May 21,2002
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Mayor Brodie and Richmond City Councillors
City of Richmond,

Ladies and Gentlemen;

On February 25, I presented to you the impact of Bill 29 on the Health care workers of this province and the possibility of cuts to services in Richmond. In the last few weeks we have received the proposal for those cuts to this community.

Now that we know exactly what those changes will mean to Richmond, I believe it is time to ask for your support in a new resolution to form a committee on Health Care to deal with the decreased services and to have a long term plan to take a look at the needs of this community.

I would respectfully request a time at your next council meeting on May 27, 2002 to do a presentation of the proposed cuts and a call for a resolution for such a committee.

Sincerely:
MHewlett RN
Marnie Hewlett RN

CITY OF RICHMOND
DATE
MAY 21 2002
RECEIVED
CITY CLERK'S OFFICE

Submission to Richmond City Council-May 27, 2002

The Impact on Richmond Community -Cuts to Services 2002

I've enclosed the proposal that we received from the management of Richmond Health Services in this submission and I will go over the plan with an explanation to you about what this actually means in terms of service to this community.

In Medicine:

The closure of 3 North will delete 16 sub-acute and relocate 8 palliative care beds. The 8 palliative care beds will be relocated to 3 South which is a busy acute medical floor. The loss of the palliative care unit is devastating-this unit has been developed over the years with donations from the community .It is a place where people can come to get the best of care from a team of professionals in a home atmosphere. This change means that dying patients will be mixed in with acutely ill medical patients and that the staff will no longer have the back-up of the sub-acute nurses for break relief. This means less time for the nurses to spend with the patients and families who need more care at this stage of their lives.

The 16 sub-acute beds will be gone-the development of this floor came from a need to have a place for people to go when then were "holding up" an acute care bed because they were not ready to go home or there was no bed available in either in Intermediate or Extended care. This closure will result in a domino effect for the acute floors as well as the Emergency department.

The latest rumour is that the Richmond Health Services is going to award a contract to a private for profit facility for $600,000 for 10 months. They will provide 10 convalescent beds and it's my understanding that the patients will not have to pay for this service. The room and food is provided for them but anything extra -diapers and supplies of any kind will have to be bought and paid for by the families. Also, we are not sure what the staffing will be in that facility and whether or not there will be a RN available for these patients.

We are seeing the increase of 1 RN to 2 South which is our acute cardiology and telemetry unit-this I feel is due to the nurses documenting the acuity levels of patients and the need to increase the ratio of RN's to patients and only fills a need that has been there since the deletion of that position about 4 years ago.

In Surgery:

If you look at the document prepared by the management of Richmond Health Services you need to note the phrase " achieve utilization efficiencies and avoiding delays in discharging patients without reducing volumes of surgical service". I'm not sure what they mean by this when they are closing 4 surgical beds on 4North. Before the job-action last year this floor had 32 beds and often they had to expand to 36 because of the volume of emergency surgeries. After the job-action , this floor was downsized to 28 and now they are further reducing to 24-so in actual fact they are losing 8-12 beds. We are losing RN's in the process and our RN to patient ratios are going to be 1 RN to 8 patients when we had 1 RN to 6 patients. Again, impact of the sub-acute floor means that we will not be able to move those patients and we will also be losing some of our home-care nurses who were able to provide support to those patients who were needing nursing services when discharged on an accelerated program. In addition, there is a new policy that says that no-one will be in "holding beds" in Emergency for more than 12 hours. We are

not sure where they are going to go and management hasn't been able to answer that question so far. We have heard that the Naniamo Hospital instituted this same policy a few months ago and they have patients on floors that are understaffed, patients in hallways where there are no call-lights or oxygen outlets etc.

Eliminate the Float Pool:
These floats were used to cover shortages that we had noticed were happening on a regular basis-they provided workload and sick relief all over the hospital and to my knowledge they were extremely cost-effective because it eliminated the need to call people on short notice to fill the gaps with reductions in overtime costs.

In Emergency:
Closing the treatment or "fast track"area from 2130-0730 and serve patients in the acute area during those periods with the additional loss of 5 acute stretchers and Emergency- trained Registered Nurses just doesn't make sense unless you put it in the context of the "leaked document" that we had in March talking about the opening of an "Urgecentre" in Richmond. The impact of the Delta Hospital Emergency department at night also leads me to believe that the plan again is to make the line-ups longer and services virtually impossible to get and then talk about how if you pay for the service -it will be better. To date, the managers just keep saying things will be much better and the statement that they will "increase the flow of admissions to nursing units from Emergency" doesn't tell me how they expect to do this when we are closing whole units and surgical beds and deleting nursing positions. This plan is undoubtably going to cause longer waits, confusion and possible deaths.

At Minoru and Richmond Lions Manor:
The plan here is to "open more LPN (Licensed Practical Nurse) positions to replace RN positions". Actually, the plan is to displace approximately 90% of the RN's and replace them with LPN's. In both areas this will mean increased patient ratios and less than the agreed to levels in essential services. In Richmond Lion's Manor there will be one RN for 133 patients on one of the shifts and in Minoru currently the ratio of RN to patients on the night shift is 1 RN to 100 patients.

In Continuing Care:
The reduction of the case managers and home care nursing contemplated in this plan is unrealistic when the nurses are having enough difficulty meeting the incredible workload now. This will leave those nurses on some shifts below their essential service levels. With the plan to "increase the discharge" of patients to the community and long term care means the need increases for more, not less RN"s. The result of this plan will be that necessary dressing changes and services will go only to those in real need and the preventative nursing care will not be provided. With the deletion of the case managers the assessments necessary for our elderly to be ready for Long term care will be delayed.

In Psychiatry:
There has already been a reduction in the number of psychiatric beds in Richmond with the

merger of 12 beds in geriatric/medical psychiatry and the acute psychiatric floor, but we have also seen the closure of some of our community based beds closed. The closure of the "fast track" area in Emergency is of concern because the locked rooms for those patients who are in the acute phase of their illness are no longer going to be available. This will mean that we will have these patients mixed in with the acute cardiac patients etc. in the Emergency department and these patients for safety will be in 4 point restraint-it seems to me that we have just taken a step back or down in humanity.

The options laid out in the proposal talk about a "retirement incentive" packages being offered to staff-sounds wonderful-but in fact the Vancouver Coastal Authority has offered a deal that is not so great. We have had very little time to consider it-nurses are being given a waiver form that will absolve the management of any errors in calculating pension benefits and decrease access to benefits and it is being handed out in a very strange fashion. Many nurses who have asked have been turned down.

The impact of these cuts and the language of Bill 29 around bumping is that those nurses with less than 5 years experience are in danger of losing their positions. In a world-wide shortage of Registered Nurses, I see these people going to the highest bidder and there will be a further reduction in the amount of Registered Nurses in this province, in spite of what the Vancouver Sun says. The result of this will be unsafe workloads, decreased patient safety, longer waits and higher rates of mortality.

It is my understanding that there is legislation coming that will give the municipalities more control over the services that will be provided in their communities.

In the package that I have provided for you, I respectfully request that we look at the formation of a committee to protect the most frail and vunerable in our community and that Richmond City Council take an active part in the plans for the future of the health care so that we have some control over the services necessary for the citizens of Richmond.

Respectfully;

Marnie Hewlett . RN

Marnie Hewlett RN.

Richmond Service Redesign Strategies
Draft Summary
April/May

Strategy	Displacements	NBA	Facilities	Paramedical	Postings	fte reduction	Notes
Medical Bed reconfiguration in Medicine (close 3N, Sub- Acute & move Palliative Care to 3 South) This will yield a 10 bed net reduction 2 South Introduce extra RN on nights & Decrease LPNs	3 North Team Leader (RFT) Educator (RPT) 14 RNs (6 RFT & 8 RPT) 10 LPNs (5 RFT & 5 RPT) 3 NUCs 1 Rehab Asst (RFT) 2 South 1 LPN (RFT) 1 LPN (RPT)	16	16		2 pt RN (3S) 3 ft RN (3S) 2 ft RN (2 S) 3 pt LPNs (3S)	25.75 fte reduction	8 medical beds on 3 South (medical unit) will open to accommodate Palliative Care & medical patient volume. Postings for RNs and LPNs at the time of displacement. (rotations are being developed this week). Additional RN on nights is being introduced on 2S.
Surgery – 4 bed reduction	1 RN (RFT) 1 LPN (RFT)	1	1			3.00	There is 1.5 vancant ftes which has decreased the displacements
Float Pool elimination	2 RNs (RFT) 4 LPNs (RFT)	2	4			6.00	Lines have not proven cost effective.
Emergency – close treatment area from 1200 –	3 RN (RFT)	3			3 RN (RPT)	5.57	Frozen vacancies and part-time positions have minimized

	1 Cleaner (RFT) 1 Cleaner (RPT) 1 FSW/hsk aide (RFT) 1 FSE /hsk aide (RPT) 1 Leisure Aide (RFT)				2 Cleaners (RPT) 1 FSW (RPT) 1 Care Aide (RFT) 1 Care Aide (RPT) 3 LPN (RFT) 2 LPN (RPT)		reduced to accommodate this change, 1 fte leisure aide reduction. Night cleaner is being eliminated
Continuing Care	2 Home Care RNS, .5 (RFT) 1 Case Manager .5 (BCNU) RPT .1 1 Case Manager (CUPE) RFT 1 Rehab Therapist (RFT) 3 Clerks (RPT) (1.80)	3	3	2	1 RN (RPT) Reassign .25 hrs. (Case Manager) Reassign or use for relief .20 clerk hrs	5.04	
		46	48	9		63.86	

Estimated Totals

Displacements: 103
NBA Postings: 19 12 RPT & 5 (RFT) RNs(current reg RN vacancies- 1.4 in Maternity and 1.0 in PAR)
Facilities Postings 32* 10 RPT LPNs & 5 RFT LPNs (no current LPN vacancies)
*(includes 5 frozen FSW 1 RPT Care Aide & 1 RFT Care Aid, 8 RPT BSW & 4 RPT FSW &BSW)
Paramedical Postings 2 1 RFT Social Worker 1 RPT Social Worker

0730 and close 5 stretchers	Displacements	NBA	Facilities	Paramedical	Postings		displacements.
Facilities (Bldg Services) Displacements from RFP shared services (2 pt), EDO elimination (6 rft) and relief reduction strategy.	7 BSW (RFT) 2 BSW (RPT)		9		6 BSW (RPT)	5.34	6 part-time positions to replace full-time positions will be posted for EDO elimination. As there are frozen vacancies, there are positions for all staff. 2 RPT displacements in Day Care are deferred due to RFP process.
Food Services – EDO elimination	6 FSW RFT		6		4 FSW (RPT)	4.58	4 positions were posted, 2 staff transferred to rpt. With frozen vacancies, there were no staff were layoffs.
Minoru Residence – RN/LPN conversion Recreation program reduction and redesign and social work redesign	6 RNs (RFT) 5 RNs (RPT) 1 Sr. Rec Programmer (RFT) 3 Rec Programmer (RPT) 3 Social Workers (RPT)	11		7	2 LPNS (RFT) 4 LPNs (RPT) 1 Social Worker (RFT) 1 Social Worker (RPT)	2.50	6 LPN positions will be posted Recreation Programmers will be reduced from 5.5 ftes to 4 ftes Social workers will be reduced by approx .40 fte.
Richmond Lions Manor	10 RNs (RPT) 2 Care Aides (RFT) 2 Care Aides (RPT)	10	9		2 Team Leader (RFT) 4 RN (RPT)	6.08	More LPNs being introduced, care aides and RNs being

	1 Cleaner (RFT) 1 Cleaner (RPT) 1 FSW/hsk aide (RFT) 1 FSE /hsk aide (RPT) 1 Leisure Aide (RFT)				2 Cleaners (RPT) 1 FSW (RPT) 1 Care Aide (RFT) 1 Care Aide (RPT) 3 LPN (RFT) 2 LPN (RPT)		reduced to accommodate this change, 1 fte leisure aide reduction. Night cleaner is being eliminated
Continuing Care	2 Home Care RNS, .5 (RFT) 1 Case Manager .5 (BCNU) RPT .1 1 Case Manager (CUPE) RFT 1 Rehab Therapist (RFT) 3 Clerks (RPT) (1.80)	3	3	2	1 RN (RPT) Reassign .25 hrs. (Case Manager) Reassign or use for relief .20 clerk hrs	5.04	
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Paramedical Postings 2 1 RFT Social Worker 1 RPT Social Worker

PROJECTED LAYOFFs: 48

Projected Layoffs by Job Class

RNs – 28
LPNs – 3
Nursing Unit Clerks – 3
Rehab Asst – 1
Sr. Rec Programmer – 1
Social Workers – 1
Care Aides – 4
FSW/Hsk – 1
Leisure Aide – 1
Case Manager – 2
Rehab Therapist – 1
Clerks – 3

refer to positions as compared to FTEs

Projected Site Layoffs

Hospital Site	**17**
Minoru	**16**
RLM	**8**
Continuing Care	**7**

- does not include vacancies
- does not include voluntary retirement

Note: All data is pre-adjustment plan and is therfore an only estimate.

RHSS | Acute, Continuing Care, Minoru, RLM, Population Health

Applications for severence pkg. 63 TOTAL

37 will probably be accepted.

Fact Sheet

May 15, 2002

Richmond Health Services

The Vancouver Coastal Health Authority re-design plan will affect safe patient care in the Emergency Department (ER) at Richmond General Hospital.

The plan for the ER is:

1. To reduce the number of qualified emergency prepared RNs by 30%
2. To eliminate five (5) ER stretchers and close the "fast track" area.

This means that:

1. Patients will have a longer wait in the ER due to less nurses, less stretchers
2. Patients who should be monitored in the waiting room won't. Right now the policy is to ensure that all patients are seen in 30 minutes and then every 30 minutes
3. Patients on "hold" who need to be admitted to the hospital will be backed up even more than they are now. On May 14, sixteen patients were on "hold" in the ER waiting for admission to the hospital. (The new policy will be that they can only be on "hold" for 12 hours). If all the beds are full - where will patients go? - given that there are bed closures in other parts of the hospital
4. If someone is seriously ill, someone who is less seriously ill may have their care compromised because there aren't enough nurses to care for them
5. Psychiatric patients who are usually held in a safe room in the ER will now be forced into "4 point" restraints and be put it an area with other patients, such as someone who has an acute heart problem
6. There will be one less RN on nights - who knows what could happen in a crisis situation?
7. If Richmond Hospital ER is full - where will ER patients actually go?

May 21, 2002

Resolution

Respectfully presented to Richmond City Council
by Marnie Hewlett, Registered Nurse

Whereas, Richmond citizens have the right to affordable, accessible public health care services in their community

Whereas, the Vancouver Coastal Health Authority health system redesign plan announced April 23 calls for a reduction in acute, long-term and community care services in the City of Richmond

Whereas, the redesign changes in Richmond include changes in the type of care and services at Minoru Residence and Lions Manor, the closure of surgical and sub-acute beds and a reduction in emergency room services at Richmond Hospital, as well as reductions in continuing and home nursing care

Whereas, these changes will have a detrimental effect on the citizens of Richmond

Whereas, the City of Richmond has a responsibility to ensure that its citizens' health needs are being met

Therefore be it resolved, that the City of Richmond call on the Vancouver Coastal Health Authority and provincial government to rescind its decision to cut services

Be it further resolved, that the City of Richmond strike a health committee of Council that would be responsible for surveying the citizens of Richmond as to their health needs

And be it finally resolved, that the City of Richmond through the auspices of a health committee conduct an impact study on the effects of the proposed changes

BR/mp opeiu-15

Privatization
putting profits before patients

British Columbia Nurses' Union
www.bcnu.org

The Campbell government is cutting services to patients in our public health care system. It wants to charge user fees. And it wants to transfer services to the private sector, where the main goal isn't the quality of care for patients, but the size of profits for investors

Inevitably, privatization brings less service at greater cost. It's a step toward a system where the wealthy can buy the care they need, while the rest of the people have to cut back or do without.

Contracting surgeries to private clinics

Proponents claim this would cut waiting times for non-emergency procedures such as cataract, knee, hip and joint surgeries. But the move would create as many problems as it solved.

- Fees paid by the government to these clinics would cover not only the cost of building the facility and providing the surgery, but the cost of providing profits to investors in the facility as well
- Public facilities would still face the burden of caring for private clinic patients suffering complications or needing more complex recovery
- Private clinics would make the nursing shortage even worse, drawing some nurses away from public hospitals when there aren't enough nurses to staff existing operating rooms now
- With doctors drawn to private clinics, they would have less time to care for patients in public facilities

NB. Experience from Alberta, Manitoba, the UK and New Zealand shows that when doctors practice in both public and private facilities, waiting lists in public facilities go up, not down. In Ontario, the government contracted out cancer radiation therapy to a private company. The Auditor-General of Ontario said there were no savings at all, and the procedures should have been delivered publicly.

Building private hospitals

The government wants the new MSA hospital in Abbotsford and other new facilities to be built and run by a private developer under a private finance scheme. This concept has been a disaster in the UK and Australia.

- Because the cost of borrowing money is much greater for a private developer than for a government, these schemes are much more expensive
- Money for doctors and nurses is allocated to shareholders to ensure they get a guaranteed return on investment
- The result is fewer beds and less staff for more money. The government can boast it got a new hospital without increasing its own debt
- The developer makes money by operating all non-clinical services ie housekeeping, dietary, laundry, pharmacy and maintenance. Even nurse educators could be contracted out to a private agency

(Over)

Contracting out hospital support services

The government wants to privatize support services such as housekeeping, laundry, pharmacy, dietary, and maintenance

- Several BC hospitals have tried it. They found the quality of service poor and the savings minimal. The result: they brought back the services into the public sector.
- Private operators aren't familiar with sanitary standards and procedures that are essential in health care. Hospitals aren't hotels. Patients aren't tourists.
- Private contractors would resist unionization and cut wages. Money spent by health support workers in their communities would be diverted into shareholders' profits

Contracting out home care

In Ontario home care nursing was contracted out to private agencies submitting the lowest bids. The result: long-standing high quality, unionized agencies such as the Victorian Order of Nurses couldn't compete and almost disappeared from the field. Quality of care deteriorated.

- The focus of home care changed to providing only specific treatments as ordered, eliminating time spent by nurses on holistic care such as education and emotional support for clients and their families
- To win contracts home care agencies cut costs by cutting wages
- With wages far less than those paid to hospital nurses, home care agencies couldn't keep and attract nurses. Service to clients suffered.

Privatizing long term care

Despite promising that new long term care beds would be created through non-profit organizations, the Campbell government now wants more long term care beds created by private, for-profit businesses. In several places, publicly-funded beds are being converted to private beds, with residents forced to pay higher fees.

- Fees skyrocket when beds are converted from public to private pay
- For-profit long term care reduces access for people on low or middle incomes
- For-profit long term care diverts public money away from care into profits
- For-profit long term care uses fewer qualified staff to cut costs and increase profits

Privatization will not work for the majority of British Columbians

Here's what Gordon Campbell said about privatization of health care before the election: *"I don't think there is any appetite in British Columbia to do any kind of privatizing of health care. And, indeed I don't believe we need to do that...We have a long way to go in British Columbia before we maximize or optimize the benefits to the public health care system and we are committed to helping the public health care system work."*

Gordon Campbell on the Bill Good Show, CKNW-Radio March 3, 2000

The bottom line: Health care is a service, not a business

Keep Medicare public. Protect patients, not profits

Stop the privatization of health care. Stop the cuts to health care services.

www.bcnu.org
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