United Nurses of Alberta

Jerry Macdonald

JM: I work in Peace Country Health centred around Grand Prairie, and I'm actually in a somewhat different position than many nurses. I no longer work in a hospital. I work in a chronic disease management program. My primary responsibility is cardiac rehabilitation. I see people who have experienced heart attacks, surgery, that sort of thing. I look after trying to restore them to a state of wellness in the longer term.

Q: Is that associated with a particular institution?

JM: Peace Country is the regional health authority. My office is in Grand Prairie because that's where the referral center for the region is, which is the Queen Elizabeth II Hospital. I've been doing this job not quite 2 years, and before that I was an intensive care nurse at the QEII for 17 years. During that time I served on the executive of local 37 at the hospital for many years, including as president for 3.

Q: So you've been nursing for how long?

JM: Graduated in 1985.

Q: What changes have you noticed in the profession?

JM: The amount of change is enormous. There has been change in the workplace in terms of the way the workplaces are organized. There's been changes in the patient or

client population, the intensity and acuity of people that we're seeing. Changes in management structure seem to happen every 6 months. I joke around that managers' office doors ought to have whiteboards on them so they can change their title every 3 months instead of having to make a new sign. The amount of organizational change is breathtaking, and it's very difficult to keep track.

Q: Is there also a tendency now for managers to come from outside of the nursing profession?

JM: We are seeing more of that. For example, in our organization we have one or two unit managers at the QEII who are from non-nursing professions. I think one's a social worker. We have some middle management positions in Peace Country Health which are not nursing. One's a respiratory therapist by profession, but the vast majority of the people that report to him are nurses. Another is a social worker in middle management responsible for women's and children's health. Yeah, there's a lot of that, going outside of nursing. There's nothing wrong with that, but when you look at programs that are predominantly provided by nurses of one sort or another, not having a nurse overseeing that process who understands the responsibilities of nursing I think is a bit problematic. When you have a program that is more multi-disciplinary, and has a lot more involvement from other areas, that's probably more reasonable. One of the things about nursing I remember being told that when I was a student, is that we are the jacks of all trades and masters of none. We know a little bit about many things but we don't tend to be experts on physiotherapy, for example, but we know a little bit about it. We don't tend to

be experts on medications the way pharmacists are, but we know a little bit about them. You have to be. We're there 24/7; at least those of us who have worked in hospitals are there 24 hours a day, 7 days a week, and all those other people go home. You have to know something about everything, from dietary to diagnostic imaging.

Q: And you can be called back to work after only 2 hours of sleep.

JM: Yes, and that's one of the drivers of the form of turnover that the health regions don't track very well, in terms of staff. What they do track is separations from the organization. But when you have a regional health authority that covers all facets of healthcare within a large geographic area, you have to actually leave the organization and go work for Safeway or move to Timbuktu before they consider that you've resigned. But when you have nurses leaving high stress high intensity high complexity acute care environments to go work in totally different areas – homecare, community health programs, chronic disease programs like the one I'm in, continuing care facilities – it's a form of turnover that they don't track, because it's internal. But it's still a symptom of something, because people are deciding that the stress is too much for them and they're sick and tired of being phoned at home for overtime on their days off over and over again, and they don't want to do it anymore. That's one of the reasons that when the position I'm in came up, I looked at that and thought, that looks like it would be fun; it looks interesting, I'm going to learn a lot, and I'm going to get away from the 5 storey brick pressure cooker, that is the Queen Elizabeth II Hospital.

Q: And there's a high attrition rate of new nurses. How do we get people to stay?

JM: That's been an ongoing dilemma. When I was a nursing student over 20 years ago, one of the things we talked about in the closing months of our education program, and I went to a hospital-associated diploma nursing school, one of the older style schools, not a university or college--but one of the things they talked about was reality shock, that transition from education to the workforce can be a major shock for a brand new graduate nurse. I don't think that system-wide we have done a very good job of addressing that. There's been a great deal of, it's not my responsibility, it's your responsibility, and back and forth. For many years the educational side of nursing, the nursing schools or faculties of nursing now in universities, have been advocating for employers to take much greater responsibility for mentoring for internships, for bringing new nurses into the workforce in a smoother transition--whereas the healthcare system wants nurses to graduate from nursing programs who are ready to hit the ground running. That lack of communication between the two sides is astounding in that it hasn't been resolved after all these years. This is the same stuff I heard in the '80s. It's nonsense; it shouldn't be happening. There should be a lot more coordination between the two. They're both publicly operated services. It's not like we're talking about two corporations that don't want to talk to each other. The healthcare system is funded by the taxpayer and the higher education system is funded by the taxpayer. They're both provincially regulated, provincially delivered services in one way or another and they need to work better together. It's ridiculous.

Q: A lot of the learning isn't structured.

JM: That's one of the challenges. I remember being told once that nurses eat their young. Having now been a senior nurse, having over 20 years in the profession, although I tend to be very supportive of learners, I understand where some of that comes from. A learner is an increase in your workload, especially early on in the learning. Later on as they start to learn, they start to actually take up some of your workload for you and you can sit back and relax and watch them do. But early on a new nurse is a burden on their more senior colleagues. Everything takes longer to do; you need to stop and teach. If your workload isn't adjusted by management to allow you to take the time, you're going to get stressed out and start to snap. Rightly or wrongly, you're going to be not very supportive of that individual because it's too much. You can't do both jobs at the same time. You can't do all of your own work and help them with theirs, because you're already stretched to the limit when you look at the hospital setting, which is where the workload issues are the most acute and obvious, those and continuing care. I remember when I was a student, when you went to a surgical ward, a post-op general surgical ward where you had people recovering from abdominal operations and leg operations and whatever, 30 beds, a certain percentage of those beds were people who were 3 or 4 or 5 days post-operative, were recovering, getting better, convalescing, getting up and around. Their actually physical care needs tended to be less. You had fewer people who were in that more acute early stages of recovery, who were still unstable and needed their vital signs checked more often, they had IV's, that sort of thing. Now in today's workplace, all those more stable people who are convalescing are gone; they're home. Every bed is high acuity. The number of nurses hasn't changed from what it was 20 years ago. The paperwork

requirements are higher. New requirements for accountability, for documentation of care. Accountability in terms of fiscal accountability, material accountability, filling out forms for everything just to get a box of pencils, all that sort of nonsense. Computers. They're a wonderful thing but they have not integrated into the workplace very well in healthcare setting. One of the things I remember some information technology experts saying is that computers need to be made to fit the user, but in healthcare the users are being shoehorned to fit the system. It's not conducive to getting our work done in a timely fashion. We spend far too much time waiting for the stupid thing to start up and log on, and there's no time for that. There's so many time pressures. They're just running around hither and yon. You've all seen that poster that hangs from the ceiling: if you're up to your ass in alligators it's difficult to remember that your initial job is to drain a swamp. Well those nurses can't drain a swamp.

Q: Would you say this workplace pressure is creating unsafe conditions?

JM: Of course, of course. You are so busy just keeping up with that list of tasks that needs to be done, answering a call bed or giving meds or doing a dressing or picking granny up who fell out of bed. It's difficult to step back and really think out what needs to be done in order to make your patients safer. People have to take shortcuts. If you did everything the way you were taught in nursing school, you would never get your work done in the course of the day. Patients would not get care, period. You don't have time for a 30 second hand scrub after every single patient contact; there's just no time. That's one of the reasons why they put all those little instant hand rub gels in the facilities. But those

are not 100% effective. There's certain bugs that are starting to emerge that are resistant to those things. So you have to go back to soap and water, and soap and water takes time. Of course we should always wash our hands after every patient contact; that's obvious. That's the most important infection control measure we can take, and it's one of the infection control measures that's been advocated by the health campaign and that sort of thing. But you can see the challenges in actually making that happen. If you're in the middle of washing somebody and in the next room somebody falls out of bed, are you going to stop and wash your hands before you go and pick them up? Probably not, because there's nobody else going to pick them up. They haven't adequately provided for break coverage. So your colleagues are all gone for lunch, and you're it. That's just one small example, and it's pervasive throughout particularly the acute care system and facility-based care, like your continuing care facilities and nursing homes, many of which are in the private sector and are barebones staffing. They're lucky to have any regulated nurses, RNs or LPNs, on a unit of 50 residents. Just this past week we had some rather alarming footage on CBC's Marketplace about resident safety in long-term care facilities. Residents who are mentally ill because of dementia and other conditions are beating each other up, and there aren't enough staff to protect them. There's not enough facilities to protect them.

Q: What is UNA's role?

JM: United Nurses of Alberta is an advocacy group for nurses. We have gone beyond the usual role of a trade union in negotiating wages and benefits and work schedules and

things like that. We feel as a union representing accountable professionals we have a role to play in making the workplace safer. There's a fundamental tug of war for a registered nurse between their duty as a professional accountable to their professional college for safe patient care and quality patient care, and their role as an employee of a healthcare organization to basically do what they're told. There's an old fundamental principle in labour relations called the master-servant relationship. When you're an employee, you're not supposed to question management's direction, whether it's staffing or policy or when to go for your breaks. It's your job to do as you're told and if it's not appropriate you file a grievance. This union does not see that as an appropriate role for representing nurses, because we have a professional responsibility to our patients. So we want to protect our members' ability to feel good about the nursing care that they provide. We have such mechanisms as the professional responsibility committee. A number of other nurses' unions within the country have similar provisions, where ordinary rank and file nurses, regular employees, can challenge management decisions on staffing or policy or any management decision that impacts patient care or quality of care, and have the union back them up. You can challenge those decisions up the chain of command, ultimately up to the board of trustees of the health authority, which is the ultimate accountability for any health region.

Q: The newer nurses need to understand that.

JM: That is a challenge. But some of the locals of the union are very effective at doing that. For example, my colleagues at the QEII, because I stay in touch with them

obviously; a lot of the work that I do in my job I'm over at the hospital. I'm a former member of that local and that executive over there; so we talk. They've got upwards of 65 professional responsibility complaints that have been filed thus far this year alone throughout that facility. That's a 160 bed hospital. Those are astounding numbers. We know that when people buy into that process it can achieve change, slowly, glacially slowly in some cases. But it can achieve change.

Q: Do you think the union has a role in the broader social context?

JM: Oh yes, and I think for me it predated my move into a community setting. In a hospital setting you do encounter people who come in because they can't afford their medication. They come in because they don't live in facilities that they can look after themselves properly, or poverty, alcohol abuse, drug situations, all sorts of issues that come forward. Of course you can't help but be affected by those sorts of things. I don't think there's any question that UNA needs to be involved in addressing the determinants of health, those things in our society that affect the health of individuals and have nothing to do with disease or illness, such as working conditions for the general population. The role I'm in now, there's an immediate impact that I've seen. Many of the clients I see, because I'm in Grand Prairie, which is at the heart of the Alberta oil and gas industry, I see people who work 12, 14, 16 hour days for 7,10,12 days in a row before they have a day off. They're constantly on the road. They're constantly eating junk food on the run. Then all of a sudden they find out at the age of 42 that they're in the hospital with a heart attack, and they're devastated. When you talk to them about healthy eating, you talk to

them about regular exercise and getting enough rest and those sorts of things, it's literally not possible for them. If you're on a rig or driving to and from a lease site and then working on the rig and driving back, and your day starts at 6 in the morning and you don't get done until 9 o'clock at night, you have time to flop into bed and get up at the crack of dawn and do it all over again. You don't have time to go for a run or a walk or a swim or ride a bike around. There's just not enough time in the day. Part of that is the way the workforce is structured with Alberta labour laws and all the rest of it. It's a bigger issue than just telling that person, well you'd better make time for it. That's not realistic.

Q: What's the union's role in protecting public healthcare?

JM: The Canadian healthcare system is one of the jewels of our democracy. As nurses, one of the things we've been trying to achieve is more evidence-based decision-making. Overwhelmingly, the evidence, in terms of efficacy, in terms of life expectancy and infant mortality and all these other issues, and in terms of cost drivers, the publicly administered single payer healthcare system by far is the most economical and gives you the most bang for the buck. No question. The Americans spend billions of dollars on healthcare and don't serve 25% of the population. In this country we serve 100% of the population. That speaks for itself. Some of the issues in the current system are related to, number one, lack of commitment on the part of right-wing governments to funding it systematically to meet the needs. Lack of comprehensiveness, in the fact that much of the healthcare system outside the walls of a hospital or doctor's office is not covered by the public system and is very much in the private sector. Those costs, as they impact people of lower

income, they tend not to seek service in that area and they end up in the acute care system and that drives costs up. The pharmacare question is an obvious one, the question of whether or not people should be required to pay hundreds of dollars a month for their prescriptions, and if they don't pay them they're going to end up in ICU with another heart attack or stroke or whatever their problem happens to be. I think it's penny wise and pound foolish to do it that way. We need to look at going beyond the bricks and mortar system. The founder of medicare in this country said himself, Tommy Douglas, that after hospitals and after physicians, we need to look at homecare and drug coverage and those sorts of things. That was back in the day when those costs were nowhere near as much a factor as they are now.

Q: What's a memory you have about something the union achieved?

JM: I think the one that really sticks in my mind in terms of achieving something positive had to be, now don't fix me firmly on the date, but I'm thinking roughly 1997. It was the year that we were in bargaining. One of the major issues that was most contentious was the issue of the union had a demand at the bargaining table to put a provision in the collective agreement to require that there be a registered nurse in charge of every nursing unit. There had been a pattern in the mid '90s during various cutbacks and restructuring of having non-nurses in charge of direct front line management of a unit. In some rural facilities they did things as silly as having a maintenance person in charge of a nursing unit. A lot of the driver for that was the fact that it was unquestionable that it was about dollars and cents. We had a provision in our collective agreement that

required that the nurse in charge be paid an additional premium for that responsibility. They said, we'll look for people that don't have that, and make them in charge, because we don't have to pay them. It's that simple. We went to the wall on that. We went to an actual strike vote on that issue. I remember vividly going to the strike vote and then going out to the movies with my family, expecting to be on strike the next day, but deciding that I was going to be defiant and go out to the movies. I remember which move it was, it was Star Wars when they did a re-release of the original theatrical version. We all went to that movie. We got the results later, and the strike vote was, the mandate for strike was overwhelming. I seem to recall they had a settlement at 4 in the morning that same night. It was amazing. Technically it was illegal to have a strike vote. We didn't get charged for it, but technically it was, because that's the way the Alberta labour law works. But we achieved something without having to do anything more than mark an X on a ballot. What it said to the employer was that the nurses feel that this issue is so important they're willing to break the law to put it forward and make it happen. That provision is still there, and I think it has done a lot to protect patients, clients, residents, whatever the term may be. It's not perfect, because when they create a new unit they're not required to put a nurse in charge on that unit. But it's an important step that I remember. That's one of the ones that really sticks in my mind.

Q: Anything else you'd like to say?

JM: I think one of the things we need to look at is examining what we can do to engage more young nurses in the activity of the union. Some of the locals have done very well.

In fact, the local I'm a member of, and I've only been a member for less than 2 years so a lot of this actually happened before I became a member, but has a member of the executive who's only 23 years old. The 4 people at this meeting, 2 of us are older nurses and 2 of us are under 25. The QEII in Grand Prairie, Local 37, has a number of young nurses who are very active on committees or on the executive, at the general meeting, getting active and getting involved. I think there's a lot we can do. Eventually we're all going to retire to Florida and somebody needs to run this union behind us. We need to make sure we nurture them and bring them up to get them going.

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