IN THE MATTER OF AN INTEREST ARBITRATION BEFORE ARBITRATOR PRICE PURSUANT TO THE HOSPITAL LABOUR DISPUTES ARBITRATION ACT, SO 1990

BETWEEN:

PARTICIPATING HOSPITALS
(REPRESENTED BY ONTARIO HOSPITAL ASSOCIATION)

Employer

and

ONTARIO NURSES' ASSOCIATION

Union

WRITTEN BRIEF OF THE ONTARIO NURSES' ASSOCIATION PRESENTED IN TORONTO, ONTARIO ON APRIL 2-3, 2025

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INTRODUCTION

This arbitration is held pursuant to the *Memorandum of Conditions for Joint Bargaining* between the Ontario Nurses' Association ("ONA" or "the Union") and the Participating Hospitals ("the Hospitals" or "the Employer").

The purpose of this arbitration is to resolve the remaining issues in dispute in renewing the Collective Agreement between the Union and the Hospitals. Only a small number of items were agreed upon in direct negotiations.[1]

This round of bargaining is about nurse safety, job security, and wages.

BARGAINING HISTORY

Notice to Bargain:	January 2, 2025
Joint Bargaining:	January 13 – January 17, 2025 January 27 – January 28, 2025
Mediation:	January 29 – January 30, 2025

THE PARTIES

THE UNION: ONTARIO NURSES' ASSOCIATION

ONA is Canada's largest nurses' union.

Its membership consists of 62,000 nurses and health-care professionals.

ONA members provide essential patient coordination, oversight, and treatment in hospitals, long-term care, public health, the community, clinics, and industry.

ONA represents the overwhelming majority of all Registered Nurses employed in hospitals in Ontario

THE WORKERS: HOSPITAL NURSES

The ONA members affected by this Board of Arbitration's award are the Registered Nurses ("RNs"), Nurse Practitioners ("NPs"), and allied health-care professionals that provide healthcare to Ontarians in Ontario's hospitals.

Without ONA nurses, hospitals in Ontario would be at a standstill.

[1] The Participating Hospitals and Ontario Nurses' Association, Items in Agreement (2025).

The hospital healthcare system in Ontario, and the rest of Canada, is reliant on the work of RNs and NPs, who comprise the largest professional group providing direct clinical care in hospitals. In a data table produced by the Canadian Institute for Health Information ("CIHI"), which posed the question: "who's taking care of you in Canada's hospitals?", the answer, overwhelmingly, was RNs. The CIHI found that 70% of all acute inpatient units and emergency service hours worked, were worked by an RN or an NP.[2] No other group of hospital care providers came close: Licensed/Registered Practical Nurses (13%); Therapeutic Service Providers (21%); Personal Support Workers (11%); Technicians (9%); Other (3%).

THE EMPLOYER: PARTICIPATING HOSPITALS

The 131 Participating Hospitals, listed in Appendix "A" of the *Memorandum of Conditions for Joint Bargaining* are the combined Employer for the purposes of the renewed Collective Agreement.

The Hospitals lead the operation of facilities where ONA nurses deliver healthcare to Ontarians.

SUMMARY OF PREVIOUS ROUND OF BARGAINING

The last round of bargaining was decided in an arbitration award by Arbitrator William Kaplan, covering the term from April 1, 2023, to March 31, 2025 ("2023 Kaplan Award").[3]

In his award, Arbitrator Kaplan provided normative 3.5% and 3% annual wage increases, plus further adjustments to the ONA grid. He also awarded improvements to premiums and language on self-isolation, layoffs, and agency use.

In his reasons, Arbitrator Kaplan explained that the award was intended to begin addressing the acute recruitment and retention issues at the Hospitals and meaningfully respond to the unprecedented inflation ONA Members experienced throughout 2022 and 2023.

This was an important, incremental, step in the right direction. However, the 2023 Kaplan Award could not, and has not, solved the nursing staffing crisis facing Ontario healthcare. The ongoing staffing crisis—and the continued threat to nurse health and safety that this crisis perpetuates—demands swift and serious action.

[2] Canadian Institute for Health Information, "Who's taking care of you in Canada's hospitals?". Accessed March 28, 2024.
[3] *Participating Hospitals (Represented by the Ontario Hospital Association) v ONA*, 2023 CanLII 65431 (Kaplan).

UNION INTEREST IN THIS ROUND OF BARGAINING

The parties are now at a major crossroads. Whatever this Board of Arbitration decides in relation nurse safety, job security, and wages will determine the trajectory of acute healthcare in Ontario for many years to come.

Ontario's per capita ratio of RNs per 100,000 people is already the worst in the country and is only getting worse.[4]

Nurses are still leaving the profession and are not being replaced. Those nurses that do remain are stretched thinner and thinner, treating more patients, with fewer resources and even less support.

Delivering exceptional services to patients under these circumstances is taxing, stressful, and often dangerous. It cannot continue.

As patient health and safety suffers, so does nurse health and safety. Hospital nurses face exhaustion and burnout at alarming rates and have become understandably disillusioned with a healthcare system that hinges on their labour but is not willing to staff appropriately to protect that labour.

Nurses are fed up. And, as a result, they continue to leave frontline care, leave the province, and, quite often, leave the profession. The cycle continues and the conditions of work continue to deteriorate.

As the largest Canadian union of a frontline public service profession that is female-dominated, ONA is used to recognizing, naming, and fighting against discrimination. Over 90% of ONA members are also from marginalized, equity-seeking groups. Predictably, the stresses and strains of Ontario's healthcare system have been carried on their shoulders. The Hospitals have ignored the clear signs of a nurse staffing crisis and, with it, a nurse health and safety crisis, for over two decades.[5] It is nurses' labour that keeps the province's hospital healthcare system running, and that labour force is at a breaking point.

The Participating Hospitals operate on the backs of ONA nurses. Without the work of ONA members, the hospital system would collapse. And yet, as the population of Ontario ages, and the need for acute care grows, ONA members are seeing their work reassigned to workers with lesser qualifications and who require greater oversight by ONA members. At the same time, patient loads continue to increase for ONA members and a portion of every hospital RNs working hours continues to go unpaid. All of this is disrespectful, undignified, and is a threat to RN health and safety at work.

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[4] See Ontario Nurses Association, "New data confirms nurse staffing ratio continues to plummet in Ontario" (July 25, 2024), from Canadian Institute of Health Information *Data on Nursing in Canada, 2023,* (July 25, 2024).

[5] Judith Shamian et al., "A Hospital-Level Analysis of the Work Environment and Workforce Health Indicators for Registered Nurses in Ontario's Acute Care Hospitals", *Canadian Journal of Nursing Research*, 2002, Vol 33, No 4 at 35-50.

Despite all of this, ONA members entered bargaining this round in good faith and with a clear message: ONA nurses are the past, present, and future of healthcare in the hospital sector. They are not here to perpetuate the years of exploitation that brought the parties to this point. They are here to build strength and sustainability.

To that end, ONA has put forward three clear solutions to the existential problems facing Ontario's Hospitals.

First, the Hospitals must institute Registered Nurse-to-patient ratios across the province. The overwhelming academic consensus is that Registered Nurse-to-patient ratios vastly improve nursing health and safety, reduce burnout, and assist with nurse retention and staffing. These conclusions are borne out by the incontrovertible evidence in every jurisdiction where Registered Nurse-to-patient ratios have been implemented.

While the time for Ontario to be a leader in Canada on this issue has passed (British Columbia has already adopted nursing ratios in hospitals, and Manitoba and Nova Scotia[6] are close behind), the OHA has the opportunity in this round to make up for lost time.

Registered Nurse-to-patient ratios in Ontario can be implemented, and they must be implemented now.

Second, along with Registered Nurse-to-patient ratios, RNs must have clear language that protects the work of the bargaining unit. The solution to the staffing crisis is not to replace RNs with less qualified personnel and increase the supervisory load already carried by RNs. The solution is safe, qualified, and high-quality staffing.

Third, RN wages in Ontario hospitals must continue to be "top of market".

Ontario is Canada's most populous, prosperous, and expensive province. The majority of top ranked hospitals in Canada, providing the most sophisticated levels of care, are in Ontario. RN wages in Ontario hospitals must always reflect that reality. While ONA made important gains on wages in the last round, those gains were not enough to make up for decades of RN wage erosion in Ontario.

The status of Ontario RN wages as "top of market" must be solidified. ONA's status as the largest nursing union, serving the most patients, in the largest province, must continue to be reflected in the wages of ONA members.

While all of ONA's remaining proposals advance the common interests of the parties, three critical issues—nurse health and safety, job protection, and wages—

[6] Collective Agreement between *Nova Scotia Health Authority and The Nova Scotia Council of Nursing Unions* (expiry October 31, 2025) at 297; Collective Agreement between *Shared Health Employers Organization and Manitoba Nurses Union* (expiry March 31, 2028) at 306-308.

will determine the future of Ontario's hospital healthcare system. As such, staffing and wages demand this Board of Arbitration's careful and considered attention.

On one point, ONA wishes to be unequivocal. In stark contrast to Ontario's male-dominated frontline public service professions (police and fire), staffing ratios to protect nurse health and safety and a declaration that Ontario RN wages must always be top of market have not happened: not because of what Ontario hospital nurses do, but because of who Ontario hospital nurses are. What makes the safety and security of nurses on the frontline less valuable than that of police officers and firefighters on the frontline? What makes the wages of physicians working in the same top tier hospitals as ONA RNs more worthy of continued "top of market" status than the wages of RNs? What makes "us" different from "them"? The answer is blindingly obvious. The vast majority of ONA members are women.

As a collective of women and allies, ONA stands behind its evidence-based proposals on staffing and wages, without compromise.

To that end, the ONA begins its brief with its nurse health and safety, job protection, and wage proposals.

SUMMARY OF UNION PROPOSALS

ISSUE	ARTICLE	PROPOSAL
SAFETY AND RESPECT FOR HOSPITAL NURSES		
a. Nurse Health and Safety (RN Staffing Ratios)	NEW	Implement minimum Registered Nurse-to-Patient Ratios
b. Work of the Bargaining Unit	10.12(a)	Basic Work of the Bargaining Unit Protection
c. Wages for all hours of work	13.01(a), (d)	Stop Unpaid Labour for Transfer of Accountability
WAGES		
a. General Wage Increase	19.01(a)	6% (2025); 6% (2026)
b. Long-Term Service Entitlement	NEW	2% at 15 Years 4% at 20 Years 6% at 25 Years 8% at 30 Years 10% at 35 years 12% at 40 Years
c. Nurse Practitioner and RPN Grid	NEW	Introduce new NP and RPN Grids
d. Percentage in Lieu for PT RNs	19.01(b), (c)	19% without reduction for participation in Pension
OVERTIME AND PREMIUMS		
a. Standard Overtime	14.01; 14.03; 14.04	Two (2) times the hourly rate for standard overtime, scheduling violations, and work past end of tour Two and a half (2.5) times the hourly rate when working overtime on a shift paid at two times the hourly rate
b. Weekend, Night and Evening Premiums	14.10; 14.15	$3.50 (evening) $5.00 (night) One and one half (1.5) the hourly rate (weekend)
NURSE HEALTH AND SAFETY		
a. Domestic, Sexual and IPV Leave	11.15	Supports, including paid leave, safety planning and protections
b. WSIB Top Up	12.06	No loss of pay or benefits on WSIB
NURSE WELLNESS		
a. Pregnancy and Parental Leave	11.07; 11.08; 16.01; 17.05	95% Parental Top Up 95% Pregnancy Top Up Parental/Pregnancy deemed on Paid Leave with benefit plan

		continuance
b. Paid Holidays at Double Time	15.08	Two (2) times the hourly rate for working on holiday
c. Vacation	16.01(d), (e), (f), (g), (h); 16.06	5 weeks at 8 years 6 weeks at 15 years 7 weeks at 21 years 8 weeks at 25 years
d. Improvements to Health Benefits	17.01(c), (f)	$550 vision + corrective surgery $2500 HCSA No cap on dispensing fees $1500 dentures $3000 crowns, bridgework, implants repairs $2500 orthodontics
e. Retiree Benefits	17.01(i)	No age of expiry after Age 57
f. PT Mental Health Coverage	NEW	Unlimited mental health for PTs
g. Sexual Assault and Domestic Violence Program Employees	NEW	Court/Inquest attendance on mutually agreed date or at two (2) times the hourly rate
h. LTD	NEW	LTD up to age 71
NURSE PRACTITIONERS		
a. NP Wage Grid	NEW	Provincial Wage Grid
b. Most Responsible Provider Premium	NEW	$10.00 Most Responsible Provider Premium
c. Non-Clinical Hours/Supervision	NEW	Dedicated non-clinical hours for NPs and vacation catchup
SENIORITY		
a. Job Postings in 30 Days	10.07(a)	Job postings 30 consecutive days from vacancy
b. Specific Time-Limited Temporary Positions	10.07(e)	Limited to special projects

RN HEALTH AND SAFETY PROPOSAL

PROPOSAL #1 – RN STAFFING RATIOS

Article 8.05 *NEW*

8.05 The parties agree to the following minimum Registered Nurse to Patient ratios (RNPR), 24 hours per day, 365 days of the year, for each setting/unit in the hospital. Superior RN patient ratios to be maintained.

Adult Medical Surgical	**1:4**
Rehabilitation	**1:4**
Palliative Care	**1:3**
Step Down	**1:2**
Telemetry	**1:4**
Critical Care/Intensive Care	**1:1**
Pediatric Medical/Surgical	**1:3**
Pediatric Step Down	**1:1**
Maternity/Antepartum & Post Partum	**1:3 (3 dyads)**
Labour & Delivery/Intrapartum	**1:1**
Mental Health	**1:4**
Mental Health Intensive Care/Intensive Observation Areas	**1:2**
Post Anesthetic Care Unit	**1:2**
Operating Room (includes outpatient procedures)	**1:1**
Outpatient Dialysis	**1:3**
Emergency Departments:	
Triage	**2 RNs at all times**
Trauma/Resuscitation	**1:1**
Visits	**1:3**

All units will have an RN designated in charge and such nurse will not have a patient assignment.

If the minimum staffing numbers cannot be met, then the hospital will put all non- urgent care on hold.

NOTE: See Appendix XX, Settings Guidelines

APPENDIX XX Hospital Settings Guidelines/Definitions

Adult Medical Surgical unit refers to:

(a) A multi day inpatient unit in which either of the following cared for:

i) Patients with an acute or chronic illness or an injury; and/or

ii) Patients preoperative and/or recovering from (surgery) surgical intervention; or

iii) A short stay observation area.

Included in this is observation area and admitted patients in the Emergency department.

(b) Excluded are telemetry, critical care, step-down (higher level of care but not critical care), maternity, emergency, psychiatry inpatient, rehabilitation, Surgical Services (OR, PACU), ambulatory units, surgical day units, palliative.

Rehabilitation unit refers to:

(a) A multi day inpatient unit which is organized, operated and maintained to:

i) Provide rehabilitation of patients following stabilization of their acute medical issue: and

ii) Improve functions of patients with musculoskeletal and neuromuscular conditions due to injury or illness, or following surgery, so that they may be safely discharged.

Palliative Care unit refers to:

(a) A multi day inpatient unit which is organized, operated and maintained to provide complex pain and symptom management, complex discharge planning, and or emotional social, practical, spiritual, grief and bereavement support and care for people living with acute or advanced life-limiting illness and for people at the end of life, family, friends and others affected by someone's life-limiting illness or death.

Step-Down Unit refers to:

(a) A multi day inpatient unit which is organized, operated and maintained to provide specialized care for patients who:

i) Have complex life-threatening medical problems requiring immediate, urgent and intensive treatment using life support technologies and interprofessional collaboration among clinicians: and

ii) Meet Level 2 Adult Critical Care

NOTE: the definition of Level 2 Critical Care is consistent with the Practice Standards for Critical Care Services Ontario (CCSO).

Telemetry unit refers to:

(a) A multi day inpatient unit which is organized, operated and maintained to provide specialized care for patients who:

i) Have complex cardiac medical problems requiring continuous cardiac monitoring.

Critical Care/Intensive Care Unit refers to:

(a) A multi day inpatient unit which is organized, operated and maintained to provide specialized care for patients who:

i) Have complex life-threatening medical problems requiring immediate, urgent and intensive treatment using life support technologies and interprofessional collaboration among clinicians: and

ii) Meet Level 3 Adult, Pediatric and Neonatal Critical Care

iii) Meet Level 2 Neonatal Critical Care

NOTE: the definition of Level 3 Critical Care is consistent with the Practice Standards for Critical Care Services Ontario (CCSO), and Level 2 Neonatal Critical Care is consistent with the Practice Standards for CCSO.

Pediatric Medical Surgical unit refers to:

(a) A multi day inpatient unit in which either of the following cared for:

i) Patients up to age 17, with an acute or chronic illness or an injury; and/or

ii) Patients, up to age 17, preoperative and/or recovering from (surgery) surgical intervention; or

iii) A short stay observation area.

Pediatric Step-Down unit refers to:

(a) A multi day inpatient unit which is organized, operated and maintained to provide specialized care for patients who:

i) Have complex life-threatening medical problems requiring immediate, urgent and intensive treatment using life support technologies and interprofessional collaboration among clinicians: and

ii) Meet Level 2 Pediatric Critical Care

NOTE: the definition Level 2 Pediatric Critical Care is consistent with the Practice Standards for CCSO.

Maternity/Antepartum & Post Partum unit refers to:

(a) A multi day inpatient unit which is organized, operated and maintained to provide specialized care for:

i) Patients that are expected to deliver a baby and/or
ii) Patients that have delivered a baby and are recovering from the delivery, and/or
iii) A short stay observation area.

Labour & Delivery/Intrapartum unit refers to:

(a) An inpatient unit which is organized, operated and maintained to provide specialized care for patients who are progressing through the stages of childbirth.

Mental Health unit refers to:

(a) A multi day inpatient unit which is organized, operated and maintained to provide specialized care for:

i) Patients with an acute or chronic mental health illness or injury: and

ii) A short stay observation area.

Mental Health Intensive care/Intensive Observation unit refers to:

(a) A multi day inpatient unit which is organized, operated and maintained to provide specialized care for patients who:

i) Are in an acute phase of a serious mental disorder and/or

ii) Have diminished capacity for self-control and/or

iii) Have increased risk of aggression, self harm or suicide.

Post Anesthetic Care unit refers to:

(a) A unit which is organized, operated and maintained to provide specialized care for patients transitioning from a totally anesthetized state or from total paresthesia, following a surgical procedure, to an optimal preanesthesia state.

Operating room unit refers to:

(a) A controlled and sterile environment which is organized, operated and maintained to provide specialized care for patients who require surgical interventions.

Outpatient Dialysis

(a) An out-patient unit which is organized, operated and maintained to provide specialized care for patients requiring hemodialysis.

Emergency Department

(a) A unit which is organized, operated and maintained to provide specialized care for patients requiring immediate medical care.

EMPLOYER POSITION

Opposed.

8.01 The parties agree that patient care is enhanced if issues relating to professional practice, patient acuity, fluctuating workloads and fluctuating staffing are resolved in a timely and effective manner **at the unit level**. This provision is intended to appropriately address employee concerns relative to their workload issues in the context of their professional responsibility **as part of a multi-disciplinary team that provides care in an environment with fluctuating patient acuity and occupancy**. **The goal of this provision is to establish a process that facilitates solution-oriented discussion at the unit level.** ~~In particular, the parties encourage nurses to raise any issues that negatively impact their workload or patient care.~~**,** ~~including but not limited to:~~

- ~~Gaps in continuity of care.~~
- ~~Balance of staff mix.~~
- ~~Access to contingency staff.~~
- ~~Appropriate number of nursing staff.~~

The parties agree that this process is not intended to:

- **Prioritize one type of health care professional or undermine collective agreement rights to assign duties and responsibilities to health care professionals consistent with quality patient care;**
- **Impact or affect the responsibility of individual nurses to the College of Nurses of Ontario;**
- **Substitute the grievance/arbitration process, including disputes under 10.12(a) and/or the collective bargaining process; and**
- **Result in agreements and/or recommendations that are inconsistent with, or seek to modify, add, or amend, provisions of the collective agreement.**

- **Impede the flexibility to adjust staffing in consideration of patient acuity and occupancy.**

In the event that the Hospital assigns a number of patients or a workload to an individual nurse or group of nurses such that they have cause to believe that they are being asked to perform more work than is consistent with proper patient care, they shall:

…

UNION RATIONALE

OVERVIEW

This critical health and safety proposal will establish minimum Registered Nurse-to-patient ratios at all participating hospitals, based on the level of acuity and patient need in each unit.

These are minimum ratios, meaning units can be upstaffed where appropriate. The proposal also establishes the requirement for every unit to have a Charge RN with no patient assignments.

This proposal is desperately needed and long overdue. Inadequate staffing levels have been at a crisis point for years, jeopardizing nurse (and patient) safety – a topic that is gaining more public awareness and media attention following the COVID-19 pandemic.[7] As the Union's expert evidence proves, there are pressing RN health and safety concerns that require minimum staffing ratios. There is a growing consensus in healthcare that nursing ratios are necessary, which is reflected in the academic literature and, most recently, evidenced in the wave of nursing ratios that are being implemented in provincial nursing Collective Agreements across the country.

In short, this proposal is justified by a compelling demonstrated need and comparability, and should be awarded in its entirety.

COMMON LANGUAGE IN THE PUBLIC SECTOR

Minimum staffing to protect worker health and safety is not a novel concept. Arbitrators have long recognized the need for staffing ratios in the male-dominated police and fire sectors for health and safety reasons.

[7] Démar Grant, Blair Bigham & Robert Cribb, "Ontario nurses raising alarm over high patient loads that put patients at risk, internal reports reveal" *Toronto Star* (March 1, 2025). See also Ontario Nurses' Association, "Mental Health Awareness Infographic" (2024); Ontario Nurses' Association, "Report It: Workplace Violence is Not Part Of Your Job", (April 10, 2024); WSIB Data Request, "Assaults, Violent Acts, and Harassment Claims in Health Care Workers" (November 6, 2023); and WSIB Data Request, "Mental Disorders or Syndromes and Assaults, Violent acts, Harassment – Ontario Healthcare Sector" (February 10, 2025).

The collective agreements for the police services in the five largest municipalities in Ontario all include some form of minimum staffing language.[8] These staffing ratios in the policing sector are primarily driven by safety needs. Over 50 years ago, the Ontario Divisional Court noted that, at night, "the vulnerability of a police officer travelling alone in a squad car is not difficult to appreciate."[9] In the following years, arbitrators consistently affirmed that safety was a primary concern when addressing staffing.[10] In police services that did not previously have staffing ratios, arbitrators have awarded language creating a joint committee to explore the implementation of minimum staffing levels.[11]

Minimum staffing provisions are also commonplace in fire fighter collective agreements. Again, those provisions are largely driven by safety concerns. As Arbitrator Simmons summarized in 2000, when considering staffing proposals, the "issue that [was] squarely before this Board [was] safety", and minimum staffing complements have been consistently awarded to protect fire fighter health and safety.[12] In one recent award, Arbitrator Hayes relied directly on expert evidence when determining what staffing level would effectively secure health and safety:

> Expert evidence establishes, beyond serious question, that firefighter health and safety requires the assignment of a minimum of four firefighters to any first arriving vehicle.[13]

As illustrated by settlements and awards in the police and fire sectors, minimum staffing ratios can be, and have been, implemented where they are necessary to protect worker health and safety. Expert evidence has played a key role in substantiating demonstrated need in relevant sectors.

GROWING CONSENSUS ON NEED FOR SAFE HOSPITAL NURSING STAFFING RATIOS, INCLUDING IN FREELY BARGAINED OUTCOMES

Historically, proposals for staffing levels have not been awarded in the healthcare sector, with the exception of Letters of Understanding in the long-term care sector.[14] Key elements of past proposals that have been rejected are distinguishable from the

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[8] Collective Agreement between Toronto Police Services Board and Toronto Police Association (ratified March 26, 2019) at Article 7.08; Collective Agreement between Ottawa Police Services Board and Ottawa Police Association (expiry December 31, 2024), Letter of Understanding on Two-Person Patrol Car Joint Committee; Collective Agreement between Hamilton Police Services Board and Hamilton Police Association (entered into December 2, 2019), Patrol Branch Schedule – Minimum Staffing Levels; Collective Agreement between Waterloo Regional Police Services Board and The Waterloo Regional Police Association (expiry December 31, 2024) at Appendix D, Letter of Understanding: Shift Schedule; Collective Agreement between London Police Services Board and London Police Association (expiry December 31, 2022) at Article 41.01(a).

[9] *Re Town of Dryden and Dryden Police Association*, 1972 CanLII 631 (ON SC) at 4.

[10] *Durham Regional Police Association v Durham Regional Police Services Board,* 2007 CanLII 45400 (Knopf); *Regional Municipality of Niagara Police Services Board v Niagara Region Police Association,* 2013 CanLII 29061 (Marcotte).

[11] *Ottawa Police Services Board v Ottawa Police Association,* 2013 CanLII 17440 (Goodfellow).

[12] *Mississauga (City) v Mississauga Professional Fire Fighters' Assn., Local 1212 (Collective Agreement Grievance),* [2000] O.L.A.A. No. 795 (Simmons) at para 92.

[13] *Greater Sudbury (City) v Sudbury Professional Fire Fighters Association Local 527, International Association of Fire Fighters,* 2020 CanLII 62019 (Hayes) at para 103.

[14] *Mon Sheong Home for the Aged v Ontario Nurses' Association,* 2020 CanLII 8770 (Gedalof).

present proposal: for example, arbitrators have previously rejected proposals to implement specific ratios of full-time and part-time staff,[15] or specific ratios of RNs and RPNs.[16]

However, the tide is clearly turning regarding the acceptance of nursing staffing ratios. The growing consensus in research and scholarship is that minimum staffing ratios are necessary for the retention, and the health and safety, of nurses.

The Canadian Federation of Nurses Unions compiled the current evidence on staffing ratios in a report published in 2024. The authors conducted a literature review of studies on nursing ratios, finding: "All of the reviews described the harmful effects that lower staffing levels have on outcomes experienced by nurses."[17] Staffing levels had a host of significant impacts on nursing outcomes:

> Adequate nurse staffing levels have a profound impact on nurse retention, contributing to a more stable and engaged workforce. The majority of literature reviews (90%) indicated that increased nurse staffing leads to greater job satisfaction among nurses. Burnout was found to decrease in 94% of the reviews when nurse staffing levels were higher. Additionally, 88% of reviews indicated that increased nurse staffing is associated with reduced turnover. It was noted that some literature reviews reported mixed findings regarding the impact of nurse staffing on nurse outcomes such as intention to leave. Overall, these findings emphasize the critical importance of maintaining appropriate staffing levels to support the health and sustainability of the nursing workforce, which is essential for maintaining high-quality patient care and supporting workforce retention.[18]

Last year, Health Canada also published a study on increasing nursing retention by improving the working lives of nurses. One of the key recommendations was to implement safe "staffing practices (e.g., nurse-patient ratios) that reflect factors like patient acuity, nurse experience, and work-life balance."[19] The report emphasizes that employers should rely on evidence-based literature in setting nursing ratios.[20]

Despite this academic consensus, the OHA, in a recent press release, without citing any evidence, characterized staffing ratios as "antiquated 20th century thinking, at a time when Ontario's hospitals are innovating to respond to the demands and complexities of the 21st century."[21] It noted that "(f)ixed RN-to-patient ratios would remove the flexibility required to tailor staffing levels."[22]

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[15] See eg *Participating Hospitals v Ontario Nurses Association*, 2021 CanLII 88531 (Gedalof).
[16] See eg *Corporation of The County of Lambton (Marshall Gowland Manor) v Ontario Nurses' Association,* 2016 CanLII 8494 (McNamee).
[17] C. McTavish & A. Blain, *Nurse-Patient Ratios: Current Evidence Report*, Canadian Federation of Nurses Unions (2024) [*emphasis added*].
[18] *Nurse-Patient Ratios: Current Evidence Report*.
[19] Health Canada, *Nursing Retention Toolkit: Improving the Working Lives of Nurses in Canada* (2024) ["Nursing Retention Toolkit"].
[20] Nursing Retention Toolkit.
[21] Ontario Hospital Association, "OHA Statement on Staffing Ratios at Ontario Hospitals" (February 27, 2025) at 1 ["OHA Statement on Staffing Ratios"].
[22] OHA Statement on Staffing Ratios at 2.

This is clearly inaccurate. There is nothing about minimum staffing levels which compromises the Hospitals' ability to tailor staffing levels. To the contrary, the only thing minimum Registered Nurse-to-patient ratios would prohibit is a hospital from staffing below set evidence-based thresholds.

Indeed, the Hospitals appear to view hospital staffing, and healthcare as whole, as a race to the bottom. Because staffing ratios are not "a one-size-fits-all approach" to the province's overworked and overleveraged healthcare system,[23] they are, apparently, not worth implementing at all. Because "the impact of rapid population growth and increasing patient complexity will outpace any of the efforts to address these challenges through solely increasing…hospital staffing",[24] it is, apparently, not worth making any effort to staff appropriately. The Hospitals' solution is inertia.

This thinking is facile, fallacious, and, frankly, dangerous to each one of ONA's 62,000 hospital members.

Unlike Ontario, other provinces have not dismissed the overwhelming evidence on staffing ratios and have begun to take steps to address minimum staffing for nurses. In 2022, Alberta Health Services ("AHS") entered into a Letter of Understanding ("LOU") with the United Nurses of Alberta ("UNA") regarding staffing and workload. As set out in the LOU, AHS is developing staffing models based on a variety of factors, including the acuity of patients and the associated workload.[25] The LOU established a Provincial Workload Advisory Committee that will collaborate with UNA to develop the staffing models. Similarly, this year, the Nova Scotia Health Authority agreed to establish a working group on nurse staffing.[26]

In its most recent provincial agreement, UNA took another broad step towards safe staffing. In a new LOU, the Employers explicitly committed to "providing safe staffing for all patients, residents, and clients."[27] To achieve this, UNA and the Employers have agreed to identify a standardized list of clinical and operational data that will form the basis of a new evidence-based safe staffing review. If there is disagreement about safe staffing going forward, UNA can bring the issue to an expedited review by a Safe Staffing Taskforce, and if necessary, to an outside Independent Assessment Committee.[28]

British Columbia went one step further, in 2023, and voluntarily implemented minimum nurse-to-patient ratios ("mNPRs") in hospitals, long-term care and assisted living, and health authority community and non-hospital care settings. The Province explained the rationale for this step:

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[23] OHA Statement on Staffing Ratios at 2.
[24] OHA Statement on Staffing Ratios at 3.
[25] Collective Agreement between Alberta Health Services Covenant Health Lamont Health Care Centre The Bethany Group (Camrose) and The United Nurses of Alberta (expiry March 31, 2024) at 169.
[26] Collective Agreement between Nova Scotia Health Authority and The Nova Scotia Council of Nursing Unions (expiry October 31, 2025) at 297.
[27] United Nurses of Alberta, "UNA reaches Tentative Agreement in Bargaining with Employers for Provincial Collective Agreement" (March 10, 2025).
[28] United Nurses of Alberta, "UNA reaches Tentative Agreement in Bargaining with Employers for Provincial Collective Agreement" (March 10, 2025).

> Implementing minimum nurse-to-patient ratios (mNPRs) is critical to ensuring stronger workplaces for nurses. This includes workplace culture, and quality practice and learning environments, which, in turn, will foster better health-care settings for patients.[29]

As part of its commitment to implement mNPRs, the Province entered into a Memorandum of Understanding ("MOU") with the Nurses' Bargaining Association. The MOU sets out proposed mNPRs in hospital-based care, and sets objectives for the Ministry, working with the Nurses' Bargaining Association, to develop and implement ratios in other care settings.[30] The MOU also includes a timeline for implementing mNPRs in each care setting.

In 2024, Manitoba further cemented the trend towards minimum staffing by committing to establish mNPRs as part of team-based care, hospital-based care, long-term and residential care, and community and non-hospital care. The Employers and the Manitoba Nurses Union will work collaboratively to develop the mNPRs through a joint sub-committee.[31]

The recent developments in British Columbia, Alberta, Manitoba, and Nova Scotia demonstrate a clear trend in favour of minimum staffing ratios. These are freely negotiated outcomes and clearly inform the replication exercise with these parties.

Ontario, on the other hand, lags behind other provinces with no firm commitments to implement minimum staffing ratios or even study the issue. As the largest complement of nurses in Canada, ONA nurses should be leading the way in ensuring nurse retention, and health and safety, by implementing minimum staffing levels.

EXPERT EVIDENCE CONFIRMS URGENT NEED FOR STAFFING RATIOS

The expert evidence of the Union,[32] provided by Dr. Linda H. Aiken, proves that ONA's proposal is wholly justified based on demonstrated need. As noted above, arbitrators have afforded significant weight to expert evidence when setting minimum staffing levels.

Dr. Aiken's credentials speak for themselves. She is a professor at the University of Pennsylvania and Senior Fellow at the Leonard Davis Institute of Health Economics. She has bachelor's and clinical master's degrees in nursing and a PhD in sociology with specialization in demography. She founded and directed the Center for Health Outcomes and Policy Research, which is the international leader in nursing outcomes research with a robust portfolio of NIH and European Union funded research. She has

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[29] Province of British Columbia, "Minimum Nurse to Patient Ratios (mNPR)" (November 25, 2024).
[30] Memorandum of Understanding, *Process for Establishing, Reviewing/Amending Minimum Nursing/Patient Staff Ratios* (2023).
[31] Collective Agreement between *Shared Health Employers Organization and Manitoba Nurses Union (expiry March 31, 2028)* at 306-308.
[32] Linda Aiken, *Staffing Ratios and their Impact on the Health and Safety of Nurses: A Policy Brief (January 22, 2025)* unpublished Expert Report [*Ratios and their Impact on the Health and Safety of Nurses*].

published more than 400 peer reviewed scientific papers and is a highly cited researcher in the top 1% of Web of Science citations in Social Sciences.

Dr. Aiken prepared a Policy Brief on staffing ratios and their impact on the health and safety of nurses for this arbitration. Dr. Aiken provided a thorough review of the academic research on nurse burnout and the need for minimum staffing ratios.
She identified that the top reason nurses leave the profession is burnout linked to insufficient staffing:

> Research consistently shows that high patient-to-nurse ratios are significantly related to high nurse burnout, increased job dissatisfaction, and greater intent to leave current job.[33]

Among the significant findings in Dr. Aiken's policy brief:

- Nurse staffing levels are directly linked to patient outcomes – each one patient added to a nurse's workload is associated with a 7% increase in hospital mortality. Staffing ratios impact the ability to rescue patients facing a complication and success in resuscitations.[34]

- It is not the inherent stress of caring for sick people that leads to burnout; it is high workloads, low staffing levels, and low control over their work.[35]

- Attempting to replace professional nurses with less qualified personnel increases burnout and does not save money.[36]

Dr. Aiken provides an overview of other jurisdictions that have implemented mNPRs. California has had minimum nursing staffing levels since 2004. Their implementation led to a documented improvement in nurse job satisfaction and reduction in burnout, a positive effect that has been sustained for the past 20 years. Importantly, although this change was 'unfunded' in the sense that no additional resources were allocated to hospitals to implement it, Dr. Aiken found no evidence that it led to reduced services or hospital closures.[37]

Other US states that have implemented mNPRs include Oregon, Massachusetts (ICU only) and New York (ICU only). There is similar legislation pending in three other US states.[38]

In Australia, the province of Victoria was a very early adopter of mNPRs in 2000. While there is little scientific research of the outcome of that policy, when Queensland introduced mNPRs in 2016, the province also funded a comprehensive evaluation of the policy, which unequivocally proved its significant benefits, including:

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[33] *Ratios and their Impact on the Health and Safety of Nurses* at 1.
[34] *Ratios and their Impact on the Health and Safety of Nurses* at 2.
[35] *Ratios and their Impact on the Health and Safety of Nurses* at 2.
[36] *Ratios and their Impact on the Health and Safety of Nurses* at 2.
[37] *Ratios and their Impact on the Health and Safety of Nurses* at 5.
[38] *Ratios and their Impact on the Health and Safety of Nurses* at 6-9.

- Nurses were 24% less likely to experience burnout and 27% less likely to report job dissatisfaction.

- In the hospitals that implemented mNPRs, there were 145 fewer deaths, 255 fewer readmissions, and 29,222 fewer hospital days within two years than if they had not implemented the policy.

- Importantly, the policy had a clear economic benefit: the savings due to fewer readmissions and shorter lengths of stay in hospitals was about $70 million (AUD), more than twice the cost of the additional nurse staffing.[39]

Dr. Aiken's conclusion to her policy brief speaks loudly and clearly—mNPRs will significantly improve nurse health and well-being, patient outcomes, and the hospitals' bottom line:

> There is a substantial body of evidence globally and in Canada that improving hospital nurse staffing is associated with lower nurse burnout, job dissatisfaction, intent to leave current job, and greater nurse safety in terms of fewer reports of emotional and physical abuse. Policies with the greatest evidence of impact on improving nurse wellbeing and retention have been those that establish minimum safe nurse-to-patient ratios. Across jurisdictions, there is little published evidence of adverse unintended consequences associated with implementation of minimum nurse to patient ratios. Depending upon health system organization and financing in different jurisdictions, there is evidence that improving hospital nurse staffing results in cost savings through reducing expensive nurse turnover, avoiding expensive adverse patient outcomes, avoiding hospital readmissions within 30 days of discharge, and reducing hospital length of stay; these savings offset the cost of employing additional nurses.[40]

THE CURRENT LANDSCAPE – DATA ON HOSPITAL STAFFING LEVELS DEMONSTRATE THE FEASIBLITY AND NECESSITY OF ONA'S PROPOSAL

ONA sought disclosure of staffing data from Ontario hospitals as part of the present arbitration. That data revealed, to the extent that the participating hospitals are tracking ratios, that nurse staffing levels are inconsistent; and ONA's proposed staffing ratios are already being implemented at various hospitals and are feasible across the province.

Current Staffing Ratios are Inexplicably Inconsistent

In Ontario, a Hospital RN is a single job classification with the same qualifications, duties, and responsibilities attached to the position. Despite this reality there is wide divergence in how Ontario hospitals staff the same types of units with RNs. An RN at one hospital is regularly tasked with caring for twice as many patients as an RN at a

[39] *Ratios and their Impact on the Health and Safety of Nurses* at 11-13.
[40] *Ratios and their Impact on the Health and Safety of Nurses* at 21.

different hospital, despite the patients having the same acuity level and requiring the same level of care.

As part of these proceedings, ONA requested data on RN staffing ratios from all of the participating hospitals. Out of 132 hospitals,[41] 40 hospitals (30%) provided RN staffing ratios, or the required data to calculate RN staffing ratios, for at least one unit.

	#	%
Hospitals without data	63	48%
Hospitals with data that include RPNs	6	5%
Hospitals with unusable data	23	17%
Hospitals with RN ratios	**40**	**30%**
Total	132	100%

The Adult Medical Surgical unit is the largest and most ubiquitous unit among the hospitals. Beds in this type of unit make up the bulk of the hospital beds. And yet, the staffing of these beds varies widely. ONA proposes a ratio of 1:4 (4 patients per RN). Some hospitals, including some major institutions, are meeting or are close to meeting that ratio: Kingston Health Sciences Centre, MIC's Group of Health Services, Mount Sinai Hospital, Tillsonburg District Memorial Hospital, Unity Health - St. Michael's, West Parry Sound Health Centre, and Winchester District Memorial Hospital all have a ratio of 1:4 to 1:5.1 during the day in these units.

At the same time, 8 hospitals are staffed at a nurse-to-patient ratio that is three to six times higher than ONA's proposal. There is no justifiable reason for this variance. Most egregiously, at one Hospital, Runnymede Healthcare Centre, the Registered Nurse-to-Patient Ratio in Adult Medical Surgical is 1:69, meaning that there is **one RN for every 69 patients**:

Hospital **1 Nurse to X Patients** ***if multi yrs given, current yr**	**Region**	**Adult Medical Surgical**	
		Day	**Night**
ONA PROPOSED		**4**	**4**
Almonte General Hospital	2	15.3	15.3
Blanche River Health	1	13.6	13.6
Brant Community Healthcare System	4	13.6	15.8
Deep River & District Hospital	2	16	16
Haldimand War Memorial Hospital	4	19.5	19.5
Norfolk General Hospital	4	15.7	23.5
North of Superior Healthcare Group	1	22.5	22.5

[41] Note: Excluding two Allied units and disaggregating Unity Health and TG/TW.

Riverside Health Care Facilities	1	17.5	17.5
Runnymede Healthcare Centre	3	69	69

It is self-evident that an RN caring for 69 patients faces a greater health and safety risk than an RN caring for 4 patients. Whatever staffing flexibility the hospitals require should not include the flexibility to assign 69 patients to a single RN in the same category of unit that assesses the need to be 1 RN for every 4 patients.

The inconsistency across units is plain to see from the data:

Unit	**# of Hospitals with Ratios**	**Lowest Daytime Ratio**	**Highest Daytime Ratio**
Adult Medical Surgical	31	4	69
Pediatric Medical/Surgical	8	3	6
Rehabilitation	11	4	68.5
Palliative Care	4	5	20
Step Down	6	1.6	3
Pediatric Step Down	1	2	2
Telemetry	2	4	4.5
CC/IC	21	1	3
Maternity/Antepartum & Post Partum	12	2	10
L&D/Intrapartum	9	1	6.75
Mental Health	13	3	15
Mental Health IC/Intensive Observation Areas	3	2	10.4
Post Anesthetic Care Unit	4	1.5	9.5
OR incl Outpatient Procedures	5	0.5	1.3
Outpatient Dialysis	2	3	3

The Union's proposal is crucial to bringing rationality and consistency across the province. The Union's proposal will standardize the approach across the province so that staffing levels are coherently linked to the protection of nurse health and safety and the required level of care.

Existing staffing levels demonstrate feasibility of proposed ratios

Despite the current inconsistency in how hospitals are staffing the same units across the province, the ratios proposed by ONA are already proven to be practical and feasible.

The practicality of ONA's proposed ratios is demonstrated by the fact that, of the 15 basic units for which ONA proposed ratios,[42] all but two are already being met.

Adult Medical Surgical (Proposed Ratio: 4)		
Hospital	Day	Night
Mount Sinai Hospital	4	5.5
Tillsonburg District Memorial Hospital	4	4
Unity Health - St. Michael's	4.2	5.5

Step Down (Proposed Ratio: 2)		
Hospital	Day	Night
Chatham-Kent Health Alliance	2	2
Guelph General Hospital	2.1	2.3
Michael Garron Hospital	2	2
Mount Sinai Hospital	2	2
St. Joseph's Healthcare (Hamilton)	1.6	1.7

Critical Care/Intensive Care (Proposed Ratio: 1)		
Hospital	Day	Night
Children's Hospital of Eastern Ontario	1	1
Michael Garron Hospital	1	1
Mount Sinai Hospital	1	1
Queensway-Carleton Hospital	1.3	1.3
Southlake Regional Health Centre	1.3	1.3

Maternity/Antepartum & Post Partum (Proposed Ratio: 3)		
Hospital	Day	Night
Riverside Health Care Facilities	2	2
Sioux Lookout Meno-Ya-Win Health Centre	2.5	2.5

Mental Health (Proposed Ratio: 4)		
Hospital	Day	Night
Children's Hospital of Eastern Ontario	3	3
Mount Sinai Hospital	3.5	7.5

Post Anesthetic Care Unit (Proposed Ratio: 2)		
Hospital	Day	Night
Michael Garron Hospital	2	2
Northumberland Hills Hospital	1.5	1.5

Rehabilitation (Proposed Ratio: 4)		
Hospital	Day	Night
Hotel-Dieu Grace Healthcare	4	10
Joseph Brant Hospital	4	4

Telemetry (Proposed Ratio: 4)		
Hospital	Day	Night
Niagara Health System	4	4

Pediatric Medical/Surgical (Proposed Ratio: 3)		
Hospital	Day	Night
Children's Hospital of Eastern Ontario	3	3

L&D/Intrapartum (Proposed Ratio: 1)		
Hospital	Day	Night
Brant Community Healthcare System	1.3	1.3
Chatham-Kent Health Alliance	1	1
Norfolk General Hospital	1.3	1.3
Northumberland Hills Hospital	1	1
Southlake Regional Health Centre	1.2	1.2

Mental Health IC/IO Areas (Proposed Ratio: 2)		
Hospital	Day	Night
Niagara Health System	2	2
Unity Health - St. Michael's	2.4	2.6

OR incl Outpatient Procedures (Proposed Ratio: 1)		
Hospital	Day	Night
Almonte General Hospital	1.3	1.3
Carleton Place & District Memorial Hospital	1.3	1.3
Haldimand War Memorial Hospital	0.5	0.5
Winchester District Memorial Hospital	0.75	0.75

Outpatient Dialysis (Proposed Ratio: 3)		
Hospital	Day	Night
Chatham-Kent Health Alliance	3	3

[42] ONA proposed three separate ratios for subunits in the Emergency Department (Triage, Trauma/Resuscitation, Visits). However, the hospitals rarely reported their ratios or beds and staffing data broken down into these subunits. An accurate analysis of existing staffing ratios in comparison to those proposed by ONA was not possible, so they have been excluded here.

Winchester District Memorial Hospital	3	3

The exceptions were Palliative Care and Pediatric Step Down, for which ONA received very few reported examples of staffing levels (4 and 1, respectively). However, even in these two units, the hospitals that did report staffing levels were close to achieving ONA's proposed ratios. In Palliative Care, Unity Health – St Michael's is staffing at a ratio of 1:5 while ONA's proposed ratio is 1:3. In Pediatric Step Down, the lone hospital to report RN ratios - Niagara Health - is staffing at 1:2, while ONA proposes a ratio of 1:1.

Importantly, it is not only large urban hospitals that are able to staff at levels to meet the proposed ratios. There are hospitals meeting the proposed ratios from every region in the province. Indeed, most of the hospitals with units staffed at the proposed ratios are from outside the GTA, including two hospitals from northern Ontario:

ONA Region	# of Hospitals Staffing a Unit to Proposed Ratio
1	2
2	6
3	4
4	7
5	3

Several hospitals are also already meeting ONA's proposed ratios in multiple units. Mount Sinai has four units staffed to ONA's proposed ratios (Adult Med/Surg, Step Down, CC/IQACU, and PACU). Chatham-Kent Health Alliance, Michael Garron, and CHEO have three units staffed at ONA's ratios, while Unity Health - St. Michael's, Southlake Regional Health Centre, Northumberland Hills Hospital, Winchester District Memorial Hospital, Niagara Health System are staffing two units each at the proposed ratios.

Hospital	**Region**	**Units Meeting Proposed Ratios**
Mount Sinai Hospital	3	4
Chatham-Kent Health Alliance	5	3
Michael Garron Hospital	3	3
Children's Hospital of Eastern Ontario	2	3
Unity Health - St. Michael's	3	2
Southlake Regional Health Centre	3	2
Northumberland Hills Hospital	2	2

Winchester District Memorial Hospital	2	2
Niagara Health System	4	2
Tillsonburg District Memorial Hospital	5	1
Guelph General Hospital	4	1
St. Joseph's Healthcare (Hamilton)	4	1
Queensway-Carleton Hospital	2	1
Riverside Health Care Facilities	1	1
Sioux Lookout Meno-Ya-Win Health Centre	1	1
Hotel-Dieu Grace Healthcare	5	1
Joseph Brant Hospital	4	1
Brant Community Healthcare System	4	1
Norfolk General Hospital	4	1
Almonte General Hospital	2	1
Carleton Place & District Memorial Hospital	2	1
Haldimand War Memorial Hospital	4	1

CONCLUSION

Setting minimum staffing ratios is by far the most significant and impactful step the parties can take in this round of bargaining to promote retention and the health and well-being of nurses in Ontario. Health and safety protection for hospital RNs though staffing ratios is long overdue for this bargaining unit, and the Union's proposal should be awarded in its entirety.

WORK OF THE BARGAINING UNIT PROPOSAL

PROPOSAL #2 – WORK OF THE BARGAINING UNIT

10.12 (a) ~~Nurses who are in supervisory positions excluded from the bargaining unit shall not perform duties normally performed by nurses in the bargaining unit which shall directly cause or result in the layoff, loss of seniority or service or reduction in benefits to nurses in the bargaining unit.~~

~~Nurses will be assigned duties and responsibilities in accordance with the *Regulated Health Professions Act* and other applicable statutes and regulations thereto.~~ Hospitals will not assign ~~such duties and responsibilities~~ **work normally performed by employees of the bargaining unit** to employees not covered by this agreement. ~~unless those duties and responsibilities are appropriate to the position occupied by the person to whom the duties and responsibilities are being assigned and are consistent with quality patient care~~.

Unless otherwise agreed by the Union and the Hospital, work performed by full-time nurses will not be assigned to part-time nurses for the purpose of eliminating full-time positions.

EMPLOYER POSITION

Opposed.

10.12(d) **The parties agree that patient care is enhanced when health care organizations collaborate to care for patients and provide the right care, at the right time, in the right place.**

To this end, partnership arrangements may be established to assign nurses to other health care organizations. These assignments are time-limited and may involve full- or part-time transfers, rotational assignments, ad hoc support, or other arrangements.

The terms and conditions of the assigned nurses will be established by agreement of the parties. The terms and conditions will include the manner by which nurses will be selected for these assignments.

The parties agree that a hospital may allow a nurse from another Employer to be assigned to the hospital for a period not greater than one (1) year. It is understood that this nurse remains the employee of the sending Employer and is subject to the terms and conditions of employment of that Employer. If the nurse is not covered by an ONA Collective Agreement, the Hospital will ensure that the Union receives the equivalent of the dues remittance for all such workers.

UNION RATIONALE

OVERVIEW

The current Article 10.12(a) is unwieldy, overly formulaic and does little, if anything, to actually protect bargaining unit work. The Union's proposal for Article 10.12(a) pares down the 'work of the bargaining unit' clause to what the clause should be: a universal and enforceable job protection clause.

Under the current language of Article 10.12(a), the Hospitals may assign nursing work to employees outside the bargaining unit where:

> those duties and responsibilities are appropriate to the position occupied by the person to whom the duties and responsibilities are being assigned and are consistent with quality patient care.

This clause is useless and provides the Hospitals with overly broad discretion to undermine, de-professionalize, and apportion ONA's work to save money. Such language would be unacceptable to any union and, indeed, there is no union across the Participating Hospitals with such permissive reassignment and contracting out language. It is certainly no accident that the Hospitals' most female-dominated Union is the one with the least respectful or robust protection for its bargaining unit work.

Significantly, this language was not freely negotiated by the parties, and ONA has tried on several occasions to change it. However, rectifying this issue can no longer be put off for future rounds for three key reasons.

First and foremost, unlike in previous rounds, there is now clear and obvious demonstrated need for increased bargaining unit protection. The assignment of RN work to RPNs has been long-standing but, increasingly, presents an existential threat to the strength of the ONA bargaining unit. The Hospitals have communicated explicitly that they intend to systematically evaluate areas where RPNs can be performing the work performed by ONA's bargaining unit. In the face of this threat, Article 10.12(a) has shown time and time again that it is entirely ineffective at protecting ONA's work.

Second, the asymmetry of the bargaining unit protection language under the ONA and CUPE Central agreements reinforces and exacerbates the erosion of RNs' work and provides a clear, compelling internal example

supporting the Union's proposal. Without any additional protection, ONA's work is free to be reassigned to CUPE Central RPNs; however, once the work falls under the scope of the CUPE work protection clause, it remains there in perpetuity. For the largest, most female-dominated Union in the country, this is simply unacceptable.

Finally, the weakened protections to job security awarded by Arbitrator Kaplan last round have upset the balance of job security provisions under the agreement, a trade off which has existed since 1998 when Article 10.12(a) was first awarded. In

order to restore this balance, the Union respectfully submits that its proposal must be awarded in full.

DEMONSTRATED NEED: THE HOSPITALS INTEND TO CONTINUE ERODING ONA'S BARGAINING UNIT BY ASSIGNING RN WORK TO RPNS

The expansion of RPNs' scope of practice by the CNO has seen RPNs introduced into numerous critical care areas across the Hospitals in an effort to contain costs. The extent to which this move is actually cost-effective is suspect, given any immediate savings on salary do not account for the increased costs of morbidity, mortality and readmission.[43]

However, in any event, the trend of replacing RNs with RPNs has already had a devastating impact on the integrity of ONA's bargaining unit and is only going to grow more acute.

As Arbitrator Albertyn summarized in 2016 when faced with a similar proposal to improve ONA's work of the bargaining unit protection:

> The Union is faced with an historical circumstance that is not to its advantage. Following the Report of the Johnson Hospital Inquiry Commission in 1974, the current structure of hospital bargaining units was established. At that time the role of nursing assistants was very different from the role now played by RPNs within the health care system. The scope of practice of RPNs has expanded significantly over the years since the 1970s and they now have considerable community of interest with RNs. The problem, though, is that they are in separate bargaining units from the RNs. This reality appears to be creating labour relations problems for some hospitals, for ONA, and for the unions representing RPNs. There is no easy solution, so the Union has understandably reacted to it by seeking greater enforcement of the protections it has to its bargaining unit work, and by seeking to extend and improve those protections.[44]

In that award, he rejected ONA's proposal but noted that "to the extent that changes on staff mix impact on the job security and professional interests of ONA members, the Union has a legitimate interest."[45]

Contrary to the repeated assertions of the Hospitals in response to ONA's proposals to improve Article 10.12(a), the Union is not seeking to make a labour relations issue out of patient care. Rather, the Union is, like all unions that negotiate work of the bargaining unit language, merely seeking to protect the job security of its members.

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[43] In 2017, the RNAO released a study of 70 years of research of RN effectiveness, which conclusively demonstrated that the use of RNs was correlated with positive financial outcomes and cost-efficiency in direct care. See Registered Nurses' Association of Ontario, "70 Years of RN Effectiveness Backgrounder", 2017; Zainab Lulat RN, MN et al, "Seventy Years of RN Effectiveness: A Database Development Project to Inform Best Practice", *World Review on Evidence-Based Nursing* 15:4, p 281-289.

[44] *Participating Hospitals v Ontario Nurses' Association*, 2016 CanLII 59375 at para 17 [*Participating Hospitals*].

[45] *Participating Hospitals* at paras 20.

Falling short of awarding improved bargaining unit work protection, Arbitrator Albertyn instead awarded language requiring the Hospitals to disclose information to properly assess the skill mix changes that, at that time, were occurring between RNs and RPNs.[46] In doing so he "concluded that the question of greater bargaining unit job security for RNs in relation to RPNs is a matter to be left to future bargaining between the parties, once fuller information becomes available under the provision awarded below."[47]

The Union respectfully submits, nearly a decade from Arbitrator Albertyn's observation, that the time is now.

On the back of repeated expansions of the RPNs' scope of responsibility, the Ontario Ministry of Health recently reported in *Your Health: A Plan for Connected and Convenient Care* that "we have been working with the College of Nurses of Ontario on proposed regulation changes to allow registered practical nurses increased responsibilities that would help patients access care for certain procedures more quickly."[48]

On March 13, 2025, at Southlake Hospital, the Manager of Employee and Labour Relations, Dan Levesque identified explicitly the Hospital's intention, as a result of the ongoing expansion of RPN practice, to systematically review areas where RN work can be assigned to RPNs:

> As discussed during LMM last week, given the ongoing expansion to the RPN scope of practice, the Hospital has determined that it may assign overall responsibility for patient care on a Unit to RPNs.
>
> This position will no longer be automatically afforded to an RN. Going forward, the Hospital will be reviewing individual areas to determine whether overall responsibility for patient care on a unit can be assigned to an RPN. The Hospital will consider factors such as complexity and acuity of patients on the unit as well as experience and qualifications of the individual nurse, to ensure patient safety prior to assigning overall responsibility for patient care on a unit.[49]

This is an existential threat to the viability of ONA's bargaining unit, as Hospitals across the province, like Southlake, will be looking to expand the use of RPNs to the detriment of RNs.

These developments are especially concerning in light of the impact the increasing reliance on RPNs as a cost-saving measure has already had on ONA's work across the Hospitals.

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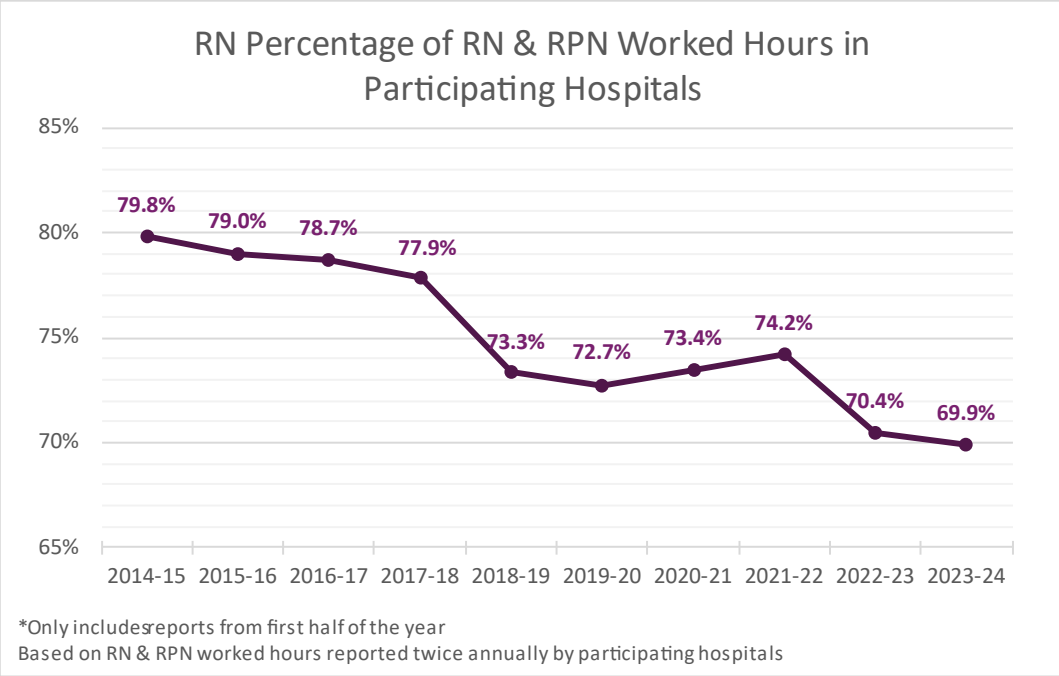
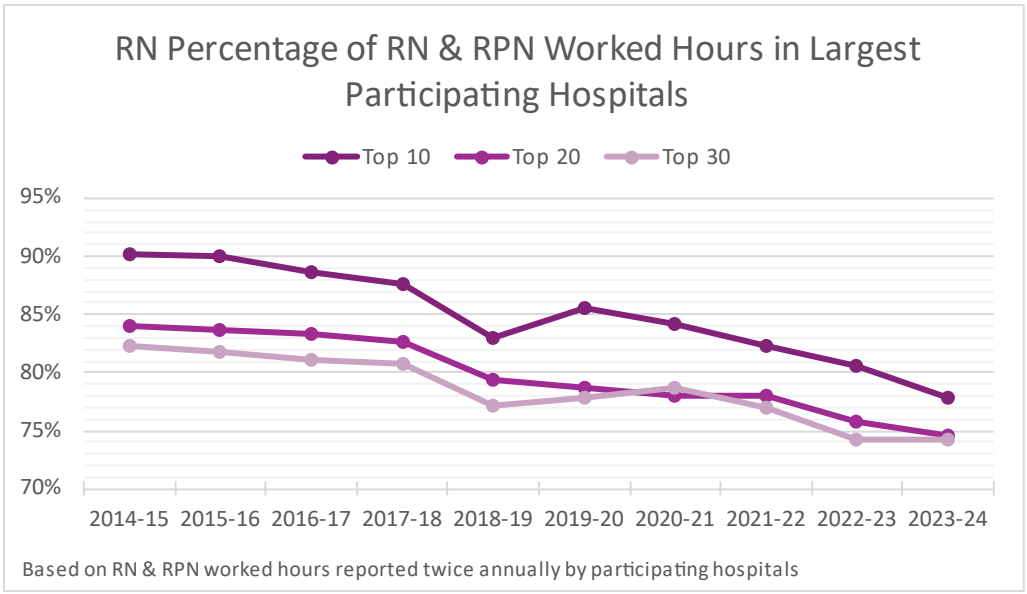
[46] *Participating Hospitals* at paras 23-24.
[47] *Participating Hospitals* at para 20.
[48] Ontario Ministry of Health, *Your Health: A Plan for Connected and Convenient Care*.
[49] Email from Dan Levesque re RPN Change, March 13, 2025

Over the decade since Arbitrator Albertyn ordered the Hospitals to disclose RN/RPN ratios to the Association, the RN percentage of RN-RPN hours worked across the Participating Hospitals has declined almost **10 percentage points**:



The situation is even more concerning at the largest of the Participating Hospitals, which are driving the overall provincial trend:



Evidently, over the last decade, RNs' share of nursing work across the Hospitals has diminished in favour of the increasing use of RPNs.

This is further evidenced in the numerous grievances that ONA has filed on this issue at hospitals across the province, which have been unsuccessful in overturning the Employer's persistent assignment of RN work to RPNs:

- Sault Area Hospital: The Union filed two separate grievances related to multiple employer decisions to replace 1 PT RN and 3 FT RN positions with four permanent RPN positions outside the bargaining unit. The grievances were filed on July 4, 2022, and did not result in the reversal of the assignment.[50]

- Health Sciences North: The Union filed two grievances related to the cancellation of RN shifts in dialysis and their replacement with two RPN shifts performing the same work. The grievances were filed on January 25, 2023, and did not result in the reversal of the assignment.[51]

- Northumberland Hills:

    - The Union filed a grievance concerning the Employer's failure to staff three RNs in the Pass Unit and its subsequent assignment of the work to an RPN float. The grievance was filed on April 12, 2023, and was withdrawn.[52]

    - The Union filed two grievances concerning the Hospital's practice of not offering RNs partial tours and instead working short or filling the tours with RPNs. The grievance was filed on March 24, 2024, and has been held in abeyance.[53]

    - The Union filed two grievances concerning the Hospital's practice of filling an RN shift with RPNs. The grievance was filed on March 28, 2024, and has been held in abeyance.[54]

- Erie Shores Healthcare: The Union filed two grievances concerning the Employer's practice of filling RN sick calls with RPNs without making any attempt to fill with another RN.[55]

- Windsor Regional Hospital: The Union filed four grievances concerning the Employer's practice of assigning RPNs to the Emergency Department,

[50] Grievance #202208304 and Grievance #202206432.
[51] Grievance #202300542 and Grievance #202300449.
[52] Grievance #202304160.
[53] Grievance #202403970 and Grievance #202403971.
[54] Grievance #202403986 and Grievance #202403985.
[55] Grievance #202500341 and Grievance #202406259.

performing responsibilities concerning admitted patients which have only been performed by RNs.[56]

- Bluewater Health: The Union filed two grievances after RPNs were called to replace RN shifts without offering them first to RNs. The grievances have been set for a hearing on September 9, 2025.[57]

- Grand River: The Union filed six grievances, including a policy grievance, concerning the Hospital's use of RPNs to fill RN sick shifts without first offering the shifts to RNs.[58]

- Halton Healthcare: The Union filed a grievance concerning the Hospital's decision to replace two RN positions with RPNs.[59]

- University Health Network – Toronto Rehabilitation Institute:

    - The Union grieved the Employer's decision to lay off nine RNs, in light of the Hospital's announcement that its changing model of care required fewer RNs.[60]

    - The Union grieved the Employer's decision to reassign RN work to RPNs and PSWs, rather than recruit RNs for 10 vacant positions.[61]

- North York General Hospital:

    - The Union grieved the Hospital's decision to change the skill mix in the Emergency Department from staffing with four RNs to two RNs and two RPNs in the Yellow Zone and 1 RN to 1 RPN in the Red Zone.[62]

    - The Union filed two individual grievances concerning the Hospital's decision to fill a vacant RN line with an RPN, when there were RNs available who would have performed the work.[63]

- North Bay Regional Hospital:

[56] Grievances #202407990, #202410061, #202410411, and #202410935.
[57] Grievance #202407193 and Grievance #202406066.
[58] Grievances #202313244, #202312161, #202312164, #202406679, #202407161, and #202406692.
[59] Grievance #202502595.
[60] Grievance #202001495.
[61] Grievance #202213689.
[62] Grievance #202413257.
[63] Grievance #202413822.

- The Union grieved a reduction of RN hours in PACU/Day Surgery/Ortho/Pain Clinic and the contracting out of the work to RPNs.[64]

- The Union filed two grievances concerning reductions in work in the Dialysis/Renal Unit, resulting in a loss of three shifts that were replaced with RPNs, and the IP Medicine Combined Unit as a result of changes to the model of care.[65]

- Southlake Hospital: The Union grieved the Hospital's decision to post a permanent RPN position after an RN was temporarily assigned to the mental health unit.[66]

In addition to the grievances that have been filed, there are also numerous incidents where, understandably, given the agreement's weak bargaining unit work language, grievances have not been filed at all.

Indeed, over the last two years, the Union has received numerous notices of elimination of vacant RN positions which were subsequently staffed by RPNs. Because these eliminations often did not result in a layoff or an individual loss of hours, there was no viable grievance to challenge the work being transferred. These incidents include:

- Lakeridge Health – 04/24/23 – 1 FT RN to be replaced with RPN[67]
- Espanola Regional Hospital – 04/14/23 – Family health team FT RN replaced with RPN[68]
- Mount Sinai – 05/27/24 – multiple positions eliminated, where the Hospital introduced RPNs[69]
- Unity Health – 04/03/2024 – Family health team FT RN replaced with RPN[70]
- West Park – 06/18/24- multiple RN position eliminated due to change in model of care and replaced with RNs[71]
- North Bay 03/01/24 – FT RN position replaced with RPN[72]

[64] Grievance #202411143.
[65] Grievance #202550126 (25-05 and 25-06).
[66] Grievance #202014581.
[67] Email from Brandon Walker re Lakeridge Health – Notice of Eliminations, April 24, 2023.
[68] Letter from Marlo DesJardin, Director of Human Resources, April 14, 2023.
[69] Letter from Kate Wilkinson, Vice President, Clinical Operations & Enterprise Risk, May 27, 2024.
[70] Email from Beverly Davis re Notice of Elimination, March 4, 2024.
[71] Email from Sheri Street re West Park Healthcare Centre – RN layoffs – ABIB unit – GEL 202403669, June 18, 2024.
[72] Letter from Kelly Hanselman, Manager, Employee Labour Relations re Notice of Elimination of Position – Full Time Registered Nurse – Ambulatory Care Unit (ACU), February 23, 2024.

- Notre Dame 07/05/24 – FT RN position replaced with an "RPN role within the CUPE union"[73]
- Brightshores – 02/20/25 – 1 FT RN position replaced with FT RPN and PT RPN[74]

These are not isolated incidents, but part of a broader pattern and approach to cost-savings in patient care that the Hospitals have been pursuing for over a decade. Notably, in all of these cases, Article 10.12(a) was not effective in reversing the Employer's systematic erosion of ONA's bargaining unit.

INTERNAL COMPARABILITY AND REPLICATION: ASYMMETRICAL BARGAINING UNIT PROTECTION CLAUSES ACROSS THE HOSPITALS

The recurrent problem of RN work being taken over by out-of-unit RPNs is not merely a feature of a cynical trade-off between cost and quality patient care. Rather, the dynamic arises directly and inevitably from the language of the Collective Agreement and the total lack of symmetry between the bargaining unit protection clauses across the Hospitals.

Notably, despite being the largest bargaining unit across the OHA, ONA's work of the bargaining unit clause is far and away the most permissive:

OHA Bargaining Unit	Work of the Bargaining Unit Clause
ONA Provincial	Nurses will be assigned duties and responsibilities in accordance with the *Regulated Health Professions Act* and other applicable statutes and regulations thereto. Hospitals will not assign such duties and responsibilities to employees not covered by this agreement unless those duties and responsibilities are appropriate to the position occupied by the person to whom the duties and responsibilities are being assigned and are consistent with quality patient care.
CUPE Central: 25,000 Employees at 54 OHA Hospitals	Employees not covered by the terms of this Agreement will not perform duties normally assigned to those employees who are covered by this Agreement, except for the purposes of instruction, experimentation, or in emergencies when regular employees are not readily available.

[73] Email from Jennifer Paul re Notre Dame Hospital – Notice of Elimination Desk nurse position, July 5, 2024.
[74] Email from Lisa Knight re Brightshores Health Services – Elimination of a vacant position, February 20, 2025

SEIU Central: 13,000 Employees at 33 OHA Hospitals	Employees not covered by the terms of this Agreement will not perform duties normally assigned to those employees who are covered by this Agreement, except for the purposes of instruction, experimentation, or in emergencies when regular employees are not readily available.
Unifor: 1,700 Employees at 9 OHA Hospitals	Employees not covered by the terms of this Agreement will not perform duties normally assigned to those employees who are covered by this Agreement, except for the purposes of instruction, experimentation, or in emergencies when regular employees are not readily available.
OPSEU: 11,000 Employees at 52 OHA Hospitals	Supervisors or Managers excluded from the bargaining unit shall not perform duties normally performed by members in the bargaining unit which shall directly cause or result in the layoff, loss of seniority or service or reduction in benefits to members in the bargaining unit.

ONA, in its agreements with the Participating Nursing Homes, where the changing scope of RN-RPN practice is also a concern, has secured identical language to the agreements the OHA has negotiated with its other units:

> 2.04 Work of the Bargaining Unit
>
> (a) In order to protect the standard of nursing care, the Employer shall not contract out the work normally performed by members of this bargaining unit except:
>
> i) For purposes of instruction,
>
> ii) In the event of an emergency situation,
>
> iii) When performing developmental or experimental work, or
>
> iv) When employees are not available due to an employee not reporting for work as scheduled or not being available for work.[75]

However, most significantly, under CUPE Central's agreement with the OHA, which includes the vast majority of Hospital RPNs, Article 11 protects the type and volume of RPNs' work.[76] This language has been in place at the Hospitals since a 1979

[75] Collective Agreement between Ontario Nurses Association and the Participating Nursing Homes (expiry June 30, 2026) at Article 2.04.
[76] CUPE Central Agreement with the Ontario Hospitals Association (expiry September 28, 2025) at Article 11.01.

award from Arbitrator Brown, which provided the following common-sense rationale for its inclusion:

> The purpose of this clause is to protect the employees in the bargaining unit from erosion of their duties performed by employees outside the bargaining unit. To state it in another way, to protect the work of the bargaining unit employees by excluding other employees from performing that work, but it cannot be taken that this provision extends the duties of work of the employees in this bargaining unit to other operations or duties performed by other employees. The purpose of the clause is the protection of the work of the bargaining unit employees and not the broadening of that work to other areas.[77]

While early jurisprudence on the CUPE provision outlined that the article did not apply when there was a historical overlap in duties between employees under different units (for instance, as is frequently the case between ONA RNs and CUPE RPNs), beginning with Arbitrator Mitchnick's award on similar language in *Extendicare,*[78] arbitrators have consistently held that Article 11 is a broad bargaining unit protection clause which protects the type and volume of CUPE's work.[79] This means that even where there is an overlap in duties, Article 11 prohibits the Hospitals from reassigning the type and volume of CUPE's existing work out of unit.

ONA's Article 10.12(a) provides far less robust protection. As one arbitrator noted in *Peterborough Regional Health Centre,* Article 10.12(a) is "bargaining unit protection language, but of a rather unusual sort."[80] He observed that, unlike Article 11, ONA's clause:

> …doesn't prevent the Hospital from assigning RN work to RPNs, but it makes such an assignment subject to the requirement that it be "consistent with quality care". As is obvious from the language, this is a potentially broad inquiry and one which places the arbitrator in the unenviable position of having to determine whether the Hospital's cost saving measure…is consistent with quality patient care.[81]

The total asymmetry between CUPE Article 11 and these parties' Article 10.12(a) creates an obvious and inevitable issue for ONA: while RN work can be freely assigned to RPNs so long as it is consistent with patient care, the moment that work is performed by a CUPE RPN, Article 11 ensures that the work remains within the CUPE unit.

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[77] *Milton District Hospital and Canadian Union of Public Employees,* November 23, 1987 (Picher, Unreported) citing Arbitrator Brown's December 15, 1979 Award.
[78] *ONA v Extendicare (Laurier Manor),* 1997 CarswellOnt 5419 (Mitchnick).
[79] See *Royal Ottawa Hospital v Canadian Union of Public Employees, Local 942*, 2019 CanLII 98881 (ON LA) (Knopf); *Health Sciences North v Canadian Union of Public Employees Local 1623,* 2018 CanLII 93856 (ON LA) (Schmidt); and *Royal Ottawa Health Care Group v CUPE, Local 942,* 2011 CarswellOnt 9706 (Goodfellow).
[80] *Peterborough Regional Health Centre v Ontario Nurses' Association,* 2013 CanLII 29332 (ON LA) (Randall).
[81] *Peterborough Regional Health Centre v Ontario Nurses' Association,* 2013 CanLII 29332 (ON LA) (Randall).

Indeed, somewhat paradoxically, despite the original rationale for Arbitrator Brown's award, the discrepancy in bargaining unit protection, in fact, provides a clear way for other units to expand, rather than merely protect, its bargaining unit work. This expansion necessarily comes at a cost to the work performed by ONA RNs.

As can be seen in the limited jurisprudence on Article 10.12(a), the provision has infrequently been relied on to attempt to protect RN work from being assigned to RPNs and when it has, it has been largely unsuccessful.

In *North Bay General Hospital,* Arbitrator Randall denied a grievance which alleged a violation of Article 10.12(a) and agreed with both the Hospitals and CUPE, appearing as intervenor, that the Article was broad and permissive:

> As importantly, I agree with both the Hospital and the Intervenor that 10.12(a) is unique in that it does not restrict the Hospital from assigning bargaining unit work to non-bargaining unit staff. Rather, the Hospital is free to do that subject to two provisos: 1) that the duties and responsibilities assigned are appropriate to the assignee's scope of practice and 2) that the assignment is "consistent with quality patient care". As work assignment clauses go, this is broad and permissive.[82]

In *North Bay Regional Health Centre,* Arbitrator Brownlee similarly dismissed 27 grievances which alleged violations of Article 10.12(a) as a result of the Hospital's practice of using RPNs to fill RN shifts.[83]

In 2016, trying a different approach, ONA applied to the Ontario Labour Relations Board under s. 99 of the *Labour Relations Act* for a finding that RN work that had been assigned to RPNs was an improper assignment.[84] It was unsuccessful. The Board, relying on Arbitrator Randall's decision in *North Bay General,* noted that "(t)he clause falls well short of an absolute restriction on an employer's ability to assign work performed by ONA bargaining unit members to others."[85]

In *Guelph General Hospital*, Arbitrator Newman, in fact, characterized Article 10.12(a) not as bargaining unit protection but as "explicit work preservation language" in favour of the Hospital:

> I accept the argument of the Hospital that it can redistribute duties between RNs and RPNs within the confines of the explicit work preservation language of Article 10.12, prior to determining if a vacancy exists requiring posting. In *North Bay General Hospital*, *supra*, Arbitrator Randall interpreted Article 10.12(a) as a broad and permissive work assignment clause, enabling the Hospital to assign bargaining unit work to non-bargaining unit employees so long as the duties and responsibilities are

[82] *North Bay General Hospital v Ontario Nurses' Association,* 2009 CanLII 55275 (ON LA) (Randall).
[83] *North Bay Regional Health Centre v Ontario Nurses' Association,* 2013 CanLII 72338 (ON LA) (Brownlee).
[84] *Lakeridge Health v Ontario Nurses' Association and Canadian Union of Public Employees and its Local 1999*, 2016 CanLII 63502 (ON LRB) (Kelly).
[85] *Lakeridge Health v Ontario Nurses' Association and Canadian Union of Public Employees and its Local 1999*, 2016 CanLII 63502 (ON LRB) (Kelly) at para 106.

> appropriate to the position to which they are assigned (within the scope of practice), and the assignment is consistent with quality patient care.[86]

In the 27 years the provision has been in effect, the only reported decision in which RNs have successfully defended their work through Article 10.12(a) is from a 2005 award, where Scarborough Hospital attempted to assign RPNs to a post-surgery unit with unpredictable, high-acuity patients, which prior to the assignment, was staffed only with RNs that had recent related experience in acute surgical nursing.[87] In allowing the grievance, Arbitrator Keller held that the notion of "quality patient care" was, essentially, coextensive with the CNO's scope of practice for RNs and RPNs.[88]

On the other hand, the notion of "public policy" considerations—like the relevant CNO scope of practice—is anathema to the operation of CUPE's Article 11. Indeed, Arbitrators have recurrently recognized that public policy considerations, such as whether an assignment is appropriate or consistent with patient care, do not and cannot enter the analysis of whether the work has been improperly reassigned.[89]

Accordingly, there is a significant body of case law on CUPE's Article 11, which has repeatedly prevented the Hospitals from assigning work performed by RPNs to RNs.[90]

What these awards make clear is that the diminishing ratios of RNs/RPNs and the erosion of ONA's bargaining unit is a direct result of Article 10.12(a) and the collective bargaining context within the Participating Hospitals as a whole.

This is the industrial reality that the parties find themselves in.

While the OHA may take the position that the delineations between RN and RPN work is a public policy matter not amenable to traditional jurisdictional disputes, it cannot avoid the fact it has negotiated language that has done precisely that in its agreement with CUPE Central and its other bargaining units.

All that ONA is requesting in the present case is that the terms of any jurisdictional dispute remain fair. Otherwise, the erosion of ONA's bargaining unit will continue while other units will maintain and even increase their strength through far superior

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[86] *Guelph General Hospital and ONA, Re,* 2017 CarswellOnt 10292 (Newman).
[87] *Scarborough Hospital and ONA, Re*, 2005 CarswellOnt 10902 (Keller).
[88] *Scarborough Hospital and ONA, Re*, 2005 CarswellOnt 10902 (Keller).
[89] See *Royal Ottawa Hospital v Canadian Union of Public Employees, Local 942*, 2019 CanLII 98881 (ON LA) (Knopf) and *CUPE, Local 400 v Ottawa Hospital,* 1999 CarswellOnt 7166 (Kates) at para 13.
[90] See *CUPE, Local 942 v Royal Ottawa Health Care Group*, 2018 CarswellOnt 22518 (Baxter); *Northumberland Health Care Corp v CUPE, Local 2628*, 2003 CarswellOnt 9611 (Verity); *CUPE, Local 400 v Ottawa Hospital,* 1999 CarswellOnt 7166 (Kates); *St. Mary's General Hospital v London & District Service Workers' Union, Local 220*, [1998] OLAA No 578 (Kaplan); *CUPE Local 1974 v Kingston Health Sciences*, October 18, 2024, Unreported (Treymayne); *University Health Network and CUPE, Local 5001*, 2019 CanLII 355323 (ON LA) (Kaplan); *Royal Ottawa Hospital and CUPE, Local 942 (2018-942-RP1), Re,* 2019 CarswellOnt 17195 (Knopf); and *Health Sciences North v Canadian Union of Public Employees Local 1623*, 2018 CanLII 93856 (ON LA) (Schmidt).

language. Given the stated intentions of the Hospitals to expand the use of RPNs and contract RNs work, there is clear demonstrated need supporting such a change.

REPLICATION: THE 2023 KAPLAN AWARD DRASTICALLY CHANGED THE LANDSCAPE AND BALANCE OF RN JOB SECURITY

In addition to the general asymmetry of job protection across OHA's bargaining units, the award of Arbitrator Kaplan in the last round overturned the parties' historic trade off between layoff and work of the bargaining unit language. This change has shifted the patchwork of job security provisions drastically in the Employer's favour and must be rectified this round.

ONA's job security language has, up until the last round of bargaining, remained largely static since a May 1998 award of Justice Houlden.[91] Justice Houlden's 1998 award arose in a period of fiscal restraint,[92] and, unsurprisingly, job security was a pressing issue between the parties.

Notably, in the arbitration, neither party proposed the language that is now Article 10.12(a). ONA, for its part, proposed to amend the language to the following clause:

> *Employees not covered by the terms of this Agreement will not perform duties normally assigned to those employees who are covered by this Agreement, except for the purposes of instruction, experimentation, or in emergencies when regular employees are not readily available*.[93]

In doing so, it noted in its Brief that "we do not believe that it provides enough protection for the bargaining unit. However, it is found in virtually all of our Agreements with the exception of the Central Hospitals."[94]

However, Justice Houlden, without reasons, rejected this language and instead awarded what is currently Article 10.12(a), allowing the Hospital to reassign bargaining unit work so long as it was consistent with patient care and the duties and responsibilities of the assignee.[95]

This was a major victory for the Hospitals. Despite the fact that ONA's main counterpart, CUPE Central, had work of the bargaining unit language since as far back as 1979, the Hospitals would be permitted to freely assign ONA's work out of unit.

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[91] ONA and OHA Interest Arbitration Award, 1998 (Justice Houlden).
[92] *Participating Hospitals (Ontario Hospital Association) v Ontario Nurses' Association,* 2020 CanLII 38651 (ON LA) (Stout) at para 47.
[93] ONA Interest Arbitration Brief 1996-1998 at 176.
[94] ONA Interest Arbitration Brief 1996-1998 at 178.
[95] ONA and OHA Interest Arbitration Award, 1998 (Justice Houlden).

However, on the other hand, Justice Houlden also awarded robust layoff protection language to ONA under Article 10.08, which provided that any assignment over one shift would be considered a layoff.[96]

The trade-off between Article 10.12(a) and what was then Article 10.08 is obvious: while the Hospital could, unlike the work of its other bargaining units, reassign ONA's work outside the unit in a manner consistent with patient care, any reassignment within unit that is longer than a shift would trigger the protections associated with a layoff.

In sum, ONA received stronger layoff language in exchange for weaker work of the bargaining unit protection.

This historical trade off is illustrated most apparently in the arbitration before Arbitrator Gedalof in 2021, where—predictably—ONA sought to introduce more bargaining unit work protection under Article 10.12(a) and the Hospitals sought to limit the definition of a layoff under Article 10.08. As Arbitrator Gedalof noted, "Neither party's proposals are novel, and the same or virtually the same proposals were made, and rejected, in the last round of interest arbitration."[97]

Arbitrator Gedalof too rejected both proposals. In rejecting changes to the layoff language, he noted that "it is… highly valued job security language to the Association's benefit, that has been entrenched in the collective agreements over many rounds of bargaining."[98] In seeking to change this language, he observed that the OHA had "offered nothing of substance in return."[99]

However, last round, Arbitrator Kaplan awarded the Hospital language under Article 10.08, which provided that reassignments of up to four shifts would not trigger a layoff.[100] Indeed, the "highly valued" and "entrenched" job security language has now been altered to remove short-term reassignments from the scope of the agreement's layoff protections. In doing so, Arbitrator Kaplan did not award any work of the bargaining unit protections to counterbalance this change in job security.

In essence, the historical trade off between inferior work of the bargaining unit protection and superior layoff protection is no more.

While ONA is not seeking to reverse the changes Arbitrator Kaplan made to layoffs—changes it vehemently opposed last round—the Union does seek to restore parity to the job security landscape and provide ONA with similar work of the

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[96] ONA and OHA Interest Arbitration Award, 1998 (Justice Houlden).
[97] *Participating Hospitals v Ontario Nurses Association,* 2021 CanLII 88531 (ON LA) (Gedalof) at para 41.
[98] *Participating Hospitals v Ontario Nurses Association,* 2021 CanLII 88531 (ON LA) (Gedalof) at para 44.
[99] *Participating Hospitals v Ontario Nurses Association,* 2021 CanLII 88531 (ON LA) (Gedalof) at para 44.
[100] *Participating Hospitals (Represented by the Ontario Hospital Association) v ONA,* 2023 CanLII 65431 (ON LA) (Kaplan).

bargaining unit protections as CUPE's agreement with the same employer, and virtually every other Union with job protection language.

Anything less, the Union submits, would fail to replicate what these parties—on the back of significant changes to highly valued and entrenched job security language—would have agreed to in free collective bargaining.

DEMONSTRATED NEED: THE EMPLOYER'S COUNTERPROPOSAL FURTHER SHOWS THE IMPERATIVE OF WORK OF THE BARGAINING UNIT PROTECTION

The Employer's counterproposal seeks to further undermine and erode the bargaining unit by weakening the bargaining unit protection language and through partnership arrangements under Article 10.12(d). This language would effectively allow the Employer to assign the Union's work to employees of another employer for up to one year.

This is a breakthrough proposal without any demonstrated need whatsoever. To the contrary, the demonstrated need, as outlined above, clearly shows that the Union requires *more* bargaining unit protection, not less. As Arbitrator Gedalof held in his 2021 award, "(t)he Association has consistently pursued expansion, and not contraction, of full-time nursing positions, as a priority."[101]

The Employer's proposal in this respect telegraphs its intention for the ONA bargaining unit: it seeks to limit what little existing protections there are over ONA's work and disassemble its bargaining unit in favour of other cheaper options. In fact, the Employer's proposal provides further justification for the necessity of strengthening the bargaining unit protection provisions under the collective agreement.

[101] *Participating Hospitals v Ontario Nurses Association,* 2021 CanLII 88531 (ON LA) at para 45 (Gedalof).

PAID WORK PROPOSAL

PROPOSAL #3 – ARTICLE 13: HOURS OF WORK

13.01 (a) The normal daily tour shall be seven and one-half (7½) consecutive hours in any twenty-four (24) hour period exclusive of an unpaid one-half (½) hour meal period~~, it being understood that at the change of tour there will normally be additional time required for reporting which shall be considered to be part of the normal daily tour, for a period of up to fifteen (15) minutes duration. Should the reporting time extend beyond fifteen (15) minutes, however, the entire period shall be considered overtime for the purposes of payment under Article 14~~.

(d) Where a nurse notifies their supervisor that they have been or will be unable to take the normal meal break due to the requirement of providing patient care, such nurse shall be paid time and one half (1½) their regular straight time hourly rate for all time worked in excess of their normal daily hours. **For employees already receiving two (2) times their regular straight time hourly rate they will receive two and a half (2.5) times their rate.**

EMPLOYER POSITION

Opposed.

UNION RATIONALE

The Union's proposal is based on a simple, uncontroversial premise: workers must be paid for their work. This critical proposal eliminates outdated language that requires RNs to provide the hospital with unpaid labour performed during transfers of accountability.

TRANSFER OF ACCOUNTABILITY IS A CRITICAL PART OF A NURSE'S RESPONSIBILITIES AND CLEARLY "WORK"

At the beginning and at the end of each RN shift, RNs are required to complete a transfer of accountability (TOA). A TOA is the process of turning over responsibility for some or all aspects of a patient's care from one care provider to another.[102]

Article 13.01(a) requires ONA nurses to start working approximately 15 minutes early and continue working approximately 15 minutes after their shift ends to allow for TOA. Under the current language, nurses are not paid for this work.

[102] Unity Health Toronto, "Information Transfer and Transfer of Accountability" *St. Joseph's Hospital* (updated December 3, 2021).

As the affidavits of Heather Bache and Devin Stephanian confirm, working for free is humiliating to nurses and sends the message that their work is not respected or valued.[103]

In addition, 13.01(a) has led to a harmful expectation that nurses should arrive and start working for their scheduled shift early and leave well after it has concluded.[104] Often, depending on patient acuity and other nursing assignments, TOA can take significantly longer than the allotted 15 minutes under the Collective Agreement.[105] When nurses try to report this time as overtime, they are exposed to additional scrutiny from their managers and the requests are denied.[106] As a result, many nurses simply do not report extended TOA as overtime and work more than 15 minutes for free.[107]

This is unacceptable.

According to the College of Nurses of Ontario (CNO), an effective TOA process is part of a nurse's responsibilities under principle 4.6 of the *Code of Conduct.*[108] The CNO has articulated what a nurse's accountabilities are when completing the TOA process:

> "Care transitions involve the process of communicating client-specific information from one caregiver to another, or from one team of caregivers to another, to ensure continuity of care and client safety. Transfer of accountability — or providing "report" or "handover" — is a crucial component of the care transition process. Care transitions happen often, such as when a client experiences a change in location or health care providers. They also include when shifts end, or when nurses go on break."[109]

Different hospitals have different internal policies regarding how nurses are expected to complete the TOA process.

At St. Michael's Hospital, their TOA policy, titled "Intershift Nursing Transfer of Accountability - St. Michael's Hospital" requires the following at every shift change:

> "**2.1 ToA at Shift Change**
>
> 2.1.1 Nursing ToA will occur face to face at every shift change between the oncoming and offgoing nurses. The ToA process includes four essential elements:
>
> 1. conducting ToA at the bedside;
> 2. engaging patient and/or family (with patient's consent except in cases where engagement may not be possible, such as in some areas of the peri-operative services)

[103] Affidavit of Heather Bache at para 5; Affidavit of Devin Stephanian at para 4.
[104] Affidavit of Heather Bacheat para 6; Affidavit of Devin Stephanian at paras 5-6, 9.
[105] Affidavit of Devin Stephanian at para 7.
[106] Affidavit of Heather Bache at paras 7-8; Affidavit of Devin Stephanian at para 8.
[107] Affidavit of Heather Bache at paras 9-10; Affidavit of Devin Stephanian at para 8.
[108] College of Nurses of Ontario, "Care Transitions: Transfer of Accountability".
[109] College of Nurses of Ontario, "Care Transitions: Transfer of Accountability".

3. performing safety checks, including but not limited to, a visual check of the patient's identification armband, allergy band, fall risk band, and ensure that call bell within patient's reach, isolation precaution in place and working oxygen wall suction, and 4. following a structured ToA format (Appendix A).

2.1.2 On admission to the unit, the nurse educates the patient and family about bedside ToA using the Nursing Report at the Patient's Bedside Information to Patients and Families (Appendix B).

2.1.3 Consent to share personal information during bedside ToA is obtained from the patient or substitute decision maker (if patient is not able to consent). If the patient or substitute decision maker does not consent, ToA can be completed at another appropriate location; however, the safety check must be completed at the bedside.

2.1.4 To promote effective bedside ToA, all unit staff not involved directly in bedside ToA will support the process by answering call lights or clarifying patient needs during shift change. For example, unit clerks triaging phone calls, and unregulated care providers answering call bells.

[…]

3.1 ToA at Shift Change

The following procedures reflect above guiding principles and redesigned evidence-based ToA process (Appendix C):

- Oncoming and offgoing nurses will go to the bedside.
- Nurses will wash their hands before entering and exiting patient's bedside.
- Offgoing nurse will introduce the oncoming nurse who will be taking over patient's care.
- Oncoming nurse will write her/his name on the whiteboard (if applicable).
- Nurses will ask patient for consent to give report at the bedside, if consent has not already been obtained.
- Nurses will ask patient if she/he wants her/his family or visitors to stay during ToA.
- Nurses conduct ToA, clarify patient's understanding of daily care goals, and provide education as necessary.
- Nurses will ask if patient has any concerns, and if she/he has anything to add.
- For safety checks, nurses will:
    - conduct visual checks of identification armband, allergy band, fall risk band
    - ensure that call bell is within patient's reach
    - ensure isolation precaution is in place
    - ensure oxygen wall suction is working, i.e., inclusive of checking connections, turning regulator on, and turning pressure gauge/flow meter on
- Nurses document the following items in the most appropriate section of the patient's health record following the unit's standard of practice:
    - Patient's agreement or refusal for the completion of ToA at the bedside
    - Completion of bedside ToA
    - Exceptional reason why ToA was not performed, e.g., bedside ultrasound being done
    - Any findings, education, or care provided
    - Any concerns and questions verbalized by the patient

3.2 Nursing Documentation at Shift Change

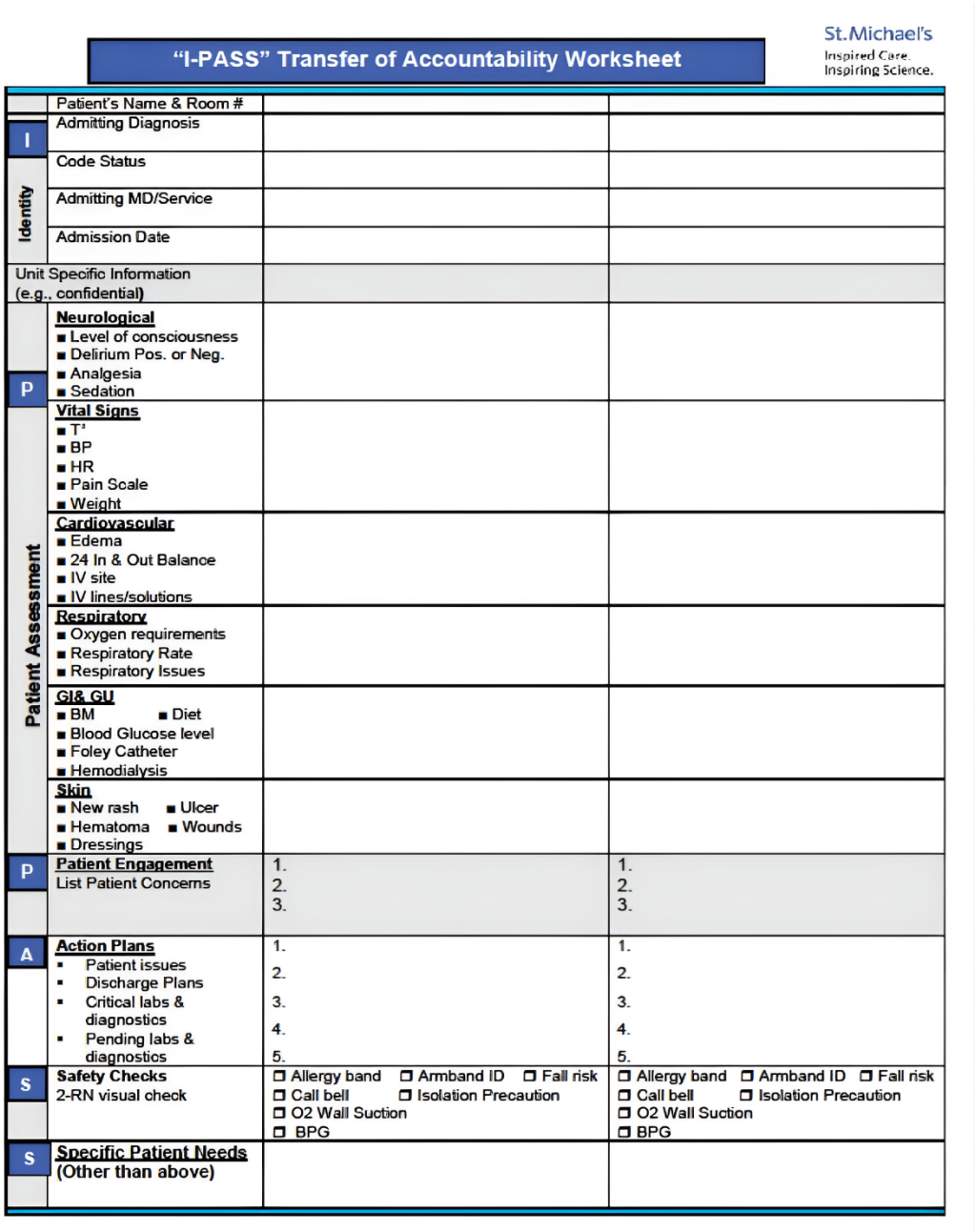
Nurses document the following items:

- Patient's consent or refusal for the completion of ToA at the bedside
- Completion of bedside ToA
- Exceptional reason why ToA was not performed, e.g., bedside ultrasound being done
- Any findings, education, or care provided
- Any concerns and questions verbalized by the patient"

The standardized communication framework to transfer patient information when performing the TOA at St. Joseph's Health Centre (SJHC) is SBAR (Situation, Background, Assessment, and Recommendation).

St. Michael's uses the IPASS model (Identity, Patient Assessment, Patient Engagement, Action plans, Safety checks, Specific Patient Needs). An example of a structured TOA guide is included at Appendix A of St. Michael's policy:[110]

[110] Unity Health Toronto, "Intershift Nursing Transfer of Accountability - St. Michael's Hospital" (updated March 24, 2022) Appendix A at 8.



"I-PASS" Transfer of Accountability Worksheet

St.Michael's
Inspired Care.
Inspiring Science.

	Patient's Name & Room #		
I	Admitting Diagnosis		
Identity	Code Status		
Identity	Admitting MD/Service		
Identity	Admission Date		
Unit Specific Information (e.g., confidential)			
P	**Neurological** ■ Level of consciousness ■ Delirium Pos. or Neg. ■ Analgesia ■ Sedation		
Patient Assessment	**Vital Signs** ■ T° ■ BP ■ HR ■ Pain Scale ■ Weight		
Patient Assessment	**Cardiovascular** ■ Edema ■ 24 In & Out Balance ■ IV site ■ IV lines/solutions		
Patient Assessment	**Respiratory** ■ Oxygen requirements ■ Respiratory Rate ■ Respiratory Issues		
Patient Assessment	**GI& GU** ■ BM ■ Diet ■ Blood Glucose level ■ Foley Catheter ■ Hemodialysis		
Patient Assessment	**Skin** ■ New rash ■ Ulcer ■ Hematoma ■ Wounds ■ Dressings		
P	**Patient Engagement** List Patient Concerns	1. 2. 3.	1. 2. 3.
A	**Action Plans** ▪ Patient issues ▪ Discharge Plans ▪ Critical labs & diagnostics ▪ Pending labs & diagnostics	1. 2. 3. 4. 5.	1. 2. 3. 4. 5.
S	**Safety Checks** 2-RN visual check	❒ Allergy band ❒ Armband ID ❒ Fall risk ❒ Call bell ❒ Isolation Precaution ❒ O2 Wall Suction ❒ BPG	❒ Allergy band ❒ Armband ID ❒ Fall risk ❒ Call bell ❒ Isolation Precaution ❒ O2 Wall Suction ❒ BPG
S	**Specific Patient Needs** **(Other than above)**		

St. Joseph's Hospital has a similar policy, titled "Information Transfer and Transfer of Accountability",[111] which contains the following requirements for the TOA:

> "For all care providers Transfer of Accountability will cover the patient's situation, background, assessment, and the care provider's recommendations. This includes, but is not limited to:
>
> - Patient's full name
> - Name of responsible providers (i.e. MRP, treating clinician)

[111] Unity Health Toronto "Information Transfer and Transfer of Accountability" *St. Joseph's Hospital* (updated December 3, 2021).

- Reason for transition
- Current condition
- any safety concerns
- outstanding items for follow up
- any recent or anticipated changes or concerns
- clinical test results and treatments as relevant
- patient goals as relevant

In addition to the items listed under TOA for all care providers, nurse to nurse transfer of accountability must always include the following items:

- age/birth date
- diagnosis/procedure
- isolation status and type of isolation (even if the patient is not on isolation please specify this)
- Cardiopulmonary Resuscitation (CPR) Status
- Allergies
- Mental Health Form status (yes or no) & expiry
- Any relevant alerts and safety concerns

[…]

INTERSHIFT TRANSFER OF ACCOUNTABILITY (handover, report)
Nursing & Respiratory Therapy

- Shift change TOA occurs face to face between oncoming and off-going care providers.
- Inter-shift handover should include the sending care provider and the receiving care provider viewing the patient record with minimal interruptions to reduce the possibility of errors.
- A standardized communication framework (i.e. SBAR) is utilized for inter-shift transfer of accountability and includes at a minimum the information listed in this policy.
- Both the sending care provider and the receiving care provider will have the opportunity to share information and ask questions. It is suggested that the sender initiate information sharing, and that the receiver follow up with questions and clarifications.
- Completion of TOA must be documented by the sending care provider and receiving care provider in the "Transfer of Accountability" parameter of the appropriate flowsheet (i.e. Acute Care Flowsheet). For areas not using the electronic documentation system, completion of TOA must be documented within the interdisciplinary notes, or in the dedicated area for TOA documentation.
- It is recommended that care providers perform TOA at the patient's bedside where appropriate to facilitate accurate bedside and safety checks and patient involvement."[112]

A basic review of these policy documents makes clear that the roughly 15 minutes spent before and after each shift on the TOA process is, in all cases, work. It is not

[112] Unity Health Toronto "Information Transfer and Transfer of Accountability" *St. Joseph's Hospital* (updated December 3, 2021) at 6.

akin to setting up a workstation or putting on a uniform, but is rather an essential, critical, and extensive review and transfer of patient information.

Unlike menial preparatory tasks, the accurate and comprehensive completion of the TOA process is of essential importance to patient safety:

- According to UHN's Clinical Documentation Policy, the completion of the TOA process "is a legal responsibility for all regulated health professionals and is an expectation for all clinical staff."[113]

- St. Joseph's policy characterizes the TOA process as a "complex and high-risk moments for patient safety (CMPA, 2021, RNAO, 2014)."[114]

- According to St. Michael's Policy, an ineffective TOA can result in "wrong treatment, delays in medical diagnosis, life-threatening adverse events, client complaints, increased health care expenditures, increased hospital length of stay and litigation."[115] St. Michael's policy cites "inadequate" TOA completion as "among the most common factors contributing to the occurrence of adverse events."[116]

Despite these repeated indications of its importance, the Hospitals do not pay RNs for their time completing and participating in the TOA process.

UNPAID TOA IS A VESTIGAL LEGACY OF OUTDATED, OVERTAKEN JURISPRUDENCE

Fifty years ago, in 1975, Arbitrator Weatherill issued an award that found an ONA nurse was not entitled to be paid at overtime rates for the time she spent completing her TOA.[117] Arbitrator Weatherill determined that a nurse's normal daily hours of work included the expectation of giving an end-of-shift report and drug count. Since the nurse was paid a monthly salary and was a professional, there was no expectation of entitlement to be paid at overtime rates. The arbitrator also held that these tasks had been a long-standing routine and that a change would have to be negotiated into the collective agreement. At the time of this decision, there was no language to this effect in the ONA collective agreement.

The language found today in the ONA collective agreement was awarded by Arbitrator O'Shea in 1981.[118] His decision did not provide reasons but was

[113] Unity Health Toronto, "Clinical Documentation Policy for Unity Health Toronto Health Professionals" (October 28, 2024).
[114] Unity Health Toronto, "Clinical Documentation Policy for Unity Health Toronto Health Professionals" (October 28, 2024).
[115] Unity Health Toronto "Information Transfer and Transfer of Accountability" *St. Joseph's Hospital* (updated December 3, 2021).
[116] Unity Health Toronto, "Intershift Nursing Transfer of Accountability - St. Michael's Hospital" (updated March 24, 2022) at 1.
[117] *Central Hospital Corp and Ontario Nurses' Assoc, Local 107*, 10 LAC (2d) 412 (Weatherill).
[118] *Ontario Hospital Association on Behalf of the Participating Hospitals and Ontario Nurses' Association*, unreported, October 23, 1981 (O'Shea).

undoubtedly influenced by and decided in the wake of the *Weatherill* decision. As a result, RNs have not been paid for completing the TOA process for the past 44 years.

Recent awards have unequivocally rejected the approach adopted by Arbitrator Weatherill.[119] Arbitrator Misra, in 2018, rejected the employer's argument that the 15-minute changeover period should remain uncompensated due to an RPN's professional responsibilities:

> I do not accept the City's argument that because RPNs have a professional responsibility to ensure that narcotics are managed properly, therefore it is their professional responsibility to come in early, or stay late, to ensure that the narcotics count is done, but they don't have to be paid for that work. I was not pointed to anything in the College of Nurses of Ontario Practice Standards, or the *Employment Standards Act*, or indeed anything other than a passing comment in the 1975 Weatherill *Central Hospital* decision, cited above, that could stand for this proposition. To the extent that decision stands for the proposition that if nurses are meeting their professional responsibilities and that work takes them beyond the end of their shift, that they do not have to be paid for such time, with all due respect, I do not agree with Arbitrator Weatherill's view in that regard...[120] (emphasis added).

Arbitrator Burkett, in 2021, also rejected the analysis of Weatherill for a decision regarding TOA reporting time and RPNs unionized with CUPE:

> I find the 1975 Weatherill Central Hospital award, finding such report time to be a voluntary professional activity, to have been wrongly decided. It makes no difference whether the employees in question are professionals in determining whether or not they are entitled to be paid under the terms of a collective agreement that governs their employment relationship nor does it matter whether these RPNs might sometimes be permitted to leave early without discipline.[121] (emphasis added)

The tide has clearly turned on Weatherill's reasoning and formed a clear consensus: nurses—like all workers—should be paid for their work.

THE EXPECTATION OF UNPAID LABOUR FROM NURSES IS ROOTED IN HARMFUL GENDERED STEREOTYPES

It is now uncontroversial that time spent performing work should be compensated. However, this self-evident principle is not always applied universally when it comes to female-dominated sectors. Indeed, beliefs regarding nurses' unpaid labour are

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[119] *Markham Stouffville Hospital v Canadian Union of Public Employees, Local 3651*, 2021 CanLII 9807 (ON LA) (Burkett); *Corporation of The City of Kingston v Canadian Union of Public Employees, Local 109*, 2018 CanLII 26065 (ON LA) (Misra); *Rosewood Senior Living/Erie Glen v UFCW, Local 175*, 2021 CanLII 58425 (ON LA) (Jesin).

[120] *Corporation of The City of Kingston v Canadian Union of Public Employees, Local 109*, 2018 CanLII 26065 (ON LA) (Misra).

[121] *Markham Stouffville Hospital v Canadian Union of Public Employees, Local 3651*, 2021 CanLII 9807 (ON LA) (Burkett); See also *Rosewood Senior Living/Erie Glen v UFCW, Local 175*, 2021 CanLII 58425 (ON LA) (Jesin).

rooted in age-old stereotypes regarding women and women's work. The acceptance of unpaid labour in women-dominated fields stems from gendered assumptions, expectations, and social conditioning.

In a study by Harvard Business Review, in mixed-sex groups, women received 44% more requests to volunteer for non-promotable tasks than men, regardless of the gender of the manager making the request.[122] Women also accept uncompensated work 76% of the time, compared to men, who only agree to perform uncompensated work 51% of the time.[123] The study found that "…although neither men nor women really want to volunteer for thankless tasks, women volunteer more, are asked to volunteer more, and accept requests to volunteer more than men."[124] In a profession where about 91% of the workers are women, it has taken over 40 years to demand they be paid for all the time they spend working.

It should go without saying that this change is long overdue.

Caring professions like nursing are often regarded as 'women's work' and are often undervalued and underpaid or, in this case, unpaid entirely.[125] Globally, more than six million women worldwide are subsidizing health systems with their unpaid or underpaid labour.[126] This includes the predominantly female profession of nursing.

According to a House of Commons Report of the Standing Committee on the Status of Women (the "*Report*"): "Women in Canada and around the world bear a disproportionate burden of invisible and unpaid work." Further, the Report adds that: "…women who perform unpaid work may have a double burden of unpaid and paid workloads, lower levels of labour force participation, less economic security, and negative mental and physical health effects".[127] In Canada, Laura Addati at the International Labour Organization (ILO) estimated that the value of unpaid work in Canada is approximately 26% of the GDP, with women working nearly two-thirds of the total unpaid hours.[128]

These 15 minutes before and after an RN's shift, across all the Participating Hospitals, directly contribute to this problem. Article 13.01 is yet another example of women's unpaid work subsidizing health systems, and it has no place in any collective agreement finalized in the year 2025.

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[122] Linda Babcock et al, "Why Women Volunteer for Tasks That Don't Lead to Promotions" *Harvard Business Review* (July 16, 2018).
[123] Linda Babcock et al, "Why Women Volunteer for Tasks That Don't Lead to Promotions" *Harvard Business Review* (July 16, 2018).
[124] Linda Babcock et al, "Why Women Volunteer for Tasks That Don't Lead to Promotions" *Harvard Business Review* (July 16, 2018).
[125] Women in Global Health, *Subsidizing Global Health: Women's Unpaid Work in Health Systems* (June 2022).
[126] Women in Global Health, *Subsidizing Global Health: Women's Unpaid Work in Health Systems* (June 2022).
[127] Marilyn Gladu, "Women's Unpaid Work in Canada" *Report of the Standing Committee on the Status of Women, House of Commons* (43rd Parliament, 2nd Session, June 2021).
[128] Marilyn Gladu, "Women's Unpaid Work in Canada" *Report of the Standing Committee on the Status of Women, House of Commons* (43rd Parliament, 2nd Session, June 2021) at 8.

ONA'S UNPAID TOA LANGUAGE IS ANOMALOUS AND CONTRARY TO REPLICATION

Arbitrators have consistently held that nurses should not be expected to perform unpaid labour.[129] ONA's collective agreement has been distinguished in arbitral decisions due to its uniqueness, specifically, as it is one of the *only* collective agreements with this language.[130]

A comparison of other provincial nursing agreements shows that ONA's language is the only nursing Collective Agreement in the country that mandates unpaid labour for TOA, with only one exception in PEI.

Province	Paid/Unpaid	Notes
BC	Paid	CBA has language explicitly stating handover work is paid; >15 mins is paid OT
AB	Paid	FT shift is 7.75hrs; 15 min scheduled overlap
SK	Paid	Considered time worked
MA	Paid	Typical practice is to schedule 15 min overlap in shifts for reporting
ON	Unpaid	Collective Agreement mandates 15 mins unpaid reporting time
NB	Unpaid	Customary to arrive early/stay late unpaid but not mandated in Collective Agreement
NS	Paid	Collective Agreement mandates coverage during shift change; OT applies after 15 mins
PEI	Unpaid	Collective Agreement (21.3) mandates 15 mins unpaid reporting time; paid as OT if >15 mins
NL	Unpaid	Customary to arrive early/stay late unpaid but not mandated in the Collective Agreement

Most significantly, prior to 2019, British Columbia had similar language to ONA premised on the same outdated, anachronistic stereotypes. However, as a result of a 2019 voluntary settlement, the British Columbia Nurses' Union and the province agreed that, as work, TOA should be paid.[131]

It is also worth noting that, irrespective of the practice in these provinces, arbitral jurisprudence has determined that silence as to whether or not the 15 minutes

[129] *Victoria Village Inc v Canadian Union of Public Employees, Local 4660,* 2020 CanLII 55857 (ON LA) (Goodfellow); *Rosewood Senior Living/Erie Glen v UFCW*, Local 175, 2021 CanLII 58425 (ON LA) (Jesin); See the historical approach in *Central Hospital Corp and ONA*, 1975 CanLII 2146 (ON LA) (Weatherill).
[130] *Corporation of The City of Kingston v Canadian Union of Public Employees, Local 109*, 2018 CanLII 26065 (ON LA) (Misra); *Victoria Village Inc v Canadian Union of Public Employees, Local 4660,* 2020 CanLII 55857 (ON LA) (Goodfellow); *Rosewood Senior Living/Erie Glen v UFCW*, Local 175, 2021 CanLII 58425 (ON LA) (Jesin); See the historical approach in *Central Hospital Corp and ONA*, 1975 CanLII 2146 (ON LA), 10 LAC (2d) 412 (Weatherill).
[131] BCNU, Proposed Terms of Settlement (2019-2022) at 35.

spent completing a TOA can be compensated means that it is presumed to be compensated.[132]

The OHA also has central collective agreements with PIPSC, SEIU, PAIRO, OPSEU, and CUPE. None of these collective agreements demand unpaid labour.

Significantly, RPNs represented by CUPE complete TOAs at the beginning and end of their shifts, and their collective agreement does not require them to complete their TOAs for free. Arbitrator Burkett recently confirmed this in a 2021 decision:

> "Whereas the ONA collective agreement expressly stipulates that "at the change of tour there will normally be additional time required for reporting which shall be considered to be part of the normal daily tour, for a period of up to fifteen (15) minutes duration," there is no such stipulation in the RPN collective agreement. It follows that where RPNs are required to report prior to the scheduled commencement of their shift for the purpose of the handover under the MyCTE model, they are entitled to overtime under article 15.02/15.03 of their collective agreement…"[133]

ARTICLE 13.01(A) VIOLATES THE *EMPLOYMENT STANDARDS ACT*

The parties cannot continue operating under an agreement which, by definition, violates the *Employment Standards Act*, ("*ESA*"). It is widely understood that a collective agreement cannot offer less protection than what is offered by the *ESA*.[134] Section 11(1)(a)(iii) of the *ESA* requires that for each employee, an employer must keep records of "the number of hours worked by the employee in each day and week". Article 13.01(a) effectively allows the employer not to keep records of the number of hours worked by the employee beyond their regular scheduled hours.

This Article does not comply with those provisions.

This was the issue in *Insurance Corp of British Columbia v CUPE Local 378.*[135] In that case, Arbitrator Taylor found that the employer's violated the applicable employment standard legislation regarding the recording of hours worked, which resulted in unjust enrichment. Specifically, Arbitrator Taylor found that the inaccurate recording of hours led to discrepancies in appropriate insurable hours for the purposes of EI, as well as a reduction in union dues. In coming to this

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[132] *Corporation of The City of Kingston v Canadian Union of Public Employees, Local 109*, 2018 CanLII 26065 (ON LA) (Misra); *Victoria Village Inc v Canadian Union of Public Employees, Local 4660,* 2020 CanLII 55857 (ON LA) (Goodfellow); *Rosewood Senior Living/Erie Glen v UFCW*, Local 175, 2021 CanLII 58425 (ON LA) (Jesin).

[133] *Markham Stouffville Hospital v Canadian Union of Public Employees, Local 3651*, 2021 CanLII 9807 (ON LA) (Burkett); See also *Rosewood Senior Living/Erie Glen v UFCW, Local 175*, 2021 CanLII 58425 (ON LA).

[134] *Employment Standards Act*, RSBC 1996*, c 113* at s 11 [*ESA*].

[135] *Insurance Corp of British Columbia v Canadian Office and Professional Employees' Union, Local 378*, 2012 CarswellBC 2585 (Taylor).

conclusion, Arbitrator Taylor cited Arbitrator Armstrong's 2000 decision in *Brantford (City) v CUPE Local 181* at para 39:

> ... Put simply, this doctrine means that where work is done or service performed and the benefit of the work or service is accepted by the employer or contractor, there is a presumption that the provider of the work or service will be paid -- and where the amount of payment is not stipulated, that it will be based on a calculation that is fair and reasonable ...[136]

The provision means that the Employer does not record approximately 30 minutes a day as part of hours worked, which is counter to the ESA. Employers are required to accurately track all hours worked by their employees, including any time spent on tasks that are necessary for their job.

By not recording this time unless a nurse files paperwork for periods over 15 minutes, the Employer effectively disregards a significant portion of the actual hours worked. All hours worked, regardless of whether paperwork is filed, should be documented to ensure fair pay and compliance with employment standards.

13.01 (D): NURSES MUST BE COMPENSATED FAIRLY FOR MISSING MEAL BREAKS

When a nurse misses a meal break because of the demands of patient care and notifies her supervisor, she will be paid overtime if she works more than the hours in her regular tour. Arbitrator Scott awarded this language in his 1985 interest arbitration decision without reasons.[137] Although this was a welcomed addition, ONA's current proposal adds much-needed adjustment for nurses already earning premium payment.

Current ONA Language	(d) Where a nurse notifies their supervisor that they have been or will be unable to take the normal meal break due to the requirement of providing patient care, such nurse shall be paid time and one half (1½) their regular straight time hourly rate for all time worked in excess of their normal daily hours.
Proposed ONA Language	(d) Where a nurse notifies their supervisor that they have been or will be unable to take the normal meal break due to the requirement of providing patient care, such nurse shall be paid time and one half (1½) their regular straight time hourly rate for all time worked in excess of their normal daily hours. **For employees already receiving two (2) times their regular straight time hourly rate they will receive two and a half (2.5) times their rate**

The current language must be read in conjunction with Article 14.01 and 14.04, reproduced in part below:

[136] *Brantford (City) v Canadian Union of Public Employees, Local 181 (Godden Grievance*), [2000] OLAA No. 844 (Armstrong) at para 39.
[137] The Participating Hospitals and ONA Arbitration Award (1985) (Scott) at 18.

> 14.01 (a) … If authorized overtime amounts to fifteen (15) minutes or more, overtime premium shall be paid for the total period in excess of the normal daily tour. Overtime premium will not be duplicated for the same hours worked under Article 13.01 (a) and (c) nor shall there be any pyramiding with respect to any other premiums payable under the provisions of this Collective Agreement. … Overtime premium will not be duplicated for the same hours worked under Article 13.01 (a) nor shall there be any pyramiding with respect to any other premiums payable under the provisions of this Collective Agreement.
>
> 4.04 Where a nurse is required to work on a paid holiday or on an overtime tour or on a tour that is paid at the rate of time and one-half (1 ½) the nurse's regular straight time hourly rate as a result of 14.03 above and the nurse is required to work additional hours following her or his full tour on that day (but not including hours on a subsequent regularly scheduled tour for such nurse) such nurse shall receive two (2) times her or his regular straight time hourly rate for such additional hours worked. Where a nurse is called back from standby and works in excess of the hours of a normal shift on her or his unit, such nurse shall receive two (2) times her or his regular straight time hourly rate for such additional hours worked.

This means that currently, nurses will be paid time and one-half (1½) of their regular rate of pay for the missed meal break of thirty (30) minutes. However, if the nurse is already receiving a two (2) times rate, by the operation of 14.01(a) or (b), that nurse will have their missed meal period go unrecognized.

There is no principled reason that simply because, for example, a nurse is called back from standby and works beyond her regular hours, the employer should not have to compensate them for any missed meal periods. Due to the rule against duplication, currently, if two nurses work through their meal period, but one is called back from standby and the other is not, the nurse not called back from standby should receive a benefit while the other does not.

The Union's proposal simply recognizes that nurses already working at the two (2) times rate should also be compensated for any missed meal periods.

WAGES & PREMIUMS PROPOSAL

PROPOSAL #4 – ARTICLES 19 & 14

Article 19.01 (a) Wage Rates

Year 1 – 6% ATB
Year 2 – 6% ATB

	April 1, 2024 (expired)	April 1, 2025	April 1, 2026
Start	$39.07	**$41.41**	**$43.89**
1 Year	$40.05	**$42.45**	**$45.00**
2 Years	$41.46	**$43.52**	**$46.13**
3 Years	$42.90	**$45.47**	**$48.20**
4 Years	$44.83	**$47.52**	**$50.37**
5 Years	$47.07	**$49.89**	**$52.88**
6 Years	$49.42	**$52.39**	**$55.53**
7 Years	$51.89	**$55.00**	**$58.30**
8 Years	$56.00	**$59.36**	**$62.92**

[...]

***NEW* Long-Term Experience Entitlements**

An employee with 15 years' experience will receive an additional 2% added to their straight time hourly rate.

An employee with 20 years' experience will receive an additional 4% added to their straight time hourly rate.

An employee with 25 years' experience will receive an additional 6% added to their straight time hourly rate.

An employee with 30 years' experience will receive an additional 8% added to their straight time hourly rate.

An employee with 35 years' experience will receive an additional 10% added to their straight time hourly rate.

An employee with 40 years' experience will receive an additional 12% added to their straight time hourly rate.

[...]

***NEW* Nurse Practitioner**

Step	April 1, 2025 (New Grid)	April 1, 2025 (6%)	April 1, 2026 (6%)
Start	**$69.85**	**$74.03**	**$78.46**

1 Year	**$73.69**	**$78.11**	**$82.80**
2 Years	**$76.76**	**$81.36**	**$86.24**
3 Years	**$78.88**	**$83.61**	**$88.63**

[...]

***NEW* Registered Practical Nurses**

Step	April 1, 2025 (New Grid)	April 1, 2025 (6%)	April 1, 2026 (6%)
Start	**$38.11**	**$40.39**	**$42.81**
1 Year	**$38.62**	**$40.93**	**$43.39**
2 Years	**$39.14**	**$41.48**	**$43.97**

[...]

Article 19.01(b) & (c) – Percentage in Lieu for Part-Time Nurses

Article	Current	Proposed
19.01 (b) Percent in Lieu (PT)	14%	**19%**
19.01 (c) Percent in Lieu (PT – Pension Plan)	10% (members of Pension Plan)	~~**10%**~~ **(eliminate reduction for participation in Pension Plan)**

19.01 (b) The hourly salary rates, inclusive of the percentage in lieu of fringe benefits in effect during the term of this Agreement for all regular and casual part-time nurses shall be those calculated in accordance with the following formula:

~~Applicable straight time hourly rate + 13%.~~

~~Effective April 1, 2024,~~ **A**pplicable straight time hourly rate + ~~14~~ **19**%.

(c) ~~The hourly salary rates payable to a regular or casual part-time nurse include compensation in lieu of all fringe benefits which are paid to full-time nurses except those specifically provided to part-time nurses in this Agreement. It is understood and agreed that holiday pay is included within the percentage in lieu of fringe benefits. It is further understood and agreed that pension is included within the percentage in lieu of fringe benefits. Notwithstanding the foregoing, all part-time nurses may, on a voluntary basis, enrol in the Hospital's Pension Plan when eligible in accordance with its terms and conditions. For part-time nurses who are members of the Pension Plan, the percentage in lieu of fringe benefits is nine percent (9%).~~

~~It is understood and agreed that the part-time nurse's hourly rate (or straight time hourly rate) in this Agreement does not include the additional 9% or 13%, as applicable, which is paid in lieu of fringe~~

~~benefits and accordingly the 9% or 13%, as applicable, add on payment in lieu of fringe benefits will not be included for the purpose of computing any premium or overtime payments.~~

~~Effective April 1, 2024,~~ **T**he hourly salary rates payable to a regular or casual part-time nurse include compensation in lieu of all fringe benefits which are paid to full-time nurses except those specifically provided to part-time nurses in this Agreement. It is understood and agreed that holiday pay is included within the percentage in lieu of fringe benefits. It is further understood and agreed that pension is included within the percentage in lieu of fringe benefits. ~~Notwithstanding the foregoing, all part-time nurses may, on a voluntary basis, enrol in the Hospital's Pension Plan when eligible in accordance with its terms and conditions. For part-time nurses who are members of the Pension Plan, the percentage in lieu of fringe benefits is ten percent (10%).~~

~~It is understood and agreed that the part-time nurse's hourly rate (or straight time hourly rate) in this Agreement does not include the additional 10% or 14%, as applicable, which is paid in lieu of fringe benefits and accordingly the 10% or 14%, as applicable, add on payment in lieu of fringe benefits will not be included for the purpose of computing any premium or overtime payments.~~

[…]

Article 14 - Premium Payments

Article	Current	Proposed
14.01 (a) & (b) Overtime – work time above 75 hours	1.5x	**2x**
14.03 Scheduling violations in the local collective agreement	1.5x	**2x**
14.04 Work on a tour at time and a half and work past end of tour. 14.04 When works overtime on a shift paid at time and one half or when called back from standby and works for more hours than a normal tour	1.5x 2x	**2x** **2.5x**
14.10 Evening Premium Night Premium	$2.25 $2.98	**$3.50** **$5.00**

Article	Current	Proposed
14.15 Weekend Shift Premium	$3.14 (2400 hrs. Friday to 2400 hrs. Sunday)	**1.5x (would include consecutive and subsequent weekends)**

14.01 (a) (Article 14.01 (a) applies to full-time nurses only)

If a nurse ~~is authorized to~~ work**s** in excess of the hours referred to in Article 13.01 (a) or (c), they shall receive overtime premium of ~~one and one-half (1½)~~ **two (2)** times their regular straight time hourly rate. ~~Notwithstanding the foregoing, no overtime premium shall be paid for a period of less than fifteen (15) minutes of overtime work where the nurse is engaged in reporting functions at the end of their normal daily tour. If authorized overtime amounts to fifteen (15) minutes or more, overtime premium shall be paid for the total period in excess of the normal daily tour~~. Overtime premium will not be duplicated for the same hours worked under Article 13.01 (a) and (c) nor shall there be any pyramiding with respect to any other premiums payable under the provisions of this Collective Agreement. Nothing herein will disentitle the nurse to payment of the normal tour differential provided herein. For purpose of clarity, a nurse who is required to work on their scheduled day off shall receive overtime premium of ~~one and one-half (1½)~~ **two (2)** times their regular straight time hourly rate except on a paid holiday the nurse shall receive two **and a half** (2**½**) times their straight time hourly rate. The Hospital agrees that if the Collective Agreement provided a greater overtime premium for overtime work immediately prior to this Agreement, the Hospital will continue to pay such greater overtime premium. ~~This is not intended to entitle the nurse to be paid for work performed while engaged in the reporting functions as provided herein.~~

(b) (Article 14.01 (b) applies to part-time nurses only.)

If a part-time nurse ~~is authorized to~~ work**s** in excess of the hours referred to in Article 13.01 (a), they shall receive overtime premium of ~~one and one-half (1½)~~ **two (2)** times their regular straight time hourly rate. A part-time nurse (including casual nurses but not including part-time nurses who are filling temporary full-time vacancies) who works in excess of seventy-five (75) hours in a two (2) week period shall receive ~~time and one-half (1½)~~ **two (2) times** their regular straight time hourly rate for all hours worked in excess of seventy-five (75). A part-time nurse who is filling a temporary full-time vacancy shall receive ~~time and one-half (1½)~~ **two (2) times** their regular straight time hourly rate for all hours worked in excess of an average of 37½ hours per week over the full-time nursing schedule determined by the Hospital. Such averaging will commence at the conclusion of the two-week period following the nurse's transfer to the temporary full-time position and will end at the conclusion of the two-week period prior to the nurse's return to their former position. ~~Notwithstanding the foregoing, no overtime premium shall be paid for a period of less than fifteen (15) minutes of overtime work where the nurse is engaged in reporting functions at the end of their normal daily tour. If authorized overtime amounts to fifteen~~

~~(15) minutes or more, overtime premium shall be paid for the total period in excess of the normal daily tour~~. Overtime premium will not be duplicated for the same hours worked under Article 13.01 (a) nor shall there be any pyramiding with respect to any other premiums payable under the provisions of this Collective Agreement. Nothing herein will disentitle the nurse to payment of the normal tour differential provided herein. The Hospital agrees that if the Collective Agreement provided a greater premium for overtime work immediately prior to this Agreement, the Hospital will continue to pay such greater overtime premium. ~~This is not intended to entitle the nurse to be paid for work performed while engaged in the reporting functions as provided herein.~~

14.03 Work scheduled by the Hospital to which a premium is attached under scheduling regulations contained in the Collective Agreement and set out in the Appendix of Local Provisions shall be paid at ~~one and one-half (1½)~~ **two (2)** times the nurse's regular straight time hourly rate or as otherwise provided.

14.04 Where a nurse is required to work on a paid holiday or on an overtime tour or on a tour that is paid at the rate of ~~time and one-half (1½)~~ **two (2) times** the nurse's regular straight time hourly rate as a result of 14.03 above and the nurse is required to work additional hours following their full tour on that day (but not including hours on a subsequent regularly scheduled tour for such nurse) such nurse shall receive two **and a half** (2**½**) times their regular straight time hourly rate for such additional hours worked. Where a nurse is called back from standby and works in excess of the hours of a normal shift on their unit, such nurse shall receive two **and a half** (2**½**) times their regular straight time hourly rate for such additional hours worked.

14.10 A nurse shall be paid a shift premium of ~~two dollars and twenty-five cents~~ **three dollars and fifty cents** ($~~2.25~~ **3.50**) per hour for each hour worked which falls within the hours defined as an evening shift and ~~two dollars and ninety-eight cents~~ **five dollars** ($~~2.98~~ **5.00**) for each hour worked which falls within the hours defined as a night shift provided that such hours exceed two (2) hours if worked in conjunction with the day shift. Tour differential will not form part of the nurse's straight time hourly rate. For purposes of this provision, the night shift and the evening shift each consist of 7.5 hours. The defined hours of a night and evening shift shall be a matter for local negotiation.

14.15 A nurse shall be paid **time and one half their straight time hourly rate** ~~a weekend premium of three dollars and fourteen cents ($3.14) per hour~~ for each hour worked between 2400 hours Friday and 2400 hours Sunday, or such other 48-hour period as the local parties may agree upon. ~~If a nurse is receiving premium pay under Article 14.03, pursuant to a local scheduling regulation with respect to consecutive weekends worked, the nurse will not receive weekend premium under this provision.~~

EMPLOYER POSITION

Opposed.

- Effective April 1, 2025 – 2.15%
- Effective April 1, 2026 – 1.50%

UNION RATIONALE

WAGE RATES AND PREMIUMS

A. TOP OF MARKET WAGES

ONA NURSES MUST REMAIN AT TOP OF MARKET

In the last round of collective bargaining, ONA resumed its proper place at the top of the nursing market in Canada. This position at "top of market" is the only reasonable place for this bargaining unit, in light of Ontario's status as the most populous province, which places the highest demands on the nursing profession. Ontario has top of market rates for other professional positions and there is no justifiable reason for the nursing profession to be treated differently. Therefore, the wage increases in the current round of bargaining must maintain ONA nurses at top of market.

ONA HISTORICALLY AT OR NEAR TOP OF MARKET

ONA nurses historically earned wages at or near the top of the nursing market in Canada. In the 2001-2004 round of collective bargaining, the OHA noted that Ontario RNs were the highest paid in Canada and that its own wage proposal maintained ONA nurses' status as the highest paid in Canada.[138]

In the 2004-2005 interest arbitration before Arbitrator Keller, ONA referenced the bargaining unit's status at the top of market, and the increase awarded by Arbitrator Keller again maintained ONA as the highest paid RNs in the country.

Ontario nurses remained the highest paid in Canada until 2007, when a mediated settlement in Alberta catapulted that province's nurses to the highest wage rate. In the following years, while ONA's top wage rates remained in 2nd or 3rd place among nurses in Canada, ONA lost ground in wages compared to the highest-paid nurses in other provinces. This period coincided with a decade of low arbitral awards that devastated the spending power of RNs in Ontario.

After years of advocating for a return to top of market, Ontario nurses resumed their position as the highest paid in Canada in the most recent round of interest arbitration. Arbitrator Kaplan's award of a 3.5% wage increase, in 2023, and a 3%, in 2024, with a grid adjustment, effective April 1, 2023, placed ONA at the top of the market compared to RNs in other provinces. This was acknowledged as an "important first step" by the Union nominee in dissent.[139]

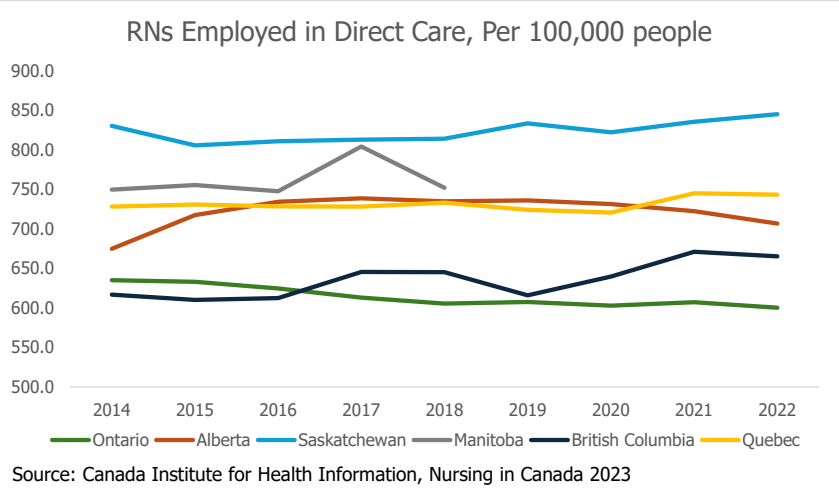
[138] Submissions to the Board of Arbitration by Ontario Nurses' Association (Arbitration May 4, 2005) at 74.
[139] *Participating Hospitals (Represented by the Ontario Hospital Association) v ONA*, 2023 CanLII 65431 (Kaplan) at 45 [*emphasis added*].

ONTARIO – THE BIGGEST MARKET WITH THE HIGHEST DEMANDS

ONA's status at top of market is fully justified by the circumstances of the province of Ontario.

Ontario is the most populous province in Canada. Since 2018 alone, Ontario's population grew by more than 17%, or nearly 2.4 million people.[140] That is the approximate population of Manitoba and Saskatchewan combined.

Yet, despite the province's massive population, Ontario has, by far, the lowest number of nurses per capita of any province. This situation has not improved and, indeed, has worsened since 2014. There are simply not enough nurses in Ontario:



Source: Canada Institute for Health Information, Nursing in Canada 2023

Ontario's population is not only rapidly growing, but its population is also rapidly aging. As Arbitrator Kaplan recognized in *R v Ontario Medical Association*, when setting compensation for Ontario's physicians, not only is Ontario "experiencing a surge in population growth", but in addition, "it is obvious that the citizenry is ageing – the Government acknowledges this brings with it increased complexity – and, accordingly, demands on doctors can only be expected to grow."[141] This increased complexity in the needs of Ontario's aging population will place similar and greater demands on Ontario's hospital nurses.

Indeed, in terms of handling complex medical issues, Ontario's nurses already face the highest demands among members of their profession. Among the Participating Hospitals in this arbitration are most of the highest-ranked hospitals in Canada. Ontario has more top hospitals than any other province by a wide margin:

Newsweek[142], Top Hospitals in Canada	
	Number in the top

[140] Statistics Canada, "Population Estimates on July 1, by Age and Gender" (September 25, 2024), at Table 17-10-0005-01.
[141] *R v Ontario Medical Association,* 2024 CanLII 86115 (Kaplan) at 57.
[142] Newsweek, *The World's Best Hospitals 2024 - Canada* (2024).

	20
Ontario	9
Quebec	4
Alberta	3
Saskatchewan	1
Nova Scotia	1
British Columbia	2

Thus, a larger proportion of ONA hospital nurses are working with higher volumes of patients with more complex and acute needs. They are also working in settings with the newest and most sophisticated equipment, technologies, and methods. The highly skilled members of ONA – Canada's largest nursing union, and one of the largest public sector unions in Canada – must be compensated at the top of the nursing market.

OTHER ONTARIO PROFESSIONALS ARE TOP OF MARKET

Because of Ontario's economic status among Canadian provinces, Ontario has top market rates for other professional positions, including teachers and doctors. There is no justifiable reason for the nursing profession to be treated any differently. Significantly, when arbitrators recognized that these other professionals were at the top of their respective markets, those arbitrators simultaneously rejected the counterargument that top of market professionals should receive less than normative across-the-board wage increases *because* they were top of market. On the contrary, workers with top of market rates are still awarded normative across-the-board increases, particularly where (like nursing in Ontario) there are ongoing recruitment and retention challenges.

TEACHERS

The bargaining units of teachers in Ontario bear many similarities to ONA nurses.

There are two province-wide bargaining units—elementary teachers represented by ETFO, and secondary teachers represented by OSSTF. Like ONA, these unions are among the largest in the country: ETFO is the largest educator union in Canada, representing 83,000 members, followed by OSSTF, which represents approximately 60,000 educators and other professionals.[143] As confirmed in the most recent interest arbitrations for these bargaining units, Ontario's teachers are the highest paid in the country.[144]

In the 2024 interest arbitration involving Ontario teachers, Arbitrator Kaplan soundly rejected the notion that higher incomes should lead to a sub-normative across-the-board increase:

[143] Elementary Teachers' Federation of Ontario; Ontario Secondary School Teachers' Federation.
[144] *The Crown in Right of Ontario v The Ontario Secondary School Teachers' Federation and The Elementary Teachers' Federation of Ontario,* 2024 CanLII 8967 (Kaplan) at 17; *Ontario (Education) v Ontario Public School Boards' Association*, 2024 CanLII 48134 (Kaplan) at 18-19.

> There is no general agreement with the proposition that just because a group of employees is already the best or well-paid that they should not receive an economic increase, or that they should receive a much smaller one than everyone else, in circumstances where there is widespread agreement that inflation and recruitment and retention necessarily drive higher wage increases.
>
> Seventy-seven percent of the teachers are already at the top of the grid, and so there is no grid movement for them. The only increase they receive are the general wage increases. There is no reason to segregate one factor – highest paid teachers in the country – and conclude from that that Ontario's teachers and education workers should get less than everyone else, in the re-opener context and otherwise, in circumstances where inflation and recruitment and retention have led to higher results in many different sectors**.** Adopting this approach would be without any rational justification.[145]

Arbitrator Kaplan pointed to ongoing recruitment and retention issues in the education sector (similar to the healthcare sector) to justify higher-end increases, despite members of ETFO and OSSTF already being at top of market.

DOCTORS

Ontario physicians also share many characteristics of Ontario nurses. They are healthcare professionals working in the same settings, often as part of the same health teams. Like Ontario nurses, doctors bargain provincially through the Ontario Medical Association. As confirmed in the most recent arbitration, Ontario doctors are the highest paid in the country.[146]

In that award, Arbitrator Kaplan again rejected the argument that Ontario doctors should receive less than a normative increase because of their status at top of market:

> We do not accept that, simply because Ontario's doctors are currently well paid (perhaps as the Ministry submitted in relation to FHO physicians the best paid in Canada although this is contested) that this means that they should not receive both a proper normative increase and redress/catch-up for past (established) losses, as described below.[147]

Arbitrator Kaplan pointed to the recruitment and retention challenges for Ontario doctors as justifying higher increases, while acknowledging that those challenges were less significant than the staffing crisis for Ontario nurses: "We conclude that there is a recruitment and retention issue. It is obviously not the same as the recruitment and retention crisis faced in Participating Hospitals & ONA, where there were thousands of RN vacancies in Ontario's public hospitals."[148]

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[145] *The Crown in Right of Ontario v The Ontario Secondary School Teachers' Federation and The Elementary Teachers' Federation of Ontario,* 2024 CanLII 8967 (Kaplan) at 27-28.
[146] *R v Ontario Medical Association,* 2024 CanLII 86115 (Kaplan) at 42.
[147] *R v Ontario Medical Association,* 2024 CanLII 86115 (Kaplan) at 59.
[148] *R v Ontario Medical Association,* 2024 CanLII 86115 (Kaplan) at 55.

Thus, to the extent that moderate recruitment and retention challenges justified a high-end increase for Ontario doctors, despite already being the highest paid in the country, the more serious staffing challenges for Ontario nurses clearly justify a similar high-end normative increase.

ANALOGY TO TORONTO PROFESSIONALS BEING TOP OF MARKET IN THE PROVINCE

In addition to the province-wide bargaining units discussed above, there are also Toronto professional bargaining units that have maintained status at the top of their respective markets in Ontario, for very similar reasons (Toronto being by far the largest municipality in the province). Just as these professionals rightly earn the highest wages in the provincial market, ONA nurses should continue to earn the highest wages in the Canadian nursing market.

UNIVERSITY PROFESSORS

Among university faculty in Ontario, the professors at the University of Toronto (represented by the University of Toronto Faculty Association) have consistently earned top-of-market wages.

Like other professional bargaining units at the top of their respective markets, UTFA has successfully defeated arguments that its members should receive more modest increases because they already earn the highest rates in the province.[149] In the most recent arbitration award for this bargaining unit, Arbitrator Gedalof awarded an additional 7% across-the-board increase, on top of the 1% increase already awarded, affirming that normative increases are fully justified even where a bargaining unit has maintained its position at top of market.[150]

FIRE FIGHTERS

Members of the Toronto Professional Fire Fighters Association have historically ranked at or near top of market in provincial wage rates. In his 2017 award, Arbitrator Hayes justified this status:

> Toronto firefighters make a case that is intuitively attractive. It seems plausible that salaries for firefighters in the largest city in Canada should be at the top or close to the top of fire wages in Ontario subject to quirks of collective bargaining timing and unexpected vicissitudes. It would appear implausible that Toronto fire wages should lag smaller semi-rural municipalities not far from the city.[151]

Arbitrator Hayes noted that "Toronto is a vital urban driver of the national economy" and held that the position of Toronto fire fighters at top of market was a relevant

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[149] *University of Toronto (Governing Council) v University of Toronto Faculty Assn. (Re)*, 2006 CanLII 93321 (Winkler) at para 22.
[150] *University of Toronto v University of Toronto Faculty Association,* 2023 CanLII 85410 (Gedalof).
[151] *Toronto (City) v Toronto Professional Fire Fighters Association Local 3888, International Association of Fire Fighters*, 2017 CanLII 53653 (Hayes) at para 20.

consideration when determining the appropriate increase.[152] He maintained that bargaining unit's position as the highest paid in the province.

As the Union nominee noted in his dissent in that award, possessing "top of market" status does not mean a bargaining unit will be the highest paid at all times. However, in each successive round of bargaining, they can expect to return to the top of market:

> Toronto firefighters, under the Award, continue to maintain their leading position at or near the top of the provincial firefighter wage table, and do not thereby inhibit other firefighters in Ontario from making further advances. Moreover, should this occur, they can expect to see their own "leading position" restored in the next round of negotiations.[153]

As discussed below, a similar approach should be followed in the present round of collective bargaining. ONA nurses should receive across-the-board increases to maintain their status at the top of the nursing market, particularly in light of expected increases for Alberta nurses.

ONA MUST MATCH EXPECTED INCREASES IN ALBERTA

ONA's current top rates compare as follows to BC and Alberta:

	April 1, 2023	**April 1, 2024**
Ontario	$54.37	$56.00
BC	$54.28 (10yrs) / $57.78 (30yrs)	$55.91* (10 yrs) / $59.52* (30 yrs)
Alberta	$51.46 (Step 9)	$55.27 (tentative)

* This wage rate does not include the $2.15/hour BC RNs receive, on top of their regularly hourly rate, for all regular shifts.[154]

A tentative agreement for Alberta nurses for the term April 1, 2024, to April 1, 2027 has been reached pending ratification, after a private mediator proposal in October 2024 was rejected by the members.[155] The new agreement includes a restructuring of the Salary Grid by 4% between each step and a 3% increase as of April 1, 2024, that would set a top rate at step 9 of $55.27, and $56.38 with a 2% Long Service Pay Adjustment (LSPA). A 3% increase as of April 1, 2025, would set a top rate at $56.93, and $58.07 with a 2% LSPA. The agreement also eliminates Step 1, so Step 2 becomes the new Step 1, moves nurses up 1 step, and adds a new Step 9 as of the ratification date with rates of $59.21 and $60.39 (with a 2% LSPA). If ratified, the top rate as of April 1, 2026, would be $60.98.

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[152] *Toronto (City) v Toronto Professional Fire Fighters Association Local 3888, International Association of Fire Fighters*, 2017 CanLII 53653 (Hayes) at para 32.
[153] *Toronto (City) v Toronto Professional Fire Fighters Association Local 3888, International Association of Fire Fighters*, 2017 CanLII 53653 (Hayes) at Partial Dissent of Association Nominee.
[154] Collective Agreement between HEABC and Nurses' Bargaining Association (expiry March 31, 2025) at 78.
[155] United Nurses of Alberta, "UNA reaches Tentative Agreement in Bargaining with Employers for Provincial Collective Agreement" (March 10, 2023).

Given ONA's current position as top of market, the current round of bargaining calls for across-the-board increases equivalent to or higher than the rates agreed to in Alberta, to avoid Ontario's nurses falling behind that province in wages.

CONCLUSION

Ontario nurses are currently in the proper place at the top of the Canadian nursing market. This places members of this bargaining unit in a similar position to other professionals in Ontario, the most populous province with the highest volume of patients with complex needs. The across-the-board increases in the current round of bargaining must maintain ONA's status at top of market, particularly in light of the ongoing, serious recruitment and retention challenges and the catch-up required, as discussed below.

B. CATCH-UP

In addition to ensuring that RNs are appropriately paid in accordance with their "top of market" status, this round of bargaining is about continuing catch-up on wages.

The stagnation of wages under the unconstitutional Bill 124, the demands of the COVID-19 pandemic, and sky-rocketing inflation, all led to critical nursing shortages that supported ONA's proposal for wage adjustments in the last round. Those wage adjustments were only partially achieved.

In the last round of bargaining, ONA demonstrated that the spending power of RN wages had fallen off a cliff since 2010. This loss of spending power was mostly driven by poor arbitral awards. Each of the last 14 years of the agreement has been decided by an arbitrator, over which time inflation-adjusted wages of the membership have declined 9.1%. In the 14 years previous, 1997 to 2010, nine of the years were freely negotiated between the parties and real wages increased 12.1%.

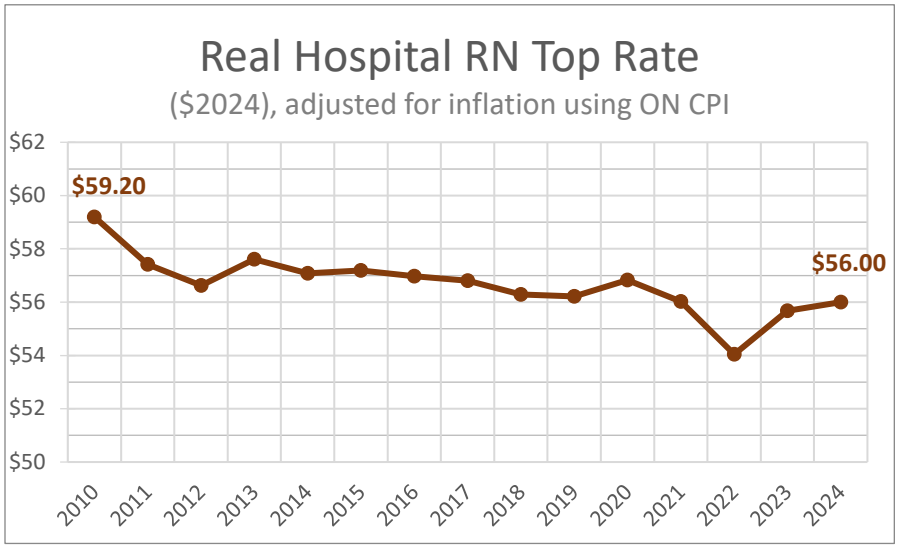
Year	Hospital Central ATBs*	ON Inflation Rate**	Inflation-Adjusted ATBs	Bargaining Outcome
1997	2.0%	1.8%	0.2%	Arbitrated
1998	2.0%	0.9%	1.1%	Settled
1999	2.0%	2.0%	0.0%	Settled
2000	2.5%	2.9%	-0.4%	Settled
2001	3.1%	3.0%	0.1%	Settled
2002	3.1%	2.0%	1.1%	Settled
2003	3.2%	2.7%	0.5%	Settled
2004	3.0%	1.9%	1.1%	Arbitrated
2005	3.0%	2.2%	0.8%	Arbitrated
2006	3.0%	1.8%	1.2%	Arbitrated
2007	4.0%	1.8%	2.2%	Arbitrated
2008	3.25%	2.3%	1.0%	Settled

2009	3.0%	0.4%	2.6%	Settled
2010	3.0%	2.5%	0.5%	Settled
2011	0.0%	3.1%	-3.1%	Arbitrated
2012	0.0%	1.4%	-1.4%	Arbitrated
2013	2.75%	1.0%	1.8%	Arbitrated
2014	1.4%	2.4%	-1.0%	Arbitrated
2015	1.4%	1.2%	0.2%	Arbitrated
2016	1.4%	1.8%	-0.4%	Arbitrated
2017	1.4%	1.7%	-0.3%	Arbitrated
2018	1.4%	2.4%	-1.0%	Arbitrated
2019	1.75%	1.9%	-0.1%	Arbitrated
2020	1.75%	0.7%	1.1%	Arbitrated
2021	2.0%	3.5%	-1.5%	Arbitrated
2022	3.0%	6.8%	-3.8%	Arbitrated
2023	3.50%	3.8%	-0.3%	Arbitrated
2024	3.0%	2.4%	0.6%	Arbitrated

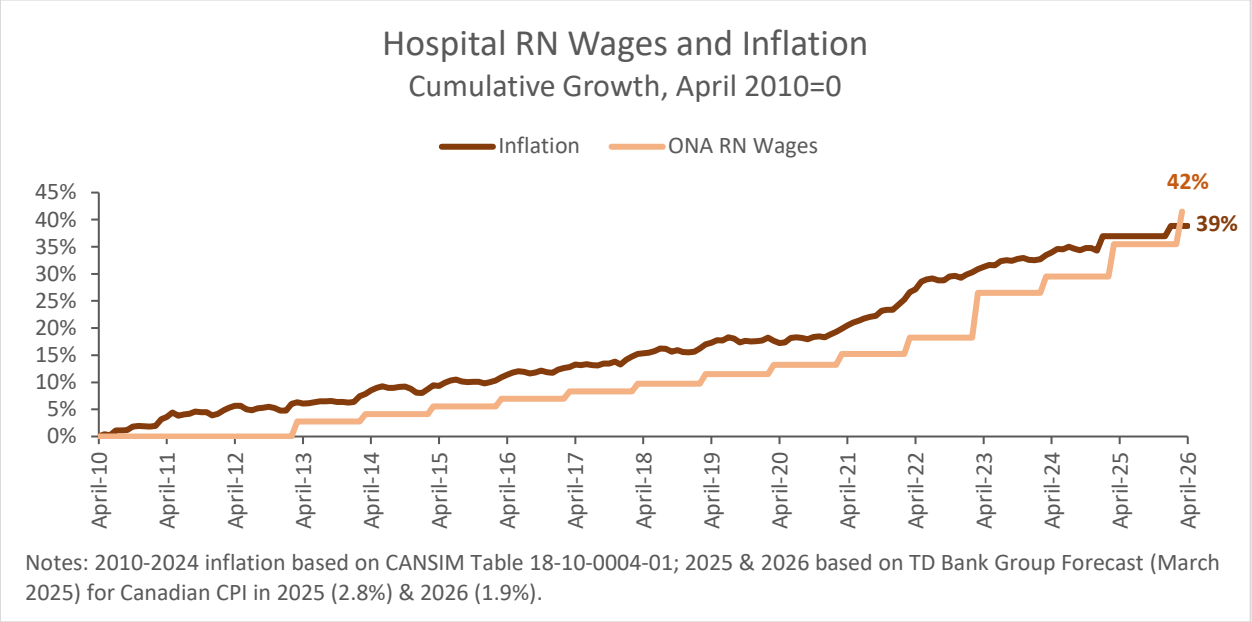
* ONA Central Hospital Agreements & Awards; average of all steps if differentiated
** Calculations based on All-items CPI, Statistics Canda Table 18-10-0005-01

The unprecedented spike in inflation in 2022 meant that even with the modest 3% wage increase and lowering of the top rate from 25 years to 8 years, ONA members experienced the largest, single-year decline in their purchasing power since central bargaining began. In today's dollars, the top-rate fell nearly $2, from $56.02 in 2021 to $54.04 in 2022. Of course, this decimation of nurse's income unfolded at the same that COVID-19 was devastating Ontario's hospitals.

While the Kaplan Award provided significant wage gains above inflation in 2023, and slightly above inflation in 2024, a sizeable loss in purchasing power remains when compared to 2010. Using 2024 dollars, ONA's top rate was $59.20 in 2010, $3.20 higher than it is now.



In this round, the Union's proposal fully restores its members purchasing power that has been eroded since 2010.



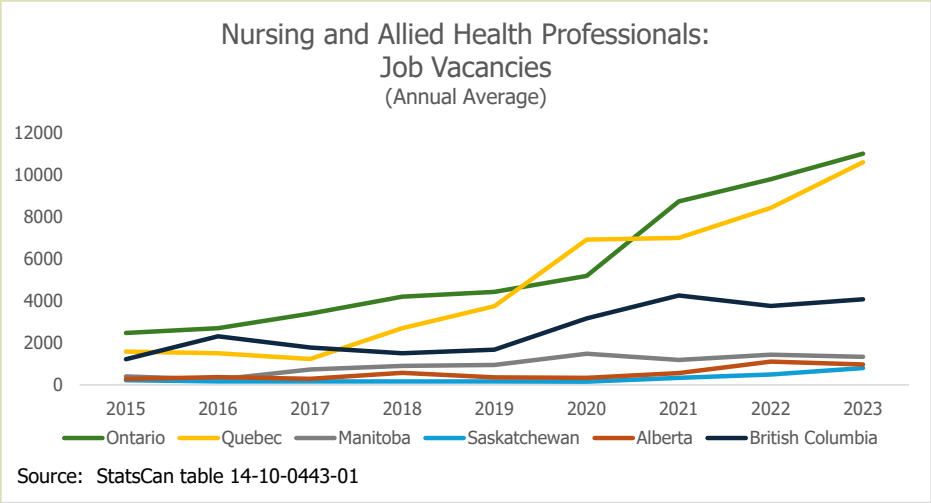
Notes: 2010-2024 inflation based on CANSIM Table 18-10-0004-01; 2025 & 2026 based on TD Bank Group Forecast (March 2025) for Canadian CPI in 2025 (2.8%) & 2026 (1.9%).

In short, at a minimum, the value of being a hospital nurse in 2026 should equal the value of being a hospital nurse in 2010. Unfortunately, it currently is not. In the interest of recruitment and retainment, this wage gap must be corrected without further delay.

C. RECRUITMENT AND RETENTION

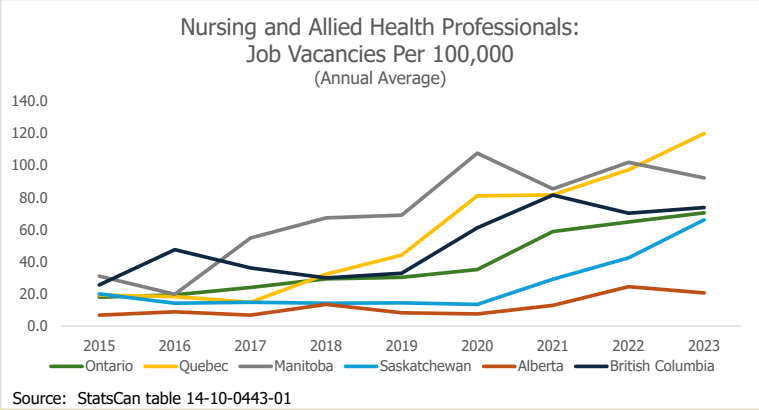
Arbitrator Kaplan acknowledged the nurse staffing crisis in this province in the previous round of bargaining. Contrary to the Employer's claims, this crisis is far from resolved. The wage increases in this round of bargaining must address the ongoing, serious shortage of nurses in Ontario.

Nursing vacancies in Ontario remain the highest in Canada. In 2023, on average, Ontario had three times as many vacancies as British Columbia, 11 times that of Alberta, and 13 times that of Saskatchewan:



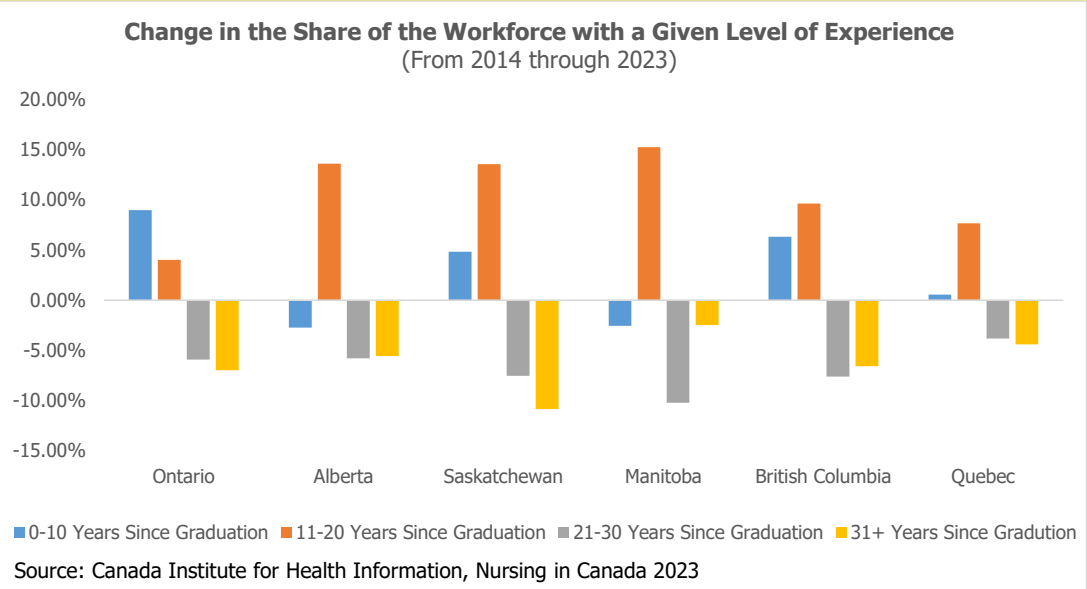
Source: StatsCan table 14-10-0443-01

This vacancy rate is unacceptably high, even after adjusting per capita:



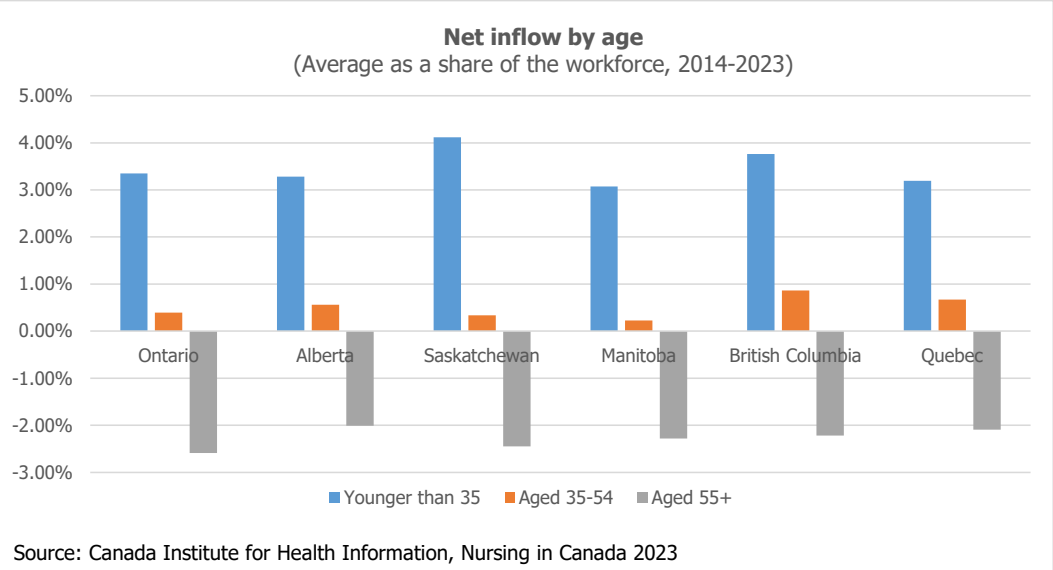
Source: StatsCan table 14-10-0443-01

Ontario has an urgent need for inflow of new nurses and retention of existing employees. Yet, the province is struggling to attract nurses, particularly those with more years of experience. Among the largest Canadian provinces, Ontario ranks last in growth of nurses with 11-20 years of experience as a share of the workforce:



Source: Canada Institute for Health Information, Nursing in Canada 2023

Similarly, Ontario ranks last in attracting nurses between the ages of 35-54 among comparator provinces:



Source: Canada Institute for Health Information, Nursing in Canada 2023

There can be no dispute that Ontario continues to face recruitment and retention challenges in the nursing profession. It is also beyond dispute that increased wages are an indispensable tool to address staffing shortages. As Arbitrator Kaplan acknowledged both in *Ontario Medical Association*, and in the previous award between these parties, "compensation is a key driver in recruitment and retention."[156] Thus, while increased wages are not the only answer, they are "an important one".[157]

[156] *R v Ontario Medical Association,* 2024 CanLII 86115 (Kaplan) at 56; *Participating Hospitals (Represented by the Ontario Hospital Association) v ONA*, 2023 CanLII 65431 (Kaplan) at 22.
[157] *R v Ontario Medical Association,* 2024 CanLII 86115 (Kaplan).

PROVINCIAL NURSE PRACTITIONER (NP) GRID

Step	April 1, 2025 (New Grid)	April 1, 2025 (6%)	April 1, 2026 (6%)
Start	$69.85	$74.03	$78.46
1 Year	$73.69	$78.11	$82.80
2 Years	$76.76	$81.36	$86.24
3 Years	$78.88	$83.61	$88.63

The Union's proposal for a unified provincial wage grid for Nurse Practitioners ("NPs") would align the Employer with industry standards. A unified provincial grid offers predictability and stability between Participating Hospitals, which is likely to have a significant effect on retention. The provincial grid for Nurse Practitioners that the Union is proposing also reflects the breadth and scope of Nurse Practitioners' expanded practice, qualifications, and responsibilities.

As of September 2024, there were over 5,100 NPs working in Ontario.[158] As of March 31, 2024, 917 NPs were ONA bargaining unit members working in the Participating Hospitals.

The Union's proposal is premised on the fundamental principle of equal pay for equal work. This principle has been enshrined in ONA agreements for RNs for over forty years. NPs are a single classification. They should be treated as such and paid accordingly.

The Union's proposal to create a provincial NP grid would harmonize the wage rates and step progression of the 917 NPs covered by the collective agreement. At present, there are NP grids with 10 steps, 4 steps, 6 steps, 7 steps, and 8 steps. The "Start" rates range from $58.82[159] to $ 73.57[160], the top rates range from $64.45[161] to $77.87[162].

The difference between the wage rates paid at some hospitals is extreme. The top rate at some hospitals is well below the start rate at others. The start rates for NPs also vary considerably, even within common geographical regions.

[158] College of Nurses of Ontario, *A single classification of Nurse Practitioners (NPs)* (2025).
[159] Collective Agreement between Erie Shores Healthcare and Ontario Nurses' Association (expiry March 31, 2025).
[160] Collective Agreement between Lakeridge Health and Ontario Nurses' Association (expiry March 31, 2025).
[161] Collective Agreement between Lake of the Woods District Hospital and Ontario Nurses' Association (expiry March 31, 2025).
[162] Collective Agreement between Brightshores Health System and Ontario Nurses' Association (expiry March 31, 2025).

The Union's Proposal for a Central Grid is consistent with Gradualism

The Union has tabled a provincial grid for NPs as a priority item in several rounds of bargaining. The matter should have been resolved in 2016, when the Albertyn Board was:

> persuaded by the Union that there ought to be a salary grid for the Classification - Nurse Practitioner (NP). From the info provided by the parties in their briefs it is apparent that there is a wide discrepancy both in the number of steps of NPs' salaries, and in the salaries paid to them.[163]

Regrettably, Arbitrator Albertyn opted to leave much of the deeply inequitable wage structure intact[164] and referred the issue of a provincial grid back to the parties:

> A committee is to be struck between the Hospitals and the Union to make recommendations to the parties on an integrated Classification Grid for NPs that will form part of the central agreement, having regard to the range of rates applicable across the participating hospitals, for use in future bargaining. The parties are directed to agree to a letter giving effect to this Committee. If they cannot agree to the letter, we remain seized.[165]

This did not resolve the matter. The meetings between the parties to discuss the provincial wage grid recommendations were wholly unsuccessful, as the Employer continued to object to a unified provincial wage grid in subsequent rounds.

The proposal was raised again in 2018, 2021, and 2023.

It has now been almost a decade since the Albertyn Board awarded the NP grid in principle. Resolving the item in this round is consistent with the principle of gradualism in collective bargaining. The proposal is not a breakthrough item. Rather, the Union's proposal seeks to finalize this matter in a prudent manner. The outcome proposed by the Union is preferable to maintaining the widely varying wage rates between the same professionals, doing the same work, in the same sector.

ONA's Proposal for a Central Grid is consistent with the Recommendations of other Nursing Groups

The harmonization of NP wages is not simply an ONA concern. While ONA has been raising its central grid proposal in bargaining for years, other nursing bodies have also advocated for harmonized wages to support the recruitment and retention of NPs in Ontario.

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[163] *Participating Hospitals v Ontario Nurses' Association*, 2016 CanLII 59375 (Albertyn) at para 36.
[164] The Albertyn Board improved some of the NP start rates to $47.80, but did not harmonize all start rates. See *Participating Hospitals v Ontario Nurses' Association*, 2016 CanLII 59375 (Albertyn).
[165] *Participating Hospitals v Ontario Nurses' Association*, 2016 CanLII 59375 (Albertyn) at para 38 [*emphasis added*].

In 2018, the Canadian Federation of Nurses' Unions ("CFNU") released a report examining the untapped potential of NPs in Canada's health care system. The CFNU noted that compensation for NPs varied widely in different health care settings. The report included recommendations for remuneration, including:

> Harmoniz[ing] NPs' salaries across all health care settings within each province/territory to substantially bridge the wage gap that currently exists. In determining what constitutes appropriate compensation, account for NPs' formal education and experience, their scope of practice, professional responsibilities, as well as their accountability as autonomous health care providers.[166]

In 2021, the Registered Nurses' Association of Ontario ("RNAO") released a report by its Nurse Practitioner Task Force entitled "Vision for Tomorrow". In that report, the task force made eight recommendations to the provincial government, which included harmonization of NP compensation across all sectors and settings.[167] Specifically, the task force noted:

> Retention and recruitment of NPs is essential for their successful integration and utilization within the health system. In order for the system to reap the benefits of existing NPs and to grow the number of NPs, it must be able to attract and retain them through fair, harmonized compensation across the system.[168]

Lastly, the Nurse Practitioners' Association of Ontario ("NPAO") included the harmonization of NP compensation across all sectors as part of its 2021 Ontario Budget Requests. In its presentation, the NPAO recommended that the compensation scales of NPs be aligned across all healthcare sectors. The NPAO offered the following justification:

> For almost a decade, Nurse Practitioners wages were frozen. Finally, with the announcement of the Primary Care Recruitment and Retention Funding in the 2016 and 2017 Provincial Budgets, improvements were made to compensation for NPs in funded primary care models. However, this does not address compensation for NPs employed in other healthcare sectors, such as hospitals and LTC. Most NPs working outside of the organizations covered by the recruitment and retention funding continue to make well below the minimum suggested salary rate identified in the "Developing a Provincial Compensation Structure for Primary Care Organizations – 2012 Report" produced by the Hay Group. Nurse Practitioners work across the healthcare system in a wide variety of settings. In this current compensation model, compensation equalization does not exist, resulting in NPs with similar responsibilities not getting equal pay for the same work. For this reason, the NPAO recommends a targeted investment to equalize Nurse Practitioner compensation across ALL sectors.

In sum, the harmonization of NP wages by way of a provincial grid has been a refrain echoed by professional groups across the province and at the national level. A

[166] Canadian Federation of Nurses Unions, "Pan-Canadian Nurse Practitioner Retention & Recruitment Study" (2018) at p. 39.
[167] Registered Nurses Association of Ontario, Vision for Tomorrow: Nurse Practitioner Task Force Report (February 2021).
[168] Registered Nurses Association of Ontario, Vision for Tomorrow: Nurse Practitioner Task Force Report (February 2021).

provincial wage grid for NPs is a workable proposal because a provincial wage grid has worked for RNs for over forty years. A decision by this Board awarding a central grid is not a breakthrough, but the next logical step following the Albertyn Board's decision, in 2017, that there ought to be a salary grid for the NP classification.

PROVINCIAL REGISTERED PRACTICAL NURSES (RPN) GRID

Step	April 1, 2025 (New Grid)	April 1, 2025 (6%)	April 1, 2026 (6%)
Start	$38.11	$40.39	$42.81
1 Year	$38.62	$40.93	$43.39
2 Years	$39.14	$41.48	$43.97

There are currently 96 Registered Practical Nurses ("RPNs") across all Participating Hospitals.[169] RPNs work closely with their RN colleagues to provide safe and quality patient care. Having one province-wide grid ensures RPNs across the bargaining unit are receiving equal pay for equal work.

The Union's proposal to create a provincial RPN grid would harmonize the wage rates and step progression of the RPNs covered by the collective agreement with a relatively insignificant impact on total compensation at an estimated cost of only $183,586 or 0.002% of total compensation.

Further, the Union's proposal for a unified provincial wage grid for RPNs covered by the collective agreement reflects other provincial nursing agreements and is far from an outliner in the sector. In British Columbia, Manitoba, Nova Scotia and New Brunswick, where Licensed Practical Nurses (RPNs outside of Ontario) are covered by the same nursing collective agreement, they benefit from a unified and central wage grid.[170] There is no reason why RPNs who are covered by the same collective agreement should not also benefit from being placed on a unified wage grid that ensures consistency and fairness in how they are compensated.

LONG-TERM EXPERIENCE ENTITLEMENTS

The Union's proposal to add retention premiums (i.e. Long-Term Service Entitlements) at 15 years (2%), 20 years (4%), 25 years (6%), 30 years (8%), and 35 years (10%) of service will address the Hospitals' need to retain experienced nurses.

[169] As of March 31, 2024, there were 37 full time RPNs and 59 part time RPNs in the bargaining unit.
[170] British Columbia Nurses' Union, Terms of Settlement 2022-2025 Nurses' Bargaining Association (NBA) Provincial Collective Agreement (ratified week of April 24, 2023); Collective Agreement between Shared Health Employers Organization and Manitoba Nurses Union (expiry March 31, 2028); Collective Agreement between Nova Scotia Health Authority and The Nova Scotia Council of Nursing Unions (expiry October 31, 2025); Collective Agreement between The New Brunswick Nurses' Union and Treasury Board Group: Nurses, Part III (expiry December 31, 2023).

The 2023 Gedalof Board Re-Opener Award eliminated the problematic "25-Years" step on the RN wage grid. While this addressed serious concerns about the origins and negative impact of the 25-Years step, it left RNs who had waited 25 years to reach the top of the prior wage grid with no recognition beyond the 3% across the board wage increase.[171]

Long-term service entitlements—which recognize commitment and dedication to the employer and to the profession—are standard in many collective agreements, including the collective agreements of male-dominated critical responders: Police and Firefighters. For example, in *North Bay Police Services Board v North Bay Police Association*, Arbitrator Snow outlined the relationship between service allowances and retaining experienced workers:

> The basic salary structure for sworn police officers has been in place throughout Ontario for many years. That structure changed in 2003 when the Toronto Police Service and Toronto Police Association agreed upon an additional retention allowance for experienced officers. As many experienced officers were leaving the Toronto force, the retention allowance was intended as a means of retaining the force's experienced officers. The amount of the retention allowance was 3% after 8 years, 6% after 17 years and 9% after 23 years. The parties implemented the change in two steps with the first step being 3%, 4% and 5% for one year, with 3%, 6% and 9% a year later. At the same time, the parties to the Toronto agreement made several compensating changes elsewhere in their collective agreement to help pay for this new allowance.
>
> This change in salary structure has been adopted by most of the police forces in Ontario and is now the norm**.** The collective agreements covering the vast majority of the police officers in Ontario now either have this new salary structure fully in place, or are in the process of implementing it. The retention allowance has been adopted by police forces which have no problem retaining senior police officers.[172]

Although the retention allowance originated as a tool to combat retention problems in Toronto, Arbitrator Snow awarded the retention premiums in North Bay—where there was no retention problem—because the premiums had become ubiquitous in policing contracts.

A few years later, in *Toronto Police Services Board v Toronto Police Association*, Arbitrator Kaplan noted the retention and recruitment rationale behind the Service Pay benefit in the Toronto agreement:

> Extending and increasing pay based on service was, without a doubt, the bargaining priority for the Association in negotiating the 2002-2004 collective agreement. Roger Aveling, the long-service labour relations counsel to the Association and its principal witness, testified about its importance particularly given the serious recruitment and retention problems the force was experiencing. Contributing to the problem, and the urgent need for a solution, was the large and growing cohort of members eligible, or soon to be eligible, for retirement and the implications of that on maintaining service

[171] *Participating Hospitals v Ontario Nurses Association*, 2023 CanLII 33967 (Gedalof).
[172] *North Bay Police Services Board v North Bay Police Association*, 2005 CanLII 63782 (Snow).

strength.[173]

The retention allowance in the Toronto Agreement is now the standard in both police and firefighter agreements across the province. The agreements all follow the same pattern of 3% at 8 years, 6% at 17 years, and 9% at 23 years (the "3-6-9 premiums"). The same "3-6-9 premiums" were recently awarded by Arbitrator Stout in *Port Colborne (Corporation of the City) v Port Colborne Professional Firefighters' Association* and Arbitrator Burkett in the *Corporation of The City of Windsor v Windsor Professional Fire Fighters' Association*.[174]

Notably, the 3-6-9 premiums are both more generous and achieved much earlier than the Union's 2-4-6-8-10 proposal. The 3-6-9 premiums typically start at 8 years and are paid as premiums on all hourly rates, including overtime, vacation, holiday pay etc.

Examples of police and firefighter agreements with the 3-6-9 premiums include:

Comparison of ONA LTSE Proposal vs Police/Fire LTSEs		
Collective Agreement	**Long Term Service Entitlement**	**Eligible Hours**
Toronto Police Service and Toronto Police Association (Expiry December 31, 2024)[175]	3% of PC1 salary at 8 years 6% of PC1 salary at 17 years 9% of PC1 salary at 23 years	Basic wage, overtime, call-back pay, vacation pay, sick pay, statutory holiday pay, paid lieu time, sick pay gratuity, pension contributions, etc.
Barrie Police Services Board and Barrie Police Association (Expiry December 31, 2023)	3% at 8 years 6% at 17 years 9% at 23 years	Basic wage, pension contributions, overtime, court-time, and vacation pay, and sick payouts.
Regional Municipality of Durham Police Services Board and The Durham Regional Police Association (Expiry December 31, 2024)	3% of PC1 salary at 8 years 6% of PC1 salary at 17 years 9% of PC1 salary at 23 years	Basic wage, pension contributions, statutory holiday pay, pregnancy/parental leave entitlements, sick leave pay, WSIB, and secondment

[173] *Toronto Police Services Board v Toronto Police Association*, 2008 CanLII 14935 (Kaplan).
[174] *Port Colborne (Corporation of the City) v Port Colborne Professional Firefighters' Association*, 2023 CanLII 29342 (Stout); *The Corporation of The City of Windsor v Windsor Professional Fire Fighters' Association*, 2024 CanLII 379 (Burkett).
[175] One year renewal to December 31, 2024: *Toronto Police Service Board v Toronto Police Association*, 2024 CanLII 124420 (Wright).

Greater Sudbury Police Services Board and Sudbury Police Association (Expiry December 31, 2024)	3% of PC1 salary at 8 years 6% of PC1 salary at 17 years 9% of PC1 salary at 23 years	Basic wage, pension contributions, overtime, sick time, court time, and vacation pay
Guelph Police Services Board and Guelph Police Association (Expiry December 31, 2023)	3% of PC1 salary at 8 years 6% of PC1 salary at 17 years 9% of PC1 salary at 23 years	Basic wage, overtime, court time, acting pay, call out, stand by, sick leave, pregnancy/parental leave top up, WSIB top up, annual leave, statutory leave pay and pension contributions
Halton Regional Police Services Board and Halton Regional Police Association (December 31, 2023)[176]	3% of PC1 salary at 8 years 6% of PC1 salary at 17 years 9% of PC1 salary at 23 years	Basic wage, Pregnancy/Parental Leave
Hamilton Police Services Board and Hamilton Police Association (Expiry December 31, 2025)[177]	3% of PC1 salary at 8 years 6% of PC1 salary at 17 years 9% of PC1 salary at 23 years	Basic wage, overtime, vacation and statutory holiday pay, pension contributions, sick leave pay, etc.
Kingston Police Services Board and Kingston City Police Association (Expiry December 31, 2022)	3% of PC1 salary at 8 years 6% of PC1 salary at 17 years 9% of PC1 salary at 23 years	Basic wage, pension contributions
London Police Services Board and London Police Association (Expiry December 31, 2022)	3% at 8 years 6% at 17 years 9% at 23 years	Basic wage, Overtime, Vacation, Statutory Holiday pay, pension contributions, Maternity/Parental Leave, and Sick Leave pay.
Regional Municipality of Niagara Police Services Board and Niagara Region Police Association (Expiry December 31, 2026)	3% of PC1 salary at 8 years 6% of PC1 salary at 17 years 9% of PC1 salary at 23 years	Basic wage, overtime, acting pay, emergency and call-back duty pay, stand-by duty pay, sick pay, annual leave and float time and

[176] One year renewal to December 31, 2023: *Halton Regional Police Services Board v Halton Regional Police Association*, 2024 CanLII 470 (Hayes).
[177] Renewal to December 31, 2025: *Hamilton Police Services Board v Hamilton Police Association*, 2022 CanLII 22894 (Kaplan).

		statutory holiday pay, Court pay, pension contributions and special duty pay.
Ottawa Police Services Board and Ottawa Police Association (Expiry December 31, 2024)	3% of PC1 salary at 8 years 6% of PC1 salary at 17 years 9% of PC1 salary at 23 years	Basic wage, all entitlements under the collective agreement that are presently calculated on the basis of a member's hourly or regular annual salary.
Waterloo Regional Police Services Board and Waterloo Regional Police Association (Expiry December 31, 2024)	3% of PC1 salary at 8 years 6% of PC1 salary at 16 years 9% of PC1 salary at 23 years	Basic wage, overtime, court-time pay, acting pay, call-out, on-call pay, stand-by duty pay, sick leave, pregnancy and parental supplementary benefit, annual leave and statutory holiday pay, pension contributions, and life insurance benefit pay out.
City of Ottawa and Ottawa Professional Fire Fighters Association (expiry December 31, 2023)	3% at 8 years 6% at 17 years 9% at 23 years	Basic wage, bank time, overtime, vacation, lieu days, WSIB, pregnancy leave, parental leave, sick leave, other paid leaves, stand-by pay, payout of sick leave, pension contributions, life insurance, accidental death, and course of duty death.
City of Hamilton and Hamilton Professional Fire Fighters Association (Expiry December 31, 2026)[178]	3% at 8 years 6% at 17 years 9% at 23 years	Basic wage, overtime, vacation and statutory holiday pay, pension contributions, sick leave pay, etc.
City of Vaughan and Vaughan Professional Fire Fighters Association	3% of a FF1C salary at 8 years	Basic wage, pension contributions, overtime, vacation, statutory

[178] Renewal to December 31, 2026: *Corporation of Hamilton (City) v Hamilton Professional Fire Fighters' Association, Local 288*, 2024 CanLII 66452 (Burkett).

(Expiry December 31, 2023)[179]	6% of a FF1C salary at 17 years 9% of a FF1C salary at 23 years	holiday pay, sick leave pay, and WSIB benefits, etc.
City of London and London Professional Firefighters Association (Expiry December 31, 2024)	3% of a FF1C salary at 8 years 6% of a FF1C salary at 17 years 9% of a FF1C salary at 23 years	Basic wage, overtime, vacation pay, Statutory Holiday pay, pension contributions, maternity and parental leave top up and sick pay.
City of Brampton and Brampton Professional Fire Fighters Association (Expiry December 31, 2023)	3% at 8 years 6% at 17 years 9% at 23 years	Basic wage, overtime, vacation and statutory holiday pay, pension contribution and sick leave pay and sick leave credits
City of Kitchener and the Kitchener Professional Fire Fighters Association (Expiry December 31, 2026)	3% of a FF1C salary at 8 years 6% of a FF1C salary at 17 years 9% of a FF1C salary at 23 years	Basic wage, overtime, vacation, statutory holiday pay, pension contributions, WSIB, and sick pay.
City of Barrie and the Barrie Professional Fire Fighters Association (Expiry December 31, 2023)	3% of a FF1C salary at 8 years 6% of a FF1C salary at 17 years 9% of a FF1C salary at 23 years	Basic wage, overtime, vacation, recognized holidays, pension contributions, WSIB entitlements, and sick leave entitlements (including payout).

Again, the Union's proposal is modest in comparison with the retention premiums found in these comparator agreements.

In addition to the Police and Firefighter agreements, retention premiums are commonly found in other provincial RN agreements. In the current collective agreement between the BC Nurses Union and HEABC the parties voluntarily agreed—for the first time—to additional wage increases at 10 years, 15 years, 20 years, 25 years, and 30 years of service.[180]

Retention premiums also exist in RN agreements in Alberta, Saskatchewan, and New Brunswick. New Brunswick's agreement provides a 1% premium at 15 years of

[179] Renewal to December 31, 2023: City of Vaughan and Vaughn Professional Fire Fighters Association, November 25, 2022 (Burkett).
[180] British Columbia Nurses' Union, Terms of Settlement 2022-2025 Nurses' Bargaining Association (NBA) Provincial Collective Agreement (ratified week of April 24, 2023).

service and a 5% premium at 25 years of service. Alberta and Saskatchewan both provide a 2% premium at 20 years of service.[181]

The Union's proposal for retention premiums would have a major impact on retention but would come at a relatively minor cost to the Employer. In 2023, 14% of the bargaining unit had achieved 25 years of service. As of March 31, 2024, that percentage has dwindled to 7.7% of the bargaining unit. The Hospitals need those nurses to stay within the sector for as long as possible. The demonstrated need to retain senior nurses, and an examination of the relevant comparators, all support awarding the Union's proposal for long-term service entitlements.

ARTICLE 14 - PREMIUM PAYMENTS – STANDARD OVERTIME

Overtime pay aims to compensate employees fairly for working beyond their normal hours of work or under circumstances more disruptive to their lives. It also discourages employers from routinely forcing employees to work excessive hours. In combination, both fair compensation and deterrence improves recruitment and retention. To achieve the purpose for which overtime premiums are intended, the benefit to employees and the cost to employers must be real and meaningful.

The Union's proposal to increase overtime premiums promotes both purposes. Increasing regular overtime premiums from 1.5x to 2x, and increasing overtime premium when working an overtime shift or extra hours when called back from standby from 2x to 2.5x will fairly compensate nurses for contributing extra hours of labour to keep hospitals in Ontario operational while motivating the Hospitals to find permanent staffing solutions to meet their operational needs. This is particularly important given the nursing retention crisis and the urgent need to address nurse burnout and exhaustion.[182] In its 2024 member survey, the Canadian Federation of Nurses Unions found that 9 in 10 nurses registered some amount of burnout.[183] It also found that 4 in 10 nurses intended to leave the profession, leave their job, or retire within the next year for reasons that included staffing levels, workload, and a lack of work-life balance.[184]

In its February 29, 2024 report, the Canadian Institute of Health Information's monitoring of overtime hours found that the level of overtime in Canada's health systems can result in a cycle of burnout and increased stress for health care workers:

> "[H]ospital staff (excluding physicians) performed more than 26 million hours of overtime in 2021–2022. The number of overtime hours worked by nurses and other

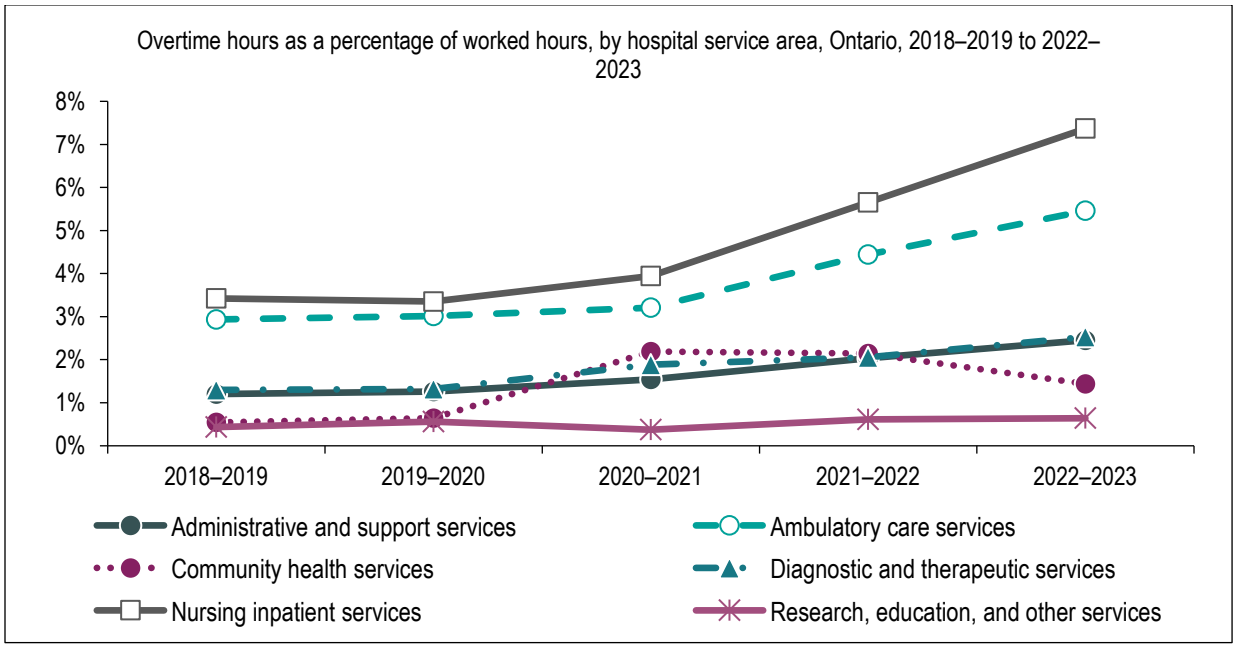
[181] Collective Agreement between The New Brunswick Nurses' Union and Treasury Board Group: Nurses, Part III (expiry December 31, 2023); Collective Agreement between Alberta Health Services Covenant Health Lamont Health Care Centre The Bethany Group (Camrose) and The United Nurses of Alberta, (expiry March 31, 2024); Collective Agreement between Saskatchewan Association of Health Organizations Inc. and The Saskatchewan Union of Nurses (expiry March 31, 2024).
[182] See Union's Introduction; see Union's Rationale re Article 8.05 – RN Staffing Ratios; See also *Nursing Retention Toolkit: Improving the Working Lives of Nurses in Canada*.
[183] CFNU, Member Survey Report (March 2024).
[184] CFNU, Member Survey Report (March 2024).

> hospital health workers (excluding physicians and management staff) on inpatient units reached 14.2 million, as highlighted in Hospital staffing and hospital harm trends throughout the pandemic. This represents a 53% increase from the previous year and is equivalent to over 7,000 full-time positions. [185]

Combined with other challenges, such as staffing shortages and increased workplace mental health and violence reports, overtime hours were found to play a key role in declining health worker wellness. It further found that this can increase the potential for negative outcome for patients:

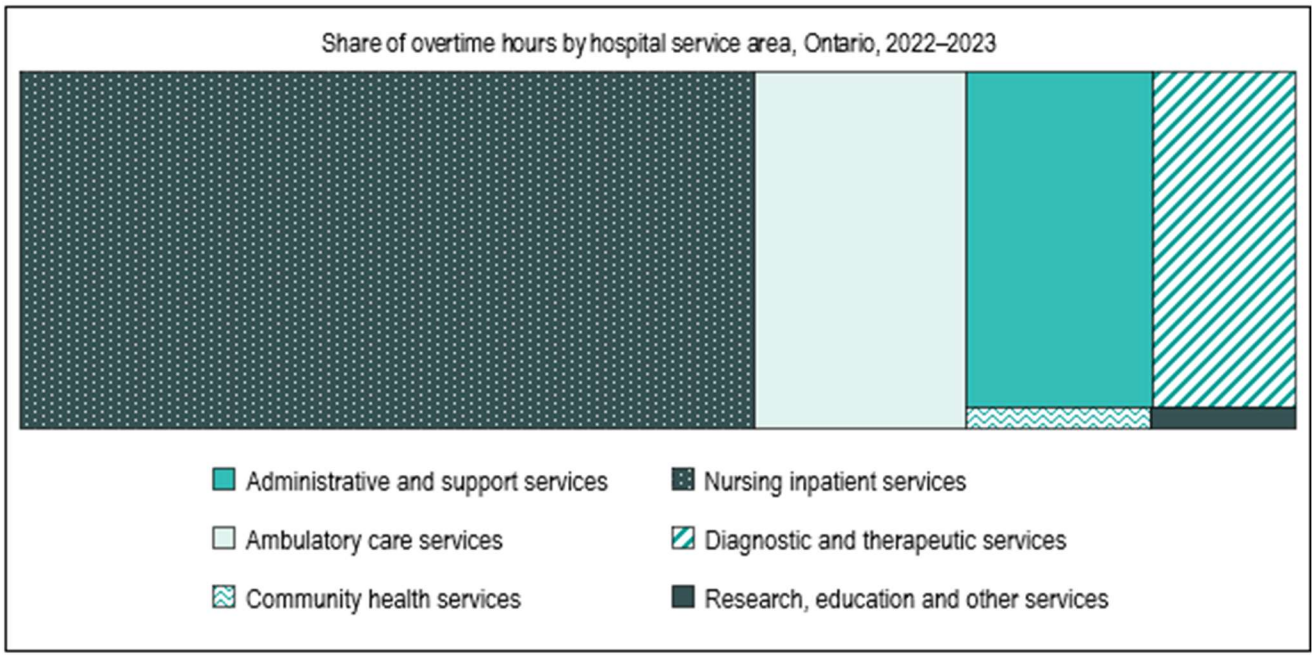
> Staffing challenges combined with the negative mental health impacts on staff stemming from increased amounts of overtime can lead to a cycle of burnout and understaffing. These issues can have a domino effect on patient care, including creating the potential for unintended harm to occur. Across Canada, the rate of hospital harm increased to 5.9% in 2020–2021 and 6% in 2021–2022 and 2022–2023 after remaining stable between 5.3% and 5.4% since 2014. [186]

In Ontario, most overtime hours worked in hospitals are worked by nurses, with a sharp increase in the first year of the pandemic in 2020 followed by a staggering exponential increase of almost double the total overtime hours worked in 2023, from 3.9% in 2020 to 7.4% in 2023 for nurses in inpatient services: [187]



In 2022-2023, nurses in inpatient services worked 57% of the total overtime hours worked in Ontario hospitals, for a total of **7,920,718 hours**:

[185] CIHI, Tracking Workplace Measures (February 29, 2024).
[186] CIHI, Tracking Workplace Measures (February 29, 2024).
[187] CIHI, Health Workforce in Canada, 2022 – Quick Stats (Updated June 27, 2024).



Overtime and burnout interact in a vicious cycle, which is facilitated by low overtime costs for the employer. Without meaningful cost implications, hospitals are not incentivized to recruit and retain additional permanent staff. Staffing shortages then burden existing staff and their compensation for these extra hours is insufficient, leading to further retention issues and greater burdens on existing staff. The consequence of this cycle is over-reliance on external labour supply and increased agency use with greater cost to the hospitals that exceed the straight time and overtime hourly rates of permanent staff. This is aptly illustrated by a staggering increase in the total purchased hours of "nursing inpatient services" from 10,548 hours in 2021-2022 to 30,941 in 2022-2023, which shows a tripling of agency usage that tracks with the increase in overtime hours worked by in-house nursing inpatient services in Ontario hospitals.[188]

An August 2023 study published by Statistics Canada found that in 2022, the proportion of health care employees working overtime and the number of hours they worked were elevated, after trending upwards throughout the pandemic. In August 2022, nurses comprised almost half (41.6%) of health care workers who indicated they intended to leave their current job within the next year with the main reason cited as being overworked.[189] Clearly, the above data shows that being overworked and working overtime among Ontario hospital nurses has neither disappeared nor even leveled-off post pandemic but has instead sharply increased since 2022.

The Union's proposal is also consistent with and brings Ontario nurses' overtime in line with its provincial comparators. Nursing Collective Agreements in Alberta, British Columbia, Nova Scotia, Saskatchewan, and Manitoba all have double pay overtime

[188] CIHI, Health Workforce in Canada, 2022 – Quick Stats (Updated June 27, 2024).
[189] Statistics Canada, Quality of employment and labour market dynamics of health care workers during the COVID-19 pandemic (August 10, 2023).

provisions. While British Columbia and Nova Scotia pay double time after a minimum threshold is passed by the nurse, [190] no minimum threshold is contained in the Alberta, Saskatchewan, and Manitoba agreements, and the rate paid for all overtime hours is double time.

ARTICLE 14 - PREMIUM PAYMENTS – EVENING, NIGHT AND WEEKEND PREMIUMS

Hospitals require a 24/7 nursing staff. Evening, night and weekend premiums are intended to compensate nurses who take on shifts that are more disruptive to their lives. The premium offsets the additional burden placed on them including the negative impact on their work-life balance and the interference with their life outside of work including familial obligations. Therefore, shift premiums are essential to the viability of the hospitals and their ability to recruit and retain nurses.

Premiums must fairly compensate nurses, given the continued acute and systemic staffing shortages at the Hospitals. They cannot be merely symbolic.

The Union is seeking the following increases:

- Evening shift premium from $2.25 to $3.50;
- Night shift premium from $2.98 to $5.00.

These increases are supported by a demonstrated need to recruit and retain nurses in Ontario and are comparable to RN agreements in other provinces. The Union's proposals provide a much-needed catch-up for Ontario nurses, who not only lag behind their comparators in other provinces but who have seen insufficient premium increases in the last several rounds.

The Union also seeks a Weekend Premium at one and one-half times the straight-time hourly rate. This increase is already being voluntarily offered by some Hospitals in an effort to maintain coverage of these shifts. The fact that this premium is being offered voluntarily reflects the actual market value of a weekend shift. Lastly, a weekend premium at one and one-half times the straight-time rate is significantly less costly to a hospital than filling the shift with agency nurses.

While, historically, ONA had either bargained or been awarded increases to shift premiums along with general wage increases, evening, night and weekend premiums have largely stagnated in recent rounds. Combined with exhaustion, burnout and

[190] Provincial Collective Agreement between Health Employers Association of BC and Nurses' Bargaining Association (NBA) (April 1, 2022 – March 31, 2025) at Article 27.05 (the RN collective agreement in British Columbia pays overtime at the rate of double (2 times) for all hours above the first two (2) hour in excess of the normal daily full shift hours, and for all hours above the first normal daily full shift hours in excess of the normal weekly full shift hours); Collective Agreement between Nova Scotia Health Authority and The Nova Scotia Council of Nursing Unions (expiry October 31, 2025) at Article 7.18 (the Nova Scotia RN collective agreement provides for double time for hours worked in excess of four (4) hours overtime in any one day).

staff shortages, the inadequacy of compensation for working more disruptive shifts has exacerbated these challenges:

Shift Premiums by Hospital Central Round															
	Devlin			Kaplan		Albertyn		Kaplan		Stout	Gedalof		Stout Reopener	Kaplan	
	Jun-11	Apr-12	Apr-13	Apr-14	Apr-15	Sep-16	Apr-17	Apr-18	Apr-19	Apr-20	Apr-21	Apr-22	Apr-21	Apr-23	Apr-24
Evening Premium	$1.95	$2.00	$2.10	$2.10	$2.10	$2.15	$2.25	$2.25	$2.25	$2.25	$2.25	$2.25	$2.25	$2.25	$2.25
Night Premium	$2.35	$2.40	$2.50	$2.50	$2.50	$2.55	$2.65	$2.65	$2.65	$2.65	$2.88	$2.88	$2.98	$2.98	$2.98
Weekend Premium	$2.50	$2.55	$2.65	$2.65	$2.65	$2.70	$2.80	$2.80	$2.80	$2.80	$2.80	$3.04	$3.14	$3.14	$3.14

Evening premiums were last increased over 8 years ago in 2017. The Union's proposal for an increase by $1.25 is meant to provide a much-needed restoration and catch-up of shift premiums specially where Ontario nurses are lagging behind their provincial counterparts.

The same is true of the Union's proposal for an increase to the night premium of $2.02 given night shift premium has increased only by $0.33 over the same 8-year period. This is wholly inadequate to be truly compensatory and contributes to the retention and recruitment challenges of nurses that is well-documented and ongoing.

Finally, the weekend premium has only been increased by $0.24 over the last 6 years. Arbitrator Stout's 2024 award, allowing an additional $0.10 for the Night and Weekend premiums, is totally divorced from the reality of the Hospitals' retention problems or the sacrifices nurses make to keep Ontario hospitals operational.[191] Within the traditional work week, weekends are supposed to be time for rest, rejuvenation, and spending time with friends and family. A 24-hour healthcare operation needs nurses who are willing to work on weekends. In a competitive labour market, the premium for that work ought to reflect its market value. The alternative is to fill staffing vacancies with agency nurses at double, triple, and quadruple the cost of paying a staff nurse time and a half.

Normative Evening and Night Premiums in Other Provincial RN Agreements

The Union's proposal is in line with the premiums offered by comparators in other provinces:

As of Nov 1, 2024	Premiums		Difference w ON	
	Evening	Night	Evening	Night
ON	$2.25	$2.98	-	-
BC	$1.40	$5.00	$0.85	$2.02
AB	$2.75	$5.00	$0.50	$2.02
SK	$3.75	$3.75	$1.50	$0.77

[191] *Ontario Hospital Association v Ontario Nurses' Association*, 2023 CanLII 29345 (Stout) at para 37.

MA	$2.25	$3.75	$0.00	$0.77
NB*	$2.10	$2.60	$0.15	$0.38
NS	$4.00	$4.00	$1.75	$1.02
PEI	$3.25	$4.00	$1.00	$1.02
NFL	$2.30	$2.30	$0.05	$0.68

* CBA expired Dec 31, 2023

Significantly, Ontario nurses' evening shift premiums are the 3rd lowest in the country while their night shift premiums rank 2nd lowest after Newfoundland and Labrador. The Union's proposal would therefore put Ontario nurses in a similar position to their comparators with respect to night shift premiums while still lagging behind in evening shift premiums compared to leading rates in the country. In the round, Arbitrator Kaplan did not award the shift premiums proposed by the Union on the basis that "they are already best in class".[192] Clearly, that conclusion is no longer accurate since currently Ontario nurses' shift premiums rank among the lowest in the country.

1.5x Weekend Premiums Are Already Being Offered by Participating Hospitals

The Employer cannot find enough nurses to fill weekend shifts. Nurses that remain in the hospital system are stressed and overworked. Such nurses are understandably reluctant to give up their weekends for wages and premiums that are out of sync with the sacrifices that weekend work demands.

In order to fill weekend shifts, the Hospitals are relying on agency nurses at rates far outside the range of the straight time and premium rates of the positions they are filling.

In order to avoid the more costly alternative, some Hospitals are offering additional incentives for nurses to take on weekend work. These incentives go well beyond the current Weekend Premiums and in some cases outstrip the Union's proposal. The reality is that, at many participating hospitals, nurses are already receiving time and a half for weekend shifts and in some cases more. The Union submits that this situation is demonstrative of the actual market rate for a nurse working a weekend shift. Throughout the past year, the following Hospitals offered time and a half for nurses who worked weekend shifts:

- Headwaters Health Care Centre
- Southlake Regional Health Centre
- West Haldimand General Hospital

These incentives are a rational, measured response to the systemic staffing and retention crisis in Ontario hospitals. Not only does a 1.5x weekend premium achieve the compensatory purpose of premium rates by offering a

[192] *Participating Hospitals (Represented by the Ontario Hospital Association) v ONA*, 2023 CanLII 65431 (Kaplan).

meaningful increase to the nurse salaries, but it also allows nurses to benefit from their placement on the pay scale. Tying the weekend premium to a nurse's regular wage rate provides a significant incentive for weekend work and assists in long-term service retention.

The Union submits that, in light of the Hospitals' recruitment and retention problems, the collective bargaining environment, and the significant toll the pandemic and a strained healthcare system has put on nurses, its weekend premium proposal replicates what the parties would have agreed to.

Now is the time to award meaningful shift premiums that truly reflect, value and appropriately compensate nurses for the additional burden placed on them for working these shifts.

For all of these reasons, the Union's proposals ought to be awarded.

OTHER MONETARY PROPOSALS

PROPOSAL #5 – ARTICLE 11: LEAVES OF ABSENCE

11.15 **Domestic, Sexual or Intimate Partner Violence Leave**

~~Domestic or Sexual Violence Leave will be granted in accordance with the Employment Standards Act.~~

The parties recognize domestic, sexual or intimate partner violence as an important workplace concern and that violence and abuse manifest in various ways, including but not limited to, disruptive phone calls, harassing emails, threats, inappropriate visits, violent confrontations, violent offences between current and/or former partners, regardless of cohabitation.

The parties acknowledge that experiencing domestic, sexual or intimate partner violence may affect nurses' attendance and performance at work, and will require specific services and supports, including but not limited to paid leave, safety planning, training, referrals and protections for a nurse or a child/children or dependents of the nurse who experiences domestic, sexual or intimate partner violence, or the threat of domestic, sexual or intimate partner violence. Such leave will not be unreasonably denied.

Note: This clause will be interpreted in accordance with the *Occupational Health and Safety Act*.

EMPLOYER POSITION

Opposed.

UNION RATIONALE

The Legislature has recognized the need for workplace protections related to sexual and domestic violence. The *Employment Standards Act* provides entitlement to a leave of absence, a portion of which is paid. Similarly, the *Occupational Health and Safety Act* requires employers who are aware, or ought to be aware, that domestic violence may occur in the workplace to take "every precaution reasonable in the circumstances for the protection of the worker."

The Union's proposal builds on these statutory provisions to provide a more comprehensive provision that acknowledges the many ways domestic, sexual, or intimate partner violence may manifest in the workplace.

Women are overwhelming the victims of domestic, sexual, and intimate partner violence, accounting for almost 8 in 10 victims of intimate partner violence.[193] Most ONA members are women and so this proposal has special resonance with the ONA bargaining unit. In May 2024, ONA member Shannan Leigh Hickey of Belleville, Ontario was murdered in her home and the man charged in her killing was her former intimate partner.[194]

The Hospitals have a duty to ensure their workers—who are also predominately women—are protected from violence and provided with resources to address this all-too-common type of risk that often crosses into the workplace. One of those resources is paid leave. In the soon to be ratified agreement between United Nurses of Alberta and the provincial Employers, the parties codified five paid leave days for a nurse to address matters associated with domestic violence.[195]

In addition to providing for paid leave, the Union's proposal ensures other measures such as safety planning and training are available to protect and support nurses who are experiencing violence and holds the Hospitals accountable for their obligations under the *Occupational Health and Safety Act.* The Union's proposals are responsive to best practices recommended by experts in the field, such as the *Make It Our Business* initiative at the Western University's Centre for Research & Education on Violence against Women & Children.[196]

The Employer's proposal is wholly inadequate and unresponsive to the pressing issue of domestic, sexual, and intimate partner violence, and shockingly fails to even mention paid leave whatsoever.

[193] Burczycka, Marta "Section 2: Police-reported intimate partner violence in Canada, 2018." In Family violence in Canada: A statistical profile, 2018 (2019) Juristat, Statistics Canada no Catalogue 85-002-X.
[194] CBC News, "Man charged with 2nd-degree murder after woman found dead in Belleville home", dated May 21, 2024 (accessed March 25, 2025); Quinte News, "Homicide victims was a nurse at BGH", dated May 23, 2024 (accessed March 25, 2025).
[195] UNA Tentative Agreement - Provincial Agreement Summary of March 25, 2025.
[196] Western Education, Guidelines for Setting up Security Measures to Stop Domestic Violence in the Workplace (2010); Western Education, Guidelines for developing workplace domestic violence policy (2010).

PROPOSAL #6 – ARTICLE 11, 16 & 17: PREGNANCY AND PARENTAL LEAVE

11.07 Pregnancy Leave

(f) On confirmation by the Employment Insurance Commission of the appropriateness of the Hospital's Supplemental Unemployment Benefit (SUB) Plan, a nurse who is on pregnancy leave as provided under this Agreement who has applied for and is in receipt of Employment Insurance pregnancy benefits pursuant to Section 22 of the *Employment Insurance Act* shall be paid a supplemental employment benefit. That benefit will be equivalent to the difference between ~~eighty-four~~ **ninety-five** percent (~~84~~ **95**%) of their regular weekly earnings and the sum of their weekly Employment Insurance benefits and any other earnings. Biweekly payment shall commence following completion of the one (1) week Employment Insurance waiting period, and receipt by the Hospital of the nurse's Employment Insurance cheque stub as proof that they are in receipt of Employment Insurance pregnancy benefits and shall continue for a maximum period of fifteen (15) weeks. The nurse's regular weekly earnings shall be determined by multiplying their regular hourly rate on their last day worked prior to the commencement of the leave times their normal weekly hours. The normal weekly hours for a part-time employee shall be calculated by using the same time period used for calculation of the Employment Insurance benefit.

The employee does not have any vested right except to receive payments for the covered employment insurance period. The plan provides that payments in respect of guaranteed annual remuneration or in respect of deferred remuneration or severance pay benefits are not reduced or increased by payments received under the plan.

The employer shall continue to pay the percentage in lieu of benefits for part-time employees based on the employee's normal weekly hours for the full duration of the pregnancy leave in addition to pension contributions if applicable.

[…]

11.08 Parental Leave

(e) On confirmation by the Employment Insurance Commission of the appropriateness of the Hospital's Supplemental Unemployment Benefit (SUB) Plan, a nurse who is on parental leave as provided under this Agreement who has applied for and is in receipt of Employment Insurance parental benefits pursuant to Section 23 of the *Employment Insurance Act* shall be paid a supplemental employment benefit. That benefit will be equivalent to the difference between ~~eighty-four~~ **ninety-five** (~~84~~ **95**%) percent of the nurse's regular weekly earnings and the sum of their weekly Employment Insurance benefits and any other earnings. Biweekly payment shall commence following completion of the one (1) week Employment Insurance waiting period, and receipt by the Hospital of the employee's Employment Insurance cheque stub as proof that they are in receipt of Employment Insurance parental benefits and

shall continue while the nurse is in receipt of such benefits for a maximum period of ~~twelve (12)~~ **fifty-two (52)** weeks. The nurse's regular weekly earnings shall be determined by multiplying their regular hourly rate on their last day worked prior to the commencement of the leave times their normal weekly hours. The normal weekly hours for a part-time employee shall be calculated by using the same time period used for calculation of the Employment Insurance benefit.

The employee does not have any vested right except to receive payments for the covered employment insurance period. The plan provides that payments in respect of guaranteed annual remuneration or in respect of deferred remuneration or severance pay benefits are not reduced or increased by payments received under the plan.

The employer shall continue to pay the percentage in lieu of benefits for part-time employees based on the employee's normal weekly hours for the portion of the parental leave for which SUB payments are being made, i.e., ~~12~~ **52** weeks, in addition to pension contributions if applicable.

Where an employee elects to receive parental leave benefits pursuant to Section 12 (3) (b) (ii) of the *Employment Insurance Act*, the amount of any Supplemental Unemployment Benefit payable by the Hospital will be no greater than what would have been payable had the employee elected to receive the parental leave benefit pursuant to Section 12 (3) (b) (i) of the *Employment Insurance Act*.

NOTE: (Note 1 applies to full-time nurses only)

Provisions in existing Collective Agreements providing for paternity leave shall be continued in effect and added to the above provisions in such Collective Agreements.

[…]

16.01 All employees shall receive vacations with pay based on length of full-time continuous service as follows:

***NEW* (i) Employees on a pregnancy or parental leave pursuant to articles 11.07 or 11.08 are deemed to be on a paid leave for the purposes of Article 16.01.**

[…]

17.05 The Hospital shall continue to pay the premiums for benefit plans under Articles 17 and 12 for nurses who are on paid leave of absence, **Pregnancy or Parental Leave,** or on WSIB or at any time when salary is received, or as provided in Article 10.04.

EMPLOYER POSITION

Opposed.

UNION RATIONALE

11.07 & 11.08

The Union's proposal seeks to increase the supplemental top up from 84% to 95% for nurses on pregnancy and parental leave to bring this provision in line with benefits available to other workers in comparable healthcare and the broader public service sectors. The Union also seeks to extend the period of parental leave top up from 12 to 52 weeks.

The supplemental top up for nurses on pregnancy or parental leave has fallen behind benefits provided to comparable public service sector workers. Ontario public service employees, employees at colleges in Ontario, and employees in the federal public service all receive a supplemental top up of 93%.[197] Moreover, comparable public sector workers receive around three times more parental leave top up (36-37 weeks) than nurses.[198] There is no justification for this gap in pregnancy and parental benefits for nurses.

The need for equitable pregnancy and parental benefits is even more pressing for the Hospitals, where nursing remains a female dominated sector. Pregnancy and parental leave, particularly in early stages of their career, leave nurses financially vulnerable.

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[197] Collective Agreement between College Employer Council (the CEC) for the Colleges of Applied Arts and Technology and Ontario Public Service Employees Union (expiry September 30, 2024) at Article 22.02C; Collective Agreement between College Employer Council (CEC) (For Colleges of Applied Arts and Technology) and Ontario Public Service Employees Union (For Full-Time Support Staff Employees), (expiry August 31, 2025) at Article 12.6; Collective Agreement between Ontario Public Service Employees Union and The Crown in Right of Ontario (expiry December 31, 2024) at Articles 51.5.2.2 and 50.3.2.2; Collective Agreement between Crown in Right of Ontario and Association of Management, Administrative and Professional Crown Employees of Ontario (expiry March 31, 2025) at Articles 24.12.2 and 24.13.2; Collective Agreement between the Treasury Board and the Public Service Alliance of Canada, Program and Administrative Service Group (expiry June 20, 2025) at Articles 38.02 and 40.02; Collective Agreement between the Treasury Board and Professional Institute of the Public Service of Canada, Applied Science and Patent Examination Group (expiry date September 30, 2026) at Articles 17.04(c) and 17.07(c); Collective Agreement between the Treasury Board and Canadian association of Professional Employees, Economics and Social Science Services Group (expiry date June 21, 2026) at Articles 21.04(c) and 21.07(c).

[198] Collective Agreement between College Employer Council (CEC) (For Colleges of Applied Arts and Technology) and Ontario Public Service Employees Union (For Full-Time Support Staff Employees) (expiry August 31, 2025) at Article 12.6; Collective Agreement between the Treasury Board and the Public Service Alliance of Canada, Program and Administrative Service Group (expiry June 20, 2025) at Articles 38.02 and 40.02; Collective Agreement between the Treasury Board and Professional Institute of the Public Service of Canada, Applied Science and Patent Examination Group (expiry date September 30, 2026) at Articles 17.04(c) and 17.07(c); Collective Agreement between the Treasury Board and Canadian association of Professional Employees, Economics and Social Science Services Group (expiry date June 21, 2026) at Articles 21.04(c) and 21.07(c);

[198] Katherine Marshall, "Employer top-ups", *Statistics Canada* (November 27, 2015).

After having a child, financial pressures only increase for nurses, with the costs of raising a child exacerbating existing stress.[199] As both an equity issue, and to support recruitment and retention, salary top up during pregnancy leave should be increased to reduce financial pressure on nurses who are on leave and to ensure nurses are not economically "punished" for pregnancy.

Increasing the length of the supplemental top for parental leave is also an equity issue that will support recruitment and retention. Increasing parental leave so that it is equal to pregnancy leave ensures that all nurses, no matter their family structure, are supported equally.[200] Moreover, the increase will support a more balanced share of parental leave, which helps to reduce gender gaps in employment and earnings between men and women, a current reality that most significantly impacts female dominated professions, such as nursing.[201]

Increases in pregnancy and parental leave benefits further directly supports the objective of employee retention and supporting women in the workforce. Women's attachment to labour market and an employer is also strongest where they have access to extended paid leave programs, as "women with top-ups are not only more likely to go back to work, but back to their previous jobs."[202]

As a female dominated profession, this proposal is critical for the financial and mental health of the workers who are at the frontlines of Ontario's healthcare system.

16.01 (i)*NEW*

The Union also seeks clarifying language to ensure that nurses continue to accrue service for the purpose of vacation entitlement while on pregnancy and parental leave. Nurses should not be penalized or lose negotiated benefits while on pregnancy and parental leave when they continue to accrue "seniority and service" pursuant to Article 10.04.

This clarifying language ensures that nurses continue to accrue vacation while on pregnancy and parental leave like workers in comparable healthcare and the broader public service sectors, including nurses in other jurisdictions and public service employees in Ontario.[203]

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[199] Maturn, *Special Report: Expecting More: The Motherhood Penalty and Its Impact on Canadian Women in the Workplace* (March 2024) at 8.
[200] Maturn, *Special Report: Expecting More: The Motherhood Penalty and Its Impact on Canadian Women in the Workplace* (March 2024) at 9.
[201] Statistics Canada, *Partners' uptake of parental benefits: An upward trend?* (May 15, 2024).
[202] Katherine Marshall, "Employer top-ups", *Statistics Canada* (November 27, 2015).
[203] Collective Agreement between Health Employers Association of BC and Nurses' Bargaining Association (expiry March 31, 2025) at Article 38.06; Collective Agreement between the Ontario Public Service Employees Union and the Crown in Right of Ontario (expiry December 31, 2024) at Articles 76.2.2 and 77.12; Collective Agreement between Waterloo Regional Police Services Board and The Waterloo Regional Police Association (expiry December 31, 2024) at Article 28.05.

Vacation is a crucial for allowing employees to recharge and return to work refreshed and ready to resume their duties. This is even more important for new parents, and in particular new mothers, who experience new stressors and are learning to balance professional responsibilities and the demands of parenthood. The mental health of nurses should not be given less priority because they are a new parent or because of pregnancy.

Ensuring nurses do not lose vacation entitlement while on pregnancy or parental will also help with retention. In a study published by Health Canada on improving nursing retention by improving the working lives of nurses, one of the key recommendations related to "Best Practices for Vacation and Time-Off" was to provide for equitable opportunity for nurses to take vacation.[204] Providing for equitable vacation must include equitable vacation for nurses who are new parents.

17.05 *NEW*

Finally, the Union seeks language clarifying that the Hospital shall pay premiums for benefit plans when nurses are on pregnancy and parental leave. Nurses should not experience a loss of benefits because they are pregnant or a new parent.

The Union's proposal ensures that nurses do not fall behind other workers in comparable healthcare and the broader public service sectors, who have collective agreements that explicitly recognize the Employer's obligation to continue paying these premiums.[205]

Pregnancy and parental leave increase the financial vulnerability of nurses. By not paying premiums on nurses' benefits during these leaves, the Employer is effectively placing an additional "penalty" for pregnancy on nurses, who are primarily women, on top of their reduction in pay.

Moreover, benefits are critical for nurses on these pregnancy and parental leaves, and help to ensure that nurses are well and ready to return to work at the end of their leave. For instance, nurses on pregnancy and parental leave face increased financial pressures and other stress that comes with being a new parent.[206] Part of this stress includes anxieties about returning to work after giving birth and stress

[204] Health Canada, *Nursing Retention Toolkit: Improving the Working Lives of Nurses in Canada* (March 2024).
[205] See eg Combined Full-Time and Part-Time Collective Agreement Between the Hospital and Ontario Public Service Employees Union (expiry March 31, 2024) at Article 10.05; Collective Agreement between College Employer Council (the CEC) for the Colleges of Applied Arts and Technology and Ontario Public Service Employees Union (expiry September 30, 2024) at Article 22.02A; Collective Agreement between Crown in Right of Ontario and Association of Management, Administrative and Professional Crown Employees of Ontario (expiry March 31, 2025) at Article 24.16; Collective Agreement between Health Employers Association of BC and Nurses' Bargaining Association (expiry March 31, 2025) at Article 38.04; Collective Agreement between the Ontario Public Service Employees Union and the Crown in Right of Ontario (expiry December 31, 2024) at Articles 77.3 and 76.4.
[206] Maturn, *Special Report: Expecting More: The Motherhood Penalty and Its Impact on Canadian Women in the Workplace* (March 2024) at 8.

leading up to the transition of being back in the workplace.[207] Comprehensive benefit coverage during their leave can ensure that nurses receive the mental health care necessary to allow for a smooth transition back into the workplace.

[207] Maturn, *Special Report: Expecting More: The Motherhood Penalty and Its Impact on Canadian Women in the Workplace* (March 2024) at 5.

PROPOSAL #7 *NEW* – ARTICLE 12: SICK LEAVE AND LONG-TERM DISABILITY

12.06 Long Term Disability will continue up to December of the year in which the employee turns 71.

[…]

12.12 No nurse shall see a reduction in pay or benefits as a result of an occupational injury or illness, as recognized by the Workplace Safety Insurance Board.

EMPLOYER POSITION

Opposed.

UNION RATIONALE

The Union seeks to make two modest changes to the sick leave, WSIB and LTD provisions under the Collective Agreement.

12.12: ADDITION OF WSIB PAY AND BENEFITS PROTECTION LANGUAGE

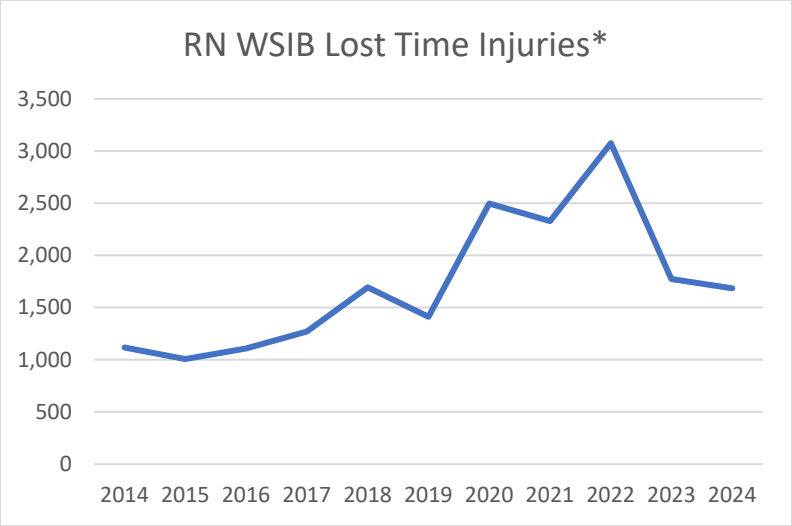
Nurses should not experience any loss of entitlements when they are absent as a result of an occupational injury or illness.

The Hospitals have allowed the nursing staffing crisis to grow so dire that nurses are continually and unnecessarily put at risk.

Healthcare remains the single biggest contributor of occupational injuries according to WSIB claim count statistics.[208]

Over the last ten years, RNs, in particular, have experienced a sharp uptick in occupational injuries. While this is partially clustered around the pandemic, there remains a sizeable increase in allowed lost time WSIB claims in the years preceding and following 2020-2022 when compared to the WSIB in 2014-2015:

[208] See WSIB Ontario, "Health and Safety Statistics" by Injury Characteristics and Occupation.



*Data collected from WSIB Ontario "Health and Safety Statistics"

Mental stress claims, in particular, have seen a 176% rise in the health care sector from 2017 to 2022.[209]

In a similar time frame, workplace violence lost-time injuries have increased by 38%.[210] In 2021/2022 alone, healthcare workers missed more than 194 years of work (71,742 days) due to workplace violence.[211]

The data is overwhelming. Clearly, within the last decade, healthcare has become a far more dangerous workplace.

However, when nurses suffer an occupational injury or illness, it is the Hospitals who benefit, in part through the reduced compensation provided to nurses on WSIB, but also by replacing senior, higher-paid nurses with more junior ones at lower rates, if at all.

In effect, the Hospitals are rewarded for not having safe processes and, as a result, are incentivized to continue ignoring the critical issue of nurse safety.

It is unacceptable for nurses to bear the entire burden of the unsafe workplaces that the Hospitals have created. Accordingly, the Union requires a material commitment from the Hospitals that workplace safety is a serious issue by ensuring that no nurse will experience any loss of pay or benefits while absent because of an occupational illness or injury.

This language is commonplace in other essential services injuries. Most significantly, in Municipal Police and Fire contracts—other essential services without the right to strike—WSIB salary and benefits protection language is ubiquitous:

[209] Ontario Nurses' Association, "Mental Health Awareness Infographic", 2024.
[210] Ontario Nurses' Association, "Report It: Workplace Violence is Not Part Of Your Job", April 10, 2024.
[211] Ontario Nurses' Association, "Report It: Workplace Violence is Not Part Of Your Job", April 10, 2024.

WSIB Protection under Police and Fire Agreements	
Toronto Police	Toronto Fire
17.01 When a member is absent by reason of an illness or injury occasioned by or as a result of his/her duty and where an award is made by the Workplace Safety and Insurance Board he/she shall, in addition to the WSIB Award(s), receive such further amount so as to provide that the total payment to the member shall approximate but not exceed the net pay such member might otherwise have received had he/she not been absent.	24.01 Payment of Salary and Certain Expenses RE: Occupational Illness or Accident (a) Each employee of the City coming within the 3888 Unit, who is under the Toronto Fire Department Superannuation and Benefit Fund and is off duty as a result of occupational illness or an accident incurred in the performance of their duties with the Fire Department of the City, shall be provided, at the expense of the City, with medical assistance and hospitalization where necessary and during such period shall receive full salary. (b) Each employee of the City coming within the 3888 Unit, who is under the Toronto Fire Department Superannuation and Benefit Fund, will be provided with prosthetic devices and dentures where necessary as a result of occupational illness or an accident incurred in the performance of their duties with the Fire Department of the City. (c) Subject to sub-clause (d) hereof, each employee of the City coming within the 3888 Unit, who is not under The Toronto Fire Department Superannuation and Benefit Fund, and is off duty as a result of occupational illness or an accident incurred in the performance of their duties with the Fire Department of the City, shall be provided, at the expense of the City, with medical assistance and hospitalization where necessary and during such period shall receive full net pay, less the benefits with respect thereto to which such employee is entitled under the Workplace Safety and Insurance Act. (d) Where an employee of the City coming within the 3888 Unit, who is entitled to the provision of benefits under sub-clause (c) hereof, as a result of an injury sustained in an accident arising, or occupational illness, out of and in the course of their employment by the City under such circumstances as entitle the employee to an

	action against some person other than the City, elects to bring their own action against such person, such employee shall as a condition of such benefits being provided as aforesaid, undertake to repay the amount of such benefits to the City out of the proceeds of any settlement of or judgement in such action.
Ottawa Police Effective January 1, 2022, for new and already approved claims, where an employee is absent from duty as a result of personal illness or injury arising out of and in the course of his/her duties within the meaning of the Workplace Safety and Insurance Board, the employee shall be provided with free hospitalization and medical care for any treatment relative to the compensable injury/illness. The Board will make up the difference between W.S.I.B. Compensation and the regular net pay for the duration of such accident or illness.	Ottawa Fire (a) Every Employee off duty as a result of personal injury by accident arising out of, and in the course of his or her employment within the meaning of the *Workplace Safety and Insurance Act, 1997* shall be provided with free hospitalization and medical care as prescribed by the *Workplace Safety and Insurance Board* and full salary during the period off duty where the Employee is receiving temporary full loss of earnings benefits from WSIB or where the Employer is providing accommodation within the Department at a wage loss.
Hamilton Police 2022 Kaplan Award (b) Where a Member's claim is allowed by the WSIB, the Member will continue to be paid by the Police Services Board under the following formula: (i) The Member will be paid the loss of earnings ("LOE") awarded by the WSIB. (ii) A top up to one hundred percent (100%) of pre-disability net using a formula which takes into consideration: a. the LOE set out in section 11.1(b)(i). b. traditional statutory deductions and Associations dues. c. the anticipated income tax that would have likely been returned to the Member had the	Hamilton Fire 12.2 Any employee of the Hamilton Fire Department who suffers an occupational injury as adjudicated by the Workplace Safety and Insurance Board (the "WSIB") shall receive from the City a WSIB benefit payment equivalent to the LOE awarded by WSIB. In addition, the Employee shall receive a top-up such that their net pay for the calendar year is equivalent to the net pay they would have received during that year if they had not had a period of disability; taking into account statutory deductions including OMERS contributions and union dues. Once an Employee becomes eligible for an OMERS disability waiver of contributions, the calculation of net pay will take into account that the Employee is in receipt of an OMERS disability waiver of contributions. The above payments shall be made on the Employee's regular pay dates and without deductions from the employee's accumulated sick leave time. While such a claim is being adjudicated by the WSIB, the employee shall continue to receive their regular pay.

Member continued to receive full salary with regular deductions, d. the individual Member's net claim code per the TD1 filed with the Employer at the time of disability. e. NEW Effective September 1, 2022, Members who are off on WSIB are entitled to top up payments until such Member is: i. eligible to retire with an unreduced pension in accordance with OMERS regulations (service - credited plus eligible service - equals 30 years and the Member meets the minimum age requirement - 50 years; and ii. has been in receipt of top-up payments for a minimum of six (6) months. If a Member is not eligible for top-up as per (e. sub i, ii), above but chooses not to retire, top up payments will cease the month following the month the Member became not eligible for top-up payments as per (e. sub i, ii) above. (iii) Annually the WSIB LOE benefit will be increased by the COLA granted by the WSIB. (iii) Annually the WSIB LOE benefit will be increased by the COLA granted by the WSIB	
Waterloo Police 20.01 When a Member of the Service is absent by reason of illness or injury occasioned by, or as a result of, their duties within the meaning of the Workplace Safety and Insurance Act, they will be entitled to their full pay while they are thereby incapacitated and there shall be no loss of accumulated sick leave credits. "Full pay"	Kitchener Fire 7:05 A Full-Time employee, who is injured on the job and is approved for Workplace Safety and Insurance Board temporary total disability benefits, shall be compensated as follows: The Employer shall:

shall be interpreted so as to preclude the possibility of a Member receiving a greater net pay while on Compensation than while working. Pension and benefit calculations are to be based upon the Member's salary as per Appendix "A".	a) Advance to the Full-Time employee on their regular pay day an amount equal to that which the Workplace Safety and Insurance Board is expected to issue as compensation for time lost during the respective pay period, on the condition that the amount payable by the Workplace Safety and Insurance Board will be paid to the Employer and the former amount will be adjusted, if necessary, to equal the latter, and The Employer shall: b) Pay to the Full-Time employee on their regular pay day an amount which, when added to the advance shown in paragraph (a), will yield to the Full-Time employee an amount equal to their normal net take home pay after all appropriate deductions have been made. Deductions for income tax, C.P.P. and Employment Insurance will be based on the employer paid portion of the Full-Time employees pay. All other deductions will be based on the Full-Time employee's normal gross pay. No payments as set out in this Clause shall be payable with respect to any absence for which a permanent disability pension or award is payable by the Workplace Safety and Insurance Board. Where a Full-Time employee is compensated under the terms of this Clause, there shall be no deduction from the Full-Time employee's sick leave benefit unless the claim is not approved by the Workplace Safety and Insurance Board. In such cases any payment made by the Employer shall be deducted from the Full-Time employee's sick leave benefit provided that such deductions shall be reimbursed to the sick leave benefit if the decision denying the claim is reversed on appeal. Payment to the employee shall not exceed the employee's accumulated sick leave benefit.

London Police	London Fire
Schedule C – Sick Leave Benefits 9. (a) Where a Member is absent from duty as a result of a new injury arising out of and in the course of duty and is receiving benefits awarded by the Workplace Safety Insurance Board, the Member shall continue to receive the same net pay. (b) A Member absent on a reoccurrence of a Workplace Safety Insurance Board injury that occurred after January 1, 1988 which has been approved as a reoccurrence by WSIB shall receive one hundred percent (100%) of the Member's current net take-home pay. Further, if the Member is in receipt of a WSIB pension or future economic loss (FEL) benefit in relation to such absences, it is agreed the Member will be compensated such that they receive the same net take home pay. (d) Extended Health Benefits ARTICLE 23 - MEDICAL AND DENTAL … (iv) Effective August 31, 2015, Where a Member is approved for any of the Extended Health Benefits provided for in Article 23.01 (d)(iii) by WSIB, the Member shall be reimbursed by the Board for any difference between the amounts covered by WSIB and the expenditure by the Member on the benefit, to a maximum of one thousand five hundred dollars ($1,500) per calendar year. Effective January 1, 2021 the maximum shall increase to one thousand six hundred and fifty ($1650) dollars.	6.06 (a) No vacation time shall be lost: (1) as the result of an accident or illness covered by an award of the Workplace Safety and Insurance Board; or (2) as the result of an accident incurred in the performance of duties; 8.02 An employee absent from work as a result of an accident or occupational disease within the meaning of Workplace Safety and Insurance Act and in receipt of WSIB loss of earnings benefits shall receive 100% of their net salary under Article 11.00 which they received prior to the accident or occupational disease. Such employees shall be provided with free hospitalization and medical care.

Clearly, Police and Fire departments recognize and respect their workforces and are incentivized to reduce risk. Nurses ask for the same courtesy.

12.06: INCREASE THE AGE MAXIMUM FOR LTD TO 71

The Union seeks an incremental, modest change to the age cut off for LTD to 71, which aligns with the cut-off for pension contributions and harmonizes the patchwork of age-based benefit thresholds under the agreement. This change would not only help better support and retain late career nurses but would also ensure the Collective Agreement's compliance with the *Human Rights Code.*

Full-time nurses working after sixty-five should continue to be provided with Long-Term Disability ("LTD") coverage. Canada's workforce has never been older.[212] There is a growing consensus that traditional age-based benefit cut-offs are divorced from this reality and driven by discriminatory stereotypes about older workers. The Hospitals would benefit from more experienced, late-career nurses and the termination of LTD at 65 sends a clear message to these nurses that they are not welcome or valued in the workplace after they reach that age threshold.

As early as 2018, a Labour Force Participation Working Group with Employment and Social Development Canada noted that in light of Canada's aging population, "there is a need to increase the labour force participation of older individuals, and of other groups of Canadians, to support businesses, economic growth and continued improvement in Canada's standard of living."[213] Among the many barriers aging workers face in the workforce, the Report identified health issues as a central obstacle to growing Canada's aging workforce.[214]

Clearly, removing barriers to the workforce participation of older workers is a vital concern across a variety of sectors and employers should no longer rely on uncritically on stereotypes about the costs and benefits of retaining older workers. As several commentators have noted, one obvious way to support older workers is to increase traditional age-based cutoffs for LTD beyond age 65. University of Toronto Labour Economist, Morley Gunderson, identifies the loss of long-term disability and other benefits at age 65 as a key barrier to retaining an older workforce.[215]

A 2024 Report from the Canadian Institute of Actuaries noted that with the increasing number of employees working past the conventional "retirement age" of 65, arbitrary age cut-offs for LTD creates a gap in the income protection regime and recommended that employers proactively explore alternative design choices for disability insurance, including higher age cut-offs.[216]

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[212] Statistics Canada, "In the midst of high job vacancies and historically low unemployment Canada faces record retirements from an aging labour force" (April 27, 2022).
[213] Employment and Social Development Canada, "Promoting The Labour Force Participation Of Older Canadians" (May 2018) at 1.
[214] Employment and Social Development Canada, "Promoting The Labour Force Participation Of Older Canadians" (May 2018) at 1.
[215] Morley Gunderson, "Barriers to the Labour Force Participation of Older Workers in Canada" *Fraser Institute* (April 21, 2022).
[216] Mathias Link, LLB and Joseph Nunes, FCIA, FSA, ICD.D, The Evolution of Employer-Sponsored Long-Term Disability Plans" *Canadian Institute of Actuaries* (October 2024).

Indeed, for nursing specifically, as the Canadian Institute of Health Information data notes,[217] the number of RNs employed in direct care over the age of 65 in Canada has been steadily rising:

Number of Age 65+ RNs in Canada	
2014	10,347
2015	10,500
2016	10,702
2017	11,022
2018	10,826
2019	10,697
2020	10,784
2021	10,427
2022	10,568
2023	11,167

These nurses, many of whom are ONA's members, are directly impacted by age cut-offs for LTD and provide clear demonstrated need for this proposal.

Parallel with this increasing recognition of the need to adjust traditional age-based cut-offs, a number of recent decisions have, in fact, found that such cut-offs are contrary to the *Human Rights Code* and the *Charter of Rights and Freedoms.* In 2018, the Ontario Human Rights Tribunal in *Talos v. Grand Erie District School Board* held that the traditional carve-out for age-based discrimination claims concerning benefits post-65 was contrary to the *Charter of Rights and Freedoms.*[218]

Similarly, in *Rayonier,* Arbitrator Knopf held that the restricting LTD to workers under the age of 65 "does amount to *prima facie* discrimination, contrary to s. 15 of the *Charter.*" While she found such restrictions may be justified under s. 1 by offering other benefits post-65,[219] both the Hospitals and the Union have a shared responsibility to ensure that their agreements remain compliant with the *Charter.*

Allowing LTD to terminate at 65 in the absence of actuarial evidence uncritically relies on stereotypes about older workers and leaves RNs with valuable experience vulnerable, pushing them out of the workforce.

[217] Canadian Institute for Health Information, "Registered Nurses" (July 25, 2024).
[218] *Talos v Grand Erie District School Board*, 2018 HRTO 680 (CanLII).
[219] *Rayonier v Unifor, Locals 256 and 89*, 2022 CanLII 75226 (ON LA) (Knopf).

PROPOSAL #8 – ARTICLE 15: PAID HOLIDAYS

15.08 (Article 15.08 and the note following Article 15.08 apply to part-time nurses only)

If a regular or casual part-time nurse works on any of the holidays listed in Article 15.01 of this Agreement, they shall be paid at the rate of ~~time and one-half (1½)~~ **two (2) times** their regular straight time hourly rate (as set out in the Wage Schedule) for all hours worked on such holiday, subject to the application of Article 14.04 regarding hours worked in addition to their full tour.

NOTE: Where existing Collective Agreements contain provisions relating to payment to nurses for holidays, whether worked or not, that exceed any payment required under the *Employment Standards Act*, such provisions shall be continued. Payment of holiday pay under this Note applies only to nurses presently enjoying such payment. Nurses presently enjoying holiday pay pursuant to this Note or otherwise as of December 14, 1987 will continue to enjoy such payment until they cease to be employed at the Hospital or until they transfer to a status to which this superior condition does not apply, whichever first occurs.

This note applies to nurses only.

EMPLOYER POSITION

Opposed.

UNION RATIONALE

Nurses who do not get the benefit of enjoying the holiday along with the rest of Ontarians and Canadians should, at minimum, be compensated fairly for their time. Accordingly, the Union is seeking to increase holiday pay for both full and part-time nurses who are required to work on holidays.

In addition to being supported by demonstrated need, the Union's proposal for additional holiday pay will also bring it in line with the superior holiday entitlements offered in other provincial nursing agreements and restore ONA's status as top of market:

Provincial Comparators	Work on Paid Holiday

The British Columbia Nurses' Bargaining Association (NBA)	2x the regular rate of pay + paid day off in lieu or monetary equivalent; 2.5x the regular rate of pay for Christmas Day, Labour Day or Good Friday
The United Nurses of Alberta (UNA)	1.5x the regular rate of pay + paid day off in lieu or monetary equivalent
The Saskatchewan Union of Nurses (SUN)	1.5x the regular rate of pay + paid day off in lieu or monetary equivalent; 2x the regular rate of pay if the employee had scheduled the holiday off
The Manitoba Nurses Union (MNU)	1.5x the regular rate of pay + paid day off in lieu or monetary equivalent
The New Brunswick Nurses Union (NBNU)	1.5x the regular rate of pay + paid day off in lieu or monetary equivalent; 2x the regular rate of pay for any work performed on Christmas Day and New Years Day; 2x the rate of pay if no notice given before work on a holiday; 2.5x the rate of pay if no notice is given for Christmas Day and New Year's Day
The Nova Scotia Nurses' Union (NSNU)	1.5x the regular rate of pay + paid day off in lieu or monetary equivalent
The Registered Nurses' Union Newfoundland & Labrador (RNUNL)	1.5x the regular rate of pay + paid day off in lieu or monetary equivalent
The Prince Edward Island Nurses' Union (PEINU)	1.5x the regular rate of pay + paid day off in lieu or monetary equivalent + 2x the regular rate of pay for Christmas Day
Ontario (ONA) Current	1.5x the regular rate of pay + paid day off in lieu or monetary equivalent
Ontario (ONA) Proposal	**2x the regular rate of pay + paid day off in lieu or monetary equivalent**

Significantly, many provinces, such as New Brunswick, Saskatchewan, British Columbia, and Prince Edward Island, already provide RNs with double rates or better for certain enumerated holidays. British Columbia, in particular, offers a double rate for *all holidays* and provides 2.5 times the regular pay for Christmas Day, Labour Day, and Good Friday.

This is a clearly superior benefit than ONA's 1.5x rate.

British Columbia is the closest province to Ontario in population (5 million vs. 16 million), and BCNU and ONA have the closest membership numbers to any other province (48,000 vs. 62,000). As the largest nursing union in the most populous province, ONA should be top of the market.

Additionally, many comparable bargaining units have two (2) times the regular rate of pay for hours worked on holidays, inclusive of a lieu day.[220] Even some ONA bargaining units have already negotiated two (2) times the regular rate of pay and a lieu day for work on a paid holiday.[221]

[220] See *Agecare Bloom Limited Partnership (Agecare) v Hospital Employees' Union (HEU),* 2025 CanLII 17241 (BC LA) (Doyle).
[221] See Collective Agreement between The Corporation of the Municipality of Chatham-Kent and Ontario Nurses Association (expiry December 31, 2026).

PROPOSAL #9 – ARTICLE 16: VACATIONS

16.01 All employees shall receive vacations with pay based on length of full-time continuous service as follows:

(a) Employees who have completed less than one (1) year of full-time continuous service (as of the date for determining vacation entitlement in the individual Hospital) shall be entitled to a vacation on the basis of 1.25 days (9.375 hours for employees whose regular hours of work are other than the standard workday) for each completed month of service with pay in the amount of 6% of gross earnings.

(b) Employees who have completed one (1) or more years of full-time continuous service (as of the date for determining vacation entitlement in the individual Hospital) shall be entitled to an annual vacation of three (3) weeks with three (3) weeks' pay (112.5 hours' pay for employees whose regular hours of work are other than the standard workday), provided the employee works or receives paid leave for a total of at least 1525 hours in the vacation year.

(c) Employees who have completed three (3) or more years of full-time continuous service (as of the date for determining vacation entitlement in the individual Hospital) shall be entitled to an annual vacation of four (4) weeks with four (4) weeks' pay (150 hours' pay for employees whose regular hours of work are other than the standard workday), provided the employee works or receives paid leave for a total of at least 1525 hours in the vacation year.

(d) Employees who have completed ~~eleven~~ **eight** (~~11~~ **8**) or more years of full-time continuous service (as of the date for determining vacation entitlement in the individual Hospital) shall be entitled to an annual vacation of five (5) weeks with five (5) weeks' pay (187.5 hours' pay for employees whose regular hours of work are other than the standard workday), provided the employee works or receives paid leave for a total of at least 1525 hours in the vacation year.

(e) Employees who have completed ~~twenty~~ **fifteen** (~~20~~ **15**) years or more of full-time continuous service (as of the date for determining vacation entitlement in the individual hospital) shall be entitled to an annual vacation of six (6) weeks with six (6) weeks' pay (225 hours' pay for employees whose regular hours of work are other than the standard workday), provided the employee works or receives paid leave for a total of at least 1525 hours in the vacation year.

(f) Employees who have completed ~~twenty-five~~ **twenty-one** (~~25~~ **21**) years or more of full-time continuous service (as of the date for determining vacation entitlement in the individual hospital) shall be entitled to an annual vacation of seven (7) weeks with seven (7) weeks' pay (262.5 hours' pay for employees whose regular hours of work are other than the standard workday), provided the employee works or receives paid leave for a total of at least 1525 hours in the vacation year.

***NEW* (g) Employees who have completed twenty-five (25) years or more of full-time continuous service (as of the date for determining vacation entitlement in the individual hospital) shall be entitled to an annual vacation of eight (8) weeks with eight (8) weeks' pay (300 hours' pay for employees whose regular hours of work are other than the standard workday), provided the employee works or receives paid leave for a total of at least 1525 hours in the vacation year.**

~~(g)~~**(h)** If an employee works or receives paid leave for less than 1525 hours in the vacation year, they will receive vacation pay based on a percentage of their gross salary for work performed on the following basis:

3-week entitlement	–	6%
4-week entitlement	–	8%
5-week entitlement	–	10%
6-week entitlement	–	12%
7-week entitlement	–	14%
8-week entitlement	**–**	**16%**

NOTE: Employees who presently enjoy better vacation benefits shall continue to receive such better benefits while employed by the Hospital.

***NEW* (i) Employees on a pregnancy or parental leave pursuant to articles 11.07 or 11.08 are deemed to be on a paid leave for the purposes of Article 16.01**

…

16.06 All regular part-time employees shall be entitled to vacation pay based upon the applicable percentage provided in accordance with the vacation entitlement of full-time employees, of their gross earnings in the preceding year. If an employee works or receives paid leave for less than 1100 hours in the vacation year, they will receive vacation pay based on a percentage of their gross salary for work performed on the following basis:

3-week entitlement	–	6%
4-week entitlement	–	8%
5-week entitlement	–	10%
6-week entitlement	–	12%
7-week entitlement	–	14%
8-week entitlement	**–**	**16%**

EMPLOYER POSITION

Opposed.

UNION RATIONALE

16.01 – VACATION ENTITLEMENT

Vacation entitlements have not improved since Arbitrator Devlin's 2011 award.[222] The landscape has significantly changed since 2011. As discussed above, nursing shortages, violence in the workplace, and burnout are now serious parts of the hospital environment. Nurses need better vacation entitlements. This increase in entitlement not only allows mid-level, experienced and late-career nurses much needed additional relief from the stressful realities of nursing in the current climate, but it would also significantly improve recruitment and retention.

In his 2021 award, Arbitrator Gedalof noted that Bill 124 precluded consideration of the Union's vacation proposal for long-service nurses.[223] Such constraints no longer exist. In the last round of arbitration, Arbitrator Kaplan noted unequivocally that "the evidence presented establishes that there is truly a nursing recruitment and retention crisis in Ontario's hospitals".[224] Therefore, the Union once again proposes two changes:

- an additional week of vacation for nurses who have competed twenty-five (25) years of service
- lowering the service threshold for entitlement to 5 weeks, 6 weeks, and 7 weeks of vacation to 8, 15, and 21 years of service.

Vacation is a crucial component of our working life by allowing employees to recharge and return to work refreshed and ready to resume their duties. This is even more significant given the current climate of nursing shortages and documented retention and recruitment challenges specially for mid-career and experienced nurses. Vacation is specifically cited in Health Canada's *Nursing Retention Toolkit* as a best practice to improve the working lives of nurses, given "the long-term benefits of nurses taking vacation and being able to disconnect from work (e.g., to support their well-being)".[225]

Currently, the progression for mid-level, experienced, and late career nurses is too slow and does not reflect the current realities of nursing challenges, exhaustion and burnout. A nurse at the early stages of their career with three or more years of service must wait an additional eight years to be entitled to an extra week of vacation for a total of 5 weeks. Similarly, an experienced nurse with more 11 years of service must wait an additional 9 years for an extra week of vacation for a total of 6 weeks. Lastly, a senior nurse with 25 years of service finally achieves 7-weeks of vacation with no additional entitlements. These slow progressions do not incentivize recruitment and retention of mid-level and experienced nurses. The Union's proposal seeks to bring

[222] *Participating Hospitals and ONA,* June 2, 2011, unreported (Devlin).
[223] *Participating Hospitals v Ontario Nurses Association*, 2021 CanLII 88531 (Gedalof) at para 39.
[224] *Participating Hospitals (Represented by the Ontario Hospital Association) v ONA*, 2023 CanLII 65431 (Kaplan).
[225] Health Canada, *Nursing Retention Toolkit: Improving the Working Lives of Nurses in Canada* (2024).

much needed relief to working lives of nurses, and is consistent with the principles of gradualism and comparability.

The Union's proposal seeks to put Ontario nurses in a comparable position with other provincial nursing unions.

In Manitoba, nurses reach 5 weeks of vacation entitlement after having completed nine years of service, and 6 weeks of vacation after having completed 19 years of service. Further, in recognition of length of service, a nurse receives an extra week of vacation after completing 20 years of service (for a total of 7 weeks) and an extra week on each subsequent fifth (5th) anniversary of employment with no limits. The Union's proposal would put Ontario nurses in a comparable position to their Manitoba counterparts, without the additional increases for nurses with 25 years of service or more.[226]

In Alberta, nurses reach 5 weeks of vacation entitlement after completing 9 years of service and 6 weeks of vacation entitlement after completing 19 years of service, with an additional week of vacation on each subsequent 5th anniversary of employment at 25, 30, 35, 40 and 45 years of service respectively, for a total vacation entitlement of 11 weeks. Again, the Union's proposal puts Ontario nurses in a comparable position relative to their counterparts in Alberta while capping total entitlement to 8 weeks after 25 years of service or more.[227]

In British Columbia, nurses receive 187.5 working hours (or 5 weeks of vacation) after 9 years of service, and 307.5 working hours (or 8.2 weeks of vacation) after 25 years of service, with an additional entitlement of an extra vacation day for each year of service after 25 years, for a total of 337.5 working hours (or 9 weeks of vacation) after 29 years of service.[228]

It is clear from the above, that the Union's proposal is well within the norm and in keeping with the standard in the sector. The Union's proposal is further supported by a demonstrated need to retain experienced mid-level and late-career nurses and is also in keeping with the principles of gradualism and comparability.

In addition to bringing Ontario nurses' entitlement in line with the sector, improving vacation entitlement will only have a positive impact on recruitment and retention particularly with respect to late-career nurses. Hospitals are continuing to struggle to retain experienced nurses and a modest increase in vacation entitlement for nurses with more than 25 years of service provides a much-needed reprieve, rest and

[226] Collective Agreement between Shared Health Employers Organization and Manitoba Nurses Union (expiry March 31, 2028), Articles 2103 & 2104 at 56-57.
[227] Collective Agreement between Alberta Health Services Covenant Health Lamont Health Care Centre The Bethany Group (Camrose) and The United Nurses of Alberta, (expiry March 31, 2024), Article 17.02 at 36-38. The newly reached tentative agreement between the UNA and the Employer does not change Article 17: Vacation With Pay.
[228] Collective Agreement between HEABC and Nurses' Bargaining Association (expiry March 31, 2025), Article 45 at 114-115.

flexibility in their work schedules and work-life balance. In a staggering almost tenfold decline, the total percentage of ONA members at or above 25 years of service went from 14.4% (or 9,391 nurses) in 2022 to 1.3% (or 943 nurses) in 2024. This is extremely concerning and highlights the significant challenges with retention of late-career and experienced nurses. Given this small proportion, the estimated cost for an additional week of vacation for this demographic of nurses is only 0.15% of total compensation or $11,733,161.

The Union also seeks clarifying language to ensure that nurses continue to accrue service for the purpose of vacation entitlement while on pregnancy and parental leave. Nurses should not be penalized or lose negotiated benefits while on pregnancy and parental leave when they continue to accrue "seniority and service" pursuant to Article 10.04. The Union's proposal clarifies that nurses continue to accrue paid vacation while on pregnancy and parental leave.

For all the reasons outlined above, the Union's proposal ought to be awarded.

PROPOSAL #10 – ARTICLE 17: HEALTH AND WELFARE BENEFITS

(Article **17.01, 17.02, 17.03, 17.05, 17.07, 17.08 and 17.09** applies to full-time nurses only)

Article	Current	Proposed
17.01 (c) Vision care; Eye surgery *NEW* HCSA *NEW* Dispensing Fees	 $450 Laser surgery N/A N/A	 **$550** **Corrective Surgery** **$2500 per annum** **No cap on dispensing fees**
17.01 (f) Complete and partial dentures Crowns, bridgework, implants, and repairs Orthodontics	 $1000 $2000 $2000	 **$1500** **$3000** **$2500**
17.01 (i) Retiree Benefits Age of Retirement	 Age 57 until age 65	 **Age 57 (no expiry)**
17.11 *NEW* Unlimited Mental Health Coverage for PT nurses	N/A	**Coverage for unlimited mental health services by a Psychologist, Registered Psychotherapist or Social Workers (MSW) will be extended to part-time employees. Superior conditions maintained.**

17.01 (c) The Hospital agrees to contribute 75% of the billed premiums towards coverage of eligible nurses in the active employ of the Hospital under the Liberty Health Extended Health Care Benefits Plan (which is comparable to the existing Blue Cross Extended Health Care Benefits Plan) or comparable coverage with another carrier providing for $22.50 (single) and $35.00 (family) deductible, providing the balance of monthly premiums are paid by the nurses through payroll deductions. In addition to the standard benefits, coverage will include hearing aids [maximum $700/person every thirty-six (36) months]; vision care

maximum $~~450~~ **550** every 24 months with ability to use coverage for ~~laser~~ **corrective** surgery); and Drug Formulary 3.

In addition to the above vision care shall include one eye exam per insured person every 24 months.

Extended Health Care benefits includes chiropractic, massage therapy and physiotherapy coverage (maximum of $450/insured person annually for chiropractic, massage therapy and physiotherapy for each service). Superior benefits are to be maintained in those hospitals where payment for one or more of these services is covered.

Introduce a Health Care Spending Account in the amount of $2500 per insured person annually.

Coverage for unlimited mental health services by a Psychologist, Registered Psychotherapist or Social Workers (MSW). Superior conditions maintained.

Reimbursement for prescribed drugs covered by the plan will be based on the cost of the lowest priced therapeutically equivalent generic version of the drug, unless there is a documented adverse reaction to the generic drug or unless the beneficiary's doctor stipulates that the generic drug is not an alternative, in which case the reimbursement will be for the prescribed drug. **There shall be no cap on dispensing fees.**

(f) The Hospital agrees to contribute 75% of the billed premiums towards coverage of eligible nurses in the active employ of the Hospital under the Liberty Health Dental #9 Dental Plan (which is comparable to the Blue Cross #9 Dental Plan) or comparable coverage with another carrier; based on the current ODA fee schedule and provide for recall oral examination to be covered once every nine (9) months (adults only); complete and partial dentures at 50/50 co-insurance to $~~1000~~ **1500** maximum per person annually; add Blue Cross Rider #4 – (Crowns, bridgework, implants and repairs to same) at 50/50 co-insurance to $~~2000~~ **3000** maximum per person annually and orthodontics 50/50 co-insurance with $~~2000~~ **2500** maximum per insured lifetime providing the balance of the monthly premiums are paid by the employees through payroll deductions.

(i) The Hospital will provide to all full-time employees who reach age 57 and retire (including disability retirements) on or after April 1, 2011 ~~and have not yet reached age 65 and~~ who are in receipt of the Hospital's pension plan benefits, semi-private, extended health care and dental benefits on the same basis as is provided to active employees as long as the retiree pays the Employer their share of the monthly premiums, in advance. The Hospital will contribute fifty-percent (50%) of the billed premiums of these benefit plans.

17.05 The Hospital shall continue to pay the premiums for benefit plans under Articles 17 and 12 for nurses who are on paid leave of absence**, pregnancy or parental leave,** or on WSIB or at any time when salary is received, or as provided in Article 10.04. Such payment shall also continue while a nurse is on

sick leave (including the Employment Insurance Period) or on Long Term Disability to a maximum of 30 months from the time the absence commenced, or for retirees who are in receipt of Pension Permanent Disability Benefits to a maximum of 30 months from the time the absence commenced.

Nurses who are on layoff may continue to participate in benefit plans, at their request, provided they make arrangements for payment and provided also that the layoff does not exceed one year.

NOTE: For clarification, "retirees" includes nurses who were on sick leave, LTD or WSIB prior to receipt of Pension Permanent Disability Benefits.

NEW

17.11 Coverage for unlimited mental health services by a Psychologist, Registered Psychotherapist or Social Workers (MSW) will be extended to part-time employees. Superior conditions maintained.

EMPLOYER POSITION

Opposed.

UNION RATIONALE

ONA has long been a leader in the sector and the country in securing health and welfare benefits for its members. However, ONA's current suite of benefits under the agreement has stagnated and requires this Board's careful attention to maintain ONA's position at the top of market.

Accordingly, the Union's proposal on health and welfare this round seeks to make modest improvements to the extended health and dental benefits offered under the current agreement. These changes are supported by demonstrated need, comparability, and will assist with the Hospitals' ability to recruit and retain nurses.

1. IMPROVEMENTS TO STAGNANT DENTAL COVERAGE MAXIMUMS MUST BE IMPLEMENTED

The Association seeks modest, incremental improvements in dental coverage maximums.

The dental coverage maximums under the agreement have **not been improved for well over a decade.**

In 2011, Arbitrator Devlin increased the maximum for crowns, bridgework and repairs from $1,500 to the current $2,000.[229]

[229] *The Participating Hospitals and Ontario Nurses' Association*, June 2, 2011 (Devlin).

For any improvements to the orthodontics maximum, one must go back to the 2008-2011 settlement where the parties agreed to increase coverage from $1,000 to $2,000.[230]

The complete and partial dentures maximum, on the other hand, has never been improved since it was implemented in 2003 as a result of the 2001-2004 voluntary settlement.[231]

In the meantime, dental costs have risen sharply as a result of inflation. In 2023 alone, the fees under the Ontario Dental Fee Guide rose by 8.5%. This increase came on the back of past increases of 4.75% in 2022, 4.6% in 2021, 1.27% in 2020 and 4.19% in 2019.[232]

Clearly, by any reasonable metric, the dental coverage maximums under the agreement that have been in place since 2011, 2008 and 2003 must be improved to maintain the equivalent coverage. The Union is requesting modest improvements that are in line with the gradual improvements implemented in 2011 and 2014.

In particular, the Union is seeking:

- A $500 increase to the $1,000 dentures coverage maximum that has been in place since 2003;
- A $500 increase to the $2,000 orthodontics coverage maximum that has been in place since 2008; and
- A $1,000 increase to the $2,000 crowns coverage maximum that has been in place since 2011.

These amounts are reasonable, gradual and supported by comparability.

Notably, the UNA-Alberta agreement contains superior dental coverage maximums, providing Alberta RNs with $3,000 in extensive dental services (equivalent to ONA's $1,000 and $2,000 maximums for dentures and crowns) and a $3,000 maximum for orthodontics.[233]

Similarly, several Police and Fire agreements contain far superior dental coverage entitlements.[234] In particular, as a result of a recent award of Arbitrator Burkett, the

[230] Memorandum of Settlement between the Participating Hospitals and Ontario Nurses Association, (February 7, 2008).
[231] Memorandum of Settlement between the Participating Hospitals and Ontario Nurses Association, (December 2001).
[232] Cowan Insurance Group, "What Every Employer Should Know About Recent Dental Fee Guide Increases" (February 21, 2023).
[233] Collective Agreement between Alberta Health Services and the United Nurses of Alberta (expiry March 31, 2024).
[234] See London Police Association Collective Agreement, which provides $3,000 in major restorative services per year and $6,000 per lifetime for orthodontics coverage ; and Toronto PFFA Collective Agreement, which provides $2,500 for major restorative per year and $4,000 per lifetime for orthodontics.

Hamilton Fire agreement contains 2026 dental coverage maximums of $3,000/year for major restorative work and $4,000/lifetime for orthodontics.[235]

As the largest nursing union in Canada's largest province, ONA should be leading and not following the pack. The Union's proposal would bring ONA's dental coverage back to its place at the top of market and provide vital coverage in light of skyrocketing dental costs in the province.

2. IMPROVEMENTS TO VISION ARE NECESSARY THIS ROUND

The Association seeks a modest $100 increase to the current $450/two-year vision entitlement and clarifying language recognizing that corrective procedures other than laser eye surgery should be covered where appropriate. This proposal is in line with gradualism, demonstrated need, comparability and replication.

The Association's proposal should be awarded for three reasons.

First, the current vision coverage has not improved since the agreement expiring in March of 2020, when the parties agreed to raise the vision care maximum from $400 to $450 every 24 months.[236] Given the drastic increases in vision costs over the last four years, the Union submits that another modest $100 increase is in order.

Second, this increase is supported by comparability among other nursing contracts and relevant essential services agreements. In particular, Alberta's agreement with the United Nurses of Alberta contains a $600 vision entitlement every 24 months.[237] Similarly, Arbitrator Burkett's recent award concerning Hamilton Firefighters provided $650 of vision coverage per 24 months.[238] These are plainly comparable employees which also bargain under strike restraint legislation. Even if the Union's proposal were granted in full, it would still lag behind these outcomes.

Finally, the current vision language requires clarification with respect to the narrow provision of laser eye surgery. While laser eye surgery is the most commonly practiced procedure in Canada to correct vision problems,[239] there are numerous other alternative refractive procedures which can be appropriate in a variety of circumstances.[240] However, where the current language only provides coverage for

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[235] *Corporation of Hamilton (City) v Hamilton Professional Fire Fighters' Association, Local 288*, 2024 CanLII 66452 (ON LA) (Burkett).
[236] Collective Agreement between The Participating Hospitals and Ontario Nurses Association (expiry March 31, 2020).
[237] Collective Agreement between Alberta Health Services and the United Nurses of Alberta (expiry March 31, 2024).
[238] *Corporation of Hamilton (City) v Hamilton Professional Fire Fighters' Association, Local 288*, 2024 CanLII 66452 (ON LA) (Burkett).
[239] Health Canada, "Laser Eye Surgery" (October 19, 2012).
[240] David Turbert & Brenda Pagan-Duran, MD, "Alternative Refractive Surgery Procedures" *American Academy of Ophthalmology* (April 25, 2023). See also Harvard Health, "Surgical alternatives to LASIK", (October 7, 2023).

"laser eye surgery", ONA's members are limited to a one-size-fits-all approach to correcting vision problems.

As an organization that prides itself on exploring innovative technologies and new models of care,[241] there is simply no reason for this narrow, outdated limitation to persist in ONA's vision coverage. Where RNs require alternative corrective vision surgery, the same coverage should apply.

3. THE INCLUSION OF A HCSA IS OVERDUE

Health care spending accounts (HCSAs) are quickly becoming a normative benefit in a variety of sectors, including in healthcare.[242] Currently, ONA is the only OHA bargaining unit without a HCSA.[243] Clearly, a HCSA must be introduced this round. Indeed, the only live question before this Board is the appropriate amount of any HCSA awarded.

While the Union acknowledges that other OHA groups have only secured nominal HSCA benefits between $100 and $500 per year, with OPSEU being the lead group, given the comprehensive and long-standing superiority of ONA's benefits entitlement, the appropriate comparators in this respect lie elsewhere.

In particular, under Manitoba's agreements with the Manitoba Nurses Union—the only other Provincial RN contract that has introduced a HCSA—Manitoba RNs receive a HCSA top up of $1,250 per year for FT members and $1,000 for PT members.[244] These same RNs also receive $500 and $250 per year respectively through the Manitoba Health Employee Benefits Plan,[245] for a total of $1,750 and $1,250 per year.

Given ONA's status as top of market, the Association respectfully submits that its proposal of a $2,500 HCSA is appropriate in the circumstances.

4. REMOVE DISPENSING FEE CAP

The current $11.99 dispensing fee cap on medications is unnecessary and out of step with RN contracts across the country.

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[241] Ontario Hospital Association, "OHA's 2024-2025 Year in Review".
[242] See *The Participating Hospitals v OCHU/CUPE*, 2024 CanLII 33105 (ON LA) (Kaplan); *Participating Hospitals v OPSEU,* 2023 CanLII 75478 (ON LA) (Kaplan); *The Participating Hospitals v SEIU,* 2024 CanLII 33108 (ON LA) (Kaplan); *Salvation Army Meighen Centre v Ontario Nurses' Association,* 2024 CanLII 98774 (ON LA) (Goodfellow); *Health Sciences North v Ontario Nurses' Association*, 2024 CanLII 102747 (ON LA) (Goodfellow); and Manitoba Healthcare Employee Benefit Plans, "Healthcare Dental & HSA" (July 1, 2024).
[243] See *The Participating Hospitals v OCHU/CUPE*, 2024 CanLII 33105 (ON LA) (Kaplan); *Participating Hospitals v OPSEU,* 2023 CanLII 75478 (ON LA) (Kaplan); *The Participating Hospitals v SEIU,* 2024 CanLII 33108 (ON LA) (Kaplan).
[244] Collective Agreement between The Shared Health Employers Organization and Manitoba Nurses Union (expiry March 31, 2028).
[245] Manitoba Healthcare Employee Benefit Plans, "Healthcare Dental & HSA" (July 1, 2024).

Among its provincial RN comparators that provide for prescription drug coverage under the agreements, ONA is alone in limiting coverage for prescription drugs dispensing fees to $11.99.

Comparison of Prescription Drug Coverage in RN Contracts	
Province	**Prescription Drug Coverage**
Ontario	Reasonable & Customary Limits, Dispensing Fee Cap of $11.99
Alberta	No Dispensing Fee Cap
British Columbia	No Dispensing Fee Cap
Manitoba	No Dispensing Fee Cap
New Brunswick	No Dispensing Fee Cap
Saskatchewan	No Dispensing Fee Cap

This cap has a real impact on ONA's members, which will only increase with the rising costs of this line item at Ontario pharmacies. In Manion's June 2024 dispensing free reports collected from Ontario pharmacies, more than 50% of Ontario pharmacies charge dispensing fees of $11.99 or higher, up from 32% in 2022.[246]

5. INCLUSION OF PART TIME BENEFITS

The Union is also seeking to include part-time nurses in the Extended Health Care and Dental Plans and extend the same unlimited Mental Health Coverage that full-time nurses.

Part-time nurses are an integral part of the Hospitals' operations in filling gaps in the full-time schedule. Part-time nurses experience the same burnout, stressors, and health challenges as full-time nurses.

There is no principled reason why part-time employees should not be able to opt in to the health and dental plans and receive the same coverage.

[246] Data from Manion, *Dispensing Fee Reports Ontario*, (June 2024).

PROPOSAL #11 – *NEW* ARTICLE 21: NURSE PRACTITIONERS

NEW

21.03 When a Nurse Practitioner is required by the employer to assume duties of the Most Responsible Provider they will receive a premium of ten dollars ($10.00) per hour in addition to their regular hourly rate.

EMPLOYER POSITION

Opposed.

UNION RATIONALE

NPs, also known as Registered Nurses in the extended class, are RNs who have met additional education, experience, and exam requirements set by the College of Nurses of Ontario. To become an NP, a nurse must have a minimum of 5 years of clinical experience and then complete a minimum of 2 years of university. They are authorized to diagnose, order, and interpret diagnostic tests, and prescribe medication and other treatment.

NPs serve an increasingly critical function in the healthcare system, particularly in underserved communities that struggle for access to physicians. They are the fastest growing nursing category in Canada and provide vital expertise as clinicians, leaders, educators, and researchers.[247] In Ontario, the number of NPs per 100,000 population has increased every year since 2017 from 21.4 to 26 in 2021.[248]

Because NPs possess additional expertise, duties, and responsibilities and are held to much higher practice standards, it is only appropriate that they receive a premium when they are required to act as the Most Responsible Provider ("MRP"), further increasing their responsibility and accountability.

The Union's proposed premium is commensurate with the level of responsibility and complexity that comes with stepping into the shoe of the MRP, with respect to supervision and direction of other registered staff on the applicable unit/department. The Proposal is also in keeping with the added legislative authority and accountability of NPs.

[247] Canadian Nurses Association, Nursing Statistics (2021).
[248] Canadian Institute for Health Information, "Health Workforce in Canada 2017 to 2021" (November 24, 2022).

PROPOSAL #12 – *NEW* LOU: SEXUAL ASSAULT AND DOMESTIC VIOLENCE (SADV) PROGRAM EMPLOYEES

The collective agreement will apply in all respects except as amended herein.

1. (Applicable to full-time only)

Where an employee is required by subpoena to attend a Court of Law or Coroner's Inquest in connection with a case arising from their duties at the Hospital, on their regularly scheduled day off, the employee may:

a) opt to attend court and reschedule their regular day off to a mutually agreeable time by the employee and the Hospital within the same pay period, or

b) attend court on their regularly scheduled day off and receive two (2) times their regular straight time hourly rate for all hours worked with a minimum guarantee of 4 hours.

2. (Applicable to part-time only)

Where a part-time employee is required by subpoena to attend a Court of Law or Coroner's Inquest in connection with a case arising from the employee's duties at the Hospital, on their regularly scheduled day off, they shall receive their regular straight time hourly rate of pay as if they had been scheduled during their regular working hours. All hours of court attendance in excess of the hours referred to in Article 13.01 (a) or (c) shall be paid at a rate of two (2) times their regular straight time hourly rate. Employees will be credited with seniority and service for all such hours paid.

3. Where a full time or part time employee is required by subpoena to attend a Court of Law or Coroner's Inquest in connection with a case arising from the employee's duties at the Hospital during their scheduled vacation period, the employee may:

a) opt to reschedule their vacation to a mutually agreeable time by the employee and the Hospital, and attend court receiving their regular straight time hourly rate of pay as if they had been scheduled during their regular working hours, or

b) attend court during their scheduled vacation with pay and receive two (2) times their regular straight time hourly rate for all hours worked with a minimum guarantee of 4 hours.

4. Employees will not work more than five (5) consecutive days as a result of attending court on scheduled days off or vacation.

EMPLOYER POSITION

Opposed.

UNION RATIONALE

Nurses should not have to use vacation where required by subpoena to attend Court or a Coroner's Inquest in connection to a case arising from their duties to the Employer. Accordingly, the Union proposes that both full and part-time employees be allowed to reschedule any planned vacation to attend or otherwise receive double time for attending court on a day off.

Domestic violence is a major global health concern that disproportionately impacts women.[249] Indeed, 44% of women and girls in Canada over the age of 15 have reported experiencing some kind of psychological, physical or sexual abuse in the context of an intimate relationship.[250] Moreover, Ontario saw an 18% increase in reported sexual assaults between 2020 and 2021.[251]

Nurses working in SADV programs play a critical role in providing comprehensive, timely, and trauma-informed care and treatment to victims/survivors of sexual and domestic violence.[252] Moreover, as the Ontario government has recognized, health care providers such as nurses play a crucial role in helping to keep individuals, in particular women and children, safe "by identifying and stopping perpetrators early — and holding them accountable for abusive behaviour."[253]

Nurses in the SADV program respond and provide care to victims/survivors of sexual assault and domestic violence as part of their duties. Inherent to these duties is the reality that nurses will at times be required to provide evidence in legal proceedings. This obligation on nurses to testify is not only necessary to help fulfil the Ontario government's stated objective of ensuring perpetrators are held accountable for abusive behaviour, but it is part of nurses' work. As such, it is indefensible to require nurses to volunteer their time when they are subpoenaed for matters that relate directly to the fulfilment of their duties.

This proposal will also bring nurses in line with other comparable public service workers who are frequently required to act as witnesses in Court or other legal proceedings. For instance, the collective agreements for the police services in the five largest municipalities in Ontario all include some form of premium pay or time in lieu when the officer is required to attend Court or other legal proceeding related to their duties on their day off.[254] There is no reason that nurses should be treated differently

[249] Government of Canada, "Intimate Partner Violence" (January 19, 2025).
[250] Government of Canada, "Intimate Partner Violence" (January 19, 2025).
[251] Statistics Canada, "Incident-based crime statistics, by detailed violations, Canada, provinces, territories, Census Metropolitan Areas and Canadian Forces Military Police" (July 25, 2024).
[252] Ontario Network of Sexual Assault/Domestic Violence Treatment Centres, *Standards of Care*, 2nd ed (2019) at 4.
[253] Ontario, "Ontario-STANDS: Standing Together Against gender-based violence Now through Decisive actions, prevention, empowerment and Supports" (October 11, 2024).
[254] Collective Agreement between Toronto Police Services Board and Toronto Police Association (ratified March 26, 2019) at Article 9; Collective Agreement between Ottawa Police Services Board and Ottawa Police Association (expiry December 31, 2024) at Article 14; Collective Agreement between Hamilton Police Services Board and Hamilton Police Association (entered into December 2, 2019) at Article 7;

when they are similarly required to attend Court or a Coroner's Inquest in connection with a case arising from their duties to the Employer.

Collective Agreement between Waterloo Regional Police Services Board and The Waterloo Regional Police Association (expiry December 31, 2024) at Article 10; Collective Agreement between London Police Services Board and London Police Association (expiry December 31, 2022) at Article 12.

NON-MONETARY PROPOSALS

PROPOSAL #13 – ARTICLE 10: SENIORITY

10.07 Job Posting

(a) i) Where a permanent full-time vacancy occurs in a classification within the bargaining unit or a new full-time position within the bargaining unit is established by the Hospital, such vacancy shall be posted **within thirty (30) consecutive calendar days,** for a period of seven (7) consecutive calendar days. Nurses in this bargaining unit and nurses in another ONA bargaining unit at the Hospital, if any, may make written application for such vacancy within the seven (7) day period referred to herein. Subsequent vacancies created by the filling of a posted vacancy are to be posted for seven (7) consecutive calendar days. Where a vacancy under this provision has remained unfilled for a period of six (6) months from the date of the initial posting, and the employer still requires the position to be filled, it will be reposted as noted above.

ii) Where a permanent regular part-time vacancy occurs in a classification within the bargaining unit or a new regular part-time position within the bargaining unit is established by the Hospital, such vacancy shall be posted **within thirty (30) consecutive calendar days,** for a period of seven (7) consecutive calendar days. Nurses in this bargaining unit and nurses in another ONA bargaining unit at the Hospital, if any, may make written application for such vacancy within the seven (7) day period referred to herein. Subsequent vacancies created by the filling of a posted vacancy are to be posted for seven (7) consecutive calendar days. Where a vacancy under this provision has remained unfilled for a period of six (6) months from the date of the initial posting, and the employer still requires the position to be filled, it will be reposted as noted above.

[...]

10.07 (e) Specific Time-Limited Temporary Positions

Specific time-limited temporary positions **for special projects,** which are expected to exceed a term of sixty (60) calendar days but no greater than six (6) months will be posted in accordance with Article 10.07 (a). This term may be extended a further six (6) months by mutual agreement of the local parties. Where a nurse is transferred under this Article, their vacated position shall be posted in accordance with Article 10.07 (a).

Upon completion of such temporary position, the nurse will be reinstated to their former position.

Should such position continue beyond the expected term, it shall be considered to be a permanent bargaining unit position and posted as such at that time.

EMPLOYER POSITION

Opposed.

10.07(a)(iv) ~~The job posting provisions take precedence over any recall rights that employees may have under this Agreement, unless otherwise provided herein.~~

Where a full-time employee on layoff is the successful candidate for a vacant part-time position, they shall retain recall rights to their former position in the full-time bargaining unit for a period of six (6) months from the date of their layoff. This shall also apply to a part-time employee on layoff who is the successful candidate for a vacant full-time position. In these circumstances, the job posting provisions will not apply.

…

10.07(e) Specific Time-Limited Temporary Positions

Specific time-limited temporary positions which are expected to exceed a term of sixty (60) calendar days but no greater than ~~six (6) months~~ **one (1) year** will be posted in accordance with Article 10.07 (a). This term may be extended a further ~~six (6) months~~ **one (1) year** by mutual agreement of the local parties. Where a nurse is transferred under this Article, their vacated position shall be posted in accordance with Article 10.07 (a).

Upon completion of such temporary position, the nurse will be reinstated to their former position.

Should such position continue beyond the expected term, it shall be considered to be a permanent bargaining unit position and posted as such at that time.

10.09(iii)(H) ~~In this Article (10.09), a "vacant position" shall mean a position for which the posting process has been completed and no successful applicant has been appointed.~~

UNION RATIONALE

The Union proposes several critical modifications to the current seniority provisions under the agreement. These modifications are aimed at bringing ONA's agreement

in line with other hospital unions and provincial comparators and implementing necessary bargaining unit protections.

10.07 (A) I) AND II): IMPLEMENT 30-DAY WINDOW FOR POSTINGS

Positions should be posted within thirty calendar days of a vacancy or the creation of a new position. This is a reasonable period of time to keep the Hospitals accountable and ensure that the obligation to post positions is being observed. The Hospitals already observe a 30-day window for other unionized employees.[255] There is no reason why an identical timeframe should not be instituted under ONA's agreement.

Furthermore, this proposal is amply supported by external comparability, given the superior posting language in provincial nursing contracts across the country:

Provincial Comparators	Time limits for position postings
British Columbia (NBA)	…Positions will be posted 2 times a week (Tuesdays and Thursdays) for a period of 72 hours…
Alberta (UNA)	…The Employer shall post notices of vacancies in the bargaining unit not less than 10 calendar days in advance of making an appointment…
Saskatchewan (SUN)	…Posting of a position shall take place no later than thirty (30) calendar days from the position becoming vacant…
New Brunswick (NBNU)	…the Hospital shall, within seven (7) calendar days post a notice of the position on the Employer's Intranet site in all facilities in the Hospital for a minimum of fourteen (14) calendar days…
Ontario (ONA) Current	… such vacancy shall be posted for a period of seven (7) consecutive calendar days…
Ontario (ONA) Proposal	…such vacancy shall be posted **within thirty (30) consecutive calendar days,** for a period of seven (7) consecutive calendar days…

British Columbia requires job positions to be posted twice a week. Alberta mandates that positions must be posted at least 10 days prior to an appointment. In Saskatchewan, a position must be posted for 30 days from the date it becomes vacant, while New Brunswick requires that positions be posted 7 days after the vacancy occurs.

Currently, ONA's agreement provides no timeframe for postings.

All the Union is seeking is to align its posting language with the least onerous of its extraprovincial counterparts and other bargaining units at the Hospitals. This measure is straightforward to implement, incurs no additional cost for the employer,

[255] Central Collective Agreement between CUPE and the OHA (expiry September 28, 2025) at Article 9.05.

adds predictability, and ensures that management does not hold onto vacancies indefinitely without posting them.

These are the same constraints it already operates under with respect to its other bargaining units and should be awarded in full.

10.07 (E): ADD "FOR SPECIAL PROJECTS" TO SPECIFIC TIME-LIMITED TEMPORARY POSITIONS

The Union has proposed a counteroffer to extend time-limited temporary positions to one year, in line with the Hospital's proposal.

This clarification ensures that the job posting provisions outlined in the collective agreement will not be compromised. The Union requests that these temporary positions be explicitly limited to special projects only.

Specific time-limited temporary positions were never intended to be a permanent feature of Hospital staffing; to the contrary, they are designed solely for particular projects, such as grant-funded initiatives, pilot projects, or assignments with a defined term. Consequently, any temporary vacancies that do not qualify as special projects, such as those created to cover employee leaves, should follow the process outlined in section 10.07(d).

Specific time-limited positions, implemented in 2020, were at that time a new type of temporary job vacancy for vacancies expected to last more than 60 days but no longer than 6 months. If both local parties agree, the temporary vacancy can be extended for another 6 months (to a total of 12 months). If the temporary vacancy lasts beyond this time, the position will become permanent. The Union's proposal allows the hospital to extend this position to 12 months without union approval, which reflects current practice as the Union rarely refuses these extensions.

The Union allowed the provision of 10.07(e) to be included for specific time-limited temporary positions in the 2020 round of central bargaining, recognizing that greater flexibility was needed to respond to the Covid-19 pandemic.[256]

However, the language lacks clarity and there remains a significant concern that, in the event the duration of these positions is extended, it will be used for situations other than the exigent circumstances which led to its introduction, namely a global pandemic and provincial public health emergency.

Accordingly, the Union merely seeks to make clear that, if these positions are to be extended up to one year, they are to be limited to special projects only, in line with the intention in the original language.

[256] Ontario Nurses' Association and the Participating Hospitals, *Items in Agreement* (February 10, 2020).

Notably, similar clarifications are found in British Columbia's Nurses' Bargaining Association (NBA) collective agreement, under Article 17.03:

> "(A) The Employer may create regular temporary positions for up to six (6) months duration for vacation relief or skill consolidation.
>
> (B) The Employer may create regular temporary project positions (i.e., grant funded, pilot projects, or term specific assignments) for up to twelve (12) months' duration, with the exception of capital projects which may be posted for up to thirty-six (36) months. These positions are not renewable after the end date of the project, unless the Union and Employer agree to renew/extend the time limits."[257]

Some provincial comparators only allow temporary vacancies to be posted for the purpose of filling in for a nurse who is on leave, including in Alberta (UNA)[258] and Nova Scotia (NSNU).[259]

10.07 (H): ENSURING ORIENTATION IS PROVIDED FOR ALL REASSIGNMENTS

10.07 (h) directs the Hospital, when reassigning nurses to meet patient care needs, to make those reassignments to units or areas where the nurses are qualified to perform the work. The Union's proposal merely clarifies that when doing so, the employer must provide the reassigned employee with an orientation.

The term "orientation" is not defined in the collective agreement; however, it is important to note that orientation does not equate to training. An employee transferring to a new position must be qualified for that role and capable of functioning effectively within the standard orientation timeframe established by the unit. The orientation required is not onerous. The orientation may include unit or area specific policies, procedures, emergency plans, physical layout, as well as orientation to the specific unit in which the employee will be working. As with Article 9.03, the duration and scope of the Orientation Program will be determined by the Hospital by considering the needs of the Hospital and the employees involved. Considering also that fact that reassignments can last as little as a single shift, orientation can be catered to such demands.

Under the current collective agreement, the Hospital cannot unreasonably deny orientation in cases where:

(i) an employee has displaced another employee in a long-term layoff under Article 9.05;

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[257] Provincial Collective Agreement between Health Employers Association of BC and Nurses' Bargaining Association (NBA) (expiry March 31, 2025).
[258] Collective Agreement between Alberta Health Services and the United Nurses of Alberta (expiry March 31, 2024) at Article 2.04(c).
[259] Collective Agreement between Health Authority and The Nova Scotia Nurses' Union (NSNU) (expiry October 31, 2025) at Article 38.02.

(ii) an employee has been recalled from lay off under Article 10.10;

(iii) an employee's probationary period has been extended under Article 10.01; or

(iv) an employee has been transferred on a permanent basis.

The purpose of orientation in any of the categories mentioned is to help the employee effectively take on the responsibilities of their new position. The reassignment under this provision is only permitted in order to meet patient care needs, and a brief orientation is necessary to meet those needs.

When the reassignment is temporary, constituting a couple shifts, the orientation does not have to be onerous. Temporary reassignments are not considered lay-offs. However, the Hospital already recognizes that laid-off employees who are permanently reassigned can receive orientation under Article 9.05.

Significantly, several other provincial nursing contracts require or permit some form of orientation for reassignments include the following:

Provincial Comparators	Orientation
British Columbia (NBA)	Employees assigned to a unit will receive and complete a unit/site specific introduction check-list.[260]
Saskatchewan (SUN)	Wherever possible, Employee(s) will not be assigned to "float" to work areas with which they are unfamiliar. The Employer shall establish a means for paid orientation of Employee(s) assigned to float. Where orientation has not been provided the Employee shall provide care within her level of skill and experience.[261]
Manitoba (MNU)	In the event of a temporary lateral work reassignment being necessitated by a staffing shortage on a nursing unit in any site within the Employer … Orientation will be provided of sufficient duration to assist the nurse in becoming acquainted with essential information such as policies and procedures, routines, location of supplies and equipment, and fire and disaster plans.[262]
New Brunswick (NBNU)	Newly hired persons shall receive a period of orientation and an existing employee who requires orientation to a new department or nursing unit shall receive the required orientation.[263]

[260] Provincial Collective Agreement between Health Employers Association of BC and Nurses' Bargaining Association (NBA) (expiry March 31, 2025).
[261] Collective Agreement between Saskatchewan Association of Health Organizations Inc. and The Saskatchewan Union of Nurses (expiry March 31, 2024) at Article 45.02.
[262] Collective Agreement between Shared Health Employers Organization and Manitoba Nurses Union (expiry March 31, 2028).
[263] Collective Agreement between The New Brunswick Nurses' Union and Treasury Board Group: Nurses, Part III (expiry December 31, 2023) at Article 45.03(a).

Nova Scotia (NSNU)	The Nurse shall only be reassigned to work where the Employer deems the Nurse to be capable of performing the required duties. The Nurse may require orientation to the assignment.[264]
Ontario (ONA) Current	Where nurses are reassigned to meet patient care needs at the hospital, they will be reassigned to units or areas where they are qualified to perform the available work.
Ontario (ONA) Proposal	Where nurses are reassigned to meet patient care needs at the hospital, they will be reassigned to units or areas where they **have been provided orientation and** are qualified to perform the available work.

EMPLOYER PROPOSAL: ARTICLE 10.07(A)(IV), 10.09(III)(H) (VACANCIES DURING LAY-OFF AND RECALL) SEEKS TO UNDERMINE SENIORITY RIGHTS

The Employer's proposal is a blatant attempt to circumvent seniority rights that have been protected under this clause for over 25 years. Vacancies are filled based on skill, ability, service and qualifications. Seniority is then used if these four factors are relatively equal.

Any bargaining unit member, including those who are laid off, can apply for the job. If a candidate is currently working in another job, her/his former job will then be posted. This ensures that the best, most senior candidate steps into a posted job.

The Union agrees with this process and would not freely agree to any change which undermines the seniority of its members.

Many job postings are for highly sought-after positions for which members have been anxiously waiting to apply. It would be unfair if laid-off nurses with relatively little seniority obtain these jobs over nurses with more seniority. Positions should be filled by postings, knowing that eventually, as the chain posting progresses, the laid-off nurse, if qualified, will be the successful candidate for one of the posted jobs and thereby return to work.

Recently, the employer has attempted to circumvent the protections afforded by this provision through the use of nurse transfers under Article 10.08. In *Niagara Health System v Ontario Nurses' Association*,[265] Arbitrator Johnston was appointed to adjudicate a dispute regarding new language under Article 10.08 in the Central Hospital Agreement awarded in 2023. In doing so, he noted the obvious policy concern with allowing laid off nurses to leapfrog the seniority rights of other members:

[264] Collective Agreement between Health Authority and The Nova Scotia Nurses' Union (NSNU) (expiry October 31, 2025) at Article 37.01(i).
[265] *Niagara Health System v Ontario Nurses' Association,* 2025 CanLII 3711 (Johnston).

> 40. The Board could have amended Article 10.07 to clarify that the job posting process took precedence over transfers described in Article 10.08(e). However, the drafters did not add that language to the agreement.
>
> 41. I have some concerns with this interpretation; once a job is posted, it creates expectations among those who wish to apply. It also engages seniority rights of nurses across the hospital, including those who could have much higher seniority than the nurses transferring under Article 10.08(e). Including these jobs as transfer opportunities effectively suspends the job competition process, and prevents nurses from using their seniority to compete for jobs under Article 10.07(c).
>
> 42. The outcome is that nurses with less seniority could transfer to the most preferred jobs ahead of other more senior nurses who no longer have the right to compete for those positions. That is not a satisfactory result and does not minimally impair seniority rights. However, the commentary in the Kaplan Award focused on protecting job security rights; there was no mention of rights in job posting process. Having carefully considered the language, I think the proper interpretation is that 'a list of vacant positions' includes all vacancies across the hospital, including those currently in the job competition process. (emphasis added)[266]

Despite Arbitrator Johnston's cautionary warning, the Hospital now wishes to eliminate this protection altogether. The Hospital's proposal should be swiftly and summarily rejected.

[266] *Niagara Health System v Ontario Nurses' Association,* 2025 CanLII 3711 (Johnston) at paras 40-42.

PROPOSAL #14 – *NEW* ARTICLE 21: NURSE PRACTITIONERS

NEW

21.01 (a) The Hospital recognizes that Nurse Practitioners have both clinical and non-clinical responsibilities. Nurse Practitioners will devote approximately 80% of their time to clinical activities and approximately 20% to non-clinical care responsibilities, including Professional Development (e.g., research, education, leadership, policy and procedure development, education material development, and administrative duties).

(b) When a minimum of one (1) week of vacation is submitted and approved, automatically two (2) days of the return week will be blocked for vacation catch up.

21.02 Nurse practitioners may be asked to supervise students enrolled in a Nurse Practitioner program. Additional Administrative and other duties will accompany this assignment/preceptor role. Stipends provided by universities or other Nurse Practitioner programs, will be accepted by the Nurse Practitioner.

EMPLOYER POSITION

Opposed.

UNION RATIONALE

21.01 – DISTRIBUTION OF EFFORT AND PROTECTED TIME

Nurse Practitioners perform work at a high level of skill and qualifications. They have several competing demands on their time, including direct patient care, administrative work, and professional development obligations. Without any clarity, NPs struggle to complete all their responsibilities to patients, and to the Hospital, during a shift.

The Union's proposal would make explicit the distribution of effort expected of NPs, providing much-needed clarity to all parties.

NPs require discrete, allotted, and paid time to attend to their non-clinical responsibilities. The Union's NP members report that their clinical responsibilities often overwhelm their time for administrative tasks, research, and professional development. The result leaves NPs with insufficient time to harness the key capacities of their role. While this is an urgent concern for the Union, it ought to be a concern for the Hospitals as well.

In 2018, the Canadian Federation of Nursing Unions ("CFNU") conducted a Canada-wide study of NPs which found that a general lack of understanding of the NP role by hospital and health care leaders contributes to job dissatisfaction and suboptimal utilization of the NPs to meet the health care needs of Canadians.[267]

The CFNU study further identified that, to maintain specialist knowledge and competence, "it is essential that NPs be given the support, protected time, and resources" to do so.[268] It found that 47% of NPs reported dissatisfaction with the opportunities for professional development, and the amount of paperwork and time required to complete it.[269] These ranked among the top five most important factors for improved recruitment and retention.

The Union's proposal also recognizes that when NPs return from vacation they must catch up on all their files. This can take considerable time and may be impossible if they are fully occupied with direct patient care.

21.02 - SUPERVISION

NPs often supervise RNs enrolled in NP placements as part of an educational program. Mentoring the next generation of NPs is extremely important to NPs, but it is also time consuming, both in working with the students and in other administrative duties.

This proposal simply provides that, if the educational institution provides a stipend for this work, this stipend will be paid to the NP, rather than to their employer. This proposal provides basic fairness to NPs for the additional work they contribute to mentoring future NPs.

[267] Canadian Federation of Nurses Unions, "Pan-Canadian Nurse Practitioner Retention & Recruitment Study" (2018).
[268] Canadian Federation of Nurses Unions, "Pan-Canadian Nurse Practitioner Retention & Recruitment Study" (2018) at p 36.
[269] Canadian Federation of Nurses Unions, "Pan-Canadian Nurse Practitioner Retention & Recruitment Study" (2018) at p 15.

OTHER EMPLOYER PROPOSALS

ARTICLE 14.01(A) AND 14.06 (OVERTIME)

14.01 (a) (Article 14.01 (a) applies to full-time nurses only)

If a nurse is authorized to work in excess of the hours referred to in Article 13.01 (a) or (c), they shall receive overtime premium of one and one-half (1½) times their regular straight time hourly rate. Notwithstanding the foregoing, no overtime premium shall be paid for a period of less than fifteen (15) minutes of overtime work where the nurse is engaged in reporting functions at the end of their normal daily tour. If authorized overtime amounts to fifteen (15) minutes or more, overtime premium shall be paid for the total period in excess of the normal daily tour. Overtime premium will not be duplicated for the same hours worked under Article 13.01 (a) and (c) nor shall there be any pyramiding with respect to any other premiums payable under the provisions of this Collective Agreement. Nothing herein will disentitle the nurse to payment of the normal tour differential provided herein. ~~For purpose of clarity, a nurse who is required to work on their scheduled day off shall receive overtime premium of one and one-half (1½) times their regular straight time hourly rate except on a paid holiday the nurse shall receive two (2) times their straight time hourly rate.~~ The Hospital agrees that if the Collective Agreement provided a greater overtime premium for overtime work immediately prior to this Agreement, the Hospital will continue to pay such greater overtime premium.—This is not intended to entitle the nurse to be paid for work performed while engaged in the reporting functions as provided herein.

14.06 ~~Where a full-time or regular part-time nurse has completed their regularly scheduled tour and left the hospital and is called in to work outside their regularly scheduled working hours, or~~ ~~w~~ **W**here a nurse is called back from standby, such nurse shall receive two (2) times their regular straight time hourly rate for all hours worked with a minimum guarantee of four (4) hours' pay at two (2) times their regular straight time hourly rate except to the extent that such four (4) hour period overlaps or extends into their regularly scheduled shift. In such a case, the nurse will receive time two (2) times their regular straight time hourly rate for actual hours worked up to the commencement of their regular shift.

This article does not apply where an employee elects to work additional unscheduled hours made available by the Hospital.

UNION RESPONSE

Opposed.

There is no demonstrated need for these proposals.

If the Hospitals need to contact a nurse on their day of, it should be paid as overtime.

Furthermore, Article 14.06 has been interpreted numerous times and is a mainstay of the parties' collective agreement. The OHA now seeks to amend this language and render this article effectively inoperative.