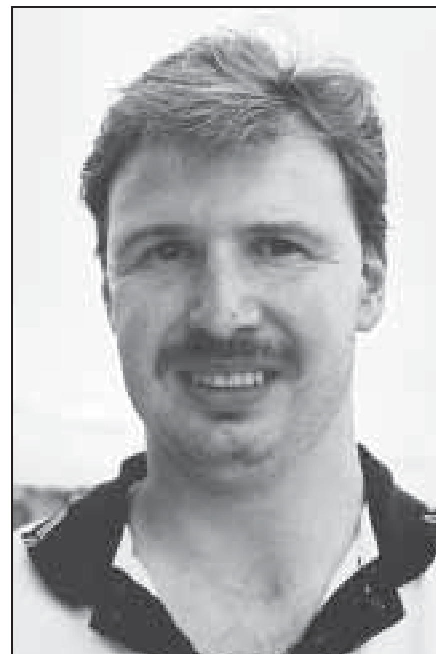
"On behalf of HSA, I extend condolences to David's family, friends, and co-workers," Stewart said. "But words cannot express the sorrow we are still feeling at losing a member of our team, particularly under such violent circumstances." (See article "HSA encourages contributions to David Bland Vocational Rehabilitation Scholarship Fund," page 16.)

Randy Vance, HSA's occupational health and safety steward at Richmond Mental Health, said staff are still saddened and shocked. "David was a great man – he was very articulate, very organized, and very good at his job," he said. "He was able to cut through all the bureaucracies to help people figure out their goals, and get what they needed. He was very much admired by his co-workers, and by the various clients he worked with.

"David was a vocational therapist. He worked with people specifically in terms of helping them find jobs, job programs, going back to school, and volunteer work," he said. "Coming to work and seeing him not here – it's still rough. It's still rough here."

Stewart said that while the employer – Vancouver Coastal Health – has been quick in responding to the incident, ensuring workers are offered the supports they need

"Words cannot express the sorrow we are still feeling at losing a member of our team, particularly under such violent circumstances."



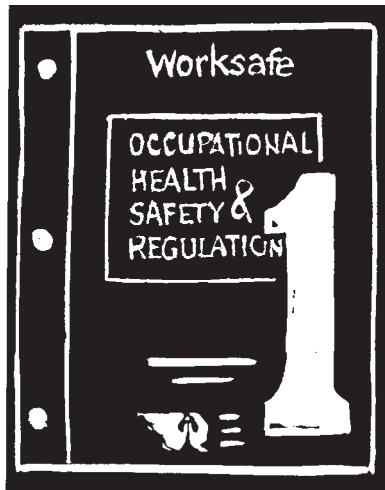
A violent patient assaulted Dave De Bruin, a psychiatric nurse. De Bruin took up the issue of violence and workplace safety with his MLA.

What's the difference between violence and aggression?

Although the Occupational Health and Safety Regulation does not define **aggression**, this term describes hostile, unpleasant, or unacceptable behaviour that may include everything from offensive gestures or expressions to physical violence. Workers unfamiliar with the broad scope of the term "violence" may deny having experienced a violent incident, but may report having experienced incidents of aggression.

Thus it may be helpful to use both "violence" and "aggression" in enlisting the support of co-workers and conducting discussions about workplace safety concerns.

Source: "Preventing Violence in Health Care" WCB handbook



What is a threat?

Threats are considered a form of violence under the OH&S regulation. They generally involve any communication of intent to injure that gives a worker reasonable cause to believe there is a risk of injury. A threat against a worker's family arising from the worker's employment is considered a threat against the worker.

Examples of threats include:

- Threats (direct or indirect) delivered in person or through letters, phone calls, or electronic mail
- Intimidating or frightening gestures such as shaking fists at another person, pounding a desk or counter, punching a wall, angrily jumping up and down, or screaming
- Throwing or striking objects
- Stalking
- Wielding a weapon, or carrying a concealed weapon for the purpose of threatening or injuring a person
- Not controlling a dog menacing (for example, growling at) a worker

Source: "Preventing Violence in Health Care" WCB handbook

during such a difficult time, HSA expects a full and thorough review of the incident will be undertaken with a view to improving workplace safety for HSA members.

However, Stewart has concerns about the BC government's reaction to Bland's death. "A week after David's tragic death, the Campbell Liberals announced a new $10 million fund to promote 'patient and health worker safety,'" she said.

In fact, $9 million of this fund is to be used to address patient safety issues, which will likely focus on issues such as reducing hospital-acquired infections, medication errors, and falls.

"Patient safety is very important," Stewart said, "but this has little to do with general workplace health and safety for health care workers, and even less to do with specifically reducing violence risks for workers. The fund's remaining $1 million is to be used to help employers implement a computerized system for tracking health and safety incidents at the workplace," she said.

"The government's response to this tragedy has been completely inadequate. It does not address the violence risks and injuries due to violence that HSA members are struggling with *right now*."

Stewart said employers are required by law to undertake violence risk assessments in the workplace. "These assessments include recommendations on how immediately to reduce violence risks," she said.

"In many cases, these measures are not being implemented because of funding shortages. If the Liberal government really wanted to improve workplace safety in health care, they would provide adequate funding to health authorities, earmarked for actually implementing measures immediately to improve occupational health and safety, not simply tracking injuries," she said.

HSA is working with the employer, the WCB and the other health unions at Richmond Mental Health to ensure that these steps are taken.

Jackie Spain, Chair of HSA's Occupational Health and Safety Committee, outlined some of HSA's concerns about mental health worksites.

"Everyone involved in the occupational health and safety of health care workers has known for years that there are serious violence risks in health care, and that these are unacceptable," she said. "At the same time, adequate resources are not being devoted to eliminate or minimize these risks, as required by law. Health care workers and their unions have repeatedly lobbied the government, WCB and employers to deal with this issue," she said.

"Tragically, it has taken the death of an HSA member to galvanize the health authority and WCB into taking action."

"The BC Liberal government's response to this tragedy has been completely inadequate. It does not address the violence risks and injuries due to violence that HSA members are struggling with *right now*."

Death threats

The weekend following Bland's murder, another Vancouver-area community mental health worker received numerous death threats from a client, who had recently served a night in jail for a previous death threat.

The mental health worker has asked to remain anonymous, partly to protect the identity of her client – for whom, despite the terror he has caused, she maintains a thoroughly caring compassion.

Upset about being transferred to a new team, the client began making threatening phone calls to after-hours emergency services. "The threats to me started in late December, and got more specific in early January," she said. "He made specific detailed threats. That's when he was thrown in jail for a night for uttering death threats.

"The weekend after Dave Bland was killed, this client phoned back to mental health emergency services, reportedly 21 times. The nature of all the threats weren't documented, because the police blocked his phone so he couldn't tie up 911 any more.

"I was spooked after that. I was just overwhelmed," she said. "I've never had conflict with a client like this. I've been working in health care for 20 years."

This mental health worker has been off work since these incidents, but added, "I work for a great team, and that has made a world of difference."

Stewart sympathizes with this worker. "It's good to know that in this case, the member feels adequately supported by the employer at her worksite, and she is receiving help and advice from HSA," she said.

"But some employers, unfortunately, take advantage of the dedication of HSA members working with patients and clients who have mental health issues – and our members' desire to protect their patients," she said.

"Employers – and mental health pro-

fessionals – can't just say, 'It goes with the territory,' or 'You've chosen to work in a high risk environment, so you have to live with the consequences,'" she said. "The fact that there are greater risks inherent in the work doesn't allow the employer to say there's nothing they can do. If anything, it actually puts a higher legal responsibility on the employer to do whatever's *possible* – not what's easy or economical – to eliminate, or at least minimize, the risk.

"This includes spending the money to implement a violence prevention program that's adequate for the particular workplace, including adequate staffing," she said.

Inadequate communication, faulty ward design

Last fall, a violent Alzheimer's patient assaulted four members and patients at Vernon Jubilee Hospital. One psychiatric nurse, punched in the ear, was off work for several weeks with post-traumatic stress and inner-ear damage. Other psychiatric nurses were pushed into walls, or fell while trying to avoid being assaulted.

Dani Demetlika, HSA's labour relations officer for the facility, described several problems that combined to make an explosive situation.

Continued on page 15

What about a threat against my family?

A threat against a worker's family that is a result of the worker's employment is considered a threat against the worker for the purpose of section 4.27 (1) of the OH&S Regulation.

All threats against a worker or the worker's family must be treated as serious matters. When the employer is made aware of the threat, the employer is required to notify the worker, if the worker is not already aware of the threat, and to notify the police or similar authority responsible for the protection of public safety.

If the employer is unable to contact the worker, the employer should advise a family member so that appropriate precautions can be taken. The employer and any other persons involved are also required to cooperate in any investigations necessary to protect the worker or worker's family. The means of fulfilling these responsibilities should be included in the written Workplace Violence Prevention Program.

Assault involves any act, gesture, or attempt to apply force that gives a worker reasonable cause to believe there is a risk of injury, whether or not an injury (physical or psychological) occurs.

Examples of assault include:

- Kicking, hitting, biting, grabbing, pinching, scratching, or spitting
- Injuring a person by using an object such as a chair, cane, or sharps container, or a weapon such as a knife, gun, or blunt instrument
- Verbal hostility and abuse

Source: "Preventing Violence in Health Care" WCB handbook

What can HSA members do about violence?

by CAROL RIVIÈRE and MARTY LOVICK

While HSA is working with the Workers' Compensation Board and Occupational Health and Safety Agency for Healthcare to ensure that employers are meeting their legal obligation to eliminate, or at least minimize, the risk of workplace violence, individual HSA members may be wondering: "What do I do if I'm concerned about my safety due to potential violence at work?"

- Tell your supervisor about your concern – be specific, and ask what measures he/she will take to rectify the situation.
- Ask your supervisor for your employer's written policies/procedures which address the issue.
- Tell your HSA Occupational Health and Safety Steward about your concern. Ask if your worksite Joint Occupational Health and Safety Committee is dealing with this issue. You can also talk to your regular area steward, or contact the HSA office.
- If you have reasonable cause to believe that carrying out certain work "would create an undue hazard to the health and safety of any person," then you have the right to refuse to perform this unsafe work.
- To ensure you are protected from any retaliation for exercising your right to refuse unsafe work, you should follow the procedure outlined under s. 3.12 of the Occupational Health and Safety Regulation, summarized here:

1. Inform your supervisor or employer that you are exercising your right under the OH&S Regulation to refuse unsafe work Immediately report the circumstances of the unsafe condition to your supervisor or employer.
2. A supervisor or employer who receives such a report must immediately investigate and:
   a) ensure that any unsafe condition is remedied without delay, or
   b) inform you that they don't think the work is unsafe.
3. If you believe an undue hazard still exists, you must tell your supervisor or employer this, and that you are still refusing to perform unsafe work.
4. Your supervisor or employer must then investigate the matter in your presence and in the presence of a worker representative. At most HSA worksites, this will be a union representative on the worksite's Joint Occupational Health and Safety Committee (preferably the HSA OH&S Steward on this committee).
5. If this investigation does not resolve the matter, and you continue to believe an undue hazard exists and continue to refuse to perform the unsafe work, then both you and your supervisor/employer, must immediately notify a WCB officer, who must investigate the matter without undue delay and issue whatever orders are deemed necessary.

- S.3.13 of the OH&S Regulation prohibits retaliation against a worker who refuses unsafe work in accordance with s.3.12.

- If you are considering refusing unsafe work, you should:
  1. Consult your HSA OH&S Steward;
  2. Review the exact procedure required under s.3.12 of the OH&S Regulation; and
  3. Contact the HSA office if you need further assistance.

Continued from page 13

"The OH&S committee at the hospital, as well as the employer's OH&S consultant, determined that the patient was not properly assessed," she said. "Yes, he had dementia and delirium, but he also had a history of being very violent.

"There seems to have been no link between the information gathered at the community mental health level, and getting that information transferred to acute mental health providers.

"Another problem is that the unit doesn't seem to have been designed to handle dementia patients who are violent," she said.

"Many of the most acute or more violent patients used to be transferred to Riverview, which is in the process of being closed. And many hospitals have psychiatric units that just aren't equipped to handle the increasing acuity of these kinds of patients who formerly would have been referred to Riverview.

"Furniture is not bolted down, for example," she said. "One day, this patient threw four chairs through a window, which turned out not to be made of tempered or safety glass, as it should have been for a psychiatric unit."

The other patients in the unit – some with dementia, others with acute depression – were not only frightened and put at risk, but their conditions were exacerbated.

"Three days after this glass-breaking incident, one of the suicidal patients voluntarily turned in to a nurse a large shard of glass," Demetlika said. "She had been holding on to this glass in her room, possibly to use it to harm herself. This was an unacceptable situation."

To make matters worse, security did not respond to 'code white,' and staff called police, who arrived in a matter of minutes.

Eventually, security did show up – an hour later. "Showing up an hour later is completely useless. The investigation found that the private security services were only around for eight hours a day," she said. "This has since been increased to 21 hours a day. And currently, they are recording all codes – code white, code blue, code yellow – because they didn't know how many code whites were being called in a month. This is part of the employer's assessment to determine whether they need to expand security coverage to 24 hours a day."

WCB's investigations at Vernon Jubilee Hospital led to some orders, and the employer is complying.

HSA OH&S Committee Chair Jackie Spain said even with WCB compliance, more work is clearly necessary. "It's good that this employer has now taken steps to conduct the required violence risk assessment and implement its recommendations at Vernon Jubilee Hospital," she said. "It's just too bad that it required such a serious incident before the employer complied with its legal obligations.

"Section 4.30 (2) of the OH&S Regulation places a legal duty on employers 'to provide information related to the risk of violence from persons who have a history of violent behaviour and whom workers are likely to encounter in the course of their work," she said.

"This means employers have a duty to make every effort to obtain this information, especially in respect of patients suffering from mental illness, where the incidence of violent behaviour is higher than the

"The investigation found that after security services were privatized, they were only around for eight hours a day," she said. "This has since been increased to 21 hours a day.

Continued on page 17

IN MEMORIAM

HSA encourages contributions to David Bland Vocational Rehabilitation Scholarship Fund

David Bland (1942-2005), Vocational Rehabilitation Counsellor, Richmond Mental Health Team. Photo courtesy Randy Vance, Richmond Mental Health Team.

David Bland was a valued member of Richmond's Mental Health Team for 27 years. He brought passion, commitment, and a strong personal ethic to his role as a vocational rehabilitation counsellor. He was dedicated to assisting individuals with mental health concerns re-integrate into the community through employment and volunteering. Dave was a peaceful, wise person who loved conversation and exchanging ideas with others. He pursued his interest in sports, travel, nature and spirituality with great enthusiasm.

The David Bland Vocational Rehabilitation Scholarship Fund was created in Dave's memory by his friends, colleagues, and the community of Richmond. It will support his life's work and the clients he supported, encouraged, and mentored in their training to gain active employment and a role in society.

HSA's Board of Directors approved $2500 towards this scholarship fund, and encourages members to add their contributions. Please contact the Richmond Hospital Foundation and specify that you would like to contribute to the David Bland Vocational Rehabilitation Scholarship Fund.

The Richmond Hospital Foundation
7000 Westminster Highway, Richmond, BC V6X 1A2
Telephone: 604/244.5252 Fax: 604/244.5547
info@richmondhospitalfoundation.com

Source: Richmond Hospital Foundation

preventing workplace violence

Continued from page 15

normal patient population. And the information regarding violent incidents must be charted consistently throughout the interior Health Authority.

Health employers often claim they can't inform staff of a patient's violent history because of the patient's privacy rights. Spain stresses that this is wrong. "The relevant privacy legislation clearly states that a person's private information may be disclosed in order to protect the safety of other people," she said.

Other concerns

Dave De Bruin's MLA Barry Penner was stunned when confronted with De Bruin's bruised, bloodied face. At De Bruin's request, Penner wrote a letter to the Minister of State for Mental Health, Brenda Locke, asking her to ensure safer work environments for mental health workers. Penner also wrote to the administrator of MSA Hospital asking for an investigation.

"There needs to be coordination between different departments – not just psychiatry and emergency, but also the police department, security services, and such," De Bruin said.

De Bruin has familiar concerns about hospital security in Abbotsford. "Unfortunately for us, because of the downsizing of all the hospital, all of our 'code white' teams now are pretty much bare bones," he said.

"We now have a private security service. As a private contractor, they can do whatever they want," he said. "We've reported this problem to the liaison person, but as long as there's a warm body there, they are fulfilling their contract. I don't know what else to say. We've filed complaints about it. We can make suggestions, but ultimately, it is their job to secure the hospital."

OH&S Committee Chair Jackie Spain said this is a common problem. "To save money, many hospitals have contracted out hospital security to private, for-profit companies," she said.

"Long-time security employees with specialized training and years of experience specifically in hospital security – many of whom had a real commitment to the hospital and its employees – have been replaced by contract staff. The turnover among these private security staff is high, and many leave the company before they can develop the skills necessary to operate effectively in a hospital.

"In some of these hospitals, the procedures that employers establish to govern how health care workers may interact with the private security staff make it difficult to obtain adequate support," she said.

And, she adds, there are concerns about inconsistency in police practices when dealing with violent patients in health care settings.

"The police routinely bring to hospital people who are exhibiting violent behaviour," she said. "In some communities, once the person is inside the hospital and a health care worker is in attendance, the police offer no further assistance in dealing with the violent behaviour, whether or not the health care worker has adequate assistance from other hospital staff."

The increased risk of workplace violence associated with private security service and inconsistent policing practices are issues that HSA's OH&S committee and labour relations staff are working with local stewards to address.

HSA members with concerns about security are encouraged to contact their OH&S steward or the HSA office. R

Watch for more information on violence in the workplace in upcoming issues of *The Report*, especially in community social service sector worksites. For past articles focusing on critical incident stress, vicarious traumatization, and other articles on workplace violence prevention, see HSA's website at www.hsabc.org.

The increased risk of workplace violence associated with private security service and inconsistent policing practices are issues that HSA's OH&S committee and labour relations staff are working with local stewards to address.

Continued next page

Workplace violence high in health care

The following information is taken from WCB data based on *accepted claims* for workers' compensation in BC from 1999-2003, inclusive.

These data understate the incidence of workplace violence in health care because, as the WCB acknowledges, violent incidents and the injuries they cause are underreported in health care, and because not all claims are accepted.

The data include violent incidents where the person who injures a health care worker can be considered to have had intent to cause injury, as well as where they may be considered to lack intent (e.g., because they suffer from dementia or some other form of mental illness).

From an occupational health and safety perspective, this distinction is irrelevant. Employers still have a legal duty to eliminate, or at least minimize, the risk of violence to workers, regardless of the culpability of the patients or clients involved.

Violence statistics

· Health care has the highest incidence of accepted claims due to workplace violence of all BC industries.

· Nine to 16 per cent of the total number of accepted claims in health care is due to violence. This is three to four times greater than the proportion in any other industry.

· Health care has five per cent of the provincial workforce, but accounts for 40 per cent of accepted violence claims.

· 95 per cent of violence claims involve interactions with patients, residents or clients.

· Violence claims are the third most common type of claim in health care (overexertion and falls are first and second, respectively).

· Psychiatric nurses had the highest number of accepted claims due to violence of all HSA professions.

· Between 1999 – 2003, the WCB paid 3,550 days of time loss to psychiatric nurses who were disabled due to workplace violence.

· By comparison, between 1999-2003 the WCB paid 1,425 days of time loss to health science professionals who were disabled due to workplace violence.

Source: Workers' Compensation Board of BC

Violence prevention resources

- WCB Prevention Information Line
  Phone: 604 / 276.3100 in the Lower Mainland or
  1.888 / 621.SAFE (7233) toll-free in BC

- WCB Publications
  The following WCB publications may be helpful:
  - *Preventing Violence in Health Care* (WCB handbook)
  - *Standards for Hospital-Based Psychiatric Emergency Services: Observation Units* (BC Ministry of Health)
  - *Violence in the Emergency Department: A Survey of Health Care Workers* (Canadian Medical Association Journal)
  - *Guidelines: Code White Response* (WCB of BC, OHSAH, and the Health Association of BC)
  - *Identification of Risk and Prevention of Aggressive Behaviour in Residential Care* (Fraser Health Authority)
  - *Health Care Industry: Focus Report on Occupational Injury and Disease*
  - *Coping with Critical Incident Stress at Work* (pamphlet)
  - *Gently into the Night: Aggression in Long-Term Care* (by Neil Boyd)

  These and other publications can be ordered from the WCB or downloaded from their website:
  healthcare.healthandsafetycentre.org/s/Violence.asp
  Phone: 604 / 276.3068 or 1 800 / 661.2112, local 3068
  E-mail: pubvid@wcb.bc.ca

CONTRACT INTERPRETATION

It's your right: questions and answers about your collective agreement rights

Job classifications

by KATHY McLENNAN

Q: I work in a position covered by the Paramedical Professional Bargaining Association collective agreement. My employer told me that my union has approved the job description for my position and the salary structure has been established for it. I think my position is not properly classified. What can I do to challenge the classification?

A: Pursuant to Article 11.01 of the collective agreement, you may file a written grievance, alleging that your job is not properly reflected by its classification.

There is no contractual requirement for the union to approve a job description. Rather, Article 11 describes the processes by which salary structures are established.

On behalf of an employer, HEABC submits a job description to the union, along with a salary structure it has set for the position. The union may object to the salary structure within 28 days of receipt of HEABC's notice pertaining to either a new or reclassified position. If HSA accepts the salary structure, or does not object to it, it is considered as established.

Nevertheless, a recent arbitration award confirmed that an incumbent can challenge a position's salary structure if the job description does not accurately describe the duties and responsibilities of, and the qualifications required for, the position *or* that it is not properly classified. There need not be a change in job content to proceed with an employee's grievance.

The arbitration award result was the opposite of "winning the battle, losing the war." Even though the arbitrator dismissed the union's grievance, he provided significant points of clarification concerning the Article 11 processes, in addition to that described above.

For example, it is now confirmed that once an employer has revised a job description, HEABC must set the salary structure for the revised position and give notice to the union, in compliance with Article 11. A revised job description may be scrutinized in its entirety as the grounds for a rate objection are not limited to changed duties or qualifications. That is, nothing limits the union from raising matters that it has not objected to in the past.

The award confirms HSA's position that HEABC must send all revised job descriptions through the Article 11 process, regardless of whether they believe a change to the classification is in order.

If you believe your position is improperly classified, you should consult with your steward. To support your grievance, you should provide your steward with a written rationale for reclassification. You should compile evidence (consistent with privacy and confidentiality policies) in support of your grievance, such as:

- Job description(s)
- Job posting
- Newspaper ad for vacancy
- Organization Chart
- Internal/External Memoranda
- Pamphlet describing service
- Job comparators (within facility)
- Job comparators (outside facility)

A grievance should state which classification or salary structure you are seeking, citing the specific collective agreement provisions.

It must be noted that exercising this contractual right is different than participating in the collective bargaining process, where the latter presents the prospect of changing existing provisions such as wages. That is, a reclassification grievance may be filed to assert a current right, but not to seek a remedy that doesn't exist under the Collective Agreement. R

Kathy McLennan is HSA's Membership Services Coordinator for Classifications.

This column is designed to help members use their collective agreement to assert or defend their rights and working conditions. Please feel free to send your questions to the editor, by fax, mail, or email [yukie@hsabc.org]. Don't forget to include a telephone number where you can be reached during the day.

ACTIVIST PROFILE

Running for office to improve health care

by CAROLE PEARSON

"Six years in Brazil taught me a lot," says Jenny Stevens, a retired Mission physiotherapist. "It gave me insight into how wrong a health program can go, particularly when it's multilayered as that one was." She is alarmed to see BC's health care system heading along a similar route. That's one reason Stevens is running as the NDP candidate in Maple Ridge – Mission in the upcoming provincial election.

Born in Devonport, England, Stevens was 12 years old when she was diagnosed with a juvenile form of ancholosis and was blind by18. When considering career options, Stevens decided to become a physiotherapist. "I thought, as a person with a disability myself, I might link well with people needing rehab which proved to be the case."

In 1974, Stevens, her husband, and five children set off from England in a 64-foot West Country Trading ketch to sail around the Atlantic Ocean. After enjoying stops along the way, they crossed the ocean in 35 days and landed in Cabedelo, Brazil.

"Clearly, something is wrong with abandoning an 80-year-old patient alone, hundreds of miles from her community."

When their boat was irreparably damaged by well-intentioned villagers, their brief stop became a stay of six years. Stevens found modern rehab techniques were largely unknown in that part of Brazil. Poliomyelitis was rampant and affected the poor "more savagely" than the rich but only the latter group could afford treatment. "I found the situation offensive and, taking the plunge, I opened my own clinic and let it be known that when it came to treating paralysis, cash was not a prerequisite."

Stevens adopted her youngest child, Xico, from a local orphanage when he was 15 months old. "He was a polio victim, the result of a bad vaccine as were many of the children at the orphanage," she explains. "When I found him, both his knees were up under his left armpit." After an osteotomy and tendon lengthening, Xico ended up with two straight legs. "Because of all that, his scoliosis was horrendous so I taught him to walk on his hands to build up his trunk." Today, at 32, he wears only one below-hip brace – and can still run on his hands!

In December 1981, Stevens came to Canada with her youngest children and settled in Mission, BC. Her two eldest were in post-secondary schools in England and Stevens' husband chose to remain in Brazil. Now a single mother with four children at home, she found employment at Mission Memorial Hospital in 1982, where she worked as an HSA member for four years.

Stevens retired as physiotherapist in1998 but her retirement lasted only three months. "I didn't like it," she says, "and that's how I got persuaded into going into municipal politics." In 1999, Stevens ran successfully for Mission municipal council where she has served her community on numerous boards and committees for nearly two terms.

"When you are doing physio, particularly rehab, you see patients over a considerable period of time so you get to know and share their concerns. Very often you have to advocate for them against the system. All that led me towards getting into community involvement so when I did retire, it was a natural progression to get into municipal politics - and I'm hoping to progress again. I've had five years on council and I think I'm ready to take on the bigger problems."

Stevens is highly critical of changes made by the Campbell government to BC's health care system,

> "Women are often more directly affected by political policies than are men. It's absolutely vital we get involved."

including the way regionalization has been implemented to the detriment of health services in smaller BC communities. Stevens says, "I am not opposed to regionalization but it will only work if adequate regional facilities and ambulances are in place before the local ones are removed or slashed."

The emergency department at MMH is "stripped to the bone" and unable to handle more than minor problems. "Essential emergency services should remain within rapid reach of each community," Stevens said.

A couple of years ago, an 80-year-old woman was struck by a car outside MMH, Stevens recalls. "She had head injuries but the ICU had been closed at MMH and the nearest bed, at that point, was in Kelowna. She was flown there at considerable cost. Even economically, this doesn't make sense."

The patient was discharged in Kelowna and left to find her own way home. "Clearly, something is wrong with abandoning an 80-year-old patient hundreds of miles from her community." When patients are transferred out, Stevens is adamant that they should be transferred back to the original hospital when they are discharged. She suggests having a subsidized shuttle service between hospitals for all patients, including those with day-surgery and outpatient appointments, and for visitors.

Stevens also wants long-term care patients kept in their communities when re-location is necessary. In Chilliwack, for example, the Fraser Health Authority closed one facility so it could be converted into additional office space. "They shuttled the residents here, there and everywhere," Stevens reports. Because elderly patients can get confused easily, it is difficult to adjust to unfamiliar surroundings. It is even worse when sent outside their community. Stevens says, "They lose their family and community support. The result? They deteriorate rapidly and, unfortunately, die very soon. It's cruel, totally cruel."

Stevens wants to be elected on May 17 to help put the 'health' back into BC's health care system. And, because she has 12 grandchildren – six of whom live in Canada – she is also particularly concerned about the impact of cuts to public education. She says, "Women are often more directly affected by political policies than are men. Women are the ones who cope with the elderly relative who is discharged from hospital, incontinent and unable to walk."

That's why Stevens encourages women to participate in the electoral process. "Governments can make it easier or more difficult for women to manage," she says, "so it's absolutely vital we get involved. It doesn't have to mean running for office. It can involve helping out in smaller ways. Women have the ability to influence what happens." R

Jenny Stevens
Physiotherapist (Retired)
Mission Municipal Councillor
Candidate, Maple Ridge – Mission Riding

While working as a rehabilitation therapist in Brazil, Stevens adopted her youngest child, Xico, from a local orphanage. "He was a polio victim. When I found him, both his knees were up under his left armpit," she said. Stevens is pictured here with Xico as she helps him take his very first steps.
Photo courtesy Jenny Stevens.

MEMBER PROFILE

Keeping records, crunching numbers – for your health

by DAN KEETON

When you look around the health care field, you'd be hard pressed to find a more specialized combination of skills than that held by Gerald Yu, a Health Records Administrator who oversees the collection and management of clinical data for the Fraser Health Authority.

Hospital Records Administrators must possess advanced computer skills and be proficient in statistics, classification systems, and pathophysiology. They must know how to interpret health records, and be able to pick out what's important – because it's based on the reading and interpretation of clinical data which ultimately become statistics that decisions are made about the management of health care.

Yu's skills are particularly in demand now that health records are being transferred to electronic health records (EHR) and that data elements are being standardized across the health regions in Canada. The task is to use the same standards and be able to compare data across the region, the province, and the rest of Canada. It's an important job and one that could have potential for high stress. Yu, based at Eagle Ridge Hospital in Port Moody, enjoys the challenge.

"I always wanted to get into health care, and I like statistics, research, and data reporting."

The advantages of modernizing health information management are numerous, he says. It helps target the right kind of information to the right user, enhance cost savings, and make unified information available for governments, health administrators, doctors, and other stakeholders in the health care system.

For the past year and a half he has been the Co-ordinator of Data Quality for the region, working to streamline how facilities keep track of their health information. "Before this, every single hospital would do something different in collecting health information. We're looking at a system where we all collect the same set of data elements for a patient with 'appendicitis' so that for example, an 'appendicitis' profile can be created for research, program management, CQI (continuous quality improvement), etc."

Quality of data is measured by what Yu calls six "dimensions." "One is relevancy: is the data valuable to the system's stakeholders? Another is accuracy: does the data reflect the reality of the subject?"

Then there's consistency, which asks, "Is the data free from variation and contradiction? We collect two types of data, one for inpatient and the other for what is called surgical daycare," Yu explains.

"We report it to the ministries of health, federal and provincial, and the Canadian Institute of Health Information, which keeps a kind of national health score card. Internally, we use the data to manage various programs. For example, we'll compare lengths of stay at different hospitals and perhaps be able to realize some cost savings through benchmarking and CQI," Yu says.

There's also the comparability dimension. Is the data comparable to data across the region, British Columbia, and the rest of Canada? And there's timeliness: can such information be made available promptly?

And finally, there's the question of accessibility. "We ask ourselves, 'Is it user friendly?' What we want is to have a lot of the data available on the Internet, Intranet, and Internal Network Drive, readily accessible to the various users."

Gerald Yu – who holds a Master's degree in health administration – is the Fraser Health Authority's coordinator of data quality, working to streamline how facilities keep track of their health information. Dan Jackson photo.

And in this age of protection of private information, privacy is closely guarded by Health Records Administrators. "We provide general statistics. No patient's personal information is attached to those numbers. Mostly people just want to know, for example, how many pneumonia cases we see, and how long they stay in the hospital.

"It's such powerful data because it's clinically based. It helps us to better manage [treatment] programs. If we see a spike in, say, respiratory cases, we see a trend and can gear towards doing some proactive things in the future. Maybe we can learn from past practices and address the issue at an ambulatory setting instead of having all the people come into the acute facility."

Yu's job has evolved over time. HRAs were once known as health records librarians because the job involved keeping paper records. "We still have paper records but a lot of the information we have is now on computer. It's more than just dealing with health records – it's the whole gamut of information.

"We still have charts," Yu says. "Some people still prefer them, and there aren't always enough computers. But eventually we'll all be using electronic health records and information."

Why did Yu opt for what he says is considered more a "geek" than a "glamour" profession? "I always wanted to get into health care, but I didn't want to be something like a nurse. I like statistics, research, and data reporting."

In BC, there are two routes to health information management (also known as health records administration). A two-year diploma program is offered at Douglas College in Greater Vancouver or online through Canadian Healthcare Association. And there's a four-year bachelor program at institutes such as the University of Victoria, University of Western Ontario in London, and Ryerson University in Toronto – this route encompasses more in depth knowledge of management, information system, and research . Yu originally obtained a diploma and went on to complete a Masters of Health Administration at the University of BC.

There are few men in the profession, says Yu. "They are maybe only about three out of every 100 HRAs. I'm hoping more men will get into it." He thinks his professional organizations, the Canadian Health Information Management Association and Health Record Association of BC, should more actively promote the profession.

An HSA steward for the past five years, Yu's commitment to health care and his co-workers is clear. "We see health care as our number-one priority. We'd rather work with management, but we won't roll over. We'll stand up for what we believe in. It's a two-way street." R

Gerald Yu
Health Records Administrator
Steward, Eagle Ridge Hospital

Committees

EQUALITY AND SOCIAL ACTION

Putting action into words

CALM GRAPHIC

Kimball Finigan and Amanda Bartlett joined HSA's Committee for Equality and Social Action this year. Finigan, a radiation therapist at Vancouver Cancer Centre, has journeyed to Belize as well as through Canada and the United States. Bartlett spent several months in 2003 using her physiotherapy skills as a volunteer in Bhutan and Vietnam, then travelled through Cambodia, Laos and Thailand. Both had a chance to reflect on their experiences at home and abroad and the links between them.

The members of your Committee for Equality and Social Action are:

- **Jackie Spain (Chair)**
- **Agnes Jackman**
- **Maureen Ashfield**
- **Kimball Finigan**
- **Amanda Bartlett**
- **Sheila Vataiki / Pam Bush (Staff)**

For information on the committee's activities, contact Pam Bush at 604/439.0994 or 1.800/663.2017.

Kimball Finigan

What has my time on the Committee for Equality and Social Action meant to me? This is the question I ask myself at the close of my one-year term on the committee. The short answer is: I've had an opportunity to open my eyes to a broader world.

I was raised with many advantages during my youth: good health, good education, a safe community, a clean environment, a home with two parents – one of whom stayed at home for me and my siblings. Many of these things I have, perhaps regrettably, taken for granted and thought to be unassailable.

However, the last few years have shown rights and freedoms to be very fragile and dependent upon the whim of a government that doesn't have our interests at heart all the time.

We have recently witnessed the loss of services which vulnerable people rely upon to make ends meet. The need for these services has not disappeared just because the government refuses to provide them – in fact in many cases that need has increased.

We see elder care being forced into the home, decreased educational opportunities for youth, and loss of family supporting jobs, to name a few examples.

How does this affect an HSA member you might ask? These changes strike right to the core of our society – the foundation upon which all of our lives is built.

We can, however, take action to counter these detrimental effects. HSA, through the Committee for Equality and Social Action, provides monetary donations to worthy groups in need – many of which rely upon donated funds for their continued operation. In addition, we work to raise awareness with the general membership of HSA

from left: **Kimball Finigan, Jackie Spain, Maureen Ashfield.**

about these areas concerning equality and social action.

I have learned how different people's lives are in "less advanced" parts of the world. To be quite honest, we are not far from living lives as marginal and unsafe as the people in Columbia – one of the least secure and safe places to live in the world. Unless we take notice of the impact our government's decisions upon our social fabric and unless we hold them accountable, we will end up in the same situation. We will lose our health care, our schools, our clean environment, and our "right" to demand better from those in power. In short, we will lose everything that we take for granted.

So here is my answer. This is why we care. This is why we act.

Amanda Bartlett

A young boy, thin twisted limbs, lying on a reed mat on a clean concrete floor. His beautiful smile lighting the darkness.

A wrinkled face, creased with sorrow, wet with tears. Limb twisted and useless. Unable to return home – dreading an institution.

Faces that remain with me, along with countless others – faces from the Third World, faces from Canada.

We all care – on some level, we are all touched by the injustices, the sorrow, and the inequities of the world around us.

But how do we respond? How do we make a difference? Does what we do, or not do really matter?

It is easy to feel helpless in the face of all the depressing news and events in the newspapers or on TV – I have been to the point where I wouldn't watch the news any more.

For me, the only way I can deal with it is to do tiny things.

I entered the dark hut once invited by the boy's mother. With my physiotherapy training I could show her how to hold, and how to feed him. How to teach him to hold his head up – to open his world. A tiny bit.

I wrote a resolution for bargaining regarding elder care – our parents and elderly have the right to dignity and the best care possible in their final years.

I'm not good at confrontations, but I heard a man tell a racist joke in an outpatient respiratory class – and I walked over and told him I wasn't comfortable with that and that our hospital's policy is a harassment-free environment. He apologized.

I joined the Committee for Equality and Social Action. We can all make a difference – even the tiny deeds matter.

Through my years with HSA I have learned a lot – gained experience, education, and had a lot of opportunities to learn about issues that have an impact on my world. But my world and your world are the same.

So whether it is speaking up about an issue you believe in, attending a rally, or simply casting a vote – we can all make a difference. R

Bartlett poses with a physiotherapy student at a physio gym in Danang, Vietnam. While in Vietnam, Bartlett also worked at an orphanage in Hoi Ann: "The Hoi Ann orphanage had a physio department because, unfortunately, many children with disabilities are abandoned," she said. Photo courtesy Amanda Bartlett.

"Whether it is speaking up about an issue you believe in, attending a rally, or simply casting a vote – we can all make an important difference."

IN MEMORIAM

Dorothy (Dolly) Mercredi Roy

July 31, 1959 – February 27, 2005

Dolly Roy, a longtime advocate for the mentally disabled, passed away suddenly on February 27, 2005, a victim of a high-speed driver.

Dolly was a valued member of the work team at the Kettle Friendship Society in East Vancouver. Her triumph over personal obstacles, her desire to be of service to others, and her unwavering humanity are her legacy.

Dolly leaves her sons Daniel and Jeremy, partner John Russell, mother Mary La Hache, father Gilbert, and brother Al. She was a woman of integrity and proud First Nations heritage. While we mourn her loss, her Creator welcomes her; to be at peace.

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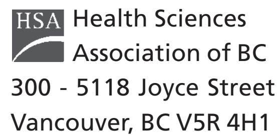

Health Sciences Association of BC
300 - 5118 Joyce Street
Vancouver, BC V5R 4H1

OR EMAIL:

memberlist@hsabc.org

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Surname

Given names

Facility/worksite(s)

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City | Province | Postal code

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ADM 0 035 CHANGE OF ADDRESS

FOCUS ON PENSIONS

You can purchase service until deadline in April 2007

Q: I was on a leave of absence during 2001. Can I purchase service for that period so it counts towards my pension?

A: One of the most popular features of the Municipal Pension Plan provides plan members the ability to purchase eligible past service in the plan.

Eligible service is time with a plan employer, such as periods when you were away from work on an employer-approved leave of absence, probationary periods, or time worked as an auxiliary or part-time worker.

If you want to purchase eligible service that took place before April 1, 2002, you should be aware that you have until April 1, 2007, or termination of employment with your current employer (whichever comes first), to buy back that old service.

Before 2002, purchasing service was very time consuming for employers because they often had to do a lot of research, and it was expensive for members since the cost was calculated with interest added.

In 2002, the Municipal Pension Plan made it easier to purchase past service. The cost is now based on your current salary multiplied by the number of months you want to buy, multiplied by the employee plus employer plan rates.

Service performed after April 1, 2002

In order to make it easier to research purchases, the plan introduced a rolling five-year window. This means that if you take a leave of absence, you have five years from the end of the leave, or termination of employment with your current employer (whichever comes first), to purchase service that occurred after April 1, 2002. For example, if you returned to work from a leave of absence in 2004, you would have until 2009 to purchase the service.

Service performed before March 31, 2002

You have until March 31, 2007, or termination of employment with your current employer (whichever comes first), to buy back service that occurred before March 31, 2002.After that date, you cannot purchase pre-2002 service. That means if you came back to work from a leave in 1997, you have until April 1, 2007, or termination of employment, to purchase that service.

You can estimate the cost to purchase service by using the Purchase Cost Estimator on the Municipal Pension Plan website at www.pensionsbc.ca. Using the Purchase Estimator and the Pension Estimator, you can predict how much of an increase a purchase will make to your pension.

Then, you can decide if it is worth your while to purchase the extra service. R

In this new regular feature, the Municipal Pension Plan answers frequently-asked questions. See pensionsbc.ca for more information about the Municipal Pension Plan.

Seniority mergers: protecting rights

by RON OHMART

Ron Ohmart
Executive Director of Labour Relations

With the announcements of the seniority merger agreements between the Vancouver Coastal Health Authority and the Paramedical Professional and Nurses' Bargaining Associations, a number of members have asked why HSA is merging seniority lists.

The answer is a simple one. Health care unions are working to merge seniority lists in order to ensure that all members working for the same employer are treated equally. HSA strongly believes that all health care workers who work for the same employer should have equal opportunity to retain employment and for career advancement regardless of the physical location of their worksite.

Achieving single seniority lists has a long and difficult history.

With Bill 29, we have seen over and over again the gross injustices created when traditional seniority rights have been trampled on.

Even though in the 1970s and '80s HSA members had a provincial collective agreement with portability provisions, if an employee worked for Facility 'A', that was their employer. All other facilities were someone else's worry and a protective wall existed around our workplaces. The only downside was that if you needed to move to another facility in order to further your career, you lost all your seniority and had to start over again. Back then, downsizing was rare and seniority was not a major concern since nobody was going to lose their job.

However, in 1993, everything changed dramatically. Regional Health Boards were established and Shaughnessy Hospital was closed. Workers were laid off and their work was transferred to another site. The three major health care unions (HSA, HEU and BCNU) all struggled with how to deal with these new and unwanted developments. In the original Health Accord, laid off employees transferring with their work or placed by the Healthcare Labour Adjustment Agency were allowed to port seniority up to the department average.

In 1996, things changed radically again with the formation of bargaining associations which included unions such as BCGEU, CUPE, and PEA. These unions all had collective agreements that recognized provincial seniority – which meant members did not lose seniority when moving from place to place. Traditional health care union members could be disadvantaged in competing for positions with other union members within the same collective agreement. Therefore, HSA established policies to acquire provincial seniority in bargaining and to merge seniority lists whenever and wherever possible. The collective agreements changed to allow displaced employees to port full seniority.

In the meantime, the former Capital Health Region (CHR) in Victoria was being very aggressive in consolidating and amalgamating services in

The recent seniority agreements don't change bumping language. What they do achieve is a level playing field for all employees of the VCHA competing for new positions.

central locations and establishing regional departments. The only way to ensure that all CHR employees were treated fairly was to merge the seniority lists. This was completed in 1997 and has been in operation ever since.

By 1998, except for Victoria, the situation was getting truly bizarre. With so much emphasis on displaced employees, a new kind of unfairness was beginning to materialize. The other side of the equation – job opportunities and career advancement – needed to be addressed. With all the restructuring going on, the laissez-faire attitude towards seniority had vanished.

People stayed in jobs they no longer wanted and were afraid to apply for new positions with new employers. Senior positions were going to out-of-province candidates because no one in BC was willing to move to another facility without their established seniority: that could only be achieved if they were displaced.

HSA went to the bargaining table again seeking a provincial seniority agreement or a regional model based on the CHR agreement. While we were unsuccessful in achieving those goals, we did manage to change the agreement to allow for the porting of seniority along with the other portable benefits. Another big improvement was the concept of regional postings so that employers had to post job opportunities throughout the region if the position was not filled by an internal candidate within the facility. While these were important gains, they were still a long way short of equal opportunity for all.

The biggest and most dramatic changes came in 2001 with the double whammy of Bill 29 and the creation of the six health authorities. Massive restructuring was underway, making previous efforts seem inconsequential.

With Bill 29, we have seen over and over again the gross injustices created when traditional seniority rights have been trampled on. We have seen employers use the bill to target individual employees for displacement. We have seen long term employees shown the door while more junior employees continue to work.

All the unions involved in health applied to the Labour Relations Board to have the new authorities declared successor employers. The main focus again was job protection, although HSA argued that health science professionals also needed mobility and career opportunities.

The LRB established the concept of the dovetailed seniority lists which provided greater access to jobs for displaced employees and included limited bumping options between workplaces. However, the LRB declined to intervene on the issues of job opportunities.

At the bargaining table in 2004 we again sought improvements on the same themes. The negotiations established fair bumping language that took into account the legitimate needs of all concerned and established better regional posting language by incorporating the use of the dovetailed seniority lists.

All this history brings us to the current situation and the VCHA. The recent agreements don't change bumping language. They don't make anyone working there more vulnerable to losing their job. What they do achieve is a level playing field for all employees of the VCHA competing for new positions. It eliminates the wide gulf that currently exists simply because someone finds themselves in the right or wrong place at this particular moment in time.

So why did the VCHA come to the unions with a proposal to merge the seniority lists when similar proposals by the unions have been rejected by HEABC and the LRB? Because it makes good business sense. The health authority will be able to attract more of the highly sought after health care professionals if they have a system that allows increased opportunity for professionals.

When this agreement comes into effect in the spring of 2006, the VCHA will be able to truthfully say they are an equal opportunity employer. It is a good agreement. It is the right thing to do. R

Ron Ohmart is HSA's Executive Director of Labour Relations.

ACROSS THE PROVINCE

Needed: Good communication, from the ground up and back down again

by AGNES JACKMAN

Agnes Jackman, Region 4 Director

Most of us are familiar with the old adage, "A house is only as strong as its foundation." Few, I'm sure, would argue it; yet, we often don't abide by it. For communication within HSA to improve, I would suggest that we pay particular attention to how we circulate information at the membership/chapter level, the foundation of our union.

Despite having certain commonalities, each of our chapters is unique in its own way. A system of communication that works well for one, won't necessarily work for another. Janice Davis, HSA's Senior Labour Organizer, has been working with some chapters to help them establish good steward and member communication networks. She told me that effective stewards and union activists are communicators and organizers and that chapters where members are informed and involved in the union usually have a strong steward communication network.

If a good system is in place, stewards can communicate quickly with members and the workload of the chief steward can be reduced. Some of the tools that can be used are group or departmental meetings, phone trees, written newsletters and strategically placed eye-catching bulletin boards. The most effective form of communication is face-to-face, the second is telephone, and the third is written.

The first step in setting up an effective communication system for a chapter should be "mapping" the chapter. This will help determine the needs of the chapter. "Mapping" would include looking at the chapter's geographical setting and answering the questions: Is it urban or rural? How many sites does it have? How spread out are they? How many members? Where are the members located? What is the mix of part-time, full-time and casual members? How many disciplines are represented? How many stewards are there? Is there at least one steward for each site? What tools of communication are the stewards and members currently using? Who is doing what? Just how successful is the current communication network? Are there gaps?

The next steps would be deciding how communication should be managed by the chapter in the future; getting the necessary tools in place and determining what tasks the individual stewards and members would be willing and able to take on, with the goal of spreading the workload over as many people as possible.

For the larger chapters this might include having "area contacts" in addition to the stewards. An advantage of an area contact system is that it provides a way to involve members who want to be active, but are not prepared or able to commit to being a steward.

"Stewards with experience in setting up these contact networks stress the importance of accepting the different levels of commitment that people are prepared to make. They also suggest that formalizing the role too much, or over-structuring, can act as a deterrent. So, simple and clear expectations seem to be the way to go," Davis says.

It is important that the valuable information that is generated and passed on to the chapters by the HSA head office actually reaches the individual members and vice versa for our union to operate well.

If you think that your chapter's steward and member communication could do with some improvement, your chapter should consider asking for assistance from HSA's Strategic Communications and Member Development department. R

Agnes Jackman represents Region 4 on HSA's Board of Directors.

HSA donates $10,000 for tsunami relief; $5,000 to British Columbia food banks

HSA's Board of Directors has donated $10,000 on behalf of HSA members to Oxfam Canada's Tsunami Relief Fund to assist with relief efforts in the aftermath of the devastating tsunami that hit Southeast Asia on Boxing Day. The donation brings the total contribution of National Union of Public and General Employees (NUPGE)-affiliated unions across Canada to date to almost $150,000.

"This donation is being made on behalf of all HSA members who, like people around the world, are looking for ways to help the millions of people affected by this tragedy. I also encourage members to make individual donations to Oxfam Canada," HSA President Cindy Stewart said.

In tandem with the donation to Oxfam Canada, the HSA Board of Directors approved a donation of $5,000 to the BC Branch of the Canadian Association of Food Banks.

"The outpouring of support for tsunami relief has created a vacuum of need for local agencies and charities. We are making this contribution today to support food banks across British Columbia because we cannot forget the local and ongoing needs of the people in our own communities," Stewart said. R

For information on how to donate to Oxfam Canada's Tsunami Relief Fund, logon to www.oxfam.ca or send your donation by mail to: Oxfam Canada, Fundraising Office, 215 Spadina Avenue, Suite 200, Toronto, ON M5T 2C7.

BC food banks thank HSA members

Thank you very much for your donation to our association, matching your contribution to Tsunami Relief.

It is wonderful to have your support and to learn that your concern for the effects of Tsunami generosity on local food banks matches ours.

I have shared portions of your letter with our provincial board and national Executive Director and all are most grateful for your support coming in this way.

At our next board meeting, an assessment of the impact on our members will be a major item for discussion. You have given us hope that our supporters will understand the need for help on an ongoing basis.

Your letterhead says you are "The Union of Caring Professionals." This donation confirms that you truly are.

Pat Burns, Treasurer
Canadian Association of Food Banks – BC Branch

HEALTH SCIENCES ASSOCIATION OF BC

THE Report MAGAZINE

The Report is dedicated to giving information to HSA members, presenting their views and providing them a forum. The Report is published six times a year as the official publication of the Health Sciences Association, a union representing health and social service professionals in BC. Readers are encouraged to submit their views, opinions and ideas.

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AWARD-WINNING CANADIAN ASSOCIATION CALM OF LABOUR MEDIA MEMBER PUBLICATION

Photo courtesy Agnes Jackman.

For International Women's Day (March 8), HSA's Committee for Equality and Social Action distributed stickers to HSA members, as well as leaflets outlining various recent BC government cuts to women's services. Above, from left: **Committee members Kimball Finigan, Jackie Spain (committee chair), Amanda Bartlett, Pam Bush (staff), Agnes Jackman, and Maureen Ashfield attend the BC Federation of Labour's Women's Day Breakfast. At this event, BCFL released a report entitled "Losing ground: the effects of government cutbacks on women in BC, 2001-2005." The report outlines the impact that recent government cuts have had on women around the province, and is available from www.bcfed.com.**

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