In the matter of a Grievance Arbitration

BETWEEN:

HEALTH SCIENCES NORTH

(the "Hospital")

And

CANADIAN UNION OF PUBLIC EMPLOYEES LOCAL 1623

(the "Union")

Grievance CS 2015-077 – Work of the Bargaining Unit

Chair: Christine Schmidt
Hospital Nominee: Greg Shaw
Union Nominee: Joe Herbert

Appearances

For the Hospital: Carolyn Kay, Counsel, Hicks Morley
Diane Barbeau, HSN Manager, Employee and Labour Relations
Russell Landry, HSN Supervisor, Nephrology In-Centre

For the Union: Ryan Newell, Counsel, Goldblatt LLP
Louis Rodrigues
Dave Shelefontiuk
Pauline Brownlee

This hearing was held in Sudbury on July 20, 2018.

AWARD

1. This award concerns a Policy grievance about the interpretation of article 11 of the Collective Agreement between the parties. The language at issue is central hospital language, which has been in effect for some time.[1] The matter proceeded by way of an Agreed Statement of Facts ("ASF"), attached in its entirety as Schedule A to this award.

2. The key facts can be briefly summarized.

3. For many years the Hospital assigned duties carried out in the Nephrology Unit ("Unit") and set out at paragraph 39 of the ASF to both RNs and RPNs to varying degrees. In November 2015, when the Hospital implemented a new model of care in the Unit, the Hospital began assigning those previously shared duties to RNs exclusively. Among the duties transferred exclusively to RNs, hourly patient checks were one of the most time consuming, amounting to 12-18 minutes per RPN per hour.

4. At the same time as the Hospital assigned the previously shared duties to RNs exclusively, it eliminated all the RPN positions, and reassigned those RPNs who did not move elsewhere in the Hospital to a new classification of Renal Aide ("RA") that falls within the bargaining unit. The new classification does not require certification by the College of Nurses. The RA's duties include machine run-up and priming, as well as machine tear down and cleaning, in addition to activities such as stocking the Unit, transferring/lifting patients, assisting with toileting patients, flagging patient concerns/changes in condition to an RN, providing oxygen to a patient under the guidance of an RN, and so forth (Tab 11 Book of Documents). However, more significant tasks previously performed by the RPNs, such as medication reviews and medication administration, central line dressing changes and taking telephone orders

[1] Article 11.01 of the central CUPE agreement was awarded in September 1979 by a board of interest arbitration chaired by Arbitrator Brown in a *Group of 54 Participating Hospitals and CUPE*.

from physicians are not within the Renal Aide's scope of practice (Tab 11 Book of Documents) and have been transferred to the RNs on the Unit. As non-regulated health workers, RAs are paid significantly less than RPNs (however, those RPNs who were reassigned to RA positions were red-circled at their RPN rate).

5. There were no RPN layoffs when the remaining RPNs were reassigned as RAs. Instead, in anticipation of the implementation of the new model of care, two full-time RPNs sought opportunities outside the Unit and therefore the planned reduction in bargaining unit Full-time Equivalents ("FTEs") was achieved through attrition. Since the implementation of the change in the model of care, the number of RN FTEs has remained the same.

6. The staffing model prior to the implementation of the new care model was 2 RNs and 1 RPN for every 6 patients. Since its implementation the ratio of RN-to-patients has remained the same but the RA patient ratio has increased to 1 RA for every 8 or 9 patients. There has also been a continuing decline in the number of patient treatments in the Unit following the introduction of the new care model.

7. A review of the schedules produced to the Union reveals the percentage decline in hours as between RNs and RAs has not been relatively equal. Specifically, Tab 19 in the Book of Documents reveals that in the period from September 2015 until June 2017 the working RN hours declined by about 9.2% compared to 30.1% for the RAs.

Collective Agreement

8. The collective agreement article at issue is article 11.01 in the hospital central agreement between the Participating Hospitals and CUPE with an expiry date of September 28, 2017. It reads:

Article 11.01 – Work of the Bargaining Unit

> Employees not covered by the terms of this Agreement shall not perform duties normally assigned to those employees who are covered by the Agreement except for purpose of instruction, experimentation, or in emergencies when regular employees are not readily available.

Argument

9. The Union does not challenge the Hospital's *bone fide* reasons for moving to the new model of care whereby those previously shared duties normally assigned to RPNs and RNs are now carried out by RNs exclusively. However, it argues that article 11.01 of the collective agreement protects the *status quo* of the volume and type of work performed by the CUPE bargaining unit. The exceptions referenced in article 11.01 the parties agree have no application in this case.

10. The Union observes that the provision at issue is unlike language found in other collective agreements, where a trade union must typically meet a threshold to establish a violation of the collective agreement. In the Union's submission, it need not demonstrate that layoffs have occurred or that hours have been reduced to establish a violation. Rather, to be successful, the Union says it need only establish that the bargaining unit's integrity has been undermined by removing those duties that had normally been assigned to employees in the bargaining unit and reassigning them to employees outside of it. That the Hospital has done so is clear on the face of paragraph 39 of the ASF in the Union's submission.

11. Notwithstanding the Union's argument that there need not be layoffs or a reduction in hours to ground a violation of Article 11.01, the Union submits that the ASF does reveal a reduction in hours to the bargaining unit, even taking into consideration the decrease in patient treatments on the Unit. That decrease in bargaining unit hours has been significant in the Union's submission.

12. The Union points to the fact that when RPNs performed the shared duties set out in the ASF, there was a 2:6 RN to patient ratio and a 1:6 RPN to patient ratio on the Unit. After the reassignment of shared duties to RNs exclusively, the RN patient ratio remained unchanged, however, the RAs with a narrower scope of practice (having regard to job descriptions and lower rate of pay for new classification (as set out in the

Book of Documents at Tabs 7, 21 and 8 respectively) saw the patient ratio increase from the RPN 1:6 ratio to an RA ratio of 1:8 or 1:9.

13. While the parties do not disagree that there has been no increase in RN FTE's as a result of the implementation of new model of care in the Unit, the Union argues that a comparison between the RN and RPN hours of work prior to the introduction of the new care model reveals that the bargaining unit's work - now performed by RAs - has seen a significant reduction in hours as a percentage of the total hours in the Unit as compared to the RN percentage decrease in hours. The Union says that the only reasonable inference from the information before the Board, revealing an approximate 9.2% decrease in RN hours and a 30.1% decrease in RA hours referred to in paragraph 7 above, is that the difference is a result of the transfer of duties previously shared to RNs exclusively.

14. The Union submits that, since the *Ontario Nurses' Association and Extendicare (Laurier Manor)* case[2] issued in 1997, the arbitral consensus on the interpretation of the bargaining unit protection language offered by article 11.01 is that the volume and type of work assigned to employees covered by the collective agreement (RPNs in this case) cannot be reassigned to employees not covered by the agreement (RNs in this case). In support of its position the Union directed the Board to the following additional cases: *Trillium Health Partners and CUPE, Local 5180* (2015), 254 L.A.C. (4th) 109 (Cummings); The *Credit Valley Hospital and Canadian Union of Public Employees, Local 3252,* June 9, 2007 (McLean, unreported); *Northumberland Health Care Corp. and CUPE, Local 2628* (2003), 75 C.L.A.S. 393 (Verity); *St. Joseph's General Hospital, Elliot Lake and Service Employee's Union, Local 478 and Ontario Nurses' Association,* October 13, 1999 (unreported, Haefling) and *Henley House Long Term Care Facility and Labourers' International Union, Local 110*, (2016) 266 L.A.C. (4th) 261 (Jesin).

[2] *Extendicare (Laurier Manor),* (1997) 48 C.L.A.S. 346 (Mitchnick) ("*Extendicare*")

15. The Hospital asserts that to uphold the Union's position in this grievance would be to effectively override the management rights clause set out in the Local Agreement between the parties. More specifically, the Hospital submits that article 11.01 could not have been intended to preclude management from implementing organizational changes like the one on the Unit simply because there were duties shared between employees who are covered by the collective agreement and others who are not. To underscore its point, the Hospital directs the Board to the management rights clause, which recognizes that "it is the function of the Hospital to exercise the regular and customary function of management and to direct the working force of the Hospital, subject to terms of the collective agreement." The Hospital also points to clauses of the central collective agreement, such as articles 9 and 20, which contemplate the elimination of positions and the reassignment of employees and provide for the establishment of new positions and classifications, respectively.

16. The Hospital says that it does not dispute the arbitral jurisprudence that has emerged since *Extendicare* to the extent that it has concluded that collective agreement provisions like article 11.01 protect duties "normally assigned," as opposed to "exclusively" assigned, to the bargaining unit. The Hospital accepts that to be the case whether one is considering the "unqualified" type of bargaining unit protection language (as we have in this case) or the "threshold" or "qualified" type of language (as was the case in *Extendicare*) where an employer's ability to assign work outside a bargaining unit is prohibited if, for example, it results in a layoff or reduction in hours of bargaining unit members.

17. The Hospital asserts, however, that arbitrators (and the Union in this case) have misinterpreted the *Extendicare* decision in finding that Arbitrator Mitchnick had reversed the approach he had taken earlier in the case of *Hospital for Sick Children and C.U.P.E, Local 286* (1993), 38 L.A.C. (4th) ("*Sick Kids*"). The Hospital submits that because the clauses in the two cases dealt with different types of clauses - the clause in *Sick Kids* was of the unqualified type, whereas the clause in *Extendicare* was of the qualified or threshold type – there really was no reversal in approach. The Hospital also

says that since *Extendicare*, arbitrators have compounded that mistake by adopting the "volume and type" interpretive approach to article 11.01. Interpreting article 11.01 as giving proprietary rights to employees with respect to their duties at an uncertain point in time and then attempting to protect the volume and type of that work when patient numbers and acuity are in flux underscores how the prevalent interpretive approach is inconsistent with the hospital workplace.

18. The Hospital therefore urges the Board to abandon the erroneously and now entrenched "volume and type" interpretive approach to shared duties in favour of what it refers to as the "balanced approach." The Hospital says its suggested approach balances the Union's interest in protecting the work of the bargaining unit with the Hospital's right to run its operation in an evolving workplace. In this proposed approach, the Union should be made to demonstrate a causal connection between a significant transfer of work out of the bargaining unit and a real erosion of the bargaining unit in order to make out a violation of article 11.01. The Hospital submits that the Union has failed to establish the causal link between the transfer of work and a real erosion of the CUPE bargaining unit. At best, the Hospital says, the Union's interpretation of the reduction in number of hours on the Unit is based on assumptions that do not support a causal connection. The Hospital also says that the time reflected in the performance of previously shared duties, which have been transferred to RNs, is insignificant.

19. The Hospital specifically points to its strategic use of attrition prior to the implementation in the change of model of care, the ongoing decrease in patient treatments and the changes to RA shifts in the Unit, all of which the Hospital argues mean the Union has failed to meet its onus to demonstrate an erosion of the bargaining unit caused by of the change in model of care. The Hospital refers the Board to the total RA work hours as of the one-year anniversary of the new model implementation,[3] and argues that there has been no, or only a minimal, erosion of the bargaining unit.

[3] The pattern of hours reveals a steady decrease in RA hours with the exception of a "blip" in the October 10, 2016 to December 10, 2016 schedule.

20. The Hospital directed the Board to many of the same cases relied on by the Union. In addition, the Hospital provided the *Sick Kids* case, as well as *Fairhaven Home for Senior Citizens and O.N.A,* (1992) 28 L.A.C. (4th) (Thorne), *Lakeridge Health Corporation and Canadian Union of Public Employees, Local 1999,* (2003) (Devlin) and *MIC's Group of Health Services and S.E.I.U., Local 2014*, (2005) 146 L.A.C. (4th) (Stephens), *Royal Ottawa Health Care Group and Canadian Union of Public Employees, Local 942*, (2011) (Goodfellow).

21. In reply, the Union re-iterates its position that the Union need not establish an erosion of the bargaining unit for the Board to find a violation of article 11.01, even though it asserts there to have been a significant erosion in this case. The Union emphasizes that the jurisprudence has established that the prohibition is on the transfer of duties – and takes the type and volume interpretive approach not because of some misinterpretation of *Extendicare* but to give effect to the protective language of the article at issue. Moreover, the Union points out that the Hospital's attempt to distinguish *Extendicare* because the Arbitrator in that matter was interpreting a "qualified" or "threshold" clause makes little sense. To do so would be to suggest that less bargaining unit work protection is afforded to employees covered by unqualified clauses than employees covered by threshold clauses.

Decision

22. On the issue of the impact in transfer of duties from the old RPN model of care to the new RA model of care, the Board's view is that the only reasonable inference to be drawn from the documentation provided is that that the transfer of normally assigned duties shared by RPNs and RNs to RNs exclusively has significantly eroded the bargaining unit.

23. According to paragraph 39 of the ASF, RNs in the new model are doing the hourly patient checks during dialysis, which represented on average 25% of an RPN's work. That cannot be characterized as insignificant or *de minimis*. Secondly, the transfer of duties out of the bargaining unit the parties agree has changed the RPN to patient ratio from 1 RPN per 6 patients to 1 RA per 8 -9 patients, while the RN to patient ratio has remained the same. That too is an indicator that the bargaining unit has been significantly eroded. Finally, if it were true that the change in work model did not erode the bargaining unit, and taking into account the decrease in patient treatment on the Unit, one would expect the percentage decrease in hours to be the same for RNs and RAs after the implementation of the new model. However, the percentage decrease for RNs was about 9%, whereas the percentage decrease for RAs was about 30% (September 2015 to June 2017), more than three times the rate of decrease for RNs.

24. So, even were we to adopt the Hospital's "balanced approach" in the assessment of the transfer of work, we do not agree with the Hospital's submission that there has been no, or a very insignificant, erosion of the Union's bargaining unit. The loss of work is measurable and more than merely nominal.

25. However, we do not accept the Hospital's proposed approach or its reading of the post-*Extendicare* line of cases. In our view, the arbitrators in those decisions correctly analyzed and interpreted the change in direction taken in *Extendicare* by the very arbitrator who had decided *Sick Kids*.

26. In the *Sick Kids* award, Arbitrator Mitchnick was dealing with, like here, article 11.01 of the central collective agreement applicable to a CUPE bargaining unit that included Registered Nursing Assistants ("RNAs"). The RNAs had historically shared nursing work with the non-union RNs. The employer gradually phased out a large number of RNA positions, first by attrition (with no objection by the trade union), then by two rounds of layoff (both of which were grieved), and transferred the work to the RNs. Following a review of the arbitral jurisprudence on bargaining unit work

protection clauses in the circumstances of overlapping work in the health sector, Arbitrator Mitchnick interpreted article 11.01 as permitting an employer "to move work freely between the overlapping classifications, where that is done solely for *bona fide* operational reasons, and is not considered to be in derogation of a commitment 'to protect the standard of nursing care'." The arbitrator concluded that the first layoff was effected pursuant to *bona fide* operational reasons, and therefore did not violate article 11.01. However, having determined that the second round of layoffs was not driven by *bona fide* operational reasons, Arbitrator Mitchnick found a violation of article 11.01.

27. In *Extendicare*, Arbitrator Mitchnick, it is true, was dealing with a different kind of work protection clause, of the threshold variety. It prohibited reassignment of bargaining unit work normally performed by bargaining unit members to other employees in circumstances where the reassignment caused the termination, layoff or reduction in hours of bargaining unit members. In that matter, RPNs and RNs (who enjoyed the protection of the threshold clause) had overlapping duties in a nursing home. Due to funding reductions, the nursing home eliminated a full-time RN position and replaced it with an RPN position, thus causing a reduction in hours of the full-time RN incumbent and the layoff of two part-time RNs. The employer argued that the facts in the case disclosed a history of overlapping duties and full interchangeability between the two classifications. Moreover, there was no evidence of bad faith by the employer or an attempt to undermine the bargaining unit, and thus the conclusion should reflect the conclusion reached in *Sick Kids*.

28. Arbitrator Mitchnick rejected the employer's argument, and in finding a violation of the bargaining unit work protection clause, declined to follow his analysis in *Sick Kids*. In doing so, the arbitrator aligned his analysis with the views of other arbitrators in awards issued after *Sick Kids*, most notably Arbitrator Harris in an unreported case, *Versa Care* (March 24, 1997) which dealt with a threshold clause, and *University Hospital* (1994), 41 L.A.C. (4th) 84 (H.D. Brown), which dealt with an unqualified clause, both in circumstances where work was shared between different classifications.

29. There is simply no doubt, as observed by Arbitrator McLean in *The Credit Valley Hospital* award, *supra*, that *Extendicare* signalled a view different from that of *Sick Kids* concerning the effect of bargaining unit work protection clauses generally in work overlap cases. The fact that a layoff was required in *Extendicare* to prove a breach, as opposed to simply a reassignment of the duties from members of one bargaining unit to another, served only to 'raise the bar' for the union in that case in order to prove a breach.

30. Arbitrators since *Extendicare* have generally been reading these clauses as protecting the type and volume of the shared work, regardless of an employer's *bona fide* operational exigencies or preferences. An example can be found in the *Royal Ottawa Health Care Group* award, *supra*, where the arbitration board interpreted article 11.01 as protective of the assignment of even a single shift normally performed by a hospital orderly to an RN, where both orderlies and RN's shared the work. Similarly, the type and volume approach was applied in *Trillium Health Partners* and *Henley House Long Term Care Facility*, *supra*.

31. The Hospital's argument urging a "balanced approach" is just another, albeit dexterous, way of advocating for a broad scope to move work freely between the overlapping classifications pursuant to its management rights clause. The management rights clause, read in isolation, might well have led to such a result. However, the analytical approach utilized in the 'type and volume' line of authority (*Henley House Long Term Care Facility; Trillium Partners*; *Royal Ottawa Hospital*; *Credit Valley Hospital*; *Northumberland Health Centre*, and *Extendicare*), is more consistent with the plain wording of the collective agreement before us and it fetters the Hospital's management right to reassign the duties normally assigned to those employees covered by the collective agreement to those who are not (except in the circumstances described in article 11.01). We agree with the view expressed by Arbitrator Goodfellow in *Royal Ottawa Health Care Group, supra*, where he stated:

> The approach represented in the more recent cases is simple, straightforward and true to the plain and ordinary meaning of the provision. It asks whether the

> assignment in question constituted a change to the "type and volume" of duties normally assigned as between bargaining unit members and others. It proceeds from, and therefore respects, the employer's own historical patterns and practices. It considers pre-existing allocation or arrangements and asks whether there has been a reallocation or rearrangement.

32. Finally, we note that the language at issue has remained unchanged since 1979. The language has also remained the same since with the ascendancy of the type and volume approach several rounds of bargaining ago. The collective bargaining implication flowing from this is that the Hospital must be taken to be aware of the jurisprudential backdrop when it makes the kind of operational decisions that it did in the Nephrology Unit.

33. For these reasons, we find that the transfer of duties previously shared by RPNs and RNs, so that these duties are now performed in greater proportion (in fact, exclusively) by RNs, constituted a violation of article 11.01 and the Board so declares. At the request of the parties, we remit the issue of remedy to the parties and remain seized should there be any issues arising out of the award or its implementation.

Dated at Toronto on this 9th day of October 2018

_____

Christine Schmidt, Chair

“I dissent” (attached)

Greg Shaw, Hospital Nominee

“I concur”

Joe Herbert, Union Nominee

SCHEDULE A

AGREED STATEMENT OF FACTS

Grievance CS 2015-077 – Work of the Bargaining Unit

WHEREAS the Union has filed a grievance which has been referred to arbitration and Arbitrator Christine Schmidt has been appointed to hear the matter;

AND WHEREAS the parties have no preliminary objections related to the Grievance or the appointment of the arbitrator;

AND WHEREAS the parties have agreed upon certain facts so as to expedite the hearing and determination of the matter without prejudice to their respective rights to argue that certain facts contained herein are irrelevant;

NOW THEREFORE the parties have agreed as follows:

A. THE PARTIES:

1. Health Sciences North ("HSN"/ "the Hospital") is a regional resource and referral centre and teaching hospital which provides hospital-based acute, transitional, rehabilitation, continuing care, community mental health, addictions, and cancer care to over 600,000 residents across Northeastern Ontario.

2. The Hospital is the product of several streams of history – first, the lineage of three former health care institutions in the city; second, the reorganization of the hospital sector by the provincial government.

3. There were three acute care hospitals in the City of Sudbury. These were Sudbury General Hospital, Laurentian Hospital and the Sudbury Memorial Hospital. The three acute care hospitals incorporated in 1998 to form the Hospital regional de Sudbury Regional Hospital ("HRSRH").

4. Construction of a one-site hospital at the Laurentian Site that began in 1998 has been completed, and more services were relocated to the Ramsey Lake Health Centre (Main Campus) in 2010.

5. In January 2004, the HRSRH assumed responsibility for the Northeastern Ontario Regional Cancer Centre which now operates as the Regional Cancer Program of the HRSRH.

6. In 2007, a second integration occurred when community mental health, addictions programs and adult acute in-patient beds were transferred from the Northeast Mental Health Centre ("NEMHC") to the HRSRH.

7. In November 2011, the Hospital underwent a rebranding and is currently operating as Health Sciences North.

8. The Canadian Union of Public Employees Local 1623 (“CUPE”/ “the Union”) represents the service employees of HSN.

9. The central CUPE Combined Collective Agreement and the Local Issues Collective Agreement together constitute the “Collective Agreement” which governs the relationship between the Hospital and the Union.

B. THE GRIEVANCE

10. Arbitrator Christine Schmidt has jurisdiction to determine the merits of the grievance CS 2015-077 – Work of the Bargaining Unit.

11. On October 25, 2015 Grievance CS-2015-077 was filed. It alleged a violation of Article 11 and the Collective Agreement as a whole whereby the Hospital is giving work of a Registered Practical Nurse (“RPN”) to the Registered Nurses (“RNs”) in the renal dialysis unit. **(Tab 1)**

12. As a remedy the Union requests that the assignment of this work be restored to employees in the CUPE bargaining unit immediately and with full redress.

13. The grievance was heard at Step 2 on November 25, 2015. The Step 2 Response was provided to the Union on December 8, 2015 (**Tab 2**).

14. The Union filed a Notice to Arbitrate on December 14, 2015.

15. On April 26, 2018, the Hospital sent the Union an addendum to the Step 2 response for CS 2015-77: Tab 15. The Hospital indicated that the role of the RPN in Nephrology no longer existed in that a new classification of Renal Aide was being introduced and that RPNs would be reassigned to that of classification. This is the subject of another grievance, which is being held in abeyance.

C. MATERIAL FACTS

16. The In-Centre Nephrology Unit consists of 5 pods with 6 dialysis stations per pod. Prior to the move to the Renal Aide model, there were 2 RNs and 1 RPN assigned to each pod and the shift schedule was a 12-hour day shift and an 8 hour evening shift.

17. On March 24, 2015, the CUPE Redeployment Committee met to discuss a variety of issues. **Tab 3** is a copy of the Minutes of that meeting. At that meeting the Hospital provided the Union a letter providing them notice of

position eliminations in the Nephrology Department. The letter indicated the Hospital would eliminate 16 RPN Full-Time Equivalent ("FTE") positions. **(Tab 4)**

18. It would be the evidence of the Hospital that the decision to move to a Renal Aide model was based on the following considerations. The RPN's in the Hospital's Nephrology unit were not assigned and therefore, did not work to full scope (as per the hospital standard). Full scope renal RPN's within Nephrology in other hospitals are able to take a full patient assignment similar to an RN but only after the three factor framework is applied to determine which patients are appropriate (typically the RN would be assigned the more complex or acutely ill clients). After conducting a review of other institutions in the province, the Hospital believed that the scope of the work being done by HSN's RPNs in Nephrology was more aligned with what certain hospitals/ programs called renal aides or dialysis assistants, technical aides, etc,: a model that was used elsewhere in the province. The Hospital believed that this model would be a good fit with the Nephrology unit and would have the least amount of impact to patient care as the RN's would remain the primary care provider of the patient and that the renal aides would be responsible to cover more of the machine prep assignment from 6 stations to 9-12 stations (again aligned with other dialysis units in the province).

19. On June 10, 2015 there was a further CUPE Redeployment Committee meeting where, among other things, the parties continued to discuss the changes to be made in Nephrology. **Tab 5** is a copy of the Minutes of that meeting.

20. On June 22, 2015 the Hospital and Union held a meeting with a number of the affected RPNs to discuss the new job classification within the department called a "renal aide" (RA). **Tab 6** is a copy of the Minutes of that meeting.

21. On July 7, 2015 the Hospital provided the Union with a final job description for the RA position: **Tab 7**

22. On July 14, 2015 the Hospital and the Union held a meeting to discuss the introduction of RAs in the Nephrology Department. The meeting agenda included discussion of the RA job description, the transition from RPNs to RAs, and the training options and expectations for becoming an RA. **Tab 8** is a copy of the Minutes of that meeting.

23. Following this meeting, the Union filed 14 individual grievances from all the employees in the Nephrology Department impacted by the reassignment along with 5 policy grievances, all of which are being held in abeyance pending adjudication of this grievance. None of these grievances are before Arbitrator Schmidt.

24. On August 27, 2015 the Hospital sent letters to RPNs in the Nephrology Department updating them on their reassignment to RA. The letter indicated that

the reassignment date was being extended to October 26, 2015 in order to ensure a complete understanding of the changes. **(Tab 9)**

25. On September 11, 2015 the Hospital sent the Union a letter indicating that one individual, Lynn Dupuis, expressed an interest in upgrading her skills to qualify for the full scope of RPN opportunities outside of the Nephrology Department. The Hospital indicated it would set up a training plan for her. **(Tab 10)**

26. On October 16, 2015, Supervisor Russell Landry, In-Centre Nephrology, sent an email to all the Nephrology RPNs attaching a document entitled “Role of the Renal Aide Scope of Practice in the Hemo Unit”: **Tab 11**

27. On October 28, 2015, Mr. Landry emailed the Nephrology Renal Aides 2 new master rotations for staff to vote on: Tab 12. Staff ultimately voted on which of the two schedules to accept.

28. On November 4, 2015 the Hospital sent the Union a letter indicating that a second individual, Ron Debray, expressed an interest in upgrading his skills to qualify for the full scope of RPN opportunities outside of the Nephrology Department. The Hospital indicated it would set up a training plan for him. **(Tab 13).**

29. There were no layoffs in Nephrology when the RPNs were reassigned to the new RA positions.

30. In the time since November 2015, there has been a decrease by attrition in the number of CUPE FTEs in the In Centre Nephrology Department. In November 2015, there were a total of 7 full-time RPN’s employed in the In-Centre Nephrology Department. Between 2015 and 2017, 1 RA (formerly classified RPN) retired, 1 posted out to another department. Neither of those individuals were replaced. As of 2017, there were 5 full-time RAs employed in the Department.

31. The staffing model involved a ratio of 2 RNs and 1 RPN for every 6 patients. Since the reassignment, the ratio has been 2 RNs for every 6 patients, and 1 RA for approximately 8-9 patients.

32. Patient volumes have over the years, decreased as a result of various factors including waiting longer before starting a patient on dialysis and a greater percentage of patients opting to have home dialysis rather than in-hospital dialysis. Tab 20 is a copy of the statistics of patient volumes showing the decline in In-Centre Nephrology treatments.

33. Tab 16 are the schedules for RPNs in Nephrology from May 2015 to October 2015.

34. Tab 17 are the schedules for the Renal Aides in Nephrology from November 2015 to June 2016.

35. Since the new RN classification was introduced, there has not been an increase in RN FTEs. Tab 18 are the schedules for the Registered Nurses in Nephrology from May 2015 to June 2016.

36. Tab 19 includes the core scheduled staffing numbers and hours for RNs and RPNs, then Renal Aides for the period November 2015 to fall of 2017.

37. A copy of a posting for an RPN position is attached at Tab 21.

38. For many years prior to the reassignment at issue, RPNs and RNs shared most duties although the percentage of time spend on the duties would vary as between the RPNs and the RNs. The tasks performed by RNs which were not performed by RPN's were

    i. inserting fistula or graft needles;

    ii. accessing central venous lines;

    iii. administering IV medications;

    iv. Initiation and termination of dialysis;

    v. ultimate responsibility for patient care, including management of patient complications during treatment, rested with the RN (although RPNs would assist under direction of the RN),

    vi. blood and blood product administration

39. In November 2015, the Hospital began assigning the following tasks exclusively to RNs, which until then had been shared duties performed at varying degrees by both RPNs and RNs:

    i. Medication history reviews where the RN or RPN would obtain the "best possible medication review" through discussion with the patient. While roughly 30 to 40 a month are done, RPNs did between 1 and 7 of those a month.

    ii. Medication administration where the RPN would provide patients with oral pain medications (assuming there was a doctor's order on file). RPN's also administered fleet enemas in dialysis baths as needed. Oral medications were stocked in the unit and RPNs could provide a patient with a tablet in the event of need. RNs administered IV push drugs and IV bag administration, which was performed less than once per shift on average.

iii. Draw up heparin where the RPN would draw up the heparin into a syringe and attach it to the dialysis machine. This would be done for each of the 6 dialysis machines operating each morning, afternoon, and evening, taking approximately 15 minutes per 12 hour shift.

iv. Co-sign for medication orders in CyberRen. After a physician wrote an order for medication, it would be entered into the CyberRen system and would have to be double checked by two staff members to ensure accurate entry: the RN would do the check together with either an RPN or another RN. Doctors did rounds once per week and orders would be written during or following those rounds. The co-signing process would take minutes.

v. Double check blood product. Patient would, on occasion, have to be given blood bank products. The RPN or RN would be responsible to check the blood product to verify that it was accurate. This was rare: maybe 1 every couple of weeks.

vi. Testing of Blood sugars. For diabetic patients, while they were undergoing dialysis, the RN or RPN would test the patient's blood sugars through the dialysis machine. Would take about 5 minutes per patient. Frequency would depend on the number of diabetic patients undergoing dialysis any given day.

vii. Central line aseptic dressing changes. Dialysis can be performed through a central venous catheter. The dressing would be changed by the RPN or RN. Predominantly it was done by the RNs. The task would take approximately 5 minutes and would happen 1-2 times per week.

viii. Saline administration (RN will administer). For patients that became hypotensive during treatment, the RPN or RN would open the saline for administration. RPNs performing this task would report back to the RN. This task would occur randomly and might occur every few days.

ix. Telephone reports from inpatient units re patients pre or post dialysis. Patients would come from other units in the Hospital and the department would receive a call to say that a patient was coming to dialysis. Whomever answered the phone, the RPN or RN, would take the information and relay that to the RN.

x. Telephone orders for patient care from physicians. Physicians would, from time to time, phone the department with medication changes or other medical interventions. Whoever answered the phone would take the order down. If it was an RPN who answered the phone she would relay that information to the RN.

xi. Reviewing bloodwork results and processing associated orders.

xii. Performing formal visual checks on patients at 15 minute intervals.

xiii. Providing health advice along with other disciplines, and along with the dieticians, making dietary recommendations.

xiv. Performing hourly checks on patients during dialysis which included the following:

- checking to ensure there was no leakage of blood lines;
- checking vital signs;
- checking all orders on dialysis machines to ensure they are correct;
- checking heparin levels;
- asking patients how they were feeling

40. The hourly checks would take approximately 2 to 3 minutes per patient. An RPN would spend approximately 12-18 minutes per hour performing hourly checks.

41. Although also performed by RNs prior to November 2015, RPNs took the lead on conducting the hourly checks referenced in subparagraph 39 (xiv).

42. The Hospital maintains that there has been no violation of the Collective Agreement.

Dissent of the Employer Nominee

With respect I must disagree with the majority in this matter.

The simple fact of the matter in this case is that the duties in question were performed by both RN's and RPN's and therefore were not the exclusive domain of the RPN's represented by CUPE. Furthermore, the duties in question did not represent a significant proportion of the work done by RPN's on any given shift, contrary to the assertion of the union and the conclusion of the majority. In my view the union has failed to show a causal relationship between the changed ratios of ONA/CUPE employees on the dialysis unit and the change in duties implemented to create efficiency on the dialysis unit. This was clearly the Union's onus.

The union's belief that shared duties cannot be altered between bargaining units that share them creates an absurd situation which will not allow thoughtful and appropriate changes to take place in the workplace and are specifically allowed under the management rights clause in this and most collective agreements. The majority are giving meaning to Article 11:01 that the Parties would never have intended. That is to prevent virtually any change and have 11:01 override all of the many management rights contained in the collective agreement. Employees do not have a proprietary right where duties overlap or in fact are shared between unions.

There has been a significant reduction in the volume of dialysis patients which obviously reduces the need for dialysis staff. The union argues that the only reason for the reduction in CUPE staffing was the change in duties. In my view they have failed to prove a causal relationship between the reduction in staff and the transfer of duties. As a result, I would have dismissed the grievance.

Respectfully submitted,

Greg Shaw
7 October 2018