NEWS BULLETIN

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VOLUME 21 NUMBER 2 UNITED NURSES OF ALBERTA FEBRUARY 1997

NEGOTIATIONS

"UNA has been in bargaining for almost one full year," said UNA president Heather Smith at the media conference announcing UNA's decision to hold a Negotiations Reporting Meeting on February 25. "We are not prepared to fiddle around at the bargaining table while working conditions and the quality of patient care continue to deteriorate around us!"

The Hospitals Negotiating Committee called for the meeting after only one day of formal mediation with the employer. At the mediation session, the Provincial Health Authorities of Alberta (PHAA) refused to alter its demands for rollbacks from Alberta's 12,000 registered nurses and registered psychiatric nurses. PHAA, which refused to meet face-to-face with UNA's Negotiating Committee, then claimed that it had 'reached the end of its mandate' to achieve an agreement.

UNA and PHAA agreed that they would go back to their members/constituents and seek further direction. The parties have also agreed to meet with the mediator one more time before UNA goes to the Reporting Meeting.

Capital RHA nurses braved bitter temperatures to hear the latest word on contract negotiations. UNA President Heather Smith, Director of Labour Relations David Harrigan and Marilyn Coady, Chair of the Hospitals Negotiating Committee, provided the update and then answered the nurses' questions about bargaining.

What happens at a Negotiations Reporting Meeting?

Negotiations reporting meetings are held at the discretion of the Negotiating Committee. Locals involved in that set of negotiations are entitled to be represented by one voting delegate per Local; other Locals not involved in the contract often send observers. The Negotiating Committee presents a summary of signed articles as well as the positions of the parties on articles which remain unresolved. The delegates then debate the direction the union should take on each outstanding article. The delegates may determine that the employer's last offer should be sent out for a vote by UNA members (a rejection of the offer would mean a mandate in support of strike action) or they may request that the Committee to return to the bargaining table.

Negotiations Diary

- January 30, 1996 - Negotiations begin with the parties exchanging ingoing proposals.
- March 31, 1996 - collective agreements expire
- September 1996 - UNA applies for *informal* mediation
- November 18 and 26, 1996 - *informal* mediation takes place
- November 27, 1996 - PHAA walks out of mediation talks; after 34 days of bargaining, a total of 12 articles in the collective agreement have been signed
- December 2, 1996 - PHAA applies for *formal* mediation
- January 23, 1997 - *formal* mediation takes place
- January 24, 1997 - UNA's Hospitals Negotiating Committee calls a Negotiations Reporting Meeting
- February 20, 1997 - UNA and PHAA scheduled to meet for mediation

New Beds, No Nurses
Lac La Biche Nurses Fight Back

by Eileen Ray, President UNA Local #10

The William J. Cadzow Health Care Centre in Lac La Biche opened 10 new acute care beds on February 5 without adding staff to care for the patients in those beds. The UNA Local at the Centre organized an information walkabout to coincide with the Grand Opening.

The sun was shining on Lac La Biche [February 5] during our information walkabout. "New Beds, No Nurses!"; "Ralph! Where's the money for front line workers?"; and, "Every patient deserves quality care" were slogans on the signs worn by our members. UNA's Vice-President Bev Dick and our Labour Relations Officer, Richard West, proudly walked with us. Almost every RN who works in our facility who wasn't working or sleeping came out. A grand opening and ribbon cutting of the newly renovated acute nursing area and rehabilitation areas was happening and we wanted to tell the community to see for themselves how unsafe the area is and why the staffing pattern is unappropriate. From the numbers out walking and the concern expressed by the community I feel it was a success. Now we expect that the RHA will take notice! CFRN News was there with their TV camera so stay tuned to the news and see us in action. We have a few others tricks up our sleeve for staff increases so stay tuned!

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Denise Palmer (Chairperson), Kathy James, Donnie Lacey, Holly Heffernan, Robert Reich-Sander
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Bentley Nurses Join UNA

UNA welcomes its newest Local members, the nurses at the Bentley Care Centre, who voted to join the UNA on January 24. A Local Executive has been established and preparations are already underway for a collective agreement.

"Managers are like cats in a litter box. They instinctively shuffle things around to conceal what they've done. In the business world this is called 'reorganizing'."

Scott Adams, *The Dilbert Principle*

Message from the President

by Heather Smith, President

Just before this NewsBulletin was sent to print, a provincial election was called for March 11, 1997. The election call followed the announcement of the 1997-98 budget—which turned out to be a public relations document containing no real news. There was no new funding for health care; just a re-run of the government's November 25, 1996 announcement. This means that Alberta will continue to spend less money per capita on health care than any other province in this country. The 'extra' $128 million to be spent in 1997-98 means that Alberta is spending only at 1993-94 levels. When our health care funding is adjusted for inflation and population growth, we have experienced a 20% reduction in per capita funding over 4 years.

Now is an important time to raise questions about health care with friends, relatives, neighbors and, most importantly, with those seeking to represent you in the legislative assembly. UNA is already developing an election edition of the NewsBulletin, which will be mailed as soon as it is completed. Please vote on March 11th.

One Thousand Nurses?

I hope the public (and our membership) is not misled by the government's statement that enough money has been infused to hire "1000 nurses and other front line workers." This statement has been repeated several times by the Premier with a pause after "1000 nurses". I know that many people believe that means that 1000 registered nurses will be hired. However, I was present during the November 24th announcement when the Department of Health clearly communicated that they meant 1000 workers in total, some of whom may be registered nurses. I believe the generic term "nurses" was deliberately chosen because it could mean RN's, RPN's, LPN's or nursing attendants. During questions about the announcement, Department of Health representatives revealed how they reached the dollar figure for hiring new health care workers. The Department indicated that the $43 million dedicated to the 1,000 workers was calculated on the following basis: approximately one third of the amount reflects the wage rate and benefits of registered nurses. The remaining two thirds is based on workers whose annual salary and benefits total $30,000. But the government immediately declared that despite using this calculation, the government would not direct the regions on how to spend the money. In other words, the government has made its announcement of more money for the regions to hire workers but it won't be telling the regions the numbers or types of staff to hire.

I have visited with many locals, both hospital and health units, in recent weeks. Common to every local is concern about workload. In at least two hospital locals, the employers have repeatedly invoked mandatory overtime. Several centres outside of Edmonton and Calgary reported increased acuity and occupancy levels due to the inability to transfer patients. In some hospitals, individual nursing units have hundreds of hours of overtime in a single month. In at least two long term care facilities, nursing attendants are administering medications. These situations make our proposals for **appropriate** staffing levels even more crucial. It is clear that we need to utilize (in the case of community nurses, **achieve**) our professional responsibility committees to address our concerns.

Across the province, managers in facilities and community care are developing budgets for the '97-'98 fiscal year. Do you know what staffing levels your manager is proposing for your area next year?

Strike?

February 14 the Calgary Herald carried a story about the new offer that will be tabled during hospital mediation talks on February 20th. The headline for the story was "Health regions brace for strike: Nurses to vote on new pay offer". Reporter Robert Walker has been told that the Provincial Health Authorities of Alberta (PHAA) will offer UNA members an increase of 6.75% over a three year agreement (0% for 1996-97 and then 6.75% to be spread across the remaining two years). There is no indication that PHAA intends to address any of our issues regarding the creation of permanent jobs, staffing mix and ratio guarantees, and ensuring an RN/RPN in charge at all times. Nor is there any indication that PHAA will remove the regressive proposals they still have on the table.

I have made the Negotiating Committee's position very clear to employers, to government as well as to each media person with whom I have spoken. UNA's **membership** will determine what is acceptable to them. UNA's **membership** will determine what, if any, actions should be taken. The nurses affected by these negotiations do not want to take a strike vote; we do not wish to go on strike. What nurses want is absolutely clear: a negotiated collective agreement which addresses our issues and which fairly compensates us for the value of our contribution to health care in Alberta! UNA's Hospitals Negotiating Committee will be available to bargain any time before our Reporting Meeting on February 25th and any time thereafter until a negotiated settlement is achieved.

Nurse Abuse:
Workplace Violence: UNA Examines Nurse Abuse, Part 3

by Trudy Richardson, UNA Education Officer

What happens to nurses who have been the victims of nurse abuse? Are they able to function effectively in their work or personal lives? In Part Three of our look at the issue of nurse abuse, the effects of abuse on nurses, patients and the workplace are examined along with a review of the possible criminal charges that can be laid against the abuser.

Effects

1. On Nurses

The impact of nurse abuse is staggering. Individuals are injured, permanently maimed and even killed; victims remain silent and become so depressed they resort to suicide; victims are left feeling frustrated, angry, helpless and powerless; fear and stress levels rise dramatically; anxiety and loss of control are heightened; distrust of and distance from patients replaces warmth and closeness; and some nurses report the total loss of psychological or emotional receptivity.

The nature of the injuries resulting from nurse abuse reported to the WCB and resulting in time loss include post-traumatic stress disorders, soreness, sprains, strains, bruises, crushes, dislocations, fractures, cuts, lacerations, inflammations, swellings, stress, scratches, burns, and infectious diseases.

"Being subjected to violence is a particularly traumatic experience for caregivers who have dedicated themselves to the care and protection of the very source of their problem. The psychic scars are, therefore, deep and frequently long-lasting." (Britt)

Many nurses report numbness, shock and disbelief followed by fright, anxiety and anger after an incident of abuse. Others report feeling permanent vulnerability with recurring nightmares and sleep disturbances.

Insomnia, eating disturbances, anxiety, avoidance, exaggerated startle response, irritability, fear of the abuser, self-doubt about competency, anger, depression, sadness and learned helplessness—all of these have been documented as following an abuse incident or incidents.

The personal cost is high. One study suggests that if nurses truly opened up to the full effects of the abuse they and their colleagues have experienced they would be overwhelmed and unable to function in their jobs.

"Being subjected to violence is a particularly traumatic experience for care givers who have dedicated themselves to the care and protection of the very source of their problem. The psychic scars are, therefore, deep and frequently long-lasting." (Britt)

Many nurses personalize the experience of abuse by feeling that they are somehow responsible for the abuse. If they had only been more professional, or more perceptive, or more accurate in predicting patient behaviour then it would not have happened. Others deny the event even occurred. Most commonly, however, is the minimizing of the incident. It wasn't that bad; the patient didn't mean to; I overreacted; I'll heal okay etc.

Other traditional methods often used by nurses to deal with abuse range from acceptance, guilt, avoidance and discussions with co-workers to verbal or physical self-defense. Few if any consider the alternative of prosecution.

The effects of nurse abuse are felt not only by the individual nurse who is the object of abuse. The effects are also felt by widening circles of people including their families.

2. On Patient Care

Leney reports that according to 54% of nurses questioned, emotional trauma and distractions from verbal abuse definitely compromised patient care. Work productivity declined for the few hours after "minor" abuse and for longer periods of time as the seriousness of the abuse increased.

Following a verbal abuse incident, 87.1% of nurses surveyed agreed that errors were more likely to occur.

The literature suggests that the delivery of safe, competent, ethical and high quality nursing care is compromised by the prevalence of nurse abuse in terms of low morale and high staff turnover.

81% of participants in one study reported greatly decreased morale and several indicated that they became physically ill and unable to care for patients as a result of an abuse incident.

3. On Morale and Turnover

Reports on turnover from nurse abuse indicated that in Ontario, 4% of the 40% of nurses who wanted to leave nursing attributed this to feeling unsafe at work. In Nova Scotia, 17% of nurses have considered leaving nursing due to violence in the workplace. Another study of 1110 nurses found that 24.3% of the annual staff turnover rate and 25.2% of the nurse manager turnover rate were attributed to verbal abuse.

Another study of 1110 nurses found that 24.3% of the annual staff turnover rate and 25.2% of the nurse manager turnover rate were attributed to verbal abuse.

88.3% of nurses surveyed believed that verbal abuse contributes to increased staff turnover—and this included abuse from patients, physicians and supervisors.

95.1% of all respondents in the same study believed that verbal abuse contributes to increasing the nursing shortage.

Verbal abuse has a definite impact on job satisfaction as shown in one study which reported a 40.6% drop in nurse manager job satisfaction and a 39% drop among staff nurses.

4. On Institutions

Staff abuse leads to lost work time; decreased work performance and productivity; interactional difficulties between co-workers, patients and physicians; increased staff turnover and job dissatisfaction; and reduced public image.

Very few researchers have attempted to put a dollar figure on the cost of workplace violence.

Increased compensation premiums, costs for repairs to equipment and to the facility, salary and overtime costs associated with staff replacement, advertising and interview costs to hire replacement nurses—all of these costs need to be figured into the costs of workplace violence. The biggest financial cost, however, is in the area of paid sick leave and WCB claims for time lost. The vast majority of injuries resulting from unreported abuse either results in lower productivity or in the use of paid sick leave.

If the estimate that only 20% of violence incidents are reported, then the most likely source for beginning a costing out the price of violence would be from WCB claims paid for time lost due to physical injury to workers. In the 1987 to 1991 statistics, 32% receiving claims lost one to five days of work and 16% lost between six and ten days of work. Twelve per cent lost more than 51 days of work as a result of injuries from workplace violence. These statistics do not include claims submitted for stress or psychological problems.

Criminal Code Violations

In her thesis, Leney identifies criminal code violations all of which may in fact take place in the worksite. For the information of UNA members who experience workplace violence and for the information of the UNA leaders who are involved in the aftermath of violence, we are providing a partial list of criminal violations:

- use of firearm during commission of offense
- pointing a firearm
- possession of a weapon or imitation
- carrying a concealed weapon
- common nuisance
- criminal negligence/causing death by criminal negligence
- causing bodily harm by criminal negligence/causing bodily harm with intent
- murder/attempt to commit murder
- manslaughter
- uttering threats
- assault/aggravated assault
- assault with a weapon or causing bodily harm
- unlawfully causing bodily harm
- sexual assault/aggravated sexual assault/sexual assault with a weapon
- kidnapping
- hostage taking
- blasphemous libel/defamatory libel

There are several complicated legal determinations that must be made in a criminal prosecution. If any UNA member is the victim of criminal violence, contact your Labour Relations Officer immediately.

This series has been the first portion of a larger UNA position paper on nurse abuse. In following NewsBulletins, UNA will present ways to address workplace violence and actions that can be taken to achieve zero tolerance of nurse abuse.

UNA Collectibles

Looking for a cozy sweatshirt to warm you through the cold winter days? Call Janice Drysdale at UNA Provincial Office at (403) 425-1025 or 1-800-252-9394 to order your sweatshirt and other UNA items today.

Sweatshirts	$20.00
T-Shirts	$12.00
Watches	$25.00
Shorts	$ 8.00
Baseball Caps	$ 5.00
Tote Bags	$ 7.00
RN/RPN Pins	$ 3.00

Order forms are also found on the UNA Network. Items will be available at the Reporting Meeting.

How to get managment's attention focused on workplace health and safety concerns. The *Wall Street Journal* used the following headline after eight workers died in a Texas explosion: "Whyman-Gordon Workers Killed At Plant, Raising Safety Concerns".

Thoughts on Nurses and Nursing

Berni Burke is a long-time UNA member who has worked at the Edmonton General/Grey Nun's for the last 17 years. Recently diagnosed with cancer, Berni has kept a journal of her thoughts on nurses and nursing. In these excerpts from her journal, she reflects on the way her illness has sharpened her realization that nurses need to work more closely together than ever to protect themselves, their profession and their patients.

From Burnout to Burning Desire

I have been there! "Burnout" has been a very real experience of my life. For the past nine months I have been on disability leave from my chosen career. I have pulled myself through a maze of feelings to reach my present wellness of mind, body and spirit. As of January 6, 1997 I will be pronounced "healthy" and capable of returning to a nursing position, within a gradual return to work program. I fee victorious, this wonderful sense of accomplishing that almost unattainable goal. How much freer I am now, for in striving to understanding my struggles I have moved toward wholeness and peace.

My symptoms of illness presented gradually, persistently, quietly to blatant intensity. The "final straw" that compelled me to STOP, to feel the reality of my body and mind pleading for rest, is now perceived as a blessing. This blessed inconvenience, this gift of time for healing, recovery and reevaluation taught me a great many lessons. Of merit is my learning that through suffering there can be growth, through experiencing the pain there can be gentle compassion for others and self, and in truth there is freedom. Dying in the helplessness of exhaustion, I have discovered some more about complex me.

At times during this journey of discovery, this urgency to regain health, acquire wisdom and trust, I felt "lucky". Fortunate to cross paths with loving, supportive, knowledgeable, gifted helpers. I see now that this is not luck. I have been granted guidance in response to my request for help, direction, expression and clarity. In trusting I have received and through determined efforts I have grown.

In my new beginning, with a fresh attitude, an openness of thought and the curiousity, wonder and joy of a child, I cherish this moment. To feel content, worthy, significance and truth, is a momentous vital sign. It is knowing that burning out has produced a renewed burning desire for living and loving.

I open my heart and hands to fellow nurses. This time of transition requires the most gentle handling of each other. Let us become sensitive to try to understand the distress in all. Let us reach out to help, believe that our caring within our profession will encourage the wisdom of the need for loving service to others.

Thank you.

November 26, 1996

For Nursing

My honest sharing with you results from dramatic recent changes in my life. Challenged are my views of purpose and meaning for living and dying.

I have been diagnosed with Ovarian Cancer Type III. This unbelievable situation unfolded this very week when I was to return to work following a nine month disability leave for burnout/depression. In my enthusiasm to begin again I am thwarted in my attempt to normalize my life.

Before I could walk through the Edmonton Grey Nuns Hospital doors as a healed "burnout" survivor, I became an active treatment patient. In a mere two weeks I have tried to grasp profound life changes. From believing that I was completely healthy to accepting a prognosis just short of a miracle needed to maintain my living.

As I became the one in need of medical, nursing care, I now communicate what became so clear to me.

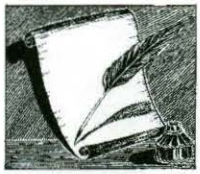
Nurses at the Grey Nuns are in trouble. We are losing our profession. We cannot give what we need to. We are forced to live our calling in ways that limit our giving—our loving. We are striving with inner strength unknown to us for its tenaciousness, yet we are weakened.

The very frame within which we choose to give of ourselves has become a twisted periphery. We are out of alignment. Our natural flow of giving to others, helping others, caring for others has become unnatural. We are forcing our essence of loving, thereby limiting our creativity. We can only respond to priority needs which eliminates our natural abilities to be FREE. By not being able—to be—we are not being our best.

Our best is giving in excellence. In being the best nurses we can be. We want to. We need to.

Help us regain our belief of our destiny to care for others. Help the veterans who remain as the strong backbone for providing love at work. It is they who keep this misguided ship afloat. Give strength to us so our purpose can be realized and achieved. Unite us with solidarity of presence. Give to us wisdom as united nurses so that our mission may be accomplished. Let us with hearts full of love, respect, dignity, care and concern for all, be the caregivers we are.

January 31, 1997



Letter to the Editor

The President of UNA Local #125 (Hanna Hospital) wrote this letter to the editor of the Hanna Herald on behalf of her Local members. The letter appeared in the January 29 edition of the paper and has received positive response from the community.

Dear Sir,

I am writing to clarify some misperceptions the public may have about the ongoing negotiations between the United Nurses of Alberta and the Provincial Health Authorities of Alberta.

The two major areas of concern for the nurses are wages and patient safety. In August 1994 members of U.N.A. along with other government workers took a 5.38% roll back in wages. We accepted this roll back because we were told it would keep beds open and save nursing jobs. It did neither. The numbers of acutely ill patients, whose care nurses are responsible for, have risen, while the numbers of adequately prepared staff have decreased.

U.N.A. has proposed a return of the 5.38 % roll back effective last April (when this contract expired) as well as an increase of 50 cents an hour in October and 50 cents an hour in April 1997. (We are now working for wages that are less than we earned in 1992.) We have also proposed increases to shift differential and weekend premium. It has been well documented that working shift work and weekends takes a toll in health, personal and family life. The employer offered a 3% hourly increase and more than 50% roll back in weekend pay and shift differential as well as cut backs to overtime pay.

Another important proposal UNA has made is to establish minimum staff:patient ratios to ensure that the proper staff mix is present on each unit to properly care for the patients on that unit. This would involve both employer and the union working together to establish the numbers and skill levels of staff required to give safe and effective nursing care to the patients. There would be a formal method of resolving disagreements, which could include the right to present the matter to the Board of Trustees. The employer offered a much less formal process with no power to enforce the ratios once they were established. This of course would allow them to alter the staff:patient ratio with cost as the determining factor not patient safety.

Registered Nurses have the education, expertise and hands on experience to be powerful patient safety advocates. This is one of our professional mandates. And now we think it is necessary to have it formalized in the next contract we ratify so that public safety and not cost becomes the bottom line. Registered Nurses, and other front line workers, have worked extremely hard over the last three years to hold a faltering health care system together. If reinvestment is to take place with an increase in operating rooms, hospital beds and diagnostic equipment, we also need to have the type of staff mix to safely look after you while you are in those O.R.'s and hospital beds.

There are some things members of U.N.A. Local 125 would like you to keep in mind when you read press reports about our negotiations. The province has unheard of budgetary surpluses and apparently lots of money for hospital building and renovations throughout the province. Should some of that money go to those front line people who helped and are still helping to keep a world class health care system running? With fewer beds and fewer staff do we have correspondingly less senior administration? During negotiations you see published reports of what the union members get paid, what our benefits cost the system. Do we know what the people who are the decision-makers get paid, or what their benefits are? Why not?

Thank you for taking the time to read this.

Sincerely,

Leslie Holm, Pres. Local 125

Election News

Watch your mailbox for a copy of UNA's Election '97 NewsBulletin.

Suggestions for questions for candidates and information for UNA members from the political parties will be included in the Bulletin!

LRB Hearing Off to a Slow Start

The Labour Relations Board has begun its hearings into the Capital Regional Health Authority's application for a single bargaining unit to cover employees working at the Royal Alexandra, Glenrose Rehabilitation and University of Alberta Hospitals. The LRB has set aside three days every two weeks until the beginning of June to deal with the issue. With only two of the employer's 14 witnesses having taken the stand thus far, most people believe that it may be early June before the employer has finished presenting its evidence. Then each of the seven unions involved in the hearing get to present their cases. Clearly, the employers have money for human resources; they'd just rather spend their dollars in the legal system.

Westchester County, New York is often held up as a model for workfare programs. But even there, officials admit that workfare (forcing welfare recipients to work in order to maintain payments) does not lead to steady jobs. "It's cheap labour that generally does not result in employment," says Greenburgh Town Supervisor. "It would be nice if someone could land a job, but it doesn't happen."

Found on the UNA Net

The following discussion is taken from UNA's latest communications tool, the UNA Net – a provincially linked network of computers. This is the forum for discussion of professional issues, a place to get feedback from your fellow UNA members, and a place to raise issues important to you and your facility. If you have a computer and modem and would like to be part of this network, contact Rena or Florence at Provincial Office.

MIGRAINE POLICIES

- At my hospital, we frequently see patients with migraine headaches (often repeatedly). We are trying to develop a policy for treating these patients. If anyone currently has a policy for routine treatment of migraine headaches, I would appreciate a copy of it and any other input that would be helpful. Thanks
- At our facility, our doctors have been using Cogentin 2mg followed by 10mg of Stemetil IV push over 2 minutes. If they have a true migraine, they will get much relief as it breaks the headache cycle rather than just masking it as narcotics do. You have to have a committed group of doctors who won't give narcotics as a rule. Interestingly enough, we now have a group of patients who are "allergic" to Stemetil IV; they still try to get narcotics, without much luck, at our facility. We have no policy in place for this; just the doctors' mode of practice.
- At Hospital C, we have seen many repeat migraine patients over many years. If they developed a pattern of frequent visits, we set up a chronic pain file that could be readily available to see the pattern of treatment, frequency of visits. If the person presenting was requesting narcotics because "nothing else worked", we would request a note from their family doctor stating need for narcotics.

  As of last year, our chronic migraine sufferers have now been registered in a headache study/clinic. Each of the patients was to register with this clinic via their family doctor. Part of this study/clinic is the requirement that patients who required prn analgesic for their headaches were to first contact their family doctor. If it is during office hours, the family doctor is to take responsibility and see the patient. On weekends, several family doctors on call are to be called; the alternative is a note with a maximum number of drugs to be given in the ER during a one month period.

  The headache study is to try alternate treatments for migraines, as well as provide counselling for stress, pain control, and narcotic addiction as required. I think a contract is made up between the FD and patient.

  This has cut down on our migraine presentations to ER that our staff and doctors have to assess. Some of the frequent patients still present but the number of visits has decreased.

  For new onset headaches/ migraines, a CT is usually ordered to rule out a bleed or some other problem. The preferred drug treatment we start with is a bolus of IV fluid followed by Stemetil IV and DHE (if the Stemetil hasn't helped). Sometimes CPZ is ordered instead of Stemetil.
- At Hospital D, we also have some regular migraine sufferers/narcotic abusers. Once the doctors feel the patient is abusing the narcotics (most times it's the nurses who alert them to the problem) and has ruled out other causes, we flag their charts on their computer file. On our computer program you can easily see how many times they have been at ER and what treatment was given. The FLAG message can be read only on the screen and is not printed on their outpatient form. Often these patients quit coming to our hospital and head down the road to another hospital for "greener pastures" For the true migraine sufferers there are a few options that various doctors use that seem to work like fluid bolus/ DHE, Stemetil, Largactil.

COSTS

- The Consumers Association needs information regarding costs for patients/families in both acute care (e.g. emergency, pre-op, out-patients) and community care. Wendy is trying to identify costs that have shifted to individuals. If you or members of your Local can provide information, we will compile it.
- I know at our hospital, patients are billed for things like TED stockings ($15.00), splints ($18-45), crutches ($32), cast boot ($11) and patients will not be provided with these items unless they agree to pay for it. If patients are in a private room, finance is up there trying to get money. If nursing places them in a private room we don't usually have an issue—on my unit, we generally place all palliatives in a private room. I will ask other members what the scoop is on other units.
- At our paeds unit, I do know parents are almost required to stay 24 hours with a child who has been admitted and it doesn't matter if the parent has a boss with about as much compassion as hospital administration or if there are other children at home alone. I for one think this is also dreadful.
- Our hospital charges for a variety of things from ER or OPD - e.g. splints, crutches, dressing supplies, etc. A lot of this is left up to the discretion of the nurse involved (for dressing supplies and splints). BUT we charge $25.00/day for BOARDER BABIES—those infants staying in the hospital with their sick mothers—for things like formula and diapers, but there is no staff to care for the baby if the mother is unable to do so herself—the expectation is that a member of her family will do it. Now, the nurses try their hardest to help out, but it seems rather interesting to me to charge for a service we don't really supply.
- Having worked in the ER, I am aware of many costs that have surfaced since the Region took over. Ortho supplies such as crutches ($32), knee immobilizers ($50), soft neck collars($11) and collar and cuff slings ($10) are some examples. I can fax a comprehensive list.
- I know it is difficult for us to cope with the costs now incurred as the result of being a patient. As an employee in long term care, this concept has become so accepted that it's never given a second thought. All incidental costs from the uncovered portion of the medication to Kleenex are paid for by the patient. It never really crossed my mind before that this has become a part of the general practice for all aspects of medical care. Must have been living in a cave somewhere. Thanks for the wake-up call.
- At Hospital B, we do an ever increasing amount of outpatient antibiotic therapy. Most of our patients can park on the street at night so parking fees are not an issue. There is supposed to be a home therapy IV program but it is for a very limited group of patients requiring long term therapy of two weeks or longer. As for now we do not charge for any splints given out in our ER but we do not supply crutches any longer due to poor compliance of bringing them back.