NEWS BULLETIN

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LPN Regulations Update

by Bev Dick, Vice-President

Registered nurses and registered psychiatric nurses spoke with one strong voice when the provincial government recently attempted to slide through changes to regulations covering licensed practical nurses. The proposed changes, which would allow LPNs to independently carry out work currently provided by registered nurses and registered psychiatric nurses, had reached Cabinet without the agreed-to notification of registered nurses by the government. But when UNA members found out what was happening, they quickly sprang into action, bombarding their MLAs and Cabinet members with letters, faxes and phone calls. The message was clear and unequivocal: registered nurses believe that, particularly in the face of increasing patient acuity and complexity, it is inappropriate for LPNs to provide nursing services without direct supervision by a registered nurse or physician.

The process to change these amendments has involved numerous levels of government. Over the past three years, UNA has contacted government officials frequently in order to find out what stage the regulations were at and when they would be moving on to the next step. This has been a frustrating experience as government departments have been unwilling or unable to provide clear information about the process and about the content of the regulations.

UNA knew that it was possible that there would be short timeframe for a lobby campaign once the amendments were in front of the political arm of the government. So, to make sure our membership would be ready to act quickly, last fall we sent information packages to each UNA members outlining the areas of concern and advising members how to lobby their MLA, cabinet ministers and the premier. Long discussions about the LPN legislation also took place at district meetings.

Action Now!

On April 23, the AARN contacted UNA with an urgent message that the amendments were on the agenda for the Cabinet meeting that day. Cabinet could approve them at that meeting.

UNA used its computer network to get the ball rolling. Information was put on the system about the proposed changes along with a request for UNA members to phone, fax and write to their elected officials.

The statement: "When UNA members are needed they are there" was true yet again! Your response was wonderful! Letters poured in and Cabinet members complained that their fax machines were kept busy day and night.

The AARN met with the Minister of Labour and the Chair of the Standing Committee on Health Policy on April 29. These officials assured the AARN that the changes would not go ahead without further input from the AARN. In fact, Murray Smith indicated that he was willing to work with the AARN on changes that might be agreeable to both government and the AARN. He also indicated that Cabinet would not be approving the changes at the April 29 Cabinet meeting. Faxes, letters and calls continued to pour into the Legislature from UNA members.

On May 6, the government attempted to "rush" the AARN into agreeing to some language changes by saying it was a "time-limited offer." It

(continued on page 3)

New Contracts Delayed

The production of copies of the new hospital/facility collective agreement has been delayed by a disagreement between UNA and PHAA regarding the content of the contract. The dispute should be settled shortly and production will then begin. Your Local Executive will be notified when they are ready for distribution by your employer.

UNA donates to Safeway workers

The Executive Board of the United Nurses of Alberta has approved a total of $10000.00 in donations to Safeway workers in Alberta who have been on strike for several weeks.

Executive Board

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Central
Andrew LeBlanc (Chairperson), Brent Smith
South Central
Denise Palmer (Chairperson), Kathy James, Donnie Lacey, Holly Heffernan, Robert Reich-Sander
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UNA members will be receiving 10 NewsBulletins each year. Any article, letter or comments for the NewsBulletins must be received by the Provincial Office no later than the 3rd of each month. Please include your name, Local number and phone number with the text. UNA reserves the right to edit any copy received and to make all final decisions on material published by the Union.

Melanie Chapman, Editor

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Medical Humour

The following quotes were taken from actual medical records dictated by physicians. They appeared in a column written by Richard Lederer, Ph.D., for the Journal of Court Reporting.

- By the time he was admitted, his rapid heart had stopped, and he was feeling better.
- Patient has chest pain if she lies on her left side for over a year.
- On the second day the knee was better and on the third day it had completely disappeared.
- The patient has been depressed ever since she began seeing me in 1983.
- I will be happy to go into her GI system; she seems ready and anxious.
- Patient was released to outpatient department without dressing.
- I have suggested that he loosen his pants before standing, and then, when he stands with the help of his wife, they should fall to the floor.
- The patient is tearful and crying constantly. She also appears to be depressed.
- Discharge status: Alive but without permission.
- The patient will need disposition, and therefore we will get Dr. Blank to dispose of him.
- Healthy appearing decrepit 69 year-old female, mentally alert but forgetful.
- The patient has no past history of suicides.
- The patient expired on the floor uneventfully.
- Patient has left his white blood cells at another hospital.
- Patient was becoming more demented with urinary frequency.
- The patient's past medical history has been remarkably insignificant with only a 40 pound weight gain in the past three days.
- She slipped on the ice and apparently her legs went in separate directions in early December.
- The patient left the hospital feeling much better except for her original complaints.

appears the government would have preferred this issue be settled prior to the AARN annual general meeting on May 8.

The Provincial Council of the AARN debated this time limited offer and decided to respond to the government after the AARN's AGM.

When the LPN issue was raised at the AGM, UNA pointed out that the government's proposed "language changes" would not provide the protection the AARN was seeking and thus should be rejected. After much debate, UNA's President Heather Smith and Pauline Worsfold, President of SNAA, co-wrote a motion endorsed unanimously by nurses at the AGM.

The motion states:

1) The AARN maintain the position that the current Regulation requirements prohibiting independent practice of LPNs must be maintained.
2) The AARN Council should not agree with nor endorse legislation that does not ensure LPN practice shall continue to be under the direction of a RN, RPN, or physician.
3) The AARN maintain and enhance the lobby of the Government in conjunction with informing the public.

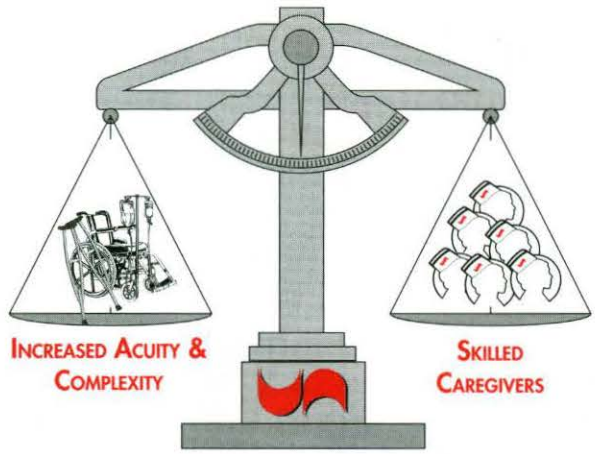
This motion was taken to the AARN Provincial Council meeting held immediately following the AGM where it received an overwhelming endorsement by the Council members.

The AARN has a clear mandate for any further discussions with the Alberta government. The registered nurses and registered psychiatric nurses of this province have made it clear that they will not stand by quietly while the government tries to de-skill the profession of nursing.

A special thank you goes to all UNA members who have written, faxed and called on this issue. You are having a tremendous effect but our work is not done yet. We must continue to work together to protect our profession and our patients.

UNA recently sponsored a ceremony dedicated to workers who have died or been injured as a result of conditions at their workplace. Nearly 300 people attended what was often an emotional event.

Fighting for Balance



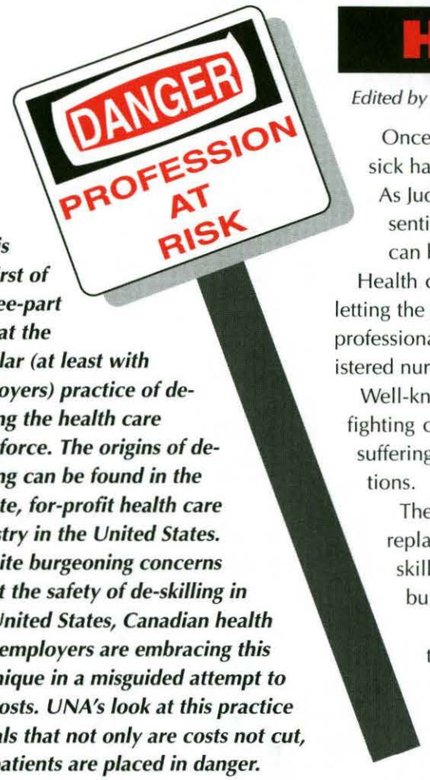
Protecting Our Profession

There's never been a greater need for registered nurses to work together for their patients and their profession. The Alberta government's changes to regulations covering licensed practical nurses will allow LPNs to independently carry out work currently provided by registered nurses.

UNA believes that LPNs make valuable contributions to patient care as members of the nursing team. However, at a time of escalating patient acuity and complexity, studies have shown that decreasing the levels of skilled professionals will result in rising hospital mortality rates, increased patient lengths of stay, increasing readmissions, rising complication rates and increased litigation. De-skilling the nursing workforce will cost money and reduce the quality of patient care.

UNA's new collective agreement provides you with a strong voice in determining the appropriate staff mix and level for your ward/unit in your facility. We encourage you to contact your Local Executive to provide the input necessary to make the contract work for you and your patients. We urge all registered nurses to contact their MLAs to express their opposition to the changes to the LPN regulations. We must work together to uphold the highest standards for the delivery of safe, effective and appropriate health care services.

Health Care for Profit



Edited by Melanie Chapman from a report written by Trudy Richardson, Education Officer

This is the first of a three-part look at the popular (at least with employers) practice of de-skilling the health care workforce. The origins of de-skilling can be found in the private, for-profit health care industry in the United States. Despite burgeoning concerns about the safety of de-skilling in the United States, Canadian health care employers are embracing this technique in a misguided attempt to cut costs. UNA's look at this practice reveals that not only are costs not cut, but patients are placed in danger.

Once viewed as charitable work and then as a social service, the care of the sick has become a commodity to be bought and sold in the global marketplace. As Judith Shindul-Rothschild says: "Health care has changed from being an essential social good that is a human right, to a corporate entity where profits can be achieved."

Health care has become the number one profit industry in the United States by letting the principles of business override the quality health care. The conditions of professional health care practice are being dictated not by medical doctors and registered nurses but by big business and profits.

Well-known consumer advocate Ralph Nader says that, in his long experience of fighting corporations who rip off the public, he has never witnessed the level of suffering that consumers are experiencing at the hands of health care corporations.

The most serious aspect of the corporatization of health care is the increasing replacement of skilled professionals with unlicensed, unregulated and unskilled workers—a process commonly called multi-skilling by the corporate bureaucrats but more accurately labeled de-skilling by health care unions.

In its testimony before the Institute of Medicine's (IOM) Commission on the Adequacy of Nurse Staffing in 1994, the American Nurses' Association (ANA) noted that health care corporations were in the process of a wholesale redesign of patient care organizations, a redesign based on an increased use of unlicensed staff. The ANA stated that hospitals and nursing homes were essentially forcing consumers to accept an untested product and were, in fact, using these patients as the subject of field experiments without their knowledge or consent.

The California Nurses' Association (CNA) filed a lawsuit against Alta Bates Medical Center in Berkeley California after the hospital announced a plan to redesign service delivery that would eliminate 50% of the RN staff. The lawsuit charged Alta Bates with consumer fraud and business practices intended to "deceive health care consumers about the potentially harmful effects on patient care standards" resulting from the proposed but untested work redesign. The CNA, which is seeking "truthful public disclosures about the impact of hospital restructuring on patient care standards", is still awaiting the results of this suit.

An international unity conference for nurses was held in San Francisco in 1995 to discuss trends and issues facing unionized nurses in North America. Along with such things as the corporatizing of health care and the effects of international free trade agreements on health care, participants also looked at the growing use of generic health care workers at the bedside. In order to hear from the employers' perspective, the conference organizers invited Connie Curran from American Practice Management. Curran, once a nurse herself, is one of the strongest proponents for replacing skilled nurses with generic health care workers. Rather than face a hostile audience, Curran turned down the invitation and then criticized the conference for being one-sided and biased. Curran is an important figurehead for the de-skilling movement and has been contracted by both the Manitoba and Alberta (the University of Alberta Hospital) employers to implement de-skilling programs in health care worksites.

Downsizing, Layoffs, Closures And De-Skilling

The practice of maximizing profit by reducing expenditures has been heartlessly and ruthlessly applied to every aspect of health care in the U.S. The 1990's may be remembered as both a decade of unparalleled greed and profiteering on the part of health care corporations and as a decade of suffering and deprivation for health care consumers. Health care providers are caught in the middle of this maelstrom feeling compelled to continue to provide quality health care services even as professional staff are laid off, patient care budgets are slashed and patient acuity levels rise. Nurses find themselves caught in this downward spiral of stress, pressure and disenchantment.

Over the last few decades, Canada has recognized that skilled nursing care is a pivotal service in the provision of high quality health care, and historically has hired twice as many nurses as the US. The RN/RPN to patient ratios and the percentage of RNs and RPNs as part of the total nursing staff in Canada are almost double those same figures in the US.

These days, however, Canadian federal and provincial governments are paying heed to the demands of the corporate agenda and are dismantling Canada's health care system and replacing it with the inefficient, profit-seeking US model.

Likert, one of the hard-nosed grandfathers of organizational theory, has stated that an increase in profit and productivity "is obtained by liquidating part of the company's investment in the human organization." Both the United States and Canada are in the process of liquidating skilled health care providers and replacing them with lesser-skilled and unskilled personnel. This is especially true in the area of nursing. Politicians and health care bureaucrats continue to claim that these layoffs have had no effect on patient care. But frontline caregivers know that the quality of care is deteriorating as unskilled and unlicensed workers replace registered and licensed personnel.

In 1989, few health care facilities reported the presence of generic workers. Today, almost all Alberta's health care facilities report the existence and increased use of generic health care workers—providing an array of services from drawing blood and monitoring heart rates to suctioning tracheotomy tubes, changing sterile dressing, inserting catheters and giving medications. And one of the ugliest aspects is that patients are unaware that the worker providing the service is in fact, unlicensed, unregulated, poorly-trained and unskilled. In one US hospital, all bedside workers were ordered to remove any pins or other identification that would indicate level of training or skill. One Alberta hospital employer asked the nurses to remove their RN and RPN pins and call themselves *Patient Hostesses* rather than nurses.

Dr. Lucien Leape, professor of health care policy at Harvard School of Public Health says, "patients have a lot of things done to them in a hospital. It is very hard to believe those things are going to be done better with less-skilled staff." Leape, a pediatric surgeon and internationally-recognized expert on iatrogenic injuries and illnesses, says that the de-skilling trend is occurring at a time when too many patients already are dying in hospitals because of mistakes in medical care. With fewer nurses and more generic workers in health care facilities, Dr. Leape says, "you are going to have more people who are less-trained and more likely to make errors. And those people who are highly trained will have increased responsibility, and therefore increased stress, and they are more likely to make errors." Leape claims that "what we're seeing is quality being sacrificed for cost."

Cost-Effectiveness

When analyzing health care it is very difficult to come up with a cost-effectiveness equation. In dealing with health care one must also factor in the quality of the service delivered which means that far more than dollars must be considered.

C. Hastings and C. Waltz, in their article called "*Assessing the Outcomes of Professional Practice Redesign*", say "organizations must begin to justify the implementation of resource-intensive practice model innovations through carefully documented performance and cost-effectiveness results." But health care employers forge ahead with massive de-skilling practices with little or no clinical evaluation or statistical feedback.

In the 1990's, the current coin of exchange is "cost-effectiveness". When nurses' salaries and benefits are viewed as "too rich", employers take the position that the economic gains made by nurses over the past few decades have "priced them out of the market" and that licensed and registered nurses can be easily replaced with lower-cost generic workers. While such a practice may boost short-term profits or help Alberta's health care employers to adjust to dwindling budgets, it will also, in the long-term, undermine profits and reduce a hospital or nursing home's competitive edge by negatively affecting the quality of service delivery and other factors that make up the effectiveness side of the cost-effectiveness equation.

At Presbyterian Hospital in Dallas, the hospital lost so many patients and drove away so many experienced nurses after it began using more and more generic aides in 1993 that it reversed the changes in 1995 and watched as profits rose when nurses and their patients returned to the facility.

Many hospital administrators say that the money that they calculated they would save by hiring generic health care workers and laying off skilled and experienced professionals actually turned out to be far less than they had planned. In some cases the real costs of generic workers was higher as things like training and turnover were factored in (growing litigation and legal costs.)

Short-term, cosmetic changes can often lead to long-term financial problems and to a long-term loss of dollars. When employers boast that their health care facility is a "centre of excellence" they should be very careful that they are describing the clinical excellence of top-rate nursing care rather than referring only to balanced budgets or growing profits.

The next installment of this report will delve deeper into the area of nursing practice as UNA examines the costs of nursing care. If you would like a copy of the UNA Report on de-skilling, please contact Kim at Provincial Office.

Negotiations for Nurses Continue

by Melanie Chapman

In the days before health care regionalization, new contracts were usually settled within days of the old ones expiring. Today, however, the length of negotiations is measured not by the clock ticking nor even by the calendar pages turning; we now calculate the length of negotiations by the seasons changing. Everyone in Alberta knows what strength the members of the United Nurses of Alberta had to show before the regional health authorities would bow to the nurses' demands for improvements to wages and to patient care. But negotiations for Alberta's nurses didn't end with that one provincial agreement. Bargaining for registered nurses and registered psychiatric nurses working in community and long-term care began in the winter of 1996; only now in the spring of 1997 is the end in sight.

Health Unit Reporting Meeting

Community health nurses became the first group of health care workers to win the return of the monies lost in the Klein rollbacks. Thanks to a sunset clause in their 1994-1996 agreement, their wages returned to pre-rollback levels in April 1996 (of course, we had to go to arbitration to force the employers to honour the contract!). From the start of contract talks, the regions repeatedly said that the contracts for community and hospital nurses should be equitable. In April, the regions denied saying any such thing. UNA then provided the employers with the employers' own documents calling for an equitable contract.

The regional health authorities recently gave UNA what they said was their "final offer" for community nurses; unfortunately, part-timers were not mentioned in the offer. When this was pointed out to the employers, they replied that it was obviously not their final offer. The proposed package did include a 1% increase in 1998 as well as clauses for severance, transfers, professional responsibility and occupational health and safety—items which the employers had strongly resisted over the last year. Representatives from UNA's community health locals met in Edmonton in April for a reporting meeting. UNA will return to the bargaining table for another attempt to resolve the contract.

Long-term care employers have also been dragging their feet. After the 85% strike vote by hospital-based nurses in March 1997, employers seemed to realize that they had an increasingly frustrated group of nurses in long-term care as well. The employers quickly removed all proposals for rollbacks from the table and agreed to most of the contract won by hospital nurses. While only a few other items still remain outstanding, the primary issue of the need for a registered nurse to be in-charge of each ward/unit remains a priority objective of UNA members. The parties will meet again on May 16.

Private Care Means No Care

- **One of out of every three children in the USA went without health insurance for one or more months in 1995 and 1996 in the United States.**
- **47% of those without insurance went at least 12 months without insurance and 15% lacked insurance for the full 24 months.**

(Families USA)

It's all just a coincidence ... or is it?

by Ed Finn (research associate with the Canadian for Policy Alternatives)

After James Winter finished speaking about his new book on how corporations control the news (*Democracy's Oxygen*), he was peppered with questions. One member of the audience was concerned about Prof. Winter's credibility.

"Aren't you going to be ridiculed as just another crazy conspiracy theorist," she asked him.

Winter, who's an associate professor of communication studies at the University of Windsor, admitted he probably will be tarred with that label — especially by the corporate media moguls whose suppression and disparagement of dissenting views he documents in his book.

"But," he added, "I'd rather be lumped in with the conspiracy theorists than the coincidence theorists. They're the ones who have — or should have — the worst credibility problem."

I think he's right. The numerous alleged coincidences that right-wing politicians, business executives, academics, and media pundits would have us swallow would make the oiliest used car salesman blush with embarrassment.

Consider just the most obvious ones:

- it's just a coincidence that the free trade agreements were followed by massive job losses
- it's just a coincidence that the new globalized economy has been marked by an exodus of plants to low-wage Third World countries
- it's just a coincidence that the Goods and Services Tax was implemented even though it was opposed by most Canadians and supported by big business
- it's just a coincidence that the banks and wealth investors who benefit from high interest rates are also the biggest contributors to the governing political parties
- it's just a coincidence that our social programs are being "harmonized" with their inferior counterparts in the US
- it's just a coincidence that high unemployment gives the corporations a more docile work force and the power to keep wages down
- it's just a coincidence that we have a tax system that favours rich individuals and profitable corporations
- it's just a coincidence that governments seeking to reduce their deficits target the poor and the unemployed by slashing UI and welfare rates, while continuing to lavish subsidies, grants and tax breaks on the corporate elite
- it's just a coincidence that groups that represent the people of Canada — unions, social coalitions, churches, women's, students, and anti-poverty organizations — are called "special interest groups" while those that represent business are portrayed as neutral, or as speaking for the whole society.

If you challenge these "coincidences" — arguing that there's a connection between corporate power and social, economic, and political developments that favour corporations — you may be labelled a "conspiracy theorist".

More and more Canadians, however, are starting to question these business-induced "coincidences." And they're also helping to expose their fraudulence. Like Prof. Winter, they're no longer afraid of being sneered at as crazy conspiracy theorists.

They've come to realize that the greatest harm they can do to their country and society is to continue to accept all the attacks on their welfare as the result of unfortunate coincidences.

Medicare Anyone?

The Medical Society of the District of Columbia, an affiliate of the American Medical Association, has endorsed a single-payer national health insurance system like we have in Canada. The Massachusetts American Medical Association has ordered a study to determine the feasibility of single-payer care, and Dr. Robert Tenery, former head of the Texas Medical Association, says that a single-payer system is preferable to managed care. The American Medical Association was once dead set against comprehensive national health insurance.

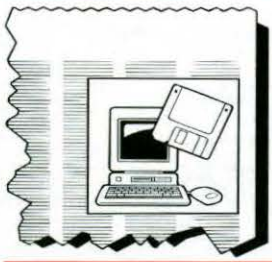
– (UAW Solidarity/CALM)

Meanwhile in Alberta ...

In a recent Alberta Medical Association poll of Alberta's physicians, 66% of the docs responding said that there is an appropriate role for privately funded, medically required services as a complement to an adequately funded public system.

Region 10 Mediator Steps In

After setting dates into December 1997 for the Labour Relations Board hearing into the employer's attempt to "carve out" referral hospitals from the region wide certificate, the LRB suggested that the parties agree to mediation. George Adams, a well-respected lawyer from Ontario and author of several textbooks on labour law, will mediate between the Capital Health Authority and the union representing health care workers.



Found on the UNA Net

The following discussions are 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 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.

Narcotic Keys

The following dialogue took place after the Calgary Regional Health Authority approved a policy allowing unit clerks to carry the narcotic keys. Nurses wanted to know whether this new policy was appropriate and whether other regions were implementing similar provisions.

- I talked to an administrator today who is responsible for keeping the policy manuals up-to-date. She verified that this was new policy as of about one month ago.
- In our facility, the RNs are supposed to be the only ones with the narcotic keys but the pharmacy assistant also has a set. When she is gone on holidays or whatever, the girl in CSR-Materials Management takes over. The thing behind this is the girl in CSR is an LPN. Another thing is that the RNs are not allowed to leave the hospital with those keys but the girl in pharmacy can. I know this because all the sets of keys got accidentally locked in the medication room so we had to phone her to come and unlock the door and she brought the keys from home.
- I think we better put this one the agenda for the PRC and even call a special meeting regarding the change of policy. Interestingly enough, they didn't bother telling the nurses about the changes.
- Why would the unit clerks want to be responsible for the keys and why would management want them to be? I would assume the clerks have not been informed of their liability in being responsible for these keys.
- The narcotic keys in Acute Care are carried by the RNs at our hospital. In LTC when the LPNs are giving the non-narcotic medications, they are carrying the keys. This has gone to PRC because of a revised policy that stated that LPNs could count with the RN. We asked why if they can't give narcotics why can they count and why they have the keys!
- We've done some investigation around the issue. Unfortunately, the answer was not what we hoped it would be. The CNPS, AARN, Health Canada and the Alberta Pharmaceutical Association all stated that they were unaware of any legislation which would prohibit the carrying of narcotic keys by non-RN staff. Having said that, they believe that there are certainly valid concerns about non-RN staff carrying keys and that we would be well-advised to make our concerns known in writing to management (i.e. via PRCs).

  According to the Narcotics Control Act, the ultimate responsibility for narcotics in a health care facility lies with the facility administrator. The actual counts/administration of narcotics etc. are delegated to employees. Thus, each facility should have a policy in place relating to narcotics and in turn to narcotic keys. In particular, the policy should address the issue of who carries keys versus responsibility for counting and a process to follow for incorrect counts.

  If and when your institution has a policy in place, concerns about the keys can and should still be raised with management. Monitor and document all situations where the keys have been unavailable or missing—and notify management of the problems.
- The following passage is from *Guidelines for the Secure Distribution of Narcotic and Controlled Drugs in Hospitals*, a January 1990 publication by Bureau of Dangerous Drugs, Canadian Hospital Association, Canadian Nurses Association and the Canadian Society of Hospital Pharmacists.

  Within each institution, a policy should be established regarding access to drug storage and the use, distribution and control of keys in a patient care area. Access to other personnel, such as agency nurses, graduates and students, should also be addressed in the hospital policy regarding this matter.

  It is suggested that only one individual per shift be assigned responsibility for control of the key. The policy established within the hospital will specify the procedures and responsibilities associated with this function. The question of who should have access to the cabinet should also be included as part of the policy. A key control log is recommended, in which nurses can sign when they take the key and return it. Under no circumstances should a key leave the hospital. If the key has been lost or removed from the hospital, the locks to the storage cabinet or compartment should be changed. Locks should also be changed when a significant loss has been discovered.

  At change of shift, responsibility for the key is formally transferred to the nurse coming on duty. At this time, the narcotic and controlled drug stock in the patient care area should be verified. The verification should be undertaken by both the nurse coming on duty and the nurse going off duty. Both should perform an actual physical count of the drugs and verify it against the records .... Both nurses should sign the administration sheet or other inventory control form which is used. In this way, the responsibility for not only the key but also the drugs is transferred to the nurse coming on duty.

PCAs In Acute Care

- Does anyone have PCAs working in active units and, if so, what kind of units do they work on?
- It appears that there are PCAs working in acute care at three facilities. In one hospital, the PCAs work on surgery, medicine and psychiatry. Allegedly, they are there to help with heavy workload.
- At this hospital, 2 PCAs work in Emerg. Their role is to help restrain for procedures and escort patients to other departments.
- We do not have PCAs but most areas do have NAs who have the duties of feeding, assisting with baths, bed-making, and transporting patients where appropriate. In ER, the orderlies also assist with things like casting.
- According to our head nurse in ER, our unit aide positions are to be deleted and replaced with PCAs. The job description hasn't been finished but we have been told they will help clean equipment, stock bedside units, transport patients within the department, do general gopher duties, make beds and help undress stable patients. Essentially it will be an expansion of the unit aide job.
- Admin. suggested that we have a PCA assist us on nights but agreed to hire an LPN instead. I then sent them a copy of Local 33's paper "The Inappropriateness of Auxiliary Health Care Workers in the Acute Care Setting".
- Glad to hear our paper is being of value to others. Region #10 has indicated that they believe that the job description for the Service Associate does not include direct patient care and that they will continue with their plans to implement this category of worker. I sent our presentation, the job description, and their letter to the AARN. The response indicated that, yes, the job description does contain direct patient care. I then sent the Board another letter informing them of the response I had received from the AARN. I have not heard from them since. The good news is that they have delayed the implementation. We were told that with this latest infusion of money, and the resulting increase in RN positions, they would be reviewing the whole issue of Service Associates.