United Nurses of Alberta

Alan Besecker

AB: My name is Alan Besecker. I work at the Cross Cancer Institute in Edmonton.

Q: How many years have you been working as a nurse?

AB: I came to nursing late in my career. I started nursing school when I was 40 years old, so I've been nursing for 17 years. Entirely at the Cross, my entire career was there.

Q: Have you notice some workplace changes over the 17 years?

AB: Yes, huge changes. Certainly cancer is growing, so there's more cases. We've seen a huge expansion as far as the programs. We've also seen, as everywhere else, kind of a staffing crisis and increased workloads. Patients are sicker. When I started in 1990 we had 77 beds at the Cross Cancer. As of right now we have 44. You have much sicker patients in the hospital, and therefore sicker patients in the out-patient department and all areas of the department. So that's the biggest change we've seen.

Q: In other areas, it means that they kick them out the door quicker when they start to get better. I guess this wouldn't be the case with cancer.

AB: It is. We do, because we have 44 beds, but we treat 2000 people a month. The majority of them do fine, they're walking in and they're walking out. But certainly the ones

that end up in the hospital are more acute. The treatments have changed somewhat, so the treatments become more acute too, in a sense. They're sicker and stay there longer than when I first started.

Q: Do you deal mainly with patients who are staying in the center?

AB: For 15 years I worked on the inpatient unit, but the last 2 years I've been in the out-patient unit, so I deal with relatively healthy patients that walk in and out on their own. The occasional wheelchair, but that's really as limited as they are.

Q: How does that impact the patient and you?

AB: The impact on the patient is you don't get to spend as much time with them. The impact on staff is that you're busier. I really think that when I first started there 17 years ago we had some flex in the system. If we had people that were having some mental health issues, maybe a bit burnt out or some struggles at home, we had enough flex that we could keep them at work. We could take over some of the workload, we could realize that as a team. Okay, Jane Doe needs a bit of help this week, and we'd get her through that. We don't have that capability anymore, because you're just flat out with the work-load you have. So those people end up off sick, that's one thing that I see sometimes. You're just tired, you're physically and mentally more tired than you ever were before. I think impacts the patients as well.

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We want to nurse the person, their whole physical and mental state. But it's also their family's physical and mental state. Not having that time to indulge those things, because that's the first thing that has to go. You need to get the treatments to the patient, you need to get the medications to the patient, those basic nursing skills. But the psycho social part of it is the part that falls apart. Having said that, we've done some things to add continuity to the care. When I first started we didn't have a discharge nurse and now we have a discharge nurse, so that's been taken away from the nurse on the floor. There's some extra staffing things that have been put in place, but still the intensity of the work has in 15 years increased close to 100%. It's that much different for me. That's where people get hurt, people get burnt out. You don't have enough staff so you try to lift somebody on your own. You still try to do all the nursing care that you want to do, but you don't have the staff, or you know they're so busy that you do it on your own and end up hurt.

Q: What's UNA's role in trying to address some of those issues?

AB: I think it's a difficult role right now, because there is acknowledged staffing shortage. So we've been trying to push for them that it's the retention that matters. The recruitment could take care of itself. Over the years that I've been there we've recruited enough nurses, but we haven't kept them there for a variety of reasons. We, through our labor management and professional responsibility committee, at our local push for added education, particularly in the first 6 months of a new nurse's career at the Cross. That's when they seem to be the most overwhelmed. Also to look at the working conditions, which is a variety of things. It's management style, it's openness, it's respecting the nurs-

es, it's hearing them and following the contract. We've had to file grievances in the last couple of years because they haven't given vacation on time or done Xmas staffing on time. Those parts of people's lives, when you're working shift work, are so important so you can plan some family time and have some balance in your life. Those are the things we've been pushing, and staffing to a certain level. We've always felt that we recruit enough nurses, we're not retaining them. One year we kept some statistics. In May and June we oriented 45 people, but by October 1st there were only 5 or 6 of them that were still working any kind of regular hours at our place. So it was a huge loss and a huge cost to them.

Q: How do we get new nurses to understand and use PRCs?

AB: I think it's just mentoring them. We're a relatively small hospital with 44 inpatient beds and roughly 100 nurses. So a couple individuals can do a lot of educating and teaching on the unit while they're working, and show leadership. I think that's what we need to do. I think recently we've neglected it a bit because of a sense that it's always staffing, and we realize we don't have the staff. To fill out a PRC about staffing gets very frustrating, because they don't have any answers or any possible solutions. We were talking recently and we'll get back to that, because I think we need to push it a bit better. There's certainly management styles and some other important, almost basic respect and common courtesy, outside of the collective agreement that they could do to make a huge difference. Young nurses, if a manager gives them a hard time and pisses them off, they're gone because there's a job across the street, there's a job in Calgary.

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Q: How can mentoring be done, with the understaffing problem?

AB: We have to make it a priority. People have to be freed up to do that, whether that means to the drastic point of closing a few beds until you have the proper staff. Particularly in that first 6 to 12 months. Cancer oncology is a breed of its own, but if people like it they stay in it. The important thing is to keep those people. Some people it's not going to suit them, and that's fine. They can go on and there's lots of other options. Hopefully our new collective agreement will help. There's some options around there as people have 70 factor towards retirement. One day a week they can do a project. They can write a proposal around a project, so hopefully there's some there. I think the education departments that were decimated in the Klein cuts were the first thing to go, because it's not direct care. They need to be built up and replenished. The in-house education, the education staff at the cancer board. And they need to make people available on all shifts. The educators can't work 9-5 Monday to Friday we are a 24-7 hospital. The majority of the in-patient staff work shifts. There's 5 shifts, there's 21 shifts in a week. One quarter of them are Monday to Friday and the rest are shifts, and you need support on those almost more. Monday to Friday you've got 2 managers and a lot of experienced charge nurses, and you've got a discharge nurse and a chemotherapy nurse, so there's all kinds of extra support there. As soon as you walk off there at 3 o'clock it just changes and there's no support left. I think some things around that, but it's going to take some resources.

Q: What are the provisions in UNA around paid educational leave?

AB: We just negotiated in 2001 and I think it's a recent thing. We get a minimum of 3 days a year paid educational leave to go to conferences or whatever you consider of benefit to your career. It's a minimum, so probably okay. Everybody gets that, whether you're permanent or casual, at each site. So if you're working at 3 sites you'd get 3 times whatever. But it's the day to day support, when there's new drugs, when there's new protocols, when there's new machines, those types of things that it's lacking. It would really help people, particularly when you're new and there's this huge curve of knowledge that you need to do. You've got drugs that you've never seen in your life, and dealing with them. You've got very complicated patients in a complicated medical situation. Then you introduce a new chemotherapy drug or a new way they're giving it, and you don't have a lot of support. Particularly when you're new on it. As you get more experienced you can figure it out, but those kinds of help we could really use. It really needs to be done off on shifts. It may be a time you could do it. Sometimes on weekends there's a little extra time you could have a mini workshop. I think we need to be creative, maybe a bit more labor intensive from the education point. Maybe we can't get 12 people at once, maybe it's going to have to be doing it to 3 people 4 times in the day to get the 12 people, or get some coverage somehow.

Q: That's on of the ways people can feel they're growing.

AB: Ya. The Cross Cancer Board actually has an online oncology certificate course that they've piloted and developed that people can take. At the cancer board we also do have a

tuition reimbursement program, and I'm not sure of the details, but it's approximately $750 a year. That's about what this course costs; it's a 3 credit university course. So there is that availability as well. We have a small education fund that you can attend conferences as well, plus those 3 days. So I think is it enough, probably not. But is it adequate, probably yes.

Q: Can you thing of memorable achievements in your history with UNA?

AB: I'm going to give you one that you may or may not have heard. When I first started with the union I was a member of the staff nurses association of Alberta. That was the University Hospital, the Alberta cancer board, and a bunch of rural community health centers. To me the most significant thing was the merger of those 2 organizations about 10 years ago. That was something that needed to be done, because we were getting played off on each other. I was on the board of the staff nurses association at the time and a promoter of that, although not always the easiest thing to do. To me that's probably the biggest accomplishment, individually and organizationally.

Q: That was an important step. You must have felt that.

AB: Yes. We'd had a couple of false starts and they were very disappointing. Maybe you needed to do that, because there was cultural differences and all kinds of differences. That was great. We took some of the best of both organizations and made it that much stronger. United Nurses of Alberta had a very organized organization. We were smaller. We were a bit more involved in extracurricular affiliations. We had been a member of Canadian Fed-

eration of Nurses unions, United Nurses hadn't been so after the merger they did eventually join in the Alberta Federation of Labor and stuff like that. The merger and then the outward reaching to the other organizations are the things I'm most proud of. I sat on the negotiating committee in 2001, which was just a great round of bargaining. But I think that happens anyway, whether I or somebody else was on that committee. Not that it wasn't a lot of hard work and we're not good bargainers, but I think those kind of things happen. I think some of the outreaches are more important.

Q: What was gained in that contract?

AB: Certainly the 3 professional development days that we mentioned earlier were there. There was quite good pay increases, there was extra vacation days for people with 25 years of service or more, an increase in benefits. Those are the main ones that come to mind. And a large salary increase, because we were just coming out of that. I think the overall compensation in that deal was around 30%. It was a huge increase, but we were just coming out of the '90s, so it was way overdue.

Q: Why is it important that UNA reaches out to the broader context?

AB: I sit on the executive board of UNA, and it's been an honor to do that. But in the scheme of the world situation, I really see nurses as a privileged group. We have an excellent organization that is well respected and I think powerful in a sense. So to me you're only as good as bringing the rest of the world up to your level, and I think you do that through affiliations and through the associations in the community that you build. Not

that other unions are poorly paid. Some are, but everything that the union gains gets passed on to the regular citizens of a country as well. The interest in the union to me is the basic human rights issue, whether it's not getting paid properly at work or whether it's being discriminated against or whatever. Only by reaching out can you have an effect around the world. It's very important that we support friends of medicare and those types of organizations, and keep the healthcare system public. Very important that we support Parkland and the research that they do, because you need an alternative, in this province particularly, and just some new ideas. Very important that we support codev and the stuff that they do in Nicaragua and those things. It's equally important that we support the other labor organizations. We have the resources to do that and we need to do that. People that are making $40 an hour, and the dues that we have, we have a lot more resources than unions that have people that are making between $10 and $15 an hour. I feel like we have to suck it up and pay that, and I think we do a good job of that, or at least we have since we've joined these affiliations. But it's really important to do that and it's important that we pay at least our fair share in the other organizations as well.

Q: Why is it important that UNA support public healthcare?

AB: I grew up in the U.S., so coming here is great. There's a couple of things. I'm going to go back to the human rights issue first, because I'm involved in the union because of basic human rights. It's a basic human right to have accessible healthcare for everybody, not only for the people who can afford it. Then I'll just go back. When my parents were 80 I was curious what they were paying for healthcare, because they're covered by

medicare in the U.S. My dad had a good benefit plan through his work pension. I said, what does it cost you yearly for your health insurance? They said $12,000 a year on top of the coverage. Public healthcare is a fair system that treats everybody the same. When people walk in to the cancer institute they get treated the same. Some of them will try to pull rank, but they go through the same process to go in there and they go through the same meetings with the doctors and nurses, the same education as everybody, whether they're a doctor, lawyer or somebody off the street. They have the same options. To me that's the fairest way of assessing a community. It means so much. That means a lot to me as a Canadian, that we do that, because a lot of other places don't do that, particularly the U.S., which I'm most familiar with. You don't go to the doctor unless you have to, and then you're real sick, and all kinds of other issues come out of that. From a human rights point of view, which I bring to the union, public healthcare is the essence of that.

Q: Anything else you want to talk about?

AB: I look at being a nurse that we're respected in the community. We're up there with the highest people as far as respect. That adds a responsibility to us. In our profession we're supposed to be patient advocates, but again we need to advocate for everybody in all situations. I think United Nurses is becoming better at that. Going back, I think that's what the affiliations have done. It's really broadened us and increased our awareness of diversity, increased our awareness of all other types of people in need. I think we need to just continue that. We have a very strong organization, right from the grassroots up. But as we were talking earlier, there's a couple people here that aren't totally convinced about

public healthcare, so there's still work to be done and we can't stop doing that. We have to continue educating and being involved and being seen, and making this place a better place to be and live.

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