Jennifer Ward

January 24, 2020 Interviewer Jared Matsunaga-Turnbull, Camera Don Bouzek

Q: What is your union, and what is your position with them?

JW: I am a member of the United Nurses of Alberta, and I hold a First Vice President executive position for Local 37 in Grande Prairie.

Q: Where were you born?

JW: Dawson Creek, British Columbia.

Q: What was that like?

JW: It's a very small town. I moved to Grande Prairie to do my nursing. I did my first year of nursing in Dawson Creek when they had a diploma program there at that time. There's only a population of 10,000, so my nursing class was seven. So rather than going to Prince George, I went to Grande Prairie to do my degree, and I met my husband and never left.

Q: So you grew up in Dawson Creek.

JW: Grew up in Dawson Creek, graduated there, did my first year of nursing there, then went to Grande Prairie, which is only about an hour and 20 minutes away.

Q: What did your parents do?

JW: My dad was a mechanic and my mom was a stay at home mom. I have three older brothers, so she stayed at home with the kids and my dad was a mechanic.

Q: Why did you decided to go into nursing?

JW: To be honest, couldn't tell you. There's no one else in my family that's in the medical profession. I recall I was working as a custodian at the college at Dawson Creek, Northern Lights, and I came across a package that was a nursing package. I thought, oh they're doing that program here. I applied and I got in, and the rest is history.

Q: Were you brought up in any specific cultural tradition?

JW: No.

Q: So you came to Alberta because of school, and ended up staying here.

JW: Correct. Like I said, at the time the diploma program, that's when nursing was going from diploma into a degree, and they were going to take out the diploma program altogether. I figured rather than going to Prince George to finish the diploma, I might as well do the degree and be done with it. It was only an hour, which was closer to my home town than Prince George, which was four hours away. So I went to GPRC [Grande Prairie Regional College] and it was in coordination with U of A [University of Alberta], the degree program at the time. I took it there and it was a smaller classroom as well, but certainly not seven. It was a great experience.

Q: Did you get work right away?

JW: I started as an undergrad actually, and got a position on the current unit that I work, the psychiatric unit at the QE2 [Queen Elizabeth 2]. I worked there my third year as a casual undergrad and then I did my senior practicum on that same unit and was hired casual right away after that.

Q: What drew you to psychiatric nursing?

JW: In my third year nursing we did a pediatric rotation, and on the pediatric unit was a 13 year old with suicidal ideation. I couldn't understand how that's possible, that somebody so young would have suicidal ideation. I asked to have that patient and I was told, well you haven't done

your mental health, you probably shouldn't be going in there. I said, well it's about relationship building, so I'll go in and talk to her, that's all I'll do. That's all I did, and from there on that was what I wanted to do.

Q: So with your degree, are you considered a registered nurse?

JW: Yes, a registered nurse with my Bachelor's Degree. Following obtaining that, I worked in the community for one year in the children's health program for mental health, where I went into the schools and did some counseling and met with parents and such. I found that really difficult, being a young mom at the time, having kids exhibiting behaviors and then trying to get the families together was really difficult. There were a lot of blended families, so you had the step mom or the step dad, and they were always at each other. To try and bring them together, I found it extremely frustrating and stressful. So I thought, this isn't for me; not yet anyway, because I'm too new for this. At that time I decided to take my mental health certificate through Mount Royal [Hospital or University?] in Calgary; it was a two-year program. I did my senior practicum in children's health, so I followed a child psychiatrist for four months and then I felt a bit more comfortable in that area. Then a position came open on the psych unit at the QE2. I applied and got the job there.

Q: You have kids?

JW: I do, I have three children. One has just graduated and is a psychologist, and I have one graduating this year as well. They're in Grande Prairie.

Q: What's a typical workday for you?

JW: I will say it's changed from the time I started there 20 years ago until today. Back then, there were so many young 18- and 19-year-olds coming with bipolar or schizophrenia kind of symptoms. They're in university and had their first break, and the next thing you know their life has changed forever. I made a lot of connections with kids like that, because over the years they've kept coming back because it's a chronic condition. To this day and age, we see more

drug related psychoses, so you don't really know what's underneath until the drugs clear. Over the period of time, like I say, I've always said, I like legitimate diagnoses. Not that drug addiction is not legitimate, but when somebody has no choice when they develop bipolar or schizophrenia or depression and anxiety compared to somebody who chooses to take meth or cannabis or whatever, but at the same time you don't know what they're masking. Were there symptoms previous to why they're taking drugs? Are they taking the drugs to mask the voices that they had previous? By the time they get so involved into the drugs, it's hard to then scale back to say, was there something previous to this or are we dealing with just an addiction versus a mental health condition?

Q: So it's changed in terms of the types of things you're seeing?

JW: I'd say the aggression is a lot worse than it was years ago. There's always been a difference if someone's diagnosed with schizophrenia – I have that rapport with them. They come in extremely psychotic and they're swearing at you – that to me personally doesn't affect me. I remember, no I know what they're like when they're well, versus somebody coming in high as a kite on something swearing, gesturing to hit you, or whatever. That affects me a lot differently personally in my opinion. I don't know why it does, other than I think this gentleman doesn't have a choice and I know what he's like when he's well, and I know he's a nice guy and he'd never hurt me. However, the voices in his head are telling him otherwise.

Q: So you form relationships with people, because they keep coming back?

JW: It's a small community. We have our manic season where typically people are more elevated in their mood. They come through the doors for whatever reason, whether it be the weather or they're off their meds, they're coming through the door and exhibiting those manic behaviors and they're not functioning in the community. So then they have to come back in and get stabilized on their medications again, and then we send them out again. But they're the same people that I've known, like there's a few that I've known since their first break when they were 18, and now they're 28, 29, 30. They come in and, "oh hey, how's it going?" It's like, "oh why are you back?" In a few days when they're settled down, they're back to their selves again.

Q: How does the context of Grande Prairie impact your work?

JW: We have a lot of transient population in Grande Prairie. We have oilfield, we have forestry, we have all the work at some time in Grande Prairie. We've accumulated a lot of people from other provinces, from the east, from Edmonton. People heard that there's work so they come to town, so we have a lot of transient people that we have no histories on. If somebody ends up on our unit, we have no history other than what we can find on Netcare or whatever. But typically, you don't know what you're dealing with, versus the people we have a history with. We're seeing a lot more that we don't know much about.

Q: What are some of the health and safety challenges of the job?

JW: I think the biggest thing is you don't know their history. When I can say, I've known this person for 20 years and in those 20 years there've been 30 admissions and never has he been aggressive, chances are he never will be aggressive. But somebody that's coming in, and say they're brought in by the RCMP for doing whatever, you don't know what to predict. We often say history is the best predictor of future. If somebody's coming in and they have an arm length of charges and assaults and stuff, chances are he's quite aggressive and we need to be cautious of that.

Q: What issues do you see as part of your job?

JW: I've been present when we've had windows broken. I've had patients come up and threaten blatantly that they're going to kill you, or "you wait 'til I get out of here, if you don't give me what I want, I know what you drive" – those kind of things, threats at the time. Somebody tore apart our lounge area, ripped off the TV, took a chair and smashed the windows, numerous times kicking in the seclusion areas where the doors are secure, kicking to extreme where they've broken arms or wrists hitting the walls.

Q: What's a seclusion room?

JW: A seclusion room is a room that is secured with magnets of heavy stature that if anybody, like that's where we would put somebody who are at risk for themselves or others. If they're threatening or if they become aggressive, we can put them into a seclusion room to decrease their stimulus and to keep everybody safe at the same time, and we can administer medication at that time. It's been proven that people that have medication and then are in an area where there's no TV or people talking, where the stimulus is low, that likely that medication is going to kick in a lot faster and it's going to de-escalate the behavior that they're exhibiting.

Q: When someone comes in, what's the process of assessment and further actions?

JW: First they come in through the ER downstairs. We will get a report from the ER before we bring the patient up to our unit as to what brought them in, what behaviors they're exhibiting. Often it's at that point that they should be assessed for violent tendencies, and they could be given a security constant at that point if they're down in emerg. We have a tool now that we hadn't had in the past, that we actually have specific questions of violence, aggression, history of, so we can score them. When they score a certain number on the matrix – that was a tool that we've just recently developed – then we can say, okay this gentleman, until we can get further assessment, requires a security constant. So that provides that extra little bit of security when the patient does come upstairs. When they come into the ER and are admitted, our unit is like no other. Visitors don't come and go on our unit. We are a non-smoking facility altogether and you have to have privileges to go down and smoke; you have to be deemed safe enough to go downstairs and smoke. Often we'll get patients up, and if they're smokers and they all of a sudden can't smoke, that often escalates their behavior into yelling, screaming, demanding to leave, threats. We do offer nicotine replacement, but for a smoker that's not always sufficient. Cellphone usage, we don't allow cellphones on the unit; they have to have privileges to use their cellphones. That's another issue that often escalates people's behavior, because everybody uses their phones. But it's also safety as well, because when people are unwell they often post things on Facebook about family members and such that aren't true, but it shows how unwell they are. Then we often get family members upset: "how do they have their phone? why are they posting this on Facebook? it's not true and it's detrimental to us." So we try to put those

kind of restrictions in place. When there's rules, not always do people like to abide by the rules, so when they come up and we clamp down on that, often we'll see an escalation in behavior.

Q: Is it a locked unit?

JW: Yes, we are a locked unit. When they do come on the unit, it's a locked unit. They go into the side room and have an assessment done. We have something like an 18 page mental health assessment, so it's pretty thorough as far as history and what brought the patient in, and collateral information from family members and such as to their behaviors in the past so we can get a good idea of what we're dealing with. Not always are people cooperative when they come in. They may not want to answer the questions; they may be angry and say, "I'm not answering." So we just let it go; we don't push them any further. If they're agitated, we just back off. If it's something that we think isn't enough we'll just say, "Okay you can go to your room." We'll just have to seek out a psychiatrist to hopefully do an assessment and determine what medications we can give. Not always do they come up in emerg with the medications that we have the opportunity to give to calm them down.

Q: How many staff are on?

JW: From 7 a.m. until 11 at night we have four staff members, usually three RN/RPNs, so registered nurse, registered psychiatric nurse , an LPN, and one healthcare aid. After 11 we usually have two RN/RPNs and one LPN and the healthcare aid. It's an improvement in staff as far as healthcare aid; we never had a healthcare aid on our unit before. But they're unregulated members, so their role is totally different. They would never be involved in if we needed to restrain somebody. They'd be the runner, so to speak, if there's something we needed. But we only have four staff on. We've had a recent increase of beds from 16 to 18, with no increase of staff. We have four staff for 18 patients throughout the day.

Q: Is that different from 20 years ago?

JW: We have bobbled around in the last 20 years. At one point we had 26 beds on the same unit. Some of the rooms that are now allocated for group rooms were actually patient rooms. We had 26 patients, we had six staff, then we went down to 22, then we went down to 18, and we were down to 10 at one point, then up to 12, then up to 14. We've been all over the place. The need has always been there for mental health beds, and back when we only had 12 beds they were putting patients on other units, like on medical floors, which created issues on medical floors because staff were not feeling comfortable doing mental health status exams, and the patient shouldn't be taking up a medical bed. So that's why we over the years now pushed the numbers back up. In the new hospital we'll actually have more than 18 beds; I think we're moving up to 36 beds, including adolescent beds and geriatric beds.

Q: So there's a new hospital being built?

JW: Ya, it's built. My understanding is we should be getting the keys soon. The mental health department will not be going over at the same time the rest of the hospital is going over. They're actually not going to even start building our wing until the keys are handed over for the rest of the hospital. We're actually going to be staying at the old hospital while everybody moves over. How that looks, as far as security, laundry, feeding patients, I have no idea. We'll be the only inpatient union there.

Q: Why did they build a new hospital? What were the issues with the old one?

JW: It's falling apart. It's old and they don't want to put any new resources into an old building, because we have a fancy new building being built. The ceiling tiles, we've had patients poke out the ceiling tiles and crawl up inside the ceiling. We're on the fifth floor, so we're right below what they call the penthouse where all the mechanical stuff is. Sometimes patients have been up there. We've had patients hide alcohol up there, hide drugs up there. It's just a matter of moving the tile and they just put it up and then they put the tile back. So there's a lot of things that need to change.

Q: Are you a president of your local?

JW: First vice president.

Q: What struggles have you had over the years?

JW: Over the years it's progressed into a lot of drug use within the facility, not only on our unit but on other floors where patients' family members or friends are bringing drugs into the unit. There's a powdered substance found next to the bed, or people overdosing in the bathrooms downstairs – those kind of things have escalated in the last few years. Previous to that, on our unit I've always been, even before I went into the union position on the executive, I look back at some of the emails I sent and I'm astonished at why I didn't just do anything. I sent an email saying, I notice this or this person's being aggressive, or we had two constants and didn't have the staff – all these really unsafe situations that I sent an email. They'd respond, "thank you for bringing it to our attention, we appreciate. . . ", but nothing was ever done. When I look back at them, I'm amazed nothing happened sooner.

Q: What is the process, if you see something that's not good?

JW: I honestly think until that situation in 2011 we always talk about, here's a situation. Until something really happens, nothing's going to be done, and that's kind of the precedent that we all went with. We report, we report, and yes we're heard, but the outcome never really changes--until we had that incident in 2011. Since then, there's been massive changes that has improved for everybody, not only our unit but the entire hospital.

Q: What happened in 2011?

JW: We had an incident where we had a patient that was brought in by the RCMP exhibiting some aggressive behavior in the community. He was brought in and he was wanting coffee late in the evening. We typically don't give caffeinated beverages after a certain period of time, because we're also giving sedative medication, so it kind of defeats the purpose of giving medication if we're going to just allow them to drink coffee all night. He wasn't pleased with

that response, and he was threatening to kill us. As we were standing at the seclusion door, which is supposed to be secure, he started kicking the door. He said, "when I get out of here I'm going to kill you." We had a constant at the door at the time. A constant is someone who sits and monitors the patient that's within the seclusion room, just to ensure that the patient is safe as well. As far as any medical distress or anything, somebody's right there to deal with it if we need to. So he started kicking the door, and as we were standing there speaking to the nurse that was sitting there, the door all of a sudden popped open. Our first response was to hold it shut, and that's what we did. Two of us held it shut, two more staff came, and we were holding it as he continued to kick it, because he realized at that point he had popped it open. We were holding it shut with our bodies, and there were four women on. I remember at the time following, there was probably 60 years of experience behind that door, with the nurses that were on. This wasn't brand new nurses. I was the youngest out of all of them that were on that day, as far as experience. I can't remember if somebody had come through the door and just phoned the police. That's all we could think of doing, because we had security at the time but our security was elderly ladies and men that were somewhere on seniors pension. I'm not kidding, that's who our security was in the hospital. They were not trained guards, they were not physically fit. I'd be scared for them going into a room. So we phoned the police, and the police came and we did some statements. He had broke the door, the frame of the door was broken. The RCMP said, well we can charge him with mischief and uttering threats. We said, well we can't contain him here; this isn't safe for us, we can't contain him here. So they arrested him and he left the building. They took him to cells that night to go to court the next morning. I remember him smiling when he left, at us in the nursing station.

Q: How had the RCMP been able to bring him in?

JW: He was brought in on a Form 10. Because he was exhibiting aggressive behavior and threatening to the community that he was in, the police were able to bring him into the hospital. He had a history of mental health admissions, so that was their choice of bringing him to the hospital versus dealing with him in the community in cells, as opposed to a mental health facility.

Q: Form 10 is the designation for that kind of thing?

JW: The RCMP can utilize a Form 10. They have to have substantial evidence to say, this gentleman is exhibiting behaviors in the community or safety risks to other people, that they can bring him into a facility. They need to bring him into a designated facility to see a psychiatrist. The psychiatrist then does his assessment, and he can deem to discharge him or to admit him and certify him under the Mental Health Act. That is what happened in this case – he was certified under the Mental Health Act.

Q: Were the security people at the time commissionaires or guards?

JW: I believe their term was commissionaires, but they wore the blue uniforms like Paladin does now. But they had nothing; they had radios, that was about it.

Q: So the cops took him away to get ready for court the next day. What happened next?

JW: We were all relieved that he was gone, until the next day when we got the call that he was going to be returned to the facility. Right away the union got involved. I remember the president and the north district rep at the time was phoning every person from the unit, "okay this is what's happening, what are your thoughts? Are you comfortable with this person coming back?" I remember getting that call at home, because I was off that day. I'm like, "you're kidding me, how can he be coming back? He threatened us, he kicked out the door." I was so bothered by it, I started calling people – "did you get the call? what do you think of this?" I was in close communication with the unit and the staff that were on that day. The next morning when they were told he was coming back, the decision was made that we're going to take the rest of the patients off the unit and we're not going to provide care, because he's coming back to the same environment where we couldn't contain him in the first place. When he came back onto the unit, the decision from the union was: we're not going to look after him but we will look after everybody else. We had at the time I can't remember how many other patients, I want to say at least a dozen other patients, that they took down to the lower level. Five South is on the fifth floor of the hospital, the highest floor, so we took them down to the lower level to the staff

lounge. They took the med cart down there, so everybody was cared for, they had their medications, they had staff there. It left the one patient on the unit, which they refused to care for. I want to say the nursing supervisor at the time, but nursing supervisors weren't in scope at the time, they were out of scope. So the nursing supervisor was providing care as well as the LPNs, the LPN float was providing care. It's my understanding that the LPNs were told at that time that they didn't have the right to refuse work, that they had to provide care for this gentleman.

Q: Who told them?

JW: Their union told them that.

Q: When he breached the door and the commissionaires came up to assess, were any of the commissionaires injured?

JW: It was actually the day previous to him actually breaching the door. He was in the room. We had at that time two seclusion rooms so we could alternate; if he made one a mess, we'd move him into the other and have it cleaned so they always have a clean environment. He was actually standing in the corner and I remember him down like a football tackle, bent over with one hand on the ground waiting for them to come through the door. They opened the door with him in that stance, and he came at them. One of them I believe injured their leg or arm. When I think back, I would never have entered the room or allowed security, or commissionaires at that time, it was so unsafe. But they felt they could go in and deal with him, and got injured.

Q: What was the policy in administering medication? Did the commissionaires go in first, or did the nurse go in first?

JW: I believe the commissionaires went in before us. They changed the policy when we got the peace officers. A lot of policies have changed around the medication. At the time, I honestly don't remember who went in the room. But if the nurses went in the room first, they came in after. But like I said, they were not equipped to be looking after any aggressive situation,

because they were so fragile. One gentleman was limping around; he had just had a hip replacement. That's what our security was.

Q: What happened after the LPNs were told they couldn't refuse work?

JW: They continued to provide him care. The psychiatrist at the time refused to decertify him, because that's what we were asking to do. Because he was certified is why the judge determined that he'd be returned to us. We've always said, we're not a forensic unit. We don't have the capacity, like Edmonton does, to look after forensic patients, nor do we have forensic psychiatrists on our floor. The psychiatrist refused to decertify him, so that resulted in him remaining certified on our unit. The next discussion that the union had was, okay we can't look after him here, he needs to be sent out. So then they looked at sending him out to Edmonton, and I believe it was within 72 hours they finally flew him out to Edmonton to a more secure unit that could look after him.

Q: Did you actually invoke your right to refuse work?

JW: The staff that were on that day did invoke their right to refuse work. But also taking care of the other patients, they made sure the other patients were taken care of. They weren't refusing work for that unit, but that specific patient.

Q: What happened after that?

JW: The nurses that were on that day were suspended. They got a letter put on their file through CARNA or I think one was CRPNA, which is the psychiatric association. So they got letters put on their file and they were suspended without pay.

Q: For refusing work?

JW: Correct.

Q: What was the union's response?

JW: Well we weren't going to take that lightly, so we appealed. It was a lengthy process with a lot of discussions and a lot of almost like court appeal hearings in front of the Occupational Health and Safety. It was very difficult. I remember being asked questions like, is it common that there's abuse on the unit? Is it common that there's violence? Is it typical of a patient? In some cases there is, but it doesn't substantiate that that's what my job is, is that I go to a workplace expecting that there be violence and nothing in place to protect us.

Q: Is the aggression verbal or physical? What are we talking about when we're talking about violence in the workplace?

JW: Aggression can be both verbal and physical. We have all capacities on that unit as far as that goes, and many different degrees. Whether it be broken windows and they're taking it out on the window versus you and it could've very easily been you, when they're not happy and they smash the window next to you, or call you every name under the sun, or threaten you, or know what car you drive, or those kind of things. The aggression, it doesn't matter if it's verbal or physical, the impact is the same.

Q: Can you talk about the impact?

JW: I think in this specific circumstance we had a nurse that never returned to nursing after that incident. Like I said, it was brought forth to us that it's the norm, that it's something that's normalized that we deal with that kind of aggression. It shouldn't be. Like I said, I think the impact of not only the incident itself – and I can recall the incident like it was yesterday – but the support that you get in coming to work every day and ensuring that this workplace is a safe place to be, and that you're there for the best interests of the patients. It's hard to be there for the best interests of the patients when you're afraid to come to work.

Q: What was the appeal process?

JW: Everybody that was involved or questioned by the appeal, it was basically like a court setting. We had a lawyer for the UNA [United Nurses of Alberta] side and the employer had a lawyer on their side. Hearing some of their responses was disheartening because not all was, in my opinion, accurate. Our emotions were downplayed a bit as far as what we should've done, or that we neglected this patient, when in fact that wasn't the case. We were advocating for our safety. When somebody's threatened, whether it be in the community or whether it be in your workplace, I don't think there's any difference.

Q: Did a resolution come out of the appeal?

JW: After the appeal, the OH&S committee said that we were within our right to refuse, and all of the suspensions and letters were reversed. There were several notifications to the employer: what they should've done properly that was absent from that whole system of reporting of refusal to work.

Q: What changes did you see as a result of this?

JW: As a result, we now have peace officers onsite on every shift. We actually now have two peace officers and, as of last year, moved up to two Paladin guards. We went from three to four, and that was only based on the number of calls to our unit and to the ER, ER being the point of entry for all the patients in our unit. In one month we had 100 calls, whether it be stand-bys or whether it just be assisting with somebody in the seclusion room. We were for the longest time advocating for a security just for our unit, so we had that added security just for our floor. We've had many arguments as far as, "well it's not a jail, we don't want to see it as a jail." Their answer to that was to add another guard to the hospital, which is fair enough. Their response time is a lot quicker than it had been in the past.

Q: What did it feel like to go through that process?

JW: To be honest, if I don't think about it, I'm good. But the more I think about it, honestly if I didn't enjoy what I do and I didn't have the support from UNA at the time and the colleagues

that I was on with, I don't know if I would continue there. I advocate, ever since that time, anything comes to me and I'm taking it to wherever it goes. I don't have any regret of reporting anything I've reported. I think every time I report something, there's substantiation to why I'm doing it. Over the years, I think there's been an increase in listening to Jennifer Ward when my name comes on an email. Since that time, as of last year, I took the assistant head nurse position on Five South. It's a change, because I'm union on this side and this is more the leadership, but I'm still in scope. But I think I'm managing it well overall. Anything comes my way, anything needs repair, the doors are not doing this or whatever, I'm right there to report it and get something done about it.

Q: Where the doors addressed?

JW: The doors were addressed. We actually replaced all the doors. We actually now have increased to four seclusion rooms, but one is used as a de-escalation room. It has speakers that go into it and a couple chairs, so we can stream music into it or meditation and that kind of thing. But the doors were replaced and increased the magnets; I think we got an extra one or two magnets on each one. They were special order doors from the U.S. that took a while to come, but when they came, I don't think anybody's coming through those doors. They're pretty sustainable.

Q: When the initial incident happened and he was returned to the hospital, had the doors been fixed or were you dealing with the same situation where the seclusion room was not secure?

JW: Yes, the doors had not been fixed. It took quite a while for the doors to be replaced, because they had to be special ordered through the U.S. When the patient was returned to the hospital, they put him in a different room than the one he breached, but same amount of capacity as far as the magnets. They also treated him, like he was given whatever he asked for, so his behavior was very calm and it didn't reflect well on what we were saying. But at the same time, when you're given what you want, you have no reason to be upset. So he was like night and day. He was given coffee at 3 in the morning. We tried to say, this is not what we should be doing; he's been given this medication.

Q: Does gender play into it?

JW: We've experienced some pretty severe aggression from females as we have from males. I don't think you can differentiate one being more severe than the other. I recall a bipolar patient who was well into his late 60s that had more strength and was able to lift eight of us off him. I think when somebody's ill or presenting psychosis, their strength is beyond what anybody can imagine for their size or weight or gender. As far as male staff members on the floor, we do have a couple. I don't think that makes a difference at all either. We're trained in de-escalation and nonviolent crisis, different holds and stuff, that we should all be comfortable doing if we're required to do it. I don't think it should matter on the basis of male staff.

Q: What is the purpose of nonviolent crisis intervention training?

JW: There's a couple different purposes. The main purpose is that if someone comes up behind you and grabs your hair from behind, that you're able to get out of certain holds. But it's also in combination with a coworker, if somebody's escalating, to remove them from the area and place them in a more secure area such as a seclusion room. However, it's very rare in my years that that has ever happened where it's done so quietly and just a couple people are able to do it. Usually when you try to de-escalate somebody you try it verbally first, but not always does that help. The aggression often kicks in way quicker than we could ever use nonviolent crisis for.

Q: Do you have a health and safety committee at your workplace?

JW: Yes, we do.

Q: During the events of 2011?

JW: I believe we did at the time. I wasn't part of the committee at that time, but I do believe we had a committee at the time.

Q: Was there any involvement from them in the refusal to work?

JW: Not to my knowledge, no. But to be honest, I was more involved with what UNA and the unit was dealing with.

Q: How did you get involved in the union?

JW: Actually the nurse that has never returned to work after that incident, she was on the PRC committee at the time, which is Professional Responsibility Committee. She was my preceptor when I graduated and did my fourth year there. She was my preceptor and she's a really smart lady. She said, you'd be really good at this. So I started going to the PRC committees, and there's also a lot of reporting there that's simultaneous with OH&S and a professional responsibility concern. As I was investigating more and talking to other people throughout the hospital about things that were going on, I'm like, "This is wrong. Why are we short staffed?" That's when things happen, is when you're short staffed and you have an episode happen. So the more I got involved in that, it just kind of escalated from there, then OH&S. Like I said, as far as safety on the unit, I've always advocated for safety on the unit, and sent a number of emails over my career. That's kind of where it evolved. Then I was asked, "well do you want to do the vice president?" I'm like, "Well I really don't have time, I'm busy." But then I put in my name, and I think it's been going on seven or eight years that I've been in that position. Then last year, even though I've been a very strong advocate of OH&S, I stepped down from the PRC committee and moved over to the OH&S committee, I guess where I belong.

Q: What's the PRC?

JW: The Professional Responsibility Committee. We have forms that staff can fill out when they have a concern, whether it be short staffing, whether it be a staff mix, based on how many RNs and LPNs, wasn't a safe situation. Those kind of things get brought to the committee with the employer and UNA, so we have that equal amount of employees versus management on the other side. We discuss the situation, how it happened and how we could rectify it from happening again, what needs to change. We kind of come up with solutions as a whole to

change those things. A lot of it comes down to staff. Probably 80 percent of PRCs have to do with staffing and the lack of, or not replacing, or not able to find anybody and then they replace with somebody with less experience or knowledge. Then something happens. That's basically what we deal with across the board.

Q: With the PRCs are you also advocating for patient safety?

JW: Absolutely. When you have a shortness of staff, or when you have no charge nurse, or you're having several other people that may not meet the same level of experience and education, it impacts patient care ultimately. If there's only four staff on and you're supposed to have six, somebody's going to lose out as far as care. They're not going to get the care they'd normally get if you had sufficient staffing.

Q: Are PRCs born out of legislation or collective agreement?

JW: It's out of the UNA collective agreement that we meet with our employer and develop a committee for professional responsibility.

Q: What's the difference between a PRC and a Health and Safety Committee?

JW: Health and Safety Committee, there's a lot more to it as far as equipment. There's some overlap too where I've submitted to both committees because I'm not sure which one it should be going to. But most of it around health and safety is employees' safety as well as patients' safety. Like I say, if it has anything to do with equipment, like the doors being able to be breached, that's a safety risk not only to the other patients on the unit but to the staff as well.

Q: Was the PRC bargained in?

JW: Yes, it's in our contract.

Q: How does the PRC actually operate?

JW: What the Professional Responsibility, like say somebody's brought forth a continued shortness of staff and it's been ongoing where there's been vacancies that are not filled, so they're chronically working on schedules that have holes in the schedule. You know that next week Friday you're working short because that position hasn't been filled, it hasn't been posted, so they're hoping casuals will pick up. That's not taking into account any sick calls that happen, and often that then escalates the concern even higher because you're already going in short and if somebody phones in sick, you're not able to replace that person. The impact when you come in to work, you might be the only RN with two LPNs and they might give you an extra 8CA to help with 16 surgical patients on the unit. How are you going to manage 16 surgical patients and do assessments, when 8CAs don't do assessments? They could be there to help turn or do personal care, but as far as actual assessments, those assessments aren't going to be as thorough or as timely as they would normally be if you had sufficient staffing.

Q: Did the PRC process kick in before the incident in 2011? Were you registering concerns prior to that that weren't being addressed?

JW: I know that prior to the incident itself, there was an OH&S in for a previous patient that had breached a door on the same unit, on our unit. It happened right before Christmas and nothing was done about it because it was at Christmas and there was nobody there to look into the incident.

Q: On November 21, 2010 you lodged a PRC.

JW: We had a patient that we had to put into a seclusion room. He had come to the nursing station, and at the time there was a nurse inside the nursing station and I was standing just outside and he was between us. He was very threatening, very paranoid. He had been brought in by the RCMP as well. He was disrobing in the community, and we're not sure what his history was, but a very unfriendly fellow. At the time, the two of us were on and the other lady was on a break. There was no way for her to get to the phone to call security and there was no way for me to move without him, like he was right there. We couldn't close the doors, we couldn't do

anything. Eventually he walked away out into the lounge, which gave us the opportunity to phone the police. I don't recall we even stopped at phoning security, we phoned the RCMP. They had come to get him back into the room, into the seclusion room. Out of that incident an OH&S was filed and I believe a PRC at the time. We have a red button that we can push that announces emergency assist to our unit. We used to only have one out where I was, but I was within no proximity to get it. Since that incident, we now have one within the nursing station for the nurse who's inside the nursing station to push. So that was something that had changed out of that outcome. But again another situation where there's only a couple staff on and in a situation where it could've went either way. I believe in the end he was discharged to the RCMP the next day.

Q: Has there been a change in the type of patients that are admitted?

JW: Yes. We are the only hospital in the north that is a designated facility. We're the only hospital north of Edmonton that takes all the patients that are certified under the Mental Health Act. If you're in any outlying community and are brought in by the RCMP and the doctor assesses you, he certifies you and then you need to be transferred to our hospital for assessment. We get everybody from the north that's exhibiting any type of behavior that warrants RCMP intervention or family intervention to bring them into the hospital. As I mentioned earlier, with the increase of drug use in the communities, that is a huge factor in a lot of patients that come through the door that are exhibiting aggressive behavior. But like I said, we're not sure what the underlying features are until that clears. But when they initially come in, there's a good 40 hours of time when they can exhibit extreme aggression. We're the only unit in the hospital that has secure rooms to house and contain patients to keep everybody safe. There is what they call a room downstairs in the emergency department, but it's not remotely comparable to our rooms upstairs. Often when they come in, there's usually a pretty quick transition if we can accommodate another patient to come right up to our seclusion room.

Q: It sounds like in 2010 there was an incident prior to that refusal. How long did the process take, from start to finish?

JW: A long time, at least a year I think by the time it went through all the appeals and discussions.

Q: And how long did it take for the resulting actions to be implemented?

JW: I remember that the peace officers were implemented in May; I don't think it was May of the same year. It was the following year I think that the peace officers were implemented as security in the hospital.

Q: How long did the doors take?

JW: The doors took a long time to come. Like I said, they were special doors and they came from the U.S. I think there were a lot of hoops they needed to jump through to get all that through. But we did finally get the doors, and like I said, they are pretty secure as far as magnet wise, about 5,500 pounds I think.

Q: What changes would you like to see?

JW: I think when there's a concern expressed the first time, I think it should be taken as seriously as if we were refusing. I don't think there should be a delay, or "we'll look into it," or "this person's away." There should be somebody allocated to look after these circumstances, and not have a delay in the response when there's a concern expressed.

Q: What support did you feel from management during this process?

JW: I would say I didn't feel support from management at the time, because it felt like. . . They brought in other people to do our care for the patient. In essence, by allowing the patient whatever he asked for, it just came across as if we were making a big deal out of nothing, which wasn't the case. Like I say, when we went through the appeal, just hearing other versions of what they felt was going on, like I said, I don't agree with what they were saying. And to think

that this is our work environment, it's the norm to have aggression and violent patients. It's not the norm and shouldn't be the norm that anybody be expected to come to work and expect a violent interaction.

Q: What kind of support did you get from the union?

JW: As I said, they were phenomenal in supporting as far as the decision making that "no, we're not going to look after him." And the follow-through, that year and a half or whatever timeline it took, and the money that it took to go through all those appeals. It was wonderful. Like I said, I felt very supported by the union as far as that goes, as far as having someone listen and say, no you don't have to come to work and expect this to happen; this is not the norm. It was very uplifting.

Q: Do you think it would've gone different had you not had the union?

JW: Absolutely. I think it wouldn't have happened, the right to refuse wouldn't have happened. A lot of people were scared of the ramifications. When they heard that there were nurses that exhibited their right, there were letters. It was like, "oh my goodness, this is my career, I can't lose my job." There was a lot of fear, and that shouldn't be the case. We shouldn't have to be fearful of losing our jobs to express our right to have a safe workplace.

Q: What was the role of CARNA and CRPNA, if any?

JW: They do have a role, but honestly I can't speak to that. I wasn't one that got a letter or anything, so I can't speak to what their role is.

Q: How do achieve work/life balance?

JW: Every time I went off on maternity leave I went back to school. I did my Masters Degree with my last child, and after having my last child, I was working permanent nights. Throughout my Masters Degree I did what they call a weekend worker. I actually worked every weekend –

Friday, Saturday, Sunday night – had my week off during the week, when I worked on my Masters Degree. I was paid full time, because weekends and nights are the most difficult shifts to cover for nurses. So I did that for a period of time until they revoked that, because they were paying me when I wasn't there apparently, so that was part of the reason that was their vote. Then I continued on permanent nights for 14 years, so for the entire life of my last child. I was available during the day, may not have got as much sleep as I'd liked to, but I was available during the day for the kids if they needed to get a hold of me. My husband travels a fair bit but he's in town a fair bit too, so we balanced between us. Him and I were like ships in the night. I'd get home in the morning when he was heading out the door, and then we'd have supper together and I'd head out the door to work. So it was ships in the night, which is difficult. I'd say that in the last ten years I really incorporated fitness into my lifestyle. I go to the gym every day, which I think plays a huge role in my mindset and my stress levels as far as how to deal with things. Then in the last year I did a total flip from permanent nights to Monday to Friday 7-3. My husband sees me all the time, which is like a new marriage. It's like, "who are you?" My daughter has never known me to not work a nightshift, so it's been a drastic change. So far, I think it's for the best. I think it works well. But definitely I was fortunate enough to have a permanent night rotation. I couldn't imagine bouncing back and forth from days to nights – that would be a lot more difficult I think. It's a balance, but I think you need to find something outside work and outside your family to also have a focus on, versus just be family and just be work. Work can engulf you, as in many occasions it does me. I like to see a job done and I like to see it seen through. Not always can I do that Monday to Friday in an eight hour day. I just need to remind myself that it'll be there tomorrow when I get there.

Q: Some say that union involvement can hinder your career. Since the right to refuse was invoked, how has management respected you?

JW: I've heard that as well, and that was part of my hesitancy going into any committees. You're a target as soon as you get involved and start speaking up. But I spoke up long before I was in a union position. I spoke up prior to that whenever I had a concern, so I didn't see that so much. However, there were times where everybody would be bringing it to me, so I'd be bringing forward on behalf of everybody else. I think initially it was kind of worrisome. "Why can't they

come and speak for themselves?" I was asked that. I said, "Well, because maybe they can't speak as well as I can and they just want me to bring this forth." I was just being respectful and professional in my communications to them, and I think over the years it has been a building relationship with most of the directors. I see them anywhere and they're saying "Hello" and "How are you?" – CEO and everybody. It's just a respectful communication. I'm not trying to be detrimental and I understand what they're trying to do; however, when safety is a concern, then that's something that everybody should be aware of and dealing with, not just management or just the union. We should be working together as a team to rectify that. It's all for the best interests of the patients.

Q: Do you have advice for those who might be facing something dangerous?

JW: I think to notify your manager right away that you are not comfortable in the situation. If it can be rectified at that level, that would be great. But if it's not rectified to the best that you feel, then definitely contact your union, if you have a union to contact, and try to resolve it. Be familiar with what your rights are. I think that's another big thing: that a lot of people don't know what their rights are under the Occupational Health and Safety with their right to refuse. I think if you make yourself familiar with what the legislation is, and utilize that to back and substantiate what you're saying, I think that'll be a benefit.

Q: Is there anything else you'd like to talk about?

JW: No, I don't think so.

Q: During the right to refuse, did management withhold any information about the doors from the nurses?

JW: I do recall something along that line, but not the specifics. I do think that one had more magnets on it than the other, or something to that degree.

Q: What happened?

JW: He walked onto the unit, he had a big smile on his face. He walked past the. . .
About a year later the same patient was brought back to the unit. It was a very brief admission. He walked past the seclusion room door that he had breached, and commented on how he had kicked that door open in the past. He also had, in the previous admission, I remember him calling me a name from, he related to me that I looked like somebody from a newscast or something. A year later he was like, "Oh it's you," and he used that name again. I don't like using the word trigger, but definitely he had awareness of what had happened and it brings it all back.

Q: You're still feeling the impact.

JW: Oh absolutely. I've never been assaulted on the unit in all the years I've been there. I'm very conscientious of my stature, where I am in proximity, and reading behaviors. There's only once since then that I was assaulted by a different patient, but nothing relates back to that specific incident. It doesn't compare. I don't know why it doesn't compare, because the physical impact that I had the last time doesn't compare to what we endured. I don't know what it is. I couldn't tell you what the difference is, other than that threat seemed harsher. I don't know.

Q: When he was readmitted a year later, was he put in a seclusion room?

JW: No, a year later there was. . . No, did he? You know how many windows have been kicked out of that unit, Dewey? You do that one. I do remember it, I do. See, I'm having post traumatic reaction.

Q: It's important that there was a psychological impact.

JW: I think when I say I was pushed by another patient and that aggression didn't impact me as much as the impact from that, whether it be psychological in my mind of what the outcome could've been, I don't know. But like I said, to be physically pushed up against a wall was traumatic but does not compare to that episode in 2011.

Q: Is the threat still there?

JW: It's there every day. Although peace officers are in place, we have personal panic alarm buttons, we have the red buttons and emergency buttons in two places now versus one place – there are things in effect. But you never know what's coming through the door. We have so many, like I previously mentioned, transient patients without known histories. We've had a lot of people come to us that have since been charged with murder, really severe charges. You think what could they have done here. The circumstance could've been a lot different.

Q: How do people go about refusing unsafe work?

JW: There had to be a lot of planning, because there were other patients we needed to look after. How are we going to administer their medications, how are we going to ensure that they get their meals? If they're not allowed outside, how are we going to monitor the ones that can go outside without hampering their stay? So there was a lot of planning went into that. I remember Roxanne calling me and saying, "Okay, this is what we're going to have in place. Do you agree? Would you feel comfortable if this is the case?" I remember saying "No, that's not enough; he shouldn't be there. It doesn't matter what you're going to put in place there, we can't contain him." I remember they hired two security guards from the community that were these big, I can't remember, they had a name for them, but these two big burly guys. I'm thinking, but what's that going to change? It's not changing the outcome that he's still not secure in that room. And they're going to do what if he comes out? Restrain him and put him where? In a room that we can't contain him. The outcome, they just weren't getting what we were saying as far as we can't contain him. It doesn't matter what you provide us to make us safe if we can't contain somebody. That's the purpose of the rooms.

Q: How was the right to refuse put forth to the employer?

JW: I don't remember. I know that Roxanne was in charge of all that.

Q: Did you ever get a report back? As part of the work refusal process, the employer is supposed to do a written report and give it to the workers. Did you ever see the written report?

JW: I don't recall ever seeing a written report of the refusal, no.

[END]