WE BEGAN BARGAINING TODAY!

Page joins bargaining team; ONA prioritizes on-call and leave proposals; ground rules limit attendance

Today, we began bargaining with our employer. In addition to our experienced co-chairs Rita Vait and Ann Richards, Zach Page has now joined our bargaining team. Please thank these nurse leaders for working on your behalf!

Last week, we agreed on ground rules with the employer that limits attendance to both bargaining teams, except when

Next Bargaining Session
Friday, April 29
9 – 11 a.m.

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Unit Representative Training In Eugene
For locations, contact Gary Aguiar aguiar@oregonRN.org

ONA has scheduled unit representative training in the Eugene/Springfield area in the coming weeks. If you know a nurse who is interested in serving, please contact your labor representative.

*Part ONE:
Thurs., April 28, 10 a.m. – 1 p.m.
Saturday, June 4, 10 a.m. – 1 p.m.
Wednesday, June 8, 10 a.m. – 1 p.m.
Saturday, July 9, 10 a.m. – 1 p.m.
Thursday, July 14, 10 a.m. – 1 p.m.

**Part TWO:
Sat., April 30, 10 a.m. – 1 p.m.
Tues., May 3, 10 a.m. – 1 p.m.
Saturday, June 11, 10 a.m. – 1 p.m.
Thursday, June 23, 10 a.m. – 1 p.m.
Saturday, July 9, 2 p.m. – 5 p.m.

Unit representatives are our on-the-floor shop stewards and serve other nurses as a conduit of information. Unit representatives are often the first contact for a nurse who has a contractual question. We would like a unit representative on every shift, every day, in every unit. Unit representatives do not serve a defined term of office, but may step up or down depending on their other obligations.

*Overview of ONA structure; roles and responsibilities of unit reps; how to organize and focus nurse power; rights and benefits of having a union
**Duty of fair representation; disciplinary proceedings; grievance processing; staffing law, SRDFs
We Began Bargaining Today!

(continued from page 1)

an individual from either side is needed to present information on a specific topic. We notified the employer that we expect our on-call nurses to deliver data they have collected about their calls over the last year. (See the ground rules on page 5).

We presented six sets of proposals that would make changes to seven articles and Appendix A of our current collective bargaining agreement (see the bargaining tracker on page 6). From the survey and our membership meetings, the bargaining team set these priorities: enhanced on-call positions, improved earned leave, and preparations for the Hospice House.

We heard you loud and clear that home health and hospice RNs strongly support our two on-call positions. You told us you want to do whatever we can to ensure their happiness and continued tenure in these challenging positions. We value their contribution to the health and happiness to both home health and hospice RNs! Our on-call proposals include (a) hiring of a part-time on-call position, (b) earned leave for the benefited positions, (c) premium pay after eight hours in a shift, and (d) self-scheduling.

Your responses to our pre-bargaining survey indicated the most serious work dissatisfaction was around earned leave. So, we proposed language that at least two RNs per unit can be on leave and a broad interpretation of leave requests. Moreover, to facilitate safe patient care at the new Hospice House, our proposals include a night shift differential with longevity pay and no mandatory floating of others RNs to this department.

HOSPICE HOUSE PROJECTIONS

CHS provides requested information; new facility will feature 12-hour shifts; projected to breakeven in third year

As a part of the bargaining process, we have a right to request—and the employer has an obligation to provide—any information relevant to our negotiations. Cascade Health Solutions promptly and completely answered all of our questions. We are grateful for their timely and comprehensive answers!

In particular, we received very helpful responses from the employer in regards to the Hospice House. We learned CHS is seeking state licensure as a “Special Inpatient Care Facility Hospice.” Since this is not an acute care license, they are not required to follow the Oregon Nurse Staffing Law, as we discussed at our membership meeting.

The property at 4010 County Farm Road in Eugene encompasses 5 acres and the building will house 16,600 square feet accompanied by 29 parking spaces, which will be shared by staff and visitors. The building will have 14 patient rooms with additional spaces for family gathering, a chapel, a great room, dining room/kitchen, and a library that

(Continued on page 3)
can also serve as a conference room.

They expect to open the unit in October or November and anticipate three types of patients: General Inpatient, Respite and Room and Board. CHS projects 50 percent occupancy the first year of operations, 72 percent occupancy the second year and 85 percent for the third and fourth years. They envision it rising to 90 percent in the fifth year. Further, they budget an operating loss in each of the first two years (more than one-third million dollars in the first year and $170,000 in the second) and breaking even beginning in the third year.

Initially CHS anticipates volume at six to seven patients. They expect the unit to be initially staffed by five benefited and two resource RNs, five benefited and two resource CNAs and a ward clerk. Nursing shift lengths will be 12 hours, seven days a week. The clerk will work weekdays, 9 a.m. – 5p.m. At opening, they anticipate 1 RN and 1 CNA working each shift.

At full occupancy with 8 to 14 patients, CHS anticipates no additional RNs positions, but will increase the number of CNAs to eight benefited and three resource as well as five benefited and two resource LPNs. At full capacity, they will staff one RN, one LPN and two CNAs for day shift and one RN, one LPN, one CNA for night shift. Since a nursing manager will be on-site Monday through Friday during dayshift, presumably she can provide meals and breaks for the day shift nursing team. It is unclear who will break night shift nurses at this point. Assuming an Aug. 1 completion date for construction, they would post RN positions June 1 and CNAs July 1, with expected start dates two months later. They are still developing orientation plans for these new hires.

In this page-turner, Robbins describes the lives of contemporary nurses, portraying their highs and lows caring for patients in America's hospitals. Based on her interviews with hundreds of nurses, this ethnographic discourse will resonate with working RNs.

Robbins follows four nurses in four hospitals in an unnamed American city. Molly, confident and brash, she disagreed with her former hospital's anti-nursing policies, signed with an agency. Lara, competent and committed, raising two small children on her own, continues to struggle with drug addiction. Juliette is "a hard-worker who advocates loudly for her patients even when it is not in her best interests to do so" (p. 24). And Sam is a recent graduate who becomes discouraged by physicians' and managers' lack of respect for nurses.

Each chapter balances these four nurses' personal stories with pointed insights from academic studies and industry reports. For example, instead of addressing underlying nurse staffing issues, hospitals game the system of patient satisfaction scores. Several hospitals print cue cards using specific jargon to trigger higher patient satisfaction scores. Even though most nurses carry too heavy a patient load, they are told to use key phrases *three times in a shift to each patient*; "Is there anything else I can do for you before I leave? I have the time while I am here in your room" (p. 216). Yet, Robbins reports "a study comparing patient satisfaction scores with surveys of almost 100,000 nurses showed that a better nurse work environment raised scores on every HCAHPS question" (p. 221).

Robbins treats readers to a unique inside view directly from the "secret club" of nursing, where RNs share their joys, rewards, struggles and pain. For nurses and those who love them, this is a hard book to put down, because it is lively, engaging and empathetic.

A nurse tells Robbins, "it is the nurse who holds the hands of a patient without a family, who talks to them while they take their last breath, who aches for them while they die alone. It is the nurse who cleans the patient's body, who wipes away the blood and fluids, and closes his eyes. It is the nurse who says goodbye to the patient for the last time. Our story needs to be told. We want to be heard" (p. 26).

And there are so many good stories to tell, we cannot review the breadth and depth of nurses' insights that Robbins shares. Using the nurses' own words, she relates the heroic roles that nurses perform daily as the archetypical multitaskers: confidantes, communicators, comforters, nurturers, teachers, advocates, reporters, watchmen, gatekeepers and diplomats. The anecdotes will validate any RN's experiences and serve as an introduction to nurse's daily work for her loved ones.

(Continued on page 5)
From the ONA Bookshelf  Continued from page 4

Robbins covers the primary topics that affect nurses today:

- workplace violence, including bullying by physicians, patients and managers;
- nurse cliques and why nurses “eat their young”;
- nurse understaffing and long shifts without breaks;
- the “sexy nurse” stereotype; and
- drug abuse by nurses and patients,

Robbins concludes with a worthwhile set of suggestions for hospitals, patients and nurses (see box on page 4). However, she overlooks a key component of nurses’ ability to affect their workplace. Nursing associations, especially labor unions, provide a safe supportive venue for nurses to bind together to advocate for each other and their profession.

Other than a single passing reference, Robbins ignores the tremendous advances in a century of effort by state and national nursing associations. ONA leaders know that nurses working together have facilitated safe patient care, including Oregon’s nurse staffing law, shared governance principles and job protection. All produced by nurses uniting for common action.

Ground Rules Between
Oregon Nurses Association and Cascade Health Solutions
2016 Bargaining Round

Both parties agree:

- To further develop our relationship in an environment of mutual trust,
- That we commit to work collaboratively to contribute to the health and quality of life in our community,
- That each party will present their full set of bargaining proposals on their respective first days of negotiations, as described below, except:
  - Each party reserves the right to prepare and present new proposals around the hospice house, if new facts warrant; and
  - The parties may agree to explore a joint problem-solving approach in regards to the on-call positions, if the traditional negotiating approach does not yield bountiful fruit.
- In order to foster a focused, productive bargaining session, attendance will be limited to the designated ONA team and CHS team, except:
  - If a specific individual from either ONA or CHS is needed for a certain topic of discussion, they will be present during that portion of the session.

ONA will present their full proposals at the first bargaining session and CHS at the second bargaining session.
### Bargaining Tracker

<table>
<thead>
<tr>
<th>Article</th>
<th>ONA Proposes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ON-CALL POSITIONS</strong></td>
<td></td>
</tr>
<tr>
<td>Article 9 – On-Call Scheduling and Positions</td>
<td>New article that gathers on-call provisions in one place.</td>
</tr>
<tr>
<td>9.1 (former 8.9 &amp; LOA point 3)</td>
<td>Creates a part-time on-call position.</td>
</tr>
<tr>
<td>9.1.1 (former LOA points 4 &amp; 5)</td>
<td>On-call holiday rotation.</td>
</tr>
<tr>
<td>9.1.3 (former 8.9.1)</td>
<td>On-call self-scheduling.</td>
</tr>
<tr>
<td>9.1.7</td>
<td>One computer for each on-call RN and paid travel time to IT for repairs/maintenance.</td>
</tr>
<tr>
<td>9.2.3 (former 8.10.3)</td>
<td>Minor update to on-call hours.</td>
</tr>
<tr>
<td>10.3 (former 9.3 and LOA point 7)</td>
<td>Return to prior experience for steps 2 and 3 (revoke additional experience from LOA).</td>
</tr>
<tr>
<td>10.7 (former 9.7)</td>
<td>Notify manager of workload OT concerns at beginning of shift.</td>
</tr>
<tr>
<td>10.15 (former 9.14 and LOA point 6)</td>
<td>Existing “benefited” on-call positions accrue earned leave, on-call part-time earns 13% in lieu of benefits.</td>
</tr>
<tr>
<td>10.15.1 (former 9.14.1)</td>
<td>On-call RNs paid straight time for IDG meetings, premium if over the guaranty.</td>
</tr>
<tr>
<td>10.15.2 &amp; 10.15.3 (former 9.14.2 &amp; 9.14.3, and LOA points 1 &amp; 2)</td>
<td>48 hours of compensation per pay period.</td>
</tr>
<tr>
<td>10.15.3 (former 9.14.3, and LOA point 2)</td>
<td>Excess at 8 hours per shift, instead of 6.9 hours in LOA.</td>
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<tr>
<td><strong>EARNED LEAVE</strong></td>
<td></td>
</tr>
<tr>
<td>11.1 (former 10.1)</td>
<td>Vacation requests broadly interpreted to be more responsive to RN requests.</td>
</tr>
<tr>
<td>11.4.1 (former 10.4.1)</td>
<td>Minimum of two nurses off on any given day.</td>
</tr>
<tr>
<td><strong>SCHEDULING</strong></td>
<td></td>
</tr>
<tr>
<td>8.1.2</td>
<td>Employer and Association jointly, separately, and individually responsible for ensuring every RN takes meal and rest periods.</td>
</tr>
<tr>
<td>8.9 (new)</td>
<td>RNs in Home Health and Hospice cannot be required to float to Hospice House. May voluntarily accept on-call shifts.</td>
</tr>
<tr>
<td><strong>ASSOCIATION</strong></td>
<td></td>
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<tr>
<td>1.2</td>
<td>Fair share required of new hires.</td>
</tr>
<tr>
<td>2.7 (new)</td>
<td>Pay for bargaining team, up to 50 hours collectively.</td>
</tr>
<tr>
<td><strong>WAGES</strong></td>
<td></td>
</tr>
<tr>
<td>Appendix A</td>
<td>3% across the board, each of three years. Step 14 for 22 years of experience.</td>
</tr>
<tr>
<td><strong>RE-OPENER AND EXPIRATION</strong></td>
<td></td>
</tr>
<tr>
<td>20.2 (new)</td>
<td>Hospice House re-opener under expedited process.</td>
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</tbody>
</table>

*Note: LOA = Letter of Agreement, December 4, 2014*