

UNDERSTAFFED

AND

UNDER PRESSURE

A reality check by

Ontario health care workers

October, 2005

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Table of Contents

INTRODUCTION.....	1
THANK YOU	5
GLOSSARY.....	6
EMERGENCY SERVICES	7
HEALTHCARE.....	17
HOSPITALS.....	27
LONG TERM CARE FACILITIES	39
MENTAL HEALTH.....	51
PUBLIC HEALTH.....	60
CONCLUSION.....	70

INTRODUCTION

UNDERSTAFFED AND UNDER PRESSURE **A reality check by Ontario health care workers**

*Home Care worker: Jeeze, I thought hospital workers
were in good shape. I had no idea you guys
were dealing with all this.*

...

*Nursing Home: Yeah and I thought we had it bad,
but Sister, hearing you talk about home care makes
my hair stand on end.*

Part of a conversation from an OFL meeting
May, 2005

In May and June, 2005, the Ontario Federation of Labour, working in conjunction with affiliated health care unions, sponsored meetings in 17 Ontario cities to examine the consequences of understaffing.

On a daily basis, those charged with providing these most vital human services were telling each other, their unions, management, and the government that patients and clients were either not receiving the care they needed, or were being placed in harm's way.

This message was the same at every regional meeting: In Hamilton, Orillia, Ottawa, St. Catharines, Kingston, Kitchener, Brockville, Thunder Bay, Sudbury, Toronto (3), Timmins, Windsor, London, Owen Sound, and Peterborough, workers were beyond a limit of being able to cope.

"The stress of trying to keep up, but of not being able to, has been unbelievable,"

said one hospital worker. "But you see when we can't keep up or do our jobs properly, people can die or get really, really ill. I feel sick every day, and every day when I get home I have a good cry for all my patients who didn't get what they deserved, and for me too. I can't take it anymore."

This report is a collection of many of the stories heard around the province. These are the accounts of what health care workers said in meetings to each other and to the Ontario Federation of Labour.

It is also a record of first-ever meetings of health care workers from all sectors and unions. Workers from nursing homes and homes for the aged, retirement homes, hospitals, emergency services, laboratories, home care, public health units, and mental health facilities shared their stories and learned from each other.

In so doing, they came to mutual conclusions that all sectors and workplaces have been hard hit by understaffing; the problems associated with understaffing, and its consequences, are systemic and serious; if the McGuinty government continues to hide behind the Mike Harris health cuts, and does not immediately and significantly increase staffing numbers in all sectors, more Ontarians will die and thousands of others will never be able to achieve full recovery.

As a worker attending the Ottawa meeting noted, "McGuinty keeps making these announcements, less waiting time, quicker access to services, stuff like that, that make the government look good for the public. But it's not true. We're the same people that have to deliver these services 24/7 and thousands of us have been cut, with more to come. Sure, you might get triaged in 15 minutes but you'll have to wait forever for help. It is just a horrible thing to do to the public and to us."

Indeed, it is.

We know that despite the serious blows to health care in the past decade, Ontario still has the ability and capacity to be one of the world's leaders. Health care workers want to see our public system restored and strengthened. So do patients.

What makes this a hopeful exercise, rather than one of despair, is the fact that it can be achieved. There is actually ample funding available – now. According to health care economist Armine Yalnizyan, more than \$1 billion has been dedicated to health care and is available for rebuilding.

Pharmaceutical drugs and medical equipment are two major pressures that are driving budgets through the roof. For hospitals, costs soared from 18% to a whopping 24% in just six years. These cost pressures come from the two parts of health care that are totally dominated by for-profit corporations, and they must be brought under control.

“Choose Change” was the slogan and promise upon which the Provincial Liberals were elected. The public did choose change. They were earnest in their belief that real change would happen. Regrettably, the government has opted for the continuation of the Mike Harris agenda. The terrible Tory legacies of privatization, contracting out of services, casualization of the workforce, service, and tax cuts have been retained as the underpinnings of the new system.

We don't want Mike Harris. We want the Liberals to make a different choice, and workers across Ontario want to get on with the job of rebuilding. That is one of the reasons why so many exhausted health care workers came out to area meetings. Their accounts were shared with us to pressure the McGuinty government to come to grips with what is really taking place.

This publication and the stories contained within it represent a test of whether the government really wants to know what is happening. Long-promised whistleblower protection has never materialized; instead, Health Minister Smitherman points workers to a government 1-800 line! This does nothing to help the Port Perry nurse who spoke out

about how layoffs at her nursing home were going to harm the seniors. She was suspended. All health care workers face firing or severe discipline if they go public.

That is why we have not put names with these stories, and it is also why you will read many comments that implore us to “let the government know,” or “tell the government.”

We will do everything possible to publicize this information. We offer our profound thanks to all of you who gave your precious time and effort to bring about positive change. We thank you all for continuing to care passionately about patients, those who depend on you, and the public health care system.

Your skill, dedication, and professionalism in the face of these cuts speak to how extraordinary you are.

In Solidarity and with great respect,

Wayne Samuelson, President
Irene Harris, Executive Vice-President
Ethel Birkett-LaValley, Secretary-Treasurer

THANK YOU

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GLOSSARY

CCAC	Community Care Access Centre
CT	Cytology
ER	Emergency Department
IV	Intravenous
MRSA	Methicillin-resistant Staphylococcus Aureus
MS	Multiple Sclerosis
OR	Operating room
OT	Occupational therapy
P3	Public-Private Partnership hospitals
PSW	Personal support worker
RN	Registered Nurse
RPN	Registered Practical Nurse
TB	Tuberculosis
VRE	Vancomycin-resistant Enterococci

EMERGENCY SERVICES

Today, through leadership, standard setting and performance monitoring, (the government) continues to play a key role in sustaining the existence of a high-quality land and air emergency medical service system that is seamless, comprehensive, accessible, accountable, integrated, and responsive.

**Ministry of Health and Long Term Care
“Program Resource Manual for Physicians” 2005**

...

We need changes in this sector, big ones, and as part of that, we desperately need more staffing. We're burning out.

Ontario Paramedic

...

Harris created this nightmare but McGuinty isn't helping either. He hasn't changed anything to make it any better – just a lot of words, blah, blah, blah, and public relations.

Ontario Paramedic

Emergency medical services provided by Ontario paramedics are a vital part of our health care system. The public knows that, but provincial and municipal politicians lag far behind in their recognition of these important life-saving services.

In 1997, when the Tories downloaded land ambulance services to specified municipalities, they agreed to fund 50% of costs. Even then, provincial funding wasn't enough. Ambulance services were struggling to maintain standards in the face of growing demand. Now, with more than 1.4 million requests per year rolling in, the “high quality” the government refers to speaks volumes about the professionalism and dedication paramedics and dispatchers who compensate daily for the serious lack of resources.

Liberal promises and lofty pronouncements have flowed but the necessary funding hasn't.

Municipalities are also falling down on the job. Even though paramedics are as highly trained as police and firefighters, they are nevertheless poor cousins when it comes to money.

For example, in London, in 2004, police were allocated \$396.95 per household, fire services were \$247, and ambulance ranked in at only \$47.45.

In Toronto, the largest municipal Emergency Medical Service in Canada, police account for \$462.09; fire at \$202.02; and EMS are way down the priority list at \$42.61.

“We are so understaffed you wouldn’t believe it. People in Toronto would freak out if they only knew the numbers of calls we get from the dispatcher telling us that we are the only ambulance available for the entire city. You can imagine what that does to our stress levels.”

All parts of the system are stretched and that includes dispatch. For example, for the years 2001-03, dispatchers in one centre handled 6,400 calls (the standard is 4,200). For workers, it was stressful and impossible to keep up, so difficult they had to urinate out the side door because there was not enough staff and therefore no down time.

The stress of working in dispatch, coupled with low wages, is a key reason why retaining trained and skilled people is so difficult.

It’s also hard to hold on to paramedics. “People don’t retire from this profession. They either die, go off on sick leave, or move on to the fire or police departments,” one paramedic noted. Indeed, the career span is only five to eight years, and then, one way or another, they move on.

“Many of our problems are based on a lack of resources. It’s driving paramedics to the breaking point and leading to overall poor health care for the public. It’s gotten

worse over the past few years because the population is growing and aging. The expectations are there but the funding just isn't keeping up.”

One consequence of the lack of adequate resources is the unacceptably low staffing levels.

Here are some accounts of what is happening, and what it means for paramedics who, despite all of the obstacles, keep fighting to deliver top quality, life-saving services to the public.

If the public only knew . . .

Medics are now being pushed to look after multiple patients. You probably don't want to be one of those. You might be though because it has started happening all over the city. The paramedic is sent to hospital emergency to relieve crews who are in "Offload Delay". The patients might have been triaged but they're backed up and someone has to remain with them since many of them can deteriorate or be in a serious condition. One medic had a dementia patient who was a wanderer, and an elderly person who had nausea and decreased awareness. What you don't want to see is the patient vomiting because aspiration Pneumonia in the elderly is extremely serious. Usually two medics would be able to move the patient together to prevent the patient from inhaling their vomit. The medic called the supervisor to report that she could not look after both patients – she had to focus on the patient with nausea, but he gave her a direct order to care for both patients. Sure enough, the patient started vomiting. The damage had been done to that patient. Multiple patients per medic is a dangerous way to go, but it's happening all the time now.

We had a drowning – a little three-year-old. When it's kids, well, it's one of the toughest things. The ambulance had just one paramedic. When you arrive on the scene with just one paramedic, it always slows everything down. No way you are going to get

things done as quickly as you do with a partner. For example, I can't start CPR and an IV at the same time. If a cop hadn't been on hand, there would have been no one to even drive that ambulance. It's overwhelming when you're alone and it's certainly not good emergency health care. This isn't our standard – ours is higher. The Ambulance Act of Ontario states every ambulance must be staffed with two qualified attendants. But instead of dealing seriously with the problems that are causing the too-low staffing, they get around the law by calling an ambulance something different. No matter what you call it, it's wrong.

One supervisor was escorted out of hospital ER. Our policy obligates him to come to the site when his vehicles are held up to see for himself why they are not being released. They actually booted him out of Emergency because they didn't want him to see what he saw: that there were actually beds available – they just had no one to staff them! I've also been there when there were nine beds but no staff. That's nuts! We can't leave our patients so a whole ambulance is down and the whole system gets strained. There was a whole trauma unit closed because there was no staff.

There is a big distance between stations in rural areas and sometimes only one ambulance for coverage. So if things get busy, other ambulances have to come from 45-minutes away, or even longer. When I have to do that, it means someone else has to leave their area to cover my ass and on and on. It's a domino effect. It's one thing for dispatch to say that an ambulance is en route, but if the ambulance is coming from way out of the area, it's not going to do much good, is it? We need a lot more staffed units. Patients in these situations deserve the best care but we can't give it to them right now.

One of our northern centres is staffed for only eight hours/day and on call for the remaining 16 hours. On the weekends, it's all on-call work. They won't look at paying people properly and it's a fair distance to drive for one shift, so understandably no one

wants to work. The problem is that it is on a busy highway and the next nearest ambulance is at least an hour away. It's only a matter of time before a major accident happens. They can fix this easily, but they won't.

Infection control and lessons not learned from SARS

Infection control in the Toronto service is almost non-existent. Even after everything we learned with SARS, management does the bare minimum – only what they absolutely have to do. They never take any initiative to insure the protection of the paramedics, our patients or our families. We received a directive, after SARS, telling us that we should reuse blankets if the previous patient wasn't coughing or sneezing. Do you believe it? What about MRSA? VRE? C difficile?¹ You would think they would have learned a lesson, but they didn't.

After a patient vomited, the supervisor told us just to throw a sheet over it and get on to the next call because there weren't enough ambulances and staff on the road to respond.

If we have a patient in the back of our vehicle and they have a fever and cough we are supposed to treat them like an isolation case. That means wearing gowns, masks, safety eyewear and gloves. Yet if one of our co-workers is sick, they are forced back to work through constant harassment. The sick time attendance programs are nothing more than an attempt to compensate for serious understaffing. Sick days are essential to the provision of good health care. They are there for the public's protection and for our protection because we are constantly exposed to infection, disease and the physical demands of caring for the sick, ill and injured. We think this is humiliating and demeaning. We are professionals - grown men and women who take our jobs seriously and give more than 100% every day. But every day they continue their harassment.

¹ MRSA (methicillin-resistant *Staphylococcus*), VRE (vancomycin-resistant enterococci)

We are all overworked. There's no time for lunches. No time to have a rest. We're pushed hard all day. The shortage of staff means that after transporting, for example, MRSA patients and other isolation cases, they want us back out again so there's no time to even thoroughly clean the ambulance. Trucks must be cleaned at base but often, we have to respond to the next call. If you have to take a truck out of service for two hours, you have to take the whole crew out of service. Our increases in staff never keep up with the increases in volume so there just isn't time. Low staffing is a problem for infection control, for the next person we transport and it also poses a threat to our health.

The stress and pressure really get to you. We're transporting someone to hospital and the dispatcher is calling to ask if you can unload quickly and take the next call, and you have to say "no" because the hospitals are backed up from understaffing and you've got to wait with your patient. And then they ask again, and you say "no." And again, and again. It doesn't stop. And the minute you can leave hospital, you're off again knowing you have go through the same thing with the next person.

**It's Not Tea For Two:
Nourishment and Rest are Critical**

Lunch seems like a small thing but it's a huge deal for all paramedics in the province. Most of the time, we don't get a lunch break until we've been at work for six hours on a 12-hour shift. Some of the time we don't get a lunch break at all, or any break, because we're so short staffed. You're speeding through crowded city streets and through red lights, and you need to be as alert as possible. And you've got to be working at the top of your abilities when you're giving medication. Bad mistakes can be made. For example, epinephrine and morphine look the same but they do completely opposite things. For all that, you need energy and concentration, not low blood-sugar.

Our chute time is 60 seconds from the moment we pick up the call to the vehicle being mobile. You're hustling all day. And when you get to a call, you might have to lug 95 pounds up three floors to get to a person with heart attack. We need nourishment and breaks, but they are few and far between.

They're implementing dangerous policies all the time in order to overcome the shortage of vehicles and resources. For example, when hospital emergency gets backed up, they strip one medic from each team and send them back on the road to respond to other calls. But you can't operate a stretcher as one person, so now you are compromising someone else's care.

Non-union, private transfer services

Don't be fooled. They're not the real thing . . .

These services began big time as a result of the Harris downloading. We used to service all the transfers and then got to the point of too many emergency calls and transfers, and not enough trucks and paramedics.

The private services are unregulated under any provincial health care legislation. They don't even need a taxi license, and no rules or qualifications exist about who can attend to a patient. There are at least three different services up here right now. I've heard that one of them – just one – has billed out \$5 million. That equates to 6-8 real vehicles on the road with real paramedics. If you totaled them all up, there would be even more real emergency service vehicles. When these guys get into real trouble, if their patient went sour, (not that they would necessarily recognize that, but if they did), they would have to call 911 and guess who would have to respond and get their patient? Us. That's what they are required to do. But some of them are real cowboys and will just flip their lights and sirens on, which is totally illegal.

If an area near me has a high call volume and the shit hits the fan, I get sucked in and away from my area. When I got to emergency, there were six real ambulances and eight of these private guys. Had they been real ambulances, I wouldn't have had to leave my area without coverage. We would have had enough.

. . . . But they're taking incubator babies, heart catheter patients and people in really serious condition.

Those private transfer services purposefully mislead the public. It's illegal to impersonate a police officer but not a paramedic. These people get access everywhere, even in some airports, because they look like us.

They've got lights and sirens, just like a real ambulance but they not allowed to use them since they aren't an emergency vehicle. Even hospital nurses get confused, because their uniforms are like ours. But the minute something serious happens, they have to pull over to the side of the road and call us to come and get them. They're not the real thing but they are taking incubator babies, heart catheter patients, people as serious as that and if something happens, it can mean serious trouble for those patients, or death. The other problem with them is that they often transport multiple patients. This is just bad health care. I've seen them take one of the patients into emergency and leave the other alone in the vehicle. Paramedics must be in physical contact with the stretcher at all times. For good reason, you are not permitted to leave patients alone in an ambulance.

Management Response – Attendance harassment letter

May 5, 2005

We have been reviewing attendance records and note that during the 12-month period ending December 31, 2004 you were absent on 5 separate occasions for a total of 19 days. This attendance record does not meet the attendance goal established by the organization which is:

- no more than 5 separate occurrences of absence for all staff (irrespective of the total number of days absent) within a 12-month period; and/or,
- a maximum of 10 days absence for paramedic staff or 7 days absence for all other staff in any 12-month period.

Every employee makes an important contribution to the organization. There is concern that the quality and continuity of the services we provide to the residents of the County may suffer through staff absences. Absenteeism also creates a burden for other employees who have to “take up the slack”. Failure to meet the attendance goal over a prolonged period of time, as set out in the program, could result in loss of employment.

Therefore, we need you to meet with _____ on 5/20/2005 at base 1 at 1830 hours and attempt to identify ways to improve your attendance record. The employer is committed, where possible, to provide assistance and support to you. If there are any extenuating circumstances that may be contributing to your absences, they should be discussed.

Yours truly,

Bill Stephenson
Director of Human Resources

c.c: Employee File (2)

Management Response – Blanket use

December 23, 2004

**“ADVISORY”
#2004-30 (Operations)
SOP 3-1**

FROM: John Lock
Deputy EMS Chief/Director, EMS Operations

SUBJECT: **BLANKET USE**

The recent cold weather has increased the use of blankets to protect our patients. In addition, we are entering the holiday season, where the frequency of linen laundering may be temporarily reduced.

It has been identified that some crews are using two or more blankets on particular patients, and then discarding the blankets for laundering. Unfortunately, the number of blankets in the system was not calculated based on this practice. Further, in most cases blankets do not need to be discarded after single use. As long as patient is adequately covered/wrapped in a sheet before a blanket is applied, and there is no involvement of blood or body fluids in the management of the patient, then the blanket is considered acceptable for re-use.

In most cases, proper use of a sheet in the handling of a patient will prevent the blanket from becoming contaminated, while still providing protection and comfort for the patient. Blankets can therefore be re-used unless they are visibly soiled.

We have ordered an additional shipment of blankets which will arrive this week. This will assist in maintaining sufficient stock in the system over the next several weeks. Through normal use, there should be no shortages. In this regard, we would also ask your co-operation in the judicious use of blankets, in order to ensure their availability for all patients.

John Lock

c: B.K. Farr, Deputy EMS Chiefs, Operations Managers, Operations Supervisors,
DOSSs, D. Viljakainen, M. Zold, PSU

HEMECARE

"Home care offers greater dignity and quality of life for people of all ages including seniors and vulnerable people. But too often this is not an option. We're strengthening these services so that people will receive the dedicated, compassionate care they deserve, in the familiarity of their own homes."

Health Minister George Smitherman, July 2004

...

No more personal touches, no basic human interaction is allowed any more. They don't realize this is a person, not a machine. It's incredibly stressful. I tell you, whatever Harris started McGuinty is finishing. We are really disappointed in this government.

...

Everything is money. We've become so cold to people. How did this happen?

...

Letting the private sector into Home Care has been a monumental disaster. It should be an example to other provinces and countries about what not to do.

...

Oh, yeah, that Caplan report. I forgot about it because it's so useless. It's not going to do one thing to fix my work life.

Mike Harris created nothing less than a disaster in Home Care, sabotaging its original intent, and creating a climate of fear, chaos and neglect. His promise of quality home care was used as the lynchpin in the plan to close hospitals, beds, and emergency departments, and get rid of health care workers.

Quality home care never materialized. But one of the finest hospital systems in the world was ravaged.

At the very heart of the Tory plan to weaken the public sector's delivery of Home Care was the introduction of "Compulsory Competitive Bidding". Big for-profit corporations went head-to-head with the not-for-profits tendering for service contracts.

And, because they had the money, manpower and time to sink into complicated and lengthy proposals, the for-profits won.

Organizations such as the Victorian Order of Nurses and the Red Cross vanished from many communities while the private companies' market share soared from 18% to over 50%. Small community-based non-profits were replaced by a handful of large for-profit organizations. In 1995, there were 24 small community-based providers in Ontario; today there are only three.

The inevitable result of inviting for-profit providers into home care has been a destabilization of the entire sector. Services have either disappeared or are rationed. When Ontarians do manage to qualify, there is no more continuity of caregivers, and no time to deliver services. Turbulence and instability are the norm. Even the culture of home care has changed.

This transformation stands as eloquent testimony to the fact that the private sector cannot do it better; but also it can't do it cheaper, more efficiently, or humanely.

At a minimum, more than 500,000 Ontarians need home care services. The need continues to grow, while at the same time, the quality and availability of services are decreasing.

For workers, the forced bidding competition for home care contracts has produced massive job insecurity and dislocation, scandalously low pay with few or no benefits, bad working conditions, stress, and injury. It is not a sector that workers can depend on. No career or job planning is possible. No long-term financial arrangements can be made. The bidding process, with its winners and losers, is driving workers away.

The closure of VHA Health and Home Support Services that employed 400 people, provided 58% of services in the Hamilton area and served 2,500 clients is an example of the chaos inherent in the competitive bidding process.

Of the 317 support workers who were laid off from this non-profit, unionized agency, only 38% remained employed in the home care sector.

As one support worker noted, “I feel like a slave with people bidding for me every few years at the cheapest rate.”

When home care workers attempt to unionize to improve their working conditions, for-profit agencies, such as Comcare in Kingston and We Care in Sarnia, close up shop.

The revolving door for workers produces daily crises for clients. For those relying on home care, continuity of caregivers has always been one of the most important elements. Many of the functions performed in the home are intimate. It can take a long time for a client to develop trust. And each client has individual needs that workers must take into account when providing services. That is why home care recipients speak of how onerous and demoralizing it is to continually train new workers.

It has been equally discouraging for those waiting for public home care services. Much of the time they can't get access to them. As one worker noted, “Oh, no. We don't have problems with waiting lists anymore, because we either cut the services or raised the bar so high they can't qualify.”

The 2004 Annual Report of Ontario's Provincial Auditor notes that a one-year freeze in funding between 2001/02 and 2002/03 led to an overall decrease in nursing visits of 22%, and a decrease in homemaking hours by 30%.

People suffered badly. They still do.

In October 2004, in order to remedy the problems, the government announced that former Health Minister Elinor Caplan had been appointed to conduct an independent review of the competitive bidding process used by Community Care Access Centres.

"There are significant concerns that the scale of contract changeovers is causing instability in the home care labour force and in the homes of patients."

However, when the report was released in May, the two most important elements of change – the end of competitive bidding and return of home care to the public, not-for-profit sector – were absent.

Instead, Caplan identified the biggest challenge as the "clear need for consistent, accessible information that can provide a basis to measure client outcomes, disseminate research and best practices and report on overall home care performance."

And, out of 70 recommendations, "the most important one, from which all else flows, is the need to establish the Centre for Quality and Research in Home Care. Accurate information is the foundation on which to build a home care sector that is focused on continuous improvement, innovation, and best practices, all of which must be aimed at the ultimate goals: client and family satisfaction."

The substitution of bureaucracy and reporting mechanisms for the fundamental changes needed and promised is fast becoming McGuinty's hallmark.

In keeping with its long history of rushing to gain favour with the government of the day, the organization representing Ontario's 42 CCACs, not only welcomed the report, but went so far as to thank Caplan for her team's collaborative approach to the review.

"We've gone through nine years of bullshit, and nothing is going to change, except they'll be more of it with all this reporting and new bureaucracy," noted one home care worker.

For the OFL and affiliated unions with members in this sector, the mission is simple: Getting rid of competitive bidding is the key challenge and is the central campaign for the next year.

As one union noted, “Tinkering with the fundamentally rotten system that currently exists will do nothing for home care workers or for their patients.”

Get in, get out, do it fast

We used to be in the home for three hours. Now it's so rushed. I only have one hour to do it all and it's not possible. In a few places it's even been cut to 45 minutes. They'd love to make it 30 minutes. I mean, we are dealing with serious acute cases just discharged from hospital, or elderly people, or people with MS. They push us to do everything quick – get in, get out, and our people are starting to see us as bullies. I'd love to give McGuinty a bath the way we have to bathe our home care clients. Maybe then he'd understand what he is doing to people.

They have a person in hospital to divvy out the home care, but people almost have to crawl to get it. They have to crawl to get 1/2 hour for a bath. It's disgusting. You go in and you are given a 1/2 hour for a bath. By the time you get them in, your 1/2 hour is shot and guess what, they expect you to leave and get on with the next person. Well, I won't walk out and leave someone. There's not a chance in hell I'll just leave them like that. No way. These people are too fragile.

Home care is getting worse and worse. So, when you ask me if it's getting better, it makes me mad. The answer is “No.” They don't care who they send out of hospital before they are ready – people with hip replacements and others who have just gone through major surgeries, and is there any adequate home care for them? No. Sometimes there is no homecare at all, never mind adequate. And this is what makes me mad and

also bothers me: these elderly people have been helping people all their lives and paying their taxes and contributing just as human beings, and when it comes their time to get a little help in life, well it's "No, you can't have it. No. No. No."

At our agency, so many people who need care can't get it. We need more home care workers, but you won't get them until we're paid fair wages. Clients are getting cheated of hours. Our CCAC has a board. That board should be required to have a PSW, an OT, nurse, doctor, people who know what it is to work in the field – not just bureaucrats. Have they actually ever done the work? No way. These people who sit behind a desk have no idea of what home care is. I want them to walk in my shoes and see what I see. Make this government look into my patients' eyes. Things would change fast. Oh, and one more thing. You know what the kicker is? They tell us we are not supposed to care or get close to our patients! Do you believe it? Who are these people running things? How did they get here?

I don't care what they say. Of course services have been cut. Our agency has 58% less staff than we used to, but we are still providing more than 40% of the services in our area. People that would have gotten care for 3 – 4 weeks are cut to one week, or 10 days max. That's a big cut. But what really blew us all away was the CCAC coming at us with a planned discharge date! They were actually deciding by what date people should get better. They were forced to stop last month, but you can see, can't you, where their instincts lie.

When you look at the lack of staff, you just know there are many people not getting service. The average nurse sees 9 – 11 people a day. We are using 30 less nurses than we used to. So where are these people going? And we're just one agency in one city in Ontario. You do the math. You can see how many thousands of people aren't getting the help they need. In fact, our numbers should be climbing, but they are gradually decreasing.

The seniors, they were lied to big time. At a time in their life when they are very ill, seniors deserve this care. Most of them still think Home Care is about letting them stay in their homes, because that was what it was supposed to be about. It's big lie. It's not about that.

People aren't getting the kind of care and support they need in our area. We are very rigid. And our policies are very restrictive with regards to what services people are eligible to receive. We used to have 2 hours, which wasn't enough time even then for a client. Now that's been cut to only one hour.

There is no comprehension. For example, someone might be able to get their hair washed and have a bath once a week. That's bad enough, only once a week. But then, if they don't have clean clothes and sheets to get into, what's the point. They deserve to be clean. And, more than that, they might have this minimal bathing support from us, but they need so much more than that. Patients with complex care needs are just being released from hospitals. Who is setting up this regime? These people are deteriorating. They can't do without a bath!! Once a week is not enough!! Sometimes they only get a sponge bath in a week. They are not clean and that puts them at risk of infection. They also feel demeaned. Who wouldn't?

Behind closed doors

Pain control for people in their homes is often bad. In hospital, there's a team and open scrutiny. In the home, it's behind closed doors. A lot of people don't get the pain control they need. They can wait and wait and wait. It is agony for us, too, when we have to watch our clients in pain and can't do anything to help them. In the hospital, they can get that help quickly. But what happens in the home can always be hidden away.

I'm frustrated and it's depressing. For a limited amount of money people could stay comfortably and safely in their homes. I had a lady die on me. I had asked for extra services. They went and did assessment and decided she didn't need any. A week later, the worker found her dead. Meanwhile, I'm told you shouldn't advocate so much for your clients. But what am I here for? I can't just stand by and watch.

I'm frustrated. I love my clients but there is a limit to what I can do. I'll often phone the CCAC office on their behalf, but nothing ever gets done. For example, they refused to give any extra support at all to an 80-year old woman just discharged from hospital after a hip operation. I put it to them this way, hoping they would get the picture: "Are you telling me that this woman, who had a fall and lay on the floor for 12 hours before getting any help and who has just been sent home from hospital after major surgery, and who has to take care of her son with a disability, can't get any extra help? No cooking, no cleaning, no laundry, nothing that will allow her to recover?" I put it just like that. There answer was "No." Just plain "No."

If you could only see what's happening to people in their homes. Most of my clients are dirty. Nobody knows that because they are in their homes. But I'm not allowed to give them any more time to bathe them. I keep telling the CCAC, but they don't care.

Some of these people are going to get sick and die. I've told them that too, but it doesn't change anything.

Wow. It's really unbelievable how many of these people actually survive, because, in a way, they are doing it on their own. We are there on paper, but not for real. I think you need to be tough to survive this home care system, because it doesn't really exist.

You wouldn't believe what I see every day. Hungry people, dirty people, people in pain. None of them are getting real help. Out of sight, out of mind, is probably the way this government thinks.

The many reasons we are leaving

If you try to phone in sick, they'll push you to come in anyway – even with a fever. They don't care what they expose clients to. One of the girls called in sick with 104 fever and they didn't want to count her out because they have no one to sub for her, so they told her to call in her status every hour! It's nuts.

A lot of our members have left because there is just no stability in this sector. Nurses are always being pressured to work huge amounts of overtime because there are not enough of them. Our clients are often called and asked if they can do without service! We have days where there are 60 clients requiring nursing care and no nurse to make the visits. I mean this sector is in very bad shape.

You know what? The stress is so bad, at this point it would probably be ok with everyone if we just lost our contract because it would finally put an end to all this craziness. We've had enough. We don't want to go through another 10 years of this.

People doing the assessments are employees like me. We are prevented from giving more and of course, clients get frustrated and angry. I would too. Not being able to give them services is tearing me apart. I tell people when they ask for more services, that I have to prove that they are at risk. This is so very psychologically damaging. They won't do it. They don't want to crawl and beg, especially when they are not well and can't muster the energy. They set this up so that it is as humiliating as possible. And I'm not sure I can bear to watch it anymore.

If a person wants a cup of tea or a meal, I'll do it on my own time. The agency takes advantage of us that way. They know I won't walk out and leave my clients in an unsafe situation. Most of the older girls, they will go that extra distance. The younger ones have been trained differently – just go by the clock. By the way, I have to work with two companies just to make ends meet, because the pay is so bad. Funny, eh? You're in charge of someone's life and you get paid crap.

This system is cheating people. It makes me feel ill to think I'm a part of it. I just don't know. What button do you have to push to get clients the care they need? We are becoming a very ugly society. Where's McGuinty? Why isn't he listening to this?

You can understand why this is so emotionally draining. Really, in this area we feel like we just don't matter. And the truth be told, we don't. And neither do our home care clients.

HOSPITALS

I know your hospital is dirty and understaffed because when our nursing home patients come back to us, every single one of them has bedsores or an infection of some kind. We always have to go into full gown and isolate them.

Nursing Home worker

...

Something's very wrong about what they said they were doing with hospitals. I mean, the people we are seeing at home don't belong there. They belong in hospital. If any reporter could ever see the people I do every day, they'd know we have to fix our hospitals.

Someone should tell them.

Home care worker

...

We see the inside of hospitals all the time and I'm telling you it's the place where you see what years of government policies have done. All the understaffing, the bed crisis, the dirt, the crazy policies, well, it's much different than it used to be.

Emergency Service worker

...

We were one of the first hospitals hit by SARS and we were hit hard, so you'd think they would take infection control seriously. Well, think again. They are so cheap, cheap, cheap about Housekeeping. No doubt about it, we'll also be one of the first hospitals to get hit by the next bug because it's dirty in here. Nope, they haven't learned anything.

Hospital worker

...

Our lab is a disgrace. The specimens are piled sky high. They're everywhere and in places they shouldn't be, but there is no more room in here. McGuinty can say what he wants, but when there are too few of us to do the work it just can't get done.

Hospital worker

In the past 10 years, so many hospitals have been closed and staff, services, and beds have been cut, Ontario's health system, including home care, emergency services, and long-term care facilities are groaning under the weight of added responsibilities.

The legacy of the irrational and dangerous cuts made, especially during the Mike Harris years (1995- 2002) has left Ontario with fewer acute care beds and shorter length of stays than any other province, and fewer staff per capita.

For seven dreadful and frightening years, communities, citizens, and unions were embroiled in pitched battles to retain their hospitals, services and staff who were responsible for delivering those services and ensuring the smooth operation of the infrastructure. And, like the Mental Health sector, media stories and “Letters to the Editor” sections of daily newspapers spoke of deaths and of seriously impaired prospects for recovery for hospital patients.

When Health Minister George Smitherman made his chilling comment about cutting lengths of stay, a collective shiver ran through the ranks. Shortened length of stay has always been a code for governments’ intentions to cut staffing and contract out services. And, indeed, another round of layoffs is now underway.

But how can this be?

- Less of the Ontario economy is now allocated to hospitals, with hospital funding falling from 2.8% of the province’s Gross Domestic Product in 1992-3, to 2.1% in 2002-03;
- The nurse to population ratio declined from 74.7 nurses per 10,000 persons in 1994, to 69.5 last year. In 2003, Ontario ranked second from the bottom;
- For hospital professionals, staff shortages are so bad that overtime costs more than doubled between 1999 and 2004, accounting for a 152% increase, and leading physiotherapists, and MRI and lab technologists to rank stress and workload as their top priority issues;

- For six years, spending on support services (housekeeping, laundry and linen) declined dramatically. High standards of hygiene should be non-negotiable, a no-brainer, but that is no longer true. Ontario's remaining support workers cannot possibly stem the tide of future large-scale epidemics and infections.

These facts and figures paint a picture of a hospital system that requires a dramatic *increase* in staff, not cuts. How can lengths of stay be shortened any further? On the basis of what evidence?

“It’s as if Mike Harris never left”

Emergency rooms are often called “the heart” of the hospital. Funding and policy decisions manifest themselves minute-by-minute. This government’s hospital emergency rooms stand as testimony to the failure of its health policies and the consequences of refusing to take real, and not rhetorical, action.

- Ambulance workers spend hours in emergency because there are not enough staff or beds. While they wait, they cannot respond to other calls;
- Emergency workers talk about “hospital waiting room rage,” that places them directly in the line of fire for verbal abuse, often escalating to physical attacks;
- Nurses describe the enormous stress and risks they take daily with their licenses because there are not enough of them to ensure that everyone is seen within 15 minutes.

These are but a few examples of what takes place every day in Ontario.

As we finalize this report, a patient at the Peterborough Regional Health Centre who spent the night in the emergency room hallway has just died. Officials report there were 18 patients on gurneys in the emergency room's halls waiting for a regular bed.

Chief of Staff Dr. Peter McLaughlin told The Peterborough Examiner "The people in the ER simply have to double and triple their efforts . . ."

No. They should not.

No worker should be called on to substitute for government policy that places us all, workers and patients, in harm's way.

Looming dangers from bad health policy

The McGuinty government's policy and legislative changes are making matters worse, not better.

For example, Bill 8, renamed by one union as "The Commitment to Hospital Privatization Act," pressures hospitals to balance their budgets through accountability agreements negotiated with the province. Over the last ten years, hospital boards have become decidedly corporate in their focus. Because patient care is no longer the priority it once was, employers will step up their assault on staffing levels and patient services in favour of false economies.

The most dramatic example of this loss of patient focus is hospitals' and governmental responses to the SARS epidemic.

Before SARS, we were already plagued with much too-low staffing levels and dirty hospitals. Staffing and cleanliness are the cornerstones of infection control. Our post-SARS reality is worse, with even less staff and dirtier hospitals. Deaths from hospital-acquired infections, such as MRSA, C. Difficile and VRE² underscore the need for a dramatic increase in housekeeping employees, but this is not even on the radar. Warnings of the potential for even higher rates of hospital infections and a possible

² Key hospital-acquired infections: methicillin-resistant *Staphylococcus aureus*; C-Difficile; vancomycin-resistant enterococci.

influenza pandemic have not led to increases in staff who provide patient care, services or infrastructure support.

This disconnection between public policy and public need has never been greater and poses serious dangers for the future. The most immediate one is the huge number of workers who will be retiring, starting next year. By 2008, it is predicted that we will face a nursing shortage of more than 30,000 RNs. Pension plans are already grappling with thousands of workers in all classifications who are leaving. Yet, despite this looming “people” crisis and the need to attract hospital workers, Premier McGuinty continues to create a culture and climate in the workplace that has never been worse.

The disrespect, grueling work days, daily harassment by management, soaring injury and infection rates, inappropriately low wages, and lack of satisfaction at the end of the day of a job well done, are fuelling an unprecedented exodus.

Workers aren’t just telling each other how bad the hospital environment is, but are also counseling family members, friends, and neighbours to stay away from hospital work. Sixteen people told us they were asked for advice about career paths and tried to dissuade the young adults from following in their footsteps.

“My neighbour told me her daughter wanted to talk to me about becoming a hospital registered practical nurse. I told her that hospitals were bad places to work and will get worse. I explained in detail about my workday. Thank god, she has decided to study as a paralegal instead. I wouldn’t have wanted that on my conscience.”

The explosion of privatization initiatives, and in particular, P3 (Public-Private Partnership) hospitals, also has the capacity to change health care forever. P3’s are for-profit initiatives that allow corporations to finance, design, own or operate the building, and then lease the hospital back to the board, community or government, for a profit. They raid public dollars by driving up costs, cutting staff and delivering second-rate

services. During the election, McGuinty promised to end the “failed policies of creeping privatization.”

But the government has plowed ahead in Brampton and has added Sault Ste. Marie, North Bay, Belleville, Mississauga, and Ottawa (Montfort), St. Catherines, Halton and the Centre for Addiction and Mental Health to its immediate P3 list.

If the Liberals are successful in implementing plans to privatize more than two dozen hospitals, there will be no going back. This will become their legacy, changing forever the entitlement and prospects of future generations of Ontarians.

There was so much to be undone after the Mike Harris years and so many promises about restoring quality to our health care system. Not only do workers report a far worse working environment but, most frightening of all, Premier McGuinty and Health Minister Smitherman do not seem inclined to want to make our hospitals the centres of health and healing that they should be.

Here are some accounts of what is really taking place.

Infection Control Post-SARS

Infection control in our hospital? What a joke. We went to a board meeting and they brought up the Avian flu pandemic. The chair of the board of our hospital asked if we are prepared for another outbreak, and in particular pointed to the Avian flu. Everyone just looked around the table. Is he kidding? Are we prepared? The answer was “no.” How can we be? Nothing has changed.

Since SARS, everyone’s work area has actually been expanded. That means we do less cleaning because we sure can’t work any harder or faster. This morning, the nurses who work on the floor with people recovering from heart attacks were talking about how

“filthy” it was – the walls, vents, beds, high and low corners, bathrooms. They’re right. Cleaning is so much different now than it used to be. Hospital management used to actually care about every inch of space being clean for the patients, because they are vulnerable. When I see their public statements, I just shake my head, because it’s much different than what is really happening in here.

They’re coming at us all the time with attendance awareness programs and it’s actually leading to more accidents, and more illness. Now you always see sick workers coming in because they are going to face possible discipline. It’s really bad for the patients with all these possible infections running around. We’re putting them in jeopardy.

There are still not enough people in housekeeping. Doctors sometimes won’t gown, and visitors are allowed to walk up and down the halls in their gowns. And the hospital is dirty. We’re going to get hit again. We just haven’t learned anything.

If we don’t get more housekeeping staff, there is no possibility of infection control. I don’t know how many years we have been saying that a hospital is not a factory, and that it has to be sterile. I mean, this is basic logic, no? The public need to be safe but they still aren’t when they come here. I don’t get why they don’t understand that in this age of superbugs, housekeeping is critical.

I’m working at that hospital, killing myself, getting sick from the workload and they still they push my attendance. Talk about potential for injury and for infecting patients.

I'm in housekeeping and when I cleaned a room, I cleaned it as though my mother was going to be the next patient. Back then that's the way the hospital wanted it and expected it. Now, we clean it as though it's an office. Hospital managements' attitudes have changed so much. They really don't care as much as they used to. That's really scary because, oh, brother, you just won't believe how dirty things have gotten.

Despite SARS there is a still a casual attitude at our hospital about infection control.

As a person who works in an operating room, I am never surprised when anyone gets an infection. We have all of the equipment but there is not enough cleaning staff, and they can't possibly do all that is expected of them. Infection spreads. Don't they know that? If huge parts of the hospital are dirty, you can't protect patients coming out of surgeries or anywhere else for that matter. They cancel surgeries when there are not enough nurses. When there is not enough cleaning staff, life just goes on as though it's normal. I don't understand the reasoning.

In pursuit of the mysterious community

They say they're taking the diabetes and ambulatory clinic "into the community". What is this community? Where is it? Someone please tell us. We can't find it.

They are closing a lot of our programs: stroke and brain injury, motor vehicle accidents, neurology, and others. They tell us that many of them are going into the community. They want us to believe there is some miraculous group of people who we don't know and never heard of who will be doing this work. Well, who are they? I bet it's us.

Programs in our hospital have been disappearing. We are discharging patients needing occupational and physiotherapy therapy into “the community.” But, really, this community is just the private sector. It’s for those who can pay.

Huge consequences for workers and the public

We’re facing terrible staffing issues, just terrible. There’s been a dramatic increase in volumes, but not staff. Cytology used to deliver results in 24 hours. It now stands at 48. And cancer care, well, we’re supposed to be spinning out results in 24 hours and we can’t do it. There is no way! And those patients, they need those results. They are really, really sick. CT people never go home or if they do, they just have to turn around and come right back. They have no family life, no real rest. The government is just driving us into the ground and so is management. People are not going to stick around. What’s going to happen to the patients then?

These days, they are throwing new RN grads right into the emergency department. We are so understaffed, you can’t leave emergency for a break if you are working with someone who isn’t skilled, and often you can’t go for a break at all because it’s all-hands-on-deck. There is no way the 15-minute triage standard can be consistently met. Because there are only two people working in emergency, you just pull the charts off the board and run. That’s not good care. It’s just one person after another, and still, you can’t keep up. I can’t begin to tell you how bad the morale is.

It never feels good not to be able to do what you need to do for a patient. As therapists, we give people the ability to function, to achieve their best potential for daily living. From a professional point of view, we are always looking at best practice and we know that is not the way it used to be and not the way it should be. As an occupational therapist, I can tell you, not being able to do what you know you should really gets to you. It’s demoralizing. We have staff leaving because they just don’t want to be around

that amount of pressure and still feel bad at the end of the day about the quality of care they have delivered.

On the night shift, you are the one RN in the emergency department, but if there are no patients there, you are expected to work on the medical surgical floor as the in-charge person. You are also the admitting clerk, the switchboard operator, and the person who runs to the pharmacy for medications. All this, when we should be attending to our patients who need us. We need more RNs and more service workers. This isn't quality care.

People used to be appalled at sick people on stretchers in the hallways of Emergency. And the media used to run stories about it because it is really bad health care. But now it's like the government just accepts it as a normal way that the health care system should operate. At our hospital, instead of doing something, they actually put up permanent numbers over the beds in the hallways. That's sick. Have our expectations dropped so low that we don't even think of this as a problem anymore?

We have a code. It was called Critical Status but that name was freaking out patients so the hospital changed the name to Level 3. It means there is no bed available and someone has to go. Imagine that. They do it all the time. The best of the worst has to get out so we can have that bed. Meanwhile a medical floor exists with empty beds waiting, but they won't staff them.

Code white is our name for get 'em out. For the longest time, we didn't know what "code white" meant. It's for physicians and nursing staff and means they have to get people out of beds because there aren't enough available. It's an emergency code and it's called a lot. That means there are a lot of sick people getting booted from our

hospital because of understaffing. It kind of says everything about understaffing and what it's doing, doesn't it?

Emergency is way overloaded. Our nurses are filing workload complaints in order to protect their licenses because they often can't meet the 15-minute triage standard set by the government. There aren't enough staff or beds. We used to have two emergency departments. Now there is only one and it is much too tight. This really upsets me because patients are at risk and we are not there because we can't be everywhere. If someone is having a stroke, or heart attack, it is vital to get to them immediately, but that's not the case any more.

No, we can't meet that 15-minute triage standard all the time. On a really busy day, there is no way. That certainly creates enormous stress for us. When people have to wait over four hours, it not uncommon to see what we call "waiting room rage". At that point, we know we are in for a lot of verbal assaults, and potentially more than that.

At our hospital, you will get triaged in 15-minutes, but then you can be here for days waiting for a bed. This has gotten worse with the Liberals.

We are losing really valuable staff. Sick kids are now on same wing as maternity moms and newborns, and that's not good for any of them. Every single one of us runs all day. They just won't hire new staff. Never mind that. We've heard there are more layoffs coming.

You should see our gross room. All tissue samples come into it. If you saw it, it would probably knock you out. Every conceivable surface is covered with specimens just

waiting for diagnosis and they are spilling out over everything. There are too many of them. We can't get to them. And we have to work in this atmosphere.

There's a big staffing shortage coming up with so many workers retiring. I have no idea how they are going to attract people to this sector. No one wants to be here anymore. It is just too stressful and dangerous too. We have full-time people working up to 150 hours in pay period. Instead of hiring more people, the hospital just runs us all into the ground. They are working people to death.

We have a CT scanner. Motor vehicle accidents, stroke patients, really serious cases depend on us, but they won't train us. I do general x-ray and mammography. I don't do CTs. I was told just to come in when I get some time and they'll go over it with me! These are specialty courses for a reason: people's lives depend on the diagnostics. But they don't want to pay properly trained people so they just give us more to do, and more, and more.

LONG TERM CARE FACILITIES

Nursing homes, retirement homes and homes for the aged

“These nursing homes, where our loved ones live out their final days, are going to be places where quality and dignity are enhanced. A new era of accountability is upon long-term care.”

Liberal Health Minister George Smitherman, Toronto Star, Dec. 04

...

*“Lord, you are going to have to help me tonight.
Please keep the people depending on me safe.”*
Ontario nursing home worker

...

“Something good has to come out of this report. I’ve seen the decline of everything.”
Ontario nursing home worker

In 2001, a PricewaterhouseCoopers study ranked Ontario’s long-term care facilities at the bottom of the heap for any jurisdiction studied. It found that in the previous year, Ontario had the lowest levels of care coupled with the sickest and oldest residents. In part, the province’s disgraceful performance was due to the Tory government’s scrapping of requirements for minimum staffing levels.

Shortly after the Liberals took power in Sept. 03, the Toronto Star ran a series of gripping articles that revealed widespread neglect and inadequate care in Ontario’s 544 long term care facilities (it now stands at 597). Problems for the almost 70,000 residents included being left alone for hours in feces-filled diapers or urine-soaked clothing, untreated bedsores, or weight loss brought on by faulty diets, bad food, and short staffing.

In response, Health Minister George Smitherman promised a "revolution" in long-term care, and told The Star he planned to make fixing Ontario's troubled nursing home system his “top priority.”

This has not happened.

The “top-to-bottom” review of this sector conducted by Smitherman’s Parliamentary Assistant Monique Smith, noted many important and urgent changes. But staffing and funding are still nowhere near the levels needed to meet the government’s stated goals of allowing seniors “to live in dignity with the highest possible quality of care.”

Worse yet, the funding announcements have become little more than public relations opportunities. The public announcements are grandiose. In actuality, the government has yet to show that any jobs have been created from the almost \$200 million that was announced last year! In part, this money was earmarked for 2,000 new staff, including 600 Registered Nurses and Registered Practical Nurses. The staff component is minimal. The hiring of 2,000 new staff will still not enable us to provide quality care.

Premier McGuinty and Health Minister Smitherman’s refusal to take action is producing crisis after crisis in this sector.

Owners and operators of private facilities have a scandalous record of using public money intended for staffing for many other things, such as paying off their deficits. For this reason, the government requires them to sign legal service agreements that spell out all the regulations that apply. They must agree to use funding to increase care hours for residents by hiring health care aides and registered staff.

This is a good idea. But given what took place at a Port Perry home in April 05, the Liberals’ commitment to their own initiative is, once again, seriously lacking.

That home cut back 111.25 hours of staffing/week in violation of the service agreement, even though it received \$1,610.69/week more than in the fall of 2003, when the Liberals were elected. The government refuses to enforce its service agreement.

In addition to serious funding issues, critical legislative and regulatory changes have not materialized.

Meanwhile, residents' care needs have increased. The number of multiple medical diagnoses has increased. Physician-ordered therapeutic interventions have increased, and so has the number of different prescribed medications that a resident must take daily. All of these indicators point to a much sicker and needier population.

Plagued with all of the old problems, and some new ones, this sector has declined even more. Some of the new issues are so serious that workers describe them as inhumane. For example:

- So many psychiatric patients and cognitively impaired people requiring mental health support are being downloaded and off-loaded, long-term care facility workers now call themselves “McGuinty’s new psychiatric hospitals and mental health facilities.” They point to their lack of training in this area, danger to other residents, danger to themselves and “the inhumanity of treating these most vulnerable people in such a casual way.”
- Palliative patients are also being downloaded from hospitals, with one worker describing the situation as “horrendous.” “They often die within 24-hours because we are not set up for this, funded for it, or trained for it.”
- Employers continue their profit-making at the expense of residents. In particular, the disgraceful rationing of incontinent pads has propelled many workers to take matters into their hands and risk discipline or firing. You will read about their actions in the interviews that follow.
- According to the government, “retirement homes are designed for seniors who need minimal to moderate support with their daily living activities. This is such a scandalous misrepresentation of how desperately ill people are in

many of these homes it begs the question of whether the Liberals have any idea at all of whom the new residents are. Retirement homes are not regulated by the Ministry of Health and have no staffing requirements attached to them. The only Act that applies to them is the *Landlord and Tenant Protection Act, 1997*.

- Despite the McGuinty government's announcement of two baths a week starting in Jan. 05, in many homes, this is not possible. In some cases, workers report that not even one bath can be guaranteed because of such short staffing. Other workers did not even know about the requirement.

The OFL meetings that took place in 17 Ontario cities produced information on disturbing, even frightening, trends and practices. Much of what we learned is borne out in the Casa Verde inquest that investigated the bludgeoning deaths of two residents by a cognitively impaired resident who was admitted earlier that day.

As this report is finalized, the government has still not acted on the jury's recommendations.

Another similar death has now taken place in Kitchener at the Forest Heights Long-Term Care Facility. From 1999-2004, eleven residents met violent deaths at the hands of other residents in Ontario nursing homes.

Workers, residents, and their families deserve immediate action.

Understaffing is killing us

In the evening, I've seen one girl on the floor with 42 patients. She was so scared for them she threatened to walk off job, so they sent in another one – just one – and then, there were two for 42. If you don't think that's stressful, it bloody well is. If families knew what was going on, they wouldn't believe it. We need whistle blowing protection.

It's scary. You can be as book-smart as you want when you get out of school but then this new reality hits and you say "Oh my God, this isn't what they taught us," and you want to get out as quick as possible. What they taught us at school is about care. What's going on here, well, let's just say it's about money. For us, it's run, run, run all day, and it's stressful. There's not enough staff for these residents and if you leave it to these owners, there never will be.

I've seen girls go home crying because they feel so bad for the residents. It's just ripping our hearts out.

Sometimes we are run off our feet. Today was an example. A palliative care patient turned sour on me and had to be shipped to hospital. I was checking on her but also had a load of other duties and by the time I got back to her, she was comatose. I got her stabilized and then sent to hospital. I mean there was just not enough time today to do it all and respond to it all.

We have one person on nights for 100 residents! That person has no medical training, so God forbid there is a problem, or worse, two problems. They don't know how to triage and even if they did, they can't be in two wings at the same time. They are running all of the time and it's stressful for them.

We're publicly owned and operated by a hospital. Get this. The staffing ratio here is often 1:96! There are two RNs during day, but after 3 p.m., watch out! Then, there's only 1:96. We told the hospital that this is crazy – but they wouldn't go for more staff, and the old just walk out. New people report to work, see the workload, and leave

at the beginning of the shift. They just don't finish the day. It's that bad. Residents have to wait too long for their pain meds and that is totally unacceptable.

Why isn't there more staff? We're exhausted. We're all working doubles and this employer is so cheap they won't hire any more people.

I'm getting bladder infections because there is no time to pee. We have big trouble getting to the bathroom. I'm running all day. If you are on a water pill, if you hold it, you are much more prone to bladder infections. It's not just me.

Residents in these retirement homes, well, it's not a good situation. People off the street, call them Bobby or Sally, are now giving you shots and meds. Legally they are required to work under the guidance of a registered staff, but dream on. There is no RN on nights and so they are forced to do this. I mean anyone and their dog can be pressed into duties in Ontario retirement homes, no matter how untrained they are.

As full-time people left, they were replaced with part-time. This in part explains why our home was closed down to admissions. We had, and continue to have, a lot of unmet standards. They found odours, areas that were filthy and a management that wasn't doing its job properly. Management is even planning the new building and guess what? They are actually planning it to be shortstaffed! We're running all day and here they are making plans to get us to run even more!

There's no TLC anymore. It's not allowed.

How can the government let this happen? These elderly people got us to where we are today and they're treated like this? No way can this continue.

Lack of staff is bad enough but there is absolutely no one to support me, and that makes the job even more difficult. RNs in nursing homes have to be able to survive on their own, make decisions on their own, and it really is quite stressful. We have 64 residents, many with more than one diagnosis, and one nurse. You can imagine my workday.

Before, if a resident was crying or had a blue day, we could take 10 minutes to chat, or you had time to have a two-minute conversation in the hall. Now, girls don't have time and you're not allowed to. It is so sad. It's hitting us all really hard because we care a lot about our residents.

The short staffing in both retirement homes and nursing homes is leading to more worker injuries and a worse quality of life, or no quality of life. Our members are going home exhausted and stressed. They have no more energy or time to talk to their kids, spend time with their families. They just need to sleep and prepare for going back to work.

Things in the homes are going from bad to worse. We are seeing extremely heavy care. The public wouldn't believe it. In fact, I challenge you to find a retirement home that doesn't have a lock down ward for people with dementia. We see assaults. We see everything. It can be brutal.

You can see how stressed out RNs in nursing homes are. Bladder infections are now common for staff because you can't even find time to go to the bathroom anymore.

All staff is stressed. Our joke is that we're going to catheterize each other. Just pee in a bag because there is no time to go, ever. You've gotta wonder what Mr. McGuinty is thinking.

Downloading and offloading

It's all trickle down in the nursing and retirement home sector. All the hospital cuts mean that we are getting really heavy care patients, and this is true not just in nursing homes, but also in retirement homes. The only thing that applies to Retirement Homes is the Landlord and Tenant Act and that's just ridiculous. This is 2005 and you can't treat people this way. It means bad working conditions, bad care and totally inadequate staffing.

Now, the hospital is even sending palliative patients here because it has to unload patients. It's horrendous. They often die within 24-hours because we are not set up for this, funded for it, or trained for it. They should be in palliative care. If the government wants us to deliver this kind of care then they should give us the rooms, staff and funding, but they haven't.

We have complex cases. They are compromised here and need more professional care. It is not unusual to see IV, peg tubes, dialysis, tracheotomies, high intensity dressing, and people with mental dementia. Many of these acute residents come from the hospital just a day after surgery.

We see aggressive residents that shouldn't be here. There are people needing psychiatric care mixed with those needing medical care. There are no locked rooms for them, only geriatric chairs and when they are put in them, they scream and get very agitated and upset others residents.

Second bath? Liberal government policy vs. reality

This second bath requirement from McGuinty is a joke. In our home, the bath girls are always being pulled because they are needed on a different floor. The home is so short staffed, residents feel it and so do workers.

Two showers? No. Absolutely no. We can't meet the MOH guidelines. Residents are only getting one.

We have only 3 of us for 66 residents and it's deadlines, deadlines, and deadlines. It's a production line with 10-12 minutes per resident and that includes a bed bath. You can guess whether that means we can really get people clean. And now there's these things "baths in a bag". They'll do anything just so they don't have to give residents real people to help them – all these stupid and useless gimmicks.

What are they talking about – this two baths. We don't even have enough time to give a weekly bath. I couldn't live like this, not being clean, but our residents are not clean.

The ministry doesn't care if we don't have time for residents. They make rules on two crummy baths as though that it is something to be proud of. No one can meet it but

they don't really care. They only care about their paperwork. We are always doing paperwork. That's our life now.

Two baths a week? Oh, no. They don't always get even one. They cut out one of the bath shifts because we're down residents and the lady that is left that does the morning bath shift gets pulled if someone is sick. There are only two bath people left but they have just too much of a workload.

The new blue line

We're not allowed to change incontinent pads until they are 75% full, or at the blue line. Have you seen what incontinent pads look like at even 50% full? Our residents are people with dignity and they are forced to walk down the halls with these things hanging between their legs. It's disgusting and inhuman, but this owner is cheap, cheap, cheap. They probably all are. Our girls feel so bad we take extra pads and hide them in the _____, just so our residents don't have to go through that. I think every government member should be made to wear incontinent pads and see what it feels like when it's 75% full. It's a disgrace.

They actually went into the garbage and weighed all the diapers to ensure we weren't cheating and giving residents diapers before we were allowed. They are taking away the residents' dignity and ours too. We aren't trained to treat people like this – just the opposite.

Yes, here too, there aren't enough incontinent pad and staff get very innovative trying to hide them. Our new hiding place this month is _____.

The management here is so cheap. They buy whatever is on sale. They actually bought teeny tiny diapers for the adults here. Maybe they might fit 90-100 lb. little lady, but no one else. So we cheated and used two per person. I'm not sure if they ever found out.

Infection Control

We used to have 5 full-time housekeeping staff. We took infections seriously. We cleaned extensively: closets, drawers, doorframes, lights,. We would get on a ladder every week to ensure ceilings and high corners were clean. Now, well, the approach to cleanliness and infection is much different. This June, we will be down to 2 full-time and one part-time. There just isn't enough time for me to clean everything. It's stressful and it also makes me angry. My wing has 12 rooms with carpets. I have to get through those 12 rooms, cleaning and bed changes. Let's say a person has an accident. The carpet isn't cleaned or shampooed usually until the next day. That's not right. This private company that was hired by the hospital to implement cuts is crazy. They send people in to tell you what to do and how to do it. You know what? You can put it all on paper and make it look good, but when it comes down to reality, it's a much different thing. The guy got really angry with me when I told him "it's just not feasible to clean your way with all the cuts you are implementing." All the money they are giving this company could be going to staffing to make sure the residents are ok and the staff don't get sick and injured from overwork. They don't care. Sure, I'm angry.

You are not allowed to spend time cleaning the floors, the toilets and there is always the potential for infection because they cut housekeeping to the bone. At the end of the day, there's going to be a big price to pay.

The possibility for infection is very high. Every time someone returns from hospital they are put on MRSA precautions. Nurses are gowned and gloved but we go in

without anything to change the sheets and laundry bags. We are not given anything – just our work clothes. We want to know what we are being exposed to, because a lot of the part-timers have young children, but they won't tell us. We always ask and they tell us "it's not a problem." Well, it is.

It's not clean here either. Some staff were told to keep reusing their masks! And isolation gowns are sometimes hung on the back of doors and reused. Talk about potential for infection.

Our management has come up with a new catch phrase: They want us to "assess". That means they want me to go into a bathroom, look around, and "assess" whether it really is dirty and perhaps doesn't need cleaning that day. They do this all day and then they preach at you. They tell you to do a better job because this is the residents' home. They just talk out of both sides of their mouth.

MENTAL HEALTH

*In the emergency department at the _____ hospital, mental health people are the GOMERS: **Get 'em out of my emergency room stat.** No one wants these patients. They're getting turfed. Where in the world are they supposed to get help? Really, I am asking you, where?*

...

How do we get through to this government? What do we have to do?

...

We're even seeing young people with psych problems in our nursing home. There is nothing for them to even occupy their mind, no activities for them. Why are they here?

Bed, staff, and service cuts, hospital closures, and divestments have had a devastating impact on people with mental health needs. Decades of neglect, funding that never materialized and policies that shifted patients into the “community” without adequate supports have produced chilling accounts of tragedies and failures. They are found in coroners’ reports, newspaper stories, and in provincial legislature debates.

By the time the Tories finished with Ontario’s mental health system, **almost 20%** of psychiatric hospital beds had been cut. The disappearance of more than 500 beds triggered a massive outpouring of needy people on to city streets where they became the new homeless. People desperate for psychiatric and mental health support are also straining the abilities of the justice and corrections systems, community agencies and even nursing and retirement homes.

That is what made the Liberal government’s re-announcement last January of \$27.5 million, such an act of hostility. The money, to be divvied up by more than 130 agencies, won’t create even one new assessment bed. It does, however, speak volumes about government intentions to inflict even more pain on this sector and those who depend on it.

“It’s insupportable what they are doing to the most vulnerable people,” said one worker. “What is this little bit of money supposed to buy? It won’t even get one full-time salary the way they’ve divided it up.”

Coupled with its refusal to release adequate funding, the government also won’t target funding. This produced a disaster in London when St. Joseph’s Healthcare reallocated \$20 million of mental health funding to other purposes. In London, the need is so high, the police department estimates it spends \$2 million/year responding to mental health patients in trouble with the law.

Despite being handed a golden opportunity to distinguish themselves from the Tories, the government has instead chosen to follow their blueprint, including the divestment of the only two provincial psychiatric hospitals left.

“They keep making all these cuts and telling everyone that service is moving to the community. Well, where is this mysterious community? No one has ever seen it.”

As we traveled across the province, the words we heard the most often from workers in this sector were: “frightening,” “alarming,” “inhumane,” “tragedy.” The message we heard everywhere was of warning: this population cannot endure one more haphazard approach that contains within it the high probability of failure.

For patients, consumers and workers, what is desperately needed is a rebuilding of mental health and psychiatric services. But public policy and funding are moving in a different direction. “They’re plowing ahead with the Harris agenda,” said one worker. “It’s unforgivable. What are they thinking?”

The new mental health facilities

We see some very aggressive people in our nursing home that need psychiatric care. One man is always talking to a person inside of him. Another one really should be in a psychiatric facility. We're not trained to deal with this and not sure how to take care of them. They can change on a dime. Too often they do.

Mental health is huge issue in our area. So many people are ending up in the wrong places. Do you know what the new mental health facilities are in our area? Long Term Care facilities. Our very own nursing homes! Families should know that and make the government rebuild the mental health system. We're not trained and can't cope with this.

When Harris did us in, our nursing home got a rash of cases from the psychiatric hospital. Now, it's gotten worse. We are not trained to look after this area. When there is a need, we get training in frontal lobe damage, schizophrenia, other conditions, by a speaker who comes in for the day. But a lot of the psych patients are controlled through chemical therapy and that is a big problem. We have actually had a few cases where we've had to call in the police, and a few where we have had to return them to the psychiatric hospital. More psych beds and hospitals need to be reopened.

Dangerous for us and for patients

They sent a mental health patient for us to care for at our hospital but he blew and attacked a frail elderly man, dragging him down the hall. The police came – he was placed in another hospital and then sent back to us again because there were no beds there. It's terrible for all of us – workers, other patients and for him. We're not trained in this area.

When you go down in staff, it puts us and the patients at risk. We keep asking for more staff, especially orderlies, and we're told no money. I've been in Psych for 25 years and it just doesn't feel safe anymore. We are working short all the time and who knows what is going to happen. In my program, we have patient deaths and that's terrible. We're a hospital but we are not run like that. I don't understand why we are open from 9-5, Mon. through Fri. We've got 32 acutely ill and often unpredictable patients but here we are with full staffing only during the week from 9-5.

Our hospital recently offered voluntary exit packages and early retirement since it wants to cut back even more in staffing. I don't know the number of layoffs yet, but when they say not to expect too many RNs to go, that's supposed to be a relief to nurses. But it just shows they don't understand the needs. If housekeeping gets cut, infection rates will soar; cut security and violence and injury will likely ensue. It's a domino effect, always has been.

Low staffing creates a really volatile atmosphere. Staff are often alone on a ward of 15 patients.. This should not be happening. And you have staff that have to run from one end of the hospital to the other if there is a code. It's ¼ mile! Our employer is completely neglecting the staffing issues. There is always some excuse. Morale is way down and frustration is up. We can't care for people the way we know we should and want to. We are seeing more injuries, more staff unrest. There's a great exodus of staff leaving mental health. It's just too stressful and unstable. More and more, they hire unclassifieds, instead of full time people. The bottom line is money: without it, you don't have staff. If you cut off the head, the body is going to die. They are starving the system and nobody cares, and that's the god awful truth. Nobody seems to give a shit.

Code White in our hospital means an extreme emergency and indicates violence. It means that staff or another patient are being attacked. In many places, there are only two

people on, leaving one to push the panic button and call the code, while the other gets living hell knocked out of them. We've seen a lot of RPNs and RNs hurt in this way, and other staff too. In a way, we are compensating for lack of staff by more injury to ourselves.

Pressure, threats and arm-twisting

Our success rate is based on whether 80% of patients can be discharged from hospital because we need to empty the beds. Professionally and ethically, I just don't feel comfortable with it. People in need are having huge difficulty. It's hard to get admitted because they have raised the bar, leaving many people without a capacity to deal with their situation. When we ask about the beds that aren't being used, they tell us there are diminishing needs. But diminishing needs exist because they raised the bar and won't staff those beds. Many people who should be admitted just aren't.

Patients aren't getting the care they deserve and staff are being placed in jeopardy. I've been doing this for 26 years. The inadequate staff has a huge effect every day on those left. Instead of any appreciation or understanding of how hard we're running to keep up, we're getting penalized. They do that by threatening our licenses. They hold your license as a club over your head. If you dare take sick time, they'll call you and say, "You've missed so many days so we're scheduling for the attendance support program and if it continues, we will report you to your college." If we are unable to handle the new workloads, they threaten to report us to our college. Some people are working twenty 12-hour shifts. When you are dealing with the 12-hour shifts, anything more than five and you screw up. It happens. You're tired, can't concentrate as well. But they keep scheduling this overtime and when you make a mistake, they threaten to report you to your college.

Even though we are expected by the government to triage in 15 minutes, it's just not possible. That really exposes us – we could lose our licenses, or get sued. We also don't have time for re-assessment. If you assess someone as emergent, you need to reassess again after ½ hour, but you can't. You just cannot. You pray a lot and hope to God that no one is hurt because of you.

We can't do a good job and because people who are depending on us can't get the services they need, complaints are rolling in to our college. So not only do we feel bad about residents, but we are also worried about our licenses. There is a big move now to a fixed period of treatment. There's just no individualized care anymore. "Take a number, please" is more like it. If cancer patients were sleeping in the streets there would be a public outcry. Someone has to see what is happening and do something.

This isn't the way we would run things!

The level of service has decreased but when I say that you must understand that when people don't receive treatment here, they don't receive treatment, period. Everyone is pushed. The caseloads are so tight. The waiting list is 8 months for people who have experienced serious trauma. For children and young people, it is really difficult. People need to get care for their children. Early detection and identification is important and produces results. The situation is worse now than it ever was and that includes the Harris years. Another consequence of low staffing is a reactive approach to problems. Since the staffing and funding are not there, it's no longer a case of early detection. It's now a process where problems are responded to only in the critical stage and by then, they are so severe they often can't be resolved. I'd say mental health, by and large, is now a maintenance program. We can't help people the way we once could. It's difficult for all of us.

Our hours have changed since restructuring. Any patients not seen after 10 p.m. must stay overnight if no beds are available anywhere else. And often, no beds exist. The psych hospital has also had bed cuts, so when they have none, we must try other places. Often those places don't have beds either and then the only place that person can go is hospital emergency. But the emergency is crazy busy and it's one of the worst places for someone needing this kind of help. It doesn't seem even civilized to put these vulnerable people into this situation.

My biggest concern from all this understaffing is for psychiatric patients. It takes a good deal of courage just to turn up at emergency and when there are no beds available it makes it very stressful. Others pretend to be ok and say they can wait until the next day, but they aren't ok, and you just hold your breath hoping they'll make it through the night. You take it home with you. Five years ago we wouldn't have sent people home that need to be admitted, but there is no room anymore.

Nurses historically go on no matter what. But even we are seeing increased stress levels, and depression. I mean you rarely go home at the end of the day feeling like you did a good job for your patients, especially in emergency. The public is totally unaware about what a restructured health care system means. They expect the same care and service. Even some of the physicians don't get it. Some don't know that we aren't open overnight anymore.

Three people have left but they've only filled one position. We have a waiting list of clients but are expected to do the same amount of work. Don't get me wrong. You want to do it because it is what the client needs. But you just can't, so sometimes you run around like chickens with your head cut off. It can be chaos. Your client might be threatening suicide and needs you now. But then, the short staffing means that backs up everything else. We are always running against time. We know that there are probably going to be

even more layoffs and most of them are front line workers! Just losing one clinician on your team has a huge impact. This week, we are two people down so we are burned out, just fried. And emotionally, it is very draining. We deal with clients who are very, very ill and it impacts on you when their needs aren't met. So, missing staff is unbearable.

In community mental health in general, programs and services are all pretty much downsized in staff, but not in clients. It's where we work, so we know what's going on, despite all this stuff about services in the community. Unless they are hidden away somewhere that no one knows about, they don't exist. It's ridiculous.

RN – It's not just the RN staffing, no staffing has kept up with the need. Housekeeping has been cut. The place is filthy. There has been sputum on the elevator doors for the past 24 hours. It's not only untidy, it's dirty and this is a hospital – we're supposed to care about hygiene and infection.

We are still under threat of being divested. Part of our fear is that we will all be replaced by lesser-skilled workers. We are going to see more layoffs, for sure, but mental health can't handle any more cuts – it can't handle what exists now. There are situations where people are just not replaced. The result is increasing pressure to get people out as soon as possible. This pressure to discharge clients in the face of scarcity of inappropriate resources is very difficult. I really struggle with this and know that I would not want to be in this situation. This is the most fragile segment of the population and they cannot advocate for themselves. We are doing mentally ill people a great disservice. We must stop bed closures and be realistic. Not every mentally ill patient belongs in the community. It's erroneous to paint everyone with the same brush.

Oh god, there are so many issues around short staffing, and therefore work

loading. The problems are everywhere in our hospital. There's an extreme problem on the seniors geriatric ward. Two or three people were still sitting in their urine from the night before, despite staff calls for more help. They couldn't be cleaned up until after lunch. One of the workers was so stressed and physically exhausted from trying to do it all, she had to book off sick the next day. So then, the next day, the floor is short staffed again, and on and on. Two people are not enough on that floor and hospital management knows it.

The overtime due to understaffing is just phenomenal. It's almost a daily occurrence that they will call me for OT. If you make the mistake and say "yes," they will call you twice a day. The workload has increased and it's intensified and you better be able to protect yourself by saying "no," because if you can't you'll burn out fast. In our hospital, because of the low staff levels, our housekeepers are actually trained to respond to a code and help restrain violent clients. This goes way above and beyond their job descriptions.

PUBLIC HEALTH

The strength of Ontario's response lay in the work of the people who stepped up and fought SARS. What went right, in a system where so much went wrong, is their dedication.

Hon. Mr. Justice Archie Campbell, SARS Commission

For the first time, I am hearing nurses saying I can't do this any longer. They are getting tired trying to meet community needs, juggling a lot of balls in the air, trying to make up for people and money that aren't there.

Public Health worker

Any one of the local health units can be the weak link in Ontario's chain of protection against infectious outbreaks. It takes only one dysfunctional health unit to incubate an epidemic that brings the province to its knees.

Hon. Mr. Justice Archie Campbell, SARS Commission

There is no way we can really deliver on everything that is mandated. We can't cover off everything. We try, but we can't.

Public Health worker

The Commission has heard continuing reports of municipalities diverting public health staff and funds to other departments, boards of health with members whose sole objective was to reduce health budgets, and medical officers of health fighting municipal bureaucracies and budget constraints to attain a proper standard of public health protection.

Hon. Mr. Justice Archie Campbell, SARS Commission

We are always training and trying to teach municipal politicians about Public Health. It's a losing battle. They are more interested in re-election and keeping their jobs rather than raising taxes.

Public Health worker

Millions of Ontarians got their first glimpse at the inner workings of Public Health when the SARS epidemic hit. Years of negligent government policies, lack of funding, inadequate capacity, mismanagement, bad politics, and other serious problems were played out in the public arena in 2003.

As a result of the intense and very public scrutiny, the provincial government established an independent SARS Commission, headed by The Hon. Mr. Justice Archie Campbell that produced sweeping interim recommendations for action.

Infectious disease control, which was of primary concern to the SARS Commission, is one of the critically important aspects of Public Health work. But there are many more: chronic disease prevention, water safety, rabies control, food safety, early detection of cancer, sexual health, reproductive health, substance abuse prevention, children's health, tuberculosis, vaccine preventable diseases, pre- and post-natal care and intervention and more, are all part of a huge basket of responsibilities.

Every day, what Ontario's 37 public health units do, or don't do, affects all of us. Much of the work may be hidden from public view, but if left undone, can have devastating consequences for the entire population.

In 1997, when the Harris government announced it was downloading responsibility for 100% of public health funding to municipalities, workers were vocal in their fear for the public. The downloading triggered substantial reductions in staffing and services. First hit, were vulnerable groups such as school-age children, elderly people and persons with mental illness. Public Health workers redoubled their efforts trying to compensate, but the system itself was broken.

As a partial fix to the catastrophe they created, the Tories announced a modification and said that effective Jan. 1999, the province would reassume 50% of the approved cost of public health services. What was notable about the announcement was that it still did not restore funding to the former provincial contribution of 75%.

This takes us to where we are today.

In response to Walkerton, the SARS epidemic, Campbell Commission recommendations and public scrutiny, the McGuinty government has pledged to restore the 75% funding level by 2007.

And while there is good news in this announcement, there is also the bad. As one worker noted, “We are so far behind from all these bad years, and the need has grown so much, that we are still not going to be able to do what we need to do to fulfill our mandate and keep the population safe.”

In his Walkerton inquiry report, Mr. Justice Dennis O’Connor noted that since the 1990’s, the province has increased the responsibility of boards of health without increasing the funding required to fulfill those responsibilities. The result has been the boards’ compliance with ministerial requirements has decreased.

This was reinforced in the Campbell report that described a “grossly underfunded public healthcare system” with “no elasticity” as a key problem.

Of all of the provinces, Ontario is the only one to extensively cost-share public health programs with municipalities. This has produced bizarre situations in which crucial health programs and services are in competition with dozens of other municipal services. Public Health programs are often the first to be sacrificed. “It’s disgusting what the elected politicians don’t know. It should be that if you aren’t pro-public health, you should not be allowed to sit on the board.”

The Public Health mandate versus reality

The province is responsible for establishing minimum requirements for public health programs and services. It does this through the *Mandatory Health Programs and Service Guidelines*. The array of programs and services that local Boards of Health are required to deliver is reassuring. But reality looks much different.

For example, the Ministry notes that chronic diseases are the leading causes of death in Ontario. “They are a modern epidemic in terms of premature death, disability and health care costs.” Common chronic diseases include heart disease, stroke, cancer, chronic lung diseases such as emphysema, diabetes, osteoporosis and many others. “While treatment and early detection efforts are important, it is prevention which has the greatest potential to reduce the significant burden of chronic diseases and increase the overall level of the population’s health.”

But in the bid for public dollars, programs like these and prevention in general is losing out. “It looks great on paper but in reality we have this rinky-dink budget for chronic disease prevention. It’s not going to do anything. We are two people down in staff. We have a huge area, and a ridiculously low budget. It’s not possible.”

The same holds true for many other programs. Sexual Health workers, for example, point to an epidemic of Gonorrhea and Chlamydia and are desperate for staffing and funding to meet the public need. They can’t get it.

And although the provincial *Mandatory Health Service and Program Guidelines* note the importance of the social determinants of health, including economic and educational factors, and workplace environments, real action with respect to these issues has almost disappeared from the public arena.

Many things have still not changed, yet they must.

Public Health is not only suffering from a serious lack of funding and staffing, but checks and balances for monies received must also be put in place.

“We urgently need funding and staffing, but we also need our Board of Health to do its job. The province gives money to the local health units, but no one audits to make sure the work is actually done.”

The “fault lines” that Mr. Justice Campbell spoke of in his report are still there. Workers are still trying to compensate for inadequate funding and staffing. But extra effort on their part will not result in a sector that is able to protect and assist the public in the way that it must. That responsibility lies with the province.

Here is what Public Health workers have to say.

We can't substitute for what is missing

Our area is short of family doctors so they look to us to fill the need. And it's not just the doctor problem, social safety nets are going and we have had to fill more and more of the gaps. I've been in public health since 1990, but I have never seen so much need. It keeps on growing and we can't fill all those holes. Fewer social services are driving a lot of the increase, but also we don't have staff to do it all. It is really stressful. It's like a balloon these days, especially with the Sexually Transmitted Infection Clinic. The balloon gets bigger and bigger and bigger. You can't do health promotion and protection and crisis management all at same time when you don't have enough staff. We have an epidemic of Chlamydia in our area and it is growing. We cannot possibly keep up with the staff we have. Also, if you get an HIV case you must treat it with priority, but people are not getting the timely care they need and that is crucial. It must be worse elsewhere, because I work at a good unit.

It's a revolving door in here because we just can't keep new nurses. It's too stressful. They just can't believe everything they are expected to do and don't feel like they are giving good care. Give us more staff, better wages, job security, time back after a crisis so that we can recuperate. Maybe then, we'll see a change. But right now, it's bad.

I am seeing a lot of stress at work: people just trying to cope with how much there is to do, and feeling bad about what they can't do, and when they can't take it anymore, they go off on stress leave and the cycle gets worse.

Sexually transmitted infections are huge and growing. In our area, we are seeing an epidemic but we can't keep up.

We need more funding, but we also need the Board of Health to act as auditors. There are insufficient funds to keep front line people happy and allow them to do the job as outlined in the legislation.

The joke in our area is if you get the short end of the straw you go to the public health board. It's not the most glamorous of jobs for municipal politicians. They are just politicians, not health experts, and they often don't get it. When they have to vote on a budget, they want to get re-elected. They don't want to be seen to raise taxes for Public Health.

Understaffing is money. It's as simple as that. We have a big mandate from the province, but we don't have "the big boy budget" because our local politicians don't want to raise taxes and then find themselves out of a job.

We MUST meet the need. Right now a full extension of services and programs is urgent. We have an epidemic of sexually transmitted infections. Public health units should be arguing with the province and speaking up for programs and funding. Tell them that we need to do what public health should be doing, and that is protecting the public.

Health promotion and prevention are hard hit

No new sexual health clinics have opened under McGuinty, but we need them. They might be extending some of the hours but that's not an answer because there is not enough staff. We are overextended. That's bad news for the public. We can't even meet the demand of the community development work and it is a critical component of what we do. We no longer just parachute in and do sex, drugs and rock 'n roll. It doesn't work like that when there is a crisis. And there is a crisis now. We have an epidemic but not enough people or funding to deal with it. One of the things we are supposed to be doing is going into the Board of Education and working with teachers so they feel confident. But where do the too few of us get the time? And now I just got told I am responsible for 23 schools on top of the other responsibilities. It's nuts, and just can't be done.

They come to us and say go out and deliver these programs. But we can't do it all. I work with people that can't sleep at night because they will never get it done. We always find ourselves confronted by huge ethical dilemmas. For example, mental health waiting lists are so very long that teens can't get help they often urgently need. Do they really expect us to say to a suicidal teen, "Here is your referral and good-bye?" Yes, they do. We have to deliver a teaching program, but the time allotted to teach is so short that our College is calling it unsafe. Our chronic disease program is understaffed and can't meet its obligations, and promotion and prevention programs are getting less and less. The understaffing is reflected in so many ways. The mandatory guidelines say one thing and that's all well and good, but it doesn't reflect what is really taking place. My workload is overwhelming.

Public Health used to deliver pre-natal classes in Toronto, but it is stopping now for all but high-risk moms. For the rest, it is shifting to the private sector and you will have to pay. It is not inexpensive. We already pay our taxes and now there will be one

more added expense for you if you want to understand labour and delivery. Post-natal and parenting classes also going to private sector.

There are days I don't know if I'm coming or going. It is unbelievable. I am stressed. There used to be six of us, but now it's down to me, and our city hasn't gotten any smaller, just the opposite. When the province puts out its mandate and guidelines, they use those nice words, "must ensure" it is being done. So we take care of that by sending a memo to the schools and telling them they "must ensure" these things are done. So the responsibility gets passed on for vision tests, hearing tests, and of course, because of the delisting, this now comes out of parents' pockets.

We lost our dental hygiene clinic. It was running like a top – really awesome in its service quality. People got great care. Now, I can't even get funding for all my toothbrushes.

Before Community Care Access Centres (CCAC), Public Health had a responsibility for seniors in the community. That was given over to CCAC but they did not have enough money. And Public Health does not have the money. So now, isolated seniors who wish to remain in their own homes are falling through the safety net.

On weekends, public health nurses available to new mothers and babies are minimal or non-existent. Babies are born seven days a week, not just Monday to Friday. There needs to be more funding for more staff. If a mother is having problems nursing, we need to be available and if possible visit in the home. Babies dehydrate rapidly. It is rare to have a breastfeeding clinic open on the weekend now. Even so, many women cannot get there. Our public health staff should be in the hospitals talking with new

moms, not sitting on the phones trying to explain breast-feeding. We need to get back to the community but there is not enough staff to do that.

We are supposed to deliver prevention and health-based education programs but we don't really have enough money to do it. If all the units could do this, it would reduce expenditures for other parts of the health care system. The province should understand this. It is part of their legislation.

There was a high rate of teen pregnancy and infection in the former City of York. We had a sexual health clinic in the high school and it was booked solid every time we opened. You could really see the impact – young women getting tested for sexual health, getting educated about infections, accessing services. It was really having a major impact. Then they had a sexual health “redesign.” It couldn't have been based on need of community because they would have expanded it. No, they closed it. Now we're back to seeing the rise of teen pregnancy and infections.

Public safety was supposed to be a priority

We urgently need more public health inspectors. In our area, we are short at least three inspectors. They are responsible for so much – water, food inspection, sanitation, communicable diseases, rabies, and more. You have to ask yourself what is not getting done. It's not a good situation.

TB is the new epidemic. It is not cured. It is contained within the body. When you get older, it often liberates. We used to do TB screenings in schools. We used to have clinics. We used to test. And even though it is back and thriving, we're not treating it as

the problem that it is. That's probably because you need staff to test and treat, and we don't have enough people.

When we are down staff, important things that protect the public just don't get done. The province mandates minimum food inspection frequencies. It's an important function of Public Health. The public can be exposed to increased risks. It is our job to check the cleanliness of the premises, temperatures, and all the elements to ensure that food is handled properly. Some places need to be baby sat because they are clued out or they just don't care. Places don't get inspected if there is a shortage of staff.

CONCLUSION

There is no health care without people. The Ontario government must immediately and significantly increase staffing numbers in all sectors.

For starters, the provincial government must:

- Declare an immediate moratorium on layoffs in hospitals.
- Establish a required minimum standard of 3.5 hours per day of nursing and personal care for residents in nursing homes and homes for the aged.
- Establish required minimum standards for staffing with appropriate complement of full-time workers in all health care sectors.

If the McGuinty government continues to hide behind the Mike Harris health cuts and does not immediately and significantly increase staffing numbers in all sectors, more Ontarians will be harmed.

We need more health care workers.

It's as simple as that.

