United Nurses of Alberta

Barb LeBlanc

BL: My name is Barb LeBlanc and I work at the University Hospital in general systems ICU. I have been-- I just had my 30th anniversary, so 30 years in August.

Q: What changes have you seen over that period of time?

BL: Probably the most thing I've seen change is the acuity of the patients. The patients that we used to get when I graduated: on a 42-bed ward there'd be 2 of us on nights and we were able to do the work quite okay. Now you probably need, for the same amount of patients, you'd probably need 5 to 10 nurses, depending on the acuity of the patients. How much acuity has changed over the years is very significant.

Q: Is that because they're released before they've totally recovered?

BL: Years ago they used to keep patients just to do tests and stuff, and that very rarely happens anymore. The acuity is we move patients out of ICU to take somebody sicker. So they're sicker when they move out of ICU and we take sicker patients in again. So the patients that are going out of ICU are sicker on the floors. They're taking longer to recover. So it's just sort of this cycle of sicker moving. They're better than what they were before. But now they're moving out into an area that is taking also sicker patients. Every place you see they're sicker and sicker all the time.

Q: What changes would you like to see happen in this situation?

BL: The biggest thing from my perspective is there needs to be more long-term care beds. That seems to be one of the big bottlenecks in this system. The units can't take patients from ICU because they've got lots of long-term care patients waiting for beds out in the community. If we could have more long-term care beds to move people into, then we would be able to keep patients a bit longer so they're a bit healthier hopefully, and move them out when it's more suitable for them to be moved out onto the floor. The units then wouldn't be as heavy, plus there'd be beds for other people to come in. And there needs to be a system to move people efficiently between all the different areas when they come in. In my experience, that's not something that's totally worked out yet. We do have systems in place but they don't always work, and there's no real explanation of what you do when it doesn't work. It's just sort of you're left sitting with this problem that you can't deal with.

Q: In your workplace are you experiencing an overflow bed situation?

BL: That happens as well in the hospitals in Capital Health. We call it the full capacity protocol. When emerg is full, then they have made 26 or 27 spaces available to move people into. Those spaces are stretchers that are put into another room with 2 or 3 other patients. It's not that they were planned to have beds in there; so there's sick people on stretchers between 2 people, 2 men, or 2 women, or whatever, and another one is moved in there. The beds that I've seen, you can hardly even move in the rooms with that extra stretcher in there. If they need help to get up, then you've got to move the beds over. It

looks terrible, plus laying there and looking at somebody eye to eye that you have no clue who they are.

Q: What's UNA's role in changing that picture?

BL: I think probably the biggest role is nurses being aware of what they can say no to and what they can do. Not necessarily say no to, but that they have a responsibility to report areas that they feel are unsafe. The professional responsibility forms are what they need to do. That raises the issue. We had an issue in the unit that I work in, that the administrator of the hospital said, I've never heard about this. It hadn't been moved up. We'd been talking about it lots but it hadn't moved from our management up the system to her. . . .

We had an issue in our area and it was about the number of staff that we have. Our unit has about 40 positions, depends on what day of the week you talk to somebody. We still were open to 30 beds and we were trying to staff for 30 patients, which we were normally full. We didn't have enough staff so we were always running short, and it became very unsafe in that there was one nurse that was looking after four ICU patients during breaks and things, which in my opinion is not safe. If they're in ICU they're there for a reason and you can't leave one person with four people who are considered very ill. We had talked to our managers about it, but when it finally got to talking to the administrator of the hospital, she said she'd never heard of the issue before. It was like, well where did it go, who has been dealing with it? So PRC forms are one of the only ways that we were able to document to say, this is what the issue was, this is what happened in this time

period, this is why I feel it was unsafe, and this is what I think we should do about it. So that was one way. We were able finally, for several reasons, to be able to close some beds so that we could staff somewhat more appropriately. We're still short, but it's much better than it was before.

Q: When you first came into nursing, did you join SNA because they were with the university?

BL: Yeah, both UNA and SNA were basically formed around the same time when the split from AARN happened, that the collective bargaining areas pulled out. At that time the staff at the University Hospital decided they would stay on their own. They were under provincial legislation at the time; so it was a little bit different. The Foothills was, and there were a few other hospitals that were as well. The University, for whatever reason at that time, decided they would stay on their own. So that's where SNA started. They stayed as a separate entity until 1997. I was the president from 1986 to 1992. During that time there had been a few little discussions about should we join or should we not. We'd taken 2 votes when I was around as to whether we should join. The nurses still decided that they wanted to stay separate. At that time, I guess it depends on how you look at it, they felt there was advantages to it, but there's also disadvantages to it. They felt the advantages outweighed the disadvantages. There were 8 locals. When I was president there was the University Hospital, the Alberta Cancer Board both north and south, and 5 health units from all over the province. The reason that we started look at whether we should amalgamate with the UNA is we're talking the same things. We're

talking about nursing issues; so why duplicate things? It's better to have a bigger group talking about it. You have far more strength in a bigger group than you do as a smaller group. At times it was good to be a smaller group because you could do your own thing. It was much more amenable to talking to the president of the hospital at that time. This was also before the regional health authorities came in that I was around. It was easier to deal with individual issues within each organization on a smaller basis, which now they still can do but it's through the local president. It's a different structure and probably better, because you have far more backup than you did before. I think it was still a learning process. The whole union title was something that a lot of people were still really hesitant about doing. We were an association. So they felt that we weren't a real union. If it's a duck and it looks like a duck, it's probably a duck. It was sort of an education process in getting people to realize that it's the name of an association but it's a union. We act like a union; we do things that unions do. They do things that unions do; so let's get on with it and start move towards being a true union. I think, I hope that's what I started when I was there. Then afterwards it carried through and we all became one.

Q: Do you have memories of particular gains that were made through UNA?

BL: Probably one of the things that I remember the most was in 1988 when UNA was on strike and we weren't on strike. That was probably one of the most difficult times in my career, and certainly as president of the union. I felt so divided between I want to support UNA because they're doing things that we can't do at this point. We could've illegally gone which they could've as well, but we were at a different time in bargaining as well.

So we weren't at the same place as them. Our hospital became one big ICU area. We had patients on ventilators in the hallway. It was awful, it was absolutely awful, yet it was the one thing we could do to support patient care and support UNA at the same time. That was probably the thing that I remember most vividly. We certainly talked to UNA; we donated money to them; we went out and picketed with them. We did things that we hoped helped. We eventually did get a meeting with Premier Getty. I don't know whether it helped or not, but I know that they used us. But it was just to have them hear, this is what the concerns of nurses are. It doesn't matter whether it's UNA or SNA: these are the issues. They're dealing with the same issues we're dealing with. I say I know they used us because it's like, these are the good girls who aren't going on strike. If we could've done something different we would've I think. So there was a little bit of that. That was just one of the things you had to let go of and say, okay well we need to do what we feel we need to do to get this moving and to get nurses feeling that they're valued and that patient care is going to be delivered.

Q: How can you wind down your career without going cold turkey?

BL: That's a good question. I don't think enough has been done in looking at that. There are so many experienced nurses who . . .

This is one of the areas I know we haven't looked at enough. There's so many experienced nurses who have wonderful qualifications in doing other things, but we don't have a process for moving people into other areas and moving somebody else someplace else. There has to be a balance someplace between the rights of people who already have

jobs or if there was vacancies then maybe save a few positions for people who have experience or are old like me, and move them into an area where they can maybe not do as much lifting and things like that, but they still feel valued and they still are providing a good service to the public. The new nurses coming in--in the area I work in there are new grads coming in. They have a 6 week course and then they're buddied with somebody for a period of time before they're on their own. The unit that I work in, we run the codes. When the Mazankowski hospital opens up, we will have 2 nurses dedicated to codes. We run a medical emergency team out of the ICU as well. There's been a lot of people--we're down 40 positions. So there's a lot of seniors who have left and there's a lot of juniors who have left. The seniors who are left end up with the sicker patients. We run continuous dialysis. We run intermittent dialysis on our own patients. You have to have been there for a while before you can do those things. We've got 4 to 5 senior nurses per shift who are tied up doing other things; that I don't think we're able to mentor the junior nurses as much as we should. Our beds are set up so there's 2 on one side and 2 on the other side of the hallway. At times you can end up with 4 junior nurses in that one area. They're all floundering. They can call the charge nurse, but with 26 to 30 patients and you're trying to cover everybody and make sure things are done, and do the things that the doctors want, it's really difficult to be able to still go to the juniors and say, how are you doing, is there anything you don't understand? We're not able to give that mentoring that they need, and you can't teach everything there is in the period that they are orientating, because different things happen all the time. You give them the best you can at the time, but I feel really badly that we can't continue on that mentoring system, or we

don't whether we could or not. I'm not sure. But there are a lot of nurses who are leaving; they come and they're there for 6 months. They've had all this training and just say, I don't want anything to do with this place. It's so overwhelming at times. That happens on the units as well; it's not just ICU that that happens. A lot of them are overwhelmed with the responsibilities. They can have 6 patients out on the floor. I don't know if I can look after 6 patients anymore because I've been so used to focusing on one and two. It must be absolutely terrifying for some people. The supports are not there that need to be there.

Q: There needs to be a built-in structure that acknowledges that time you need for mentoring.

BL: Yes. And a lot of the senior. . .

There should be roles such as the mentoring part. If somebody came in 3 days a week or whatever worked for either side, and just said, okay I'm going to spend a day with you and let's go over a few things and look at what you're doing as far as standards of patient care and things like that. Are you doing everything that we need to do? A lot of our patients, we give them lots of fluids to keep their blood pressure up. But then they get boggy and their skin breaks down much easier, so we try to turn very frequently to keep patients from getting bedsores. There's no one following up to see whether or not they understand what the rules are. Not rules per se, but what is expected. It's only been very recently, within the last month, that I've seen anything that says this is what the standard of care here is. We've always had a standard of care but nothing has been given to anybody saying, this is what we expect of you. When I saw it, it was 8 pages long and it

was like, oh my God, I don't think I can do that. It's great to have those expectations but is it realistic what we are expecting anymore?

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ICU can be so intense at times. I'm not saying that other floors can't. That's just my experience where I worked for 25 years; so that's who I am. It can be so intense at times, but it's usually short-lived. It can be for a day or whatever. You don't get breaks; you don't get anything; all you do is work on your patient that entire 12 hour period. You don't get to have a down period in there. So when you go home you're still this high off the floor, and then your family wants you to deal with them too. It's like, I can't deal with you right now. I need time to myself yet. You need to find that balance in there. When you're that focused on one thing for so long it really wears on you until you learn how to. I live 5 minutes from the hospital. That's my downtime. That is when I say, okay I gotta let this go; I work through things; I have to let it go before I get home. But it takes time to learn that and to be able to say, okay I gotta switch now from being the nurse to being the mom, wife, whatever, and leaving that and letting it go. But it is difficult. The new nurses coming in, when they're put into a position like that and you don't have very much support to help you do that: it must be absolutely terrible for them.

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One of the benefits of ICU is you've got a lot more supports than they do on the floor. That is one thing. We always have a resident around; we always usually have a staff member around. There are other supports that we have as well. So that is one of the benefits of ICU. If I need somebody, they're there. I've got 3 to 4 people in the same pods

that I can say, okay, get in here now. Whereas on the floor you may have 5 nurses on the floor, but they're spread out so far that it's not as easy to get the help that you need.

Q: And you're also under stress that the choices you make have maximum impact.

BL: That's true. We are to a point allowed to make certain decisions, as far as interventions and things. But that comes with a price to it too. You make the wrong decision, it's… I don't think I've made a wrong decision, I hope I haven't but I don't know. Not that it's been that blatant.

Q: What is UNA's role in advocating for universal healthcare?

BL: You may not want to use this, but I come from Saskatchewan, from Weyburn where Tommy Douglas was a minister. My uncle was a very good friend of his. So that has been my whole philosophy for all my life. I don't think of anything else different. There really needs to be a, I won't use the socialist word, but there needs to be, I think any country needs to have some basis of a minimum of care that is provided to people. We pay taxes. I disagree with those taxes going to everything else other than healthcare. I think we have a responsibility to help look after each other, to make sure that everybody at least has some minimal basic available care. When you get up into transplants and things like that, those are decisions that have to be made at some point. My mom had a transplant; so that was part of where I came from too. She needed it. So it was provided. But there are levels. I'm not saying this right. I guess my basic premise would be I believe that we should have a responsibility to help look after each other. As a community, whether it be

your block that you live on, the city that you live in, the province that you're in, the country that you're in, I think there's a responsibility that should be there to at least give people what they need in order to stay healthy, or as much as we can to help them stay healthy. They make their choices, but if the basics are there that if they choose to they can be healthy, then I think we should provide that.

Q: What do you think of Saskatchewan paving the way with pharmacare?

BL: I think it's absolutely fantastic. One of the biggest things that I hear about. . .

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Q: Saskatchewan is talking about introducing pharmacare. Do you think that's an important initiative?

BL: I totally believe that is a very important issue. I think there needs to be more federal direction in what needs to be done. Provinces need to have autonomy. I don't question that. But there needs to be some direction, at least from the federal government to say, okay, these are the things that are going to be covered; you guys work it out how it's going to be covered. So the basics of healthcare would be there; the basics of pharmacy would be there; dental or whatever they choose to put into it would be there. The drug things, a lot of the people who are amongst the sickest are the ones who are having to put out the most money for drugs beyond any plans or anything that are out there right now. And they're the least ones who are capable of doing that. It seems we've got a total reversal of what it should be. If somebody has MS, they need extra drugs, or cancer or

any things that are very costly drug implications. We don't help those people. So how do we expect them to get any better if they can't afford the drugs? That then adds another burden onto healthcare, because as they get sicker then they come into hospitals or they are at their doctor's office more often. So I think we need to have things in place that they have the opportunity to get the drugs that they need and get themselves into a better state of health.

Q: Are there any other things you'd like to talk about?

BL: Not that I'm aware of. My history was I grew up in Saskatchewan. So I grew up in a very… my family was NDP for years. I don't necessarily vote NDP now all the time, but that was my whole upbringing was the socialist thing. That's a lot of where my values come from. So coming into the union perspective, it was very easy for me to do that because that's who I am. It's certainly not an easy job and I admire Heather tremendously for the job she's done over the years. And Margaret Ethier before that too--both of them have been very courageous and very exemplary leaders in showing what nurses can do. We have a lot of power. We still aren't using it to the potential that we can, and we need to be able to look past the small things and look at what the role is. Where are we going and what can we do along the way to help others? That's what we're here for; that's why we're nurses is to help people. We gotta start with helping ourselves first. If we can't look after ourselves then we can't look after other people. I think we are doing a good job at that so far, but we've got to do better.

. . . Nurses control the system. If there's no nurses, healthcare will not happen. Doctors' office can happen, but anything in a hospital will not happen. There's no one else to take our place. So they'd better be nice.

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