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SB: I guess it kind of starts back in high school. I kind of knew in high school in the early '80s that this is what I wanted to do. So I took courses in high school to guide me in that direction. I started nurses' training at the Grande Prairie Regional College in 1986 but my first year did not go very well. Then I reapplied in 1986 to the Royal Alec. So I finished my nurses' training at the Royal Alec in December of '88 and started with Alberta Health Services October of 1989. I've worked many different places, as a lot of us have. I've done general surgery, medicine, general systems ICU, endoscopy, and now I work at Health Link. I ended up at Health Link as a duty to accommodate after I was assaulted by a patient in 2017 and had to have hand surgery and couldn't return to the position I'd had at that time.

Q: Tell me about that experience.

SB: It still affects me to this day, to be honest with you. It profoundly affected my mental health.

Q: Did it happen on your ward?

SB: Yes. I had given the patient sedation for a procedure, and unfortunately he was on chronic narcotics because of a workplace accident himself. When I gave him the sedation, instead of getting sleepy it had the opposite effect, and he got very physical and very violent.

Q: Were you in danger?

SB: Yeah, I was. But there were two other people in the room. But yeah physically I was, yeah. So then I ended up being off work for. . .

Q: Did he physically attack you?

SB: Oh, he physically assaulted me. He grabbed me. Then I ended up being off work from the end of July until the beginning of November. I did a lot of physio through Workers Compensation. I went to see a surgeon at the end of November just as part of the process, and he determined at that time that I needed hand surgery. Then after that I was off work for another seven months. Then I started at Health Link because I couldn't go back to what I used to do.

Q: Is this normal?

SB: I don't know if I would say normal. But UNA would have to give you the exact statistics. But when I had my duty to accommodate meeting with management and UNA and Human Resources, the statistics at that time were 34 percent of nurses were reporting abuse on a daily basis. That would include physical abuse, emotional abuse, mental abuse, people yelling at you, whatever kind. At that point, UNA informed Human Resources that it was actually higher than that. So it's a lot more prevalent than people realize.

Q: And you're seeing that on a daily basis?

SB: Yes, more so depending on where you work. In an Emergency Department, perhaps it would be more prevalent than other places.

Q: Is security present in the workplace?

SB: There is a security department but there's nobody in the units specifically. When my assault happened, the doctor I was working with called the front desk, because we have two buttons that we can hit that will alert security to come down right away; they're kind of like panic buttons. Those were hit, but nobody came. Once this gentleman let go of me, I got on the phone and called Security Staff. But when you call Security Staff, the phone calls don't go directly through to your hospital, they go through to a main security switchboard at Alberta Hospital. Once I explained to the person at Alberta Hospital what was going on, they had to call our security. By the time they got down there, there was also a cardiac arrest going on on the

unit. So there was just a lot going on and they were a little confused as to where they were supposed to go because they respond to all cardiac arrests too, security does.

Q: This is bizarre.

SB: Bizarre for somebody who doesn't know what happens, yeah.

Q: When you're going to work on a daily basis, you don't anticipate this environment.

SB: No.

Q: Are you trained in martial arts?

SB: We're given a course that's called Non-violent Crisis Intervention, but that didn't apply in this situation. I couldn't have done anything to prevent this or to get myself out of the situation any easier than I did.

Q: So the patient determined when the assault was stopped?

SB: He was not of sound mind to be able to decide when he could stop it, because of the sedation I had given him. He was technically under the influence, but under the influence because of the sedation I had given him. His actions were not conscious decisions; it was just because of the medication I had given him during the procedure.

Q: That sounds like you were even more vulnerable, because, what if he had strangled you?

SB: Yep.

Q: It sounds like a complex work environment.

SB: It can be, depending upon where you work.

Q: Do you know of other instances like this?

SB: In emergency departments in particular, yes. There's quite a bit of physical abuse, physical assault in the emergency departments at most large city hospitals. Statistics I don't know off the top of my head, but it definitely happens. I've spoken to many emergency department nurses and they've told me stories, but a lot of it doesn't get reported. I have discussed this with many people outside the profession just as a public service announcement, so to speak, just to let them know that it's not always an easy job physically.

Q: Then there's the COVID patients that have to be cared for around the clock.

SB: Myself, I don't do bedside care. But yeah, for those types of nurses that do, absolutely. I can't imagine the positions that they're in.

Q: Can you talk about the return to work? Was it a smooth process?

SB: No. Through Workers Compensation and their discussions with Human Resources, it was determined that I became what's called a duty to accommodate, meaning Alberta Health Services had a duty to accommodate me within their organization according to the limitations that I have. That was not a smooth process by any stretch of the imagination. I would say though that where I used to work I was very well supported by management. They were very good to me. UNA was excellent. Where the hiccups came were within Human Resources. Without saying exactly what happened, because it's a very long story, I ended up writing a very long letter to the vice president of Human Resources detailing – it was a four-page letter – detailing exactly what happened from the moment the assault happened to what was going on at that particular time. Then I had a face to face meeting with her and I got an apology, which is basically what I went in for. I said, I can't do anything about what happened to me, but I don't want anybody else to experience what I experienced from a Human Resources perspective. She admitted that what they did they should not have done and that what they should've done was not done. So my case was handled very improperly. They had no idea what Workers

Compensation was requiring of me as far as applying for jobs. What ended up happening is the letter that I wrote they used as like a learning tool in workshops and stuff for Human Resources. Then they actually had somebody from Workers Compensation come in and give an in-service to Human Resources so that one knew what the other was doing. But most of the issues had to do with communication. One of the things I had said in that letter was that I've been an employee since 1989. I have never felt less important and more disrespected than I did by the people that were trying to deal with my case. It eventually worked out, but it was not a smooth or pleasant experience. It caused me a lot of stress and anxiety.

Q: And this was all coming from Human Resources?

SB: Yes. It was assumed by one person in Human Resources that because at that point it had been five months during my surgery, one person in the meeting had said, is this permanent? The other person in the meeting said, well it has been five months. So in other words, nobody was giving me a chance to get better. They just assumed what was going on at that point was as good as it was going to get. So they made that decision at that time themselves that this was permanent, which it ended up being, yes. But just the fact that they made that comment was very hurtful.

Q: The judgment was passed.

SB: Yes. When we go into a duty to accommodate meeting, we don't ever go into any without a UNA representative present of course. The vice-president of the local when I was at the Alec was in there. There was my unit manager and the patient care manager, two human resources people present, and then one on the telephone. So there were a lot of people.

Q: But they couldn't see that you required a long period of recuperation?

SB: No. Well it did end up being permanent, which is part of the issue. But just the comment that the person made, well, it has been five months.

Q: How did you interpret that?

SB: Very defeating. It just made me feel like, okay well I'm just a number now. Obviously I can't get any better, they're just going to put me somewhere where they can accommodate me. It was very hurtful.

Q: How did your family react?

SB: My family? To be honest with you, I can't remember. There's a lot of that, because of stress and anxiety and a diagnosed PTSD after all of this; there's some of that I can't remember.

Q: How does it make you feel about the service you provided?

SB: Right now I definitely provide a very important service, but I definitely prefer to be face to face bedside with people. I guess a little part of me, even though I know I'm a registered nurse and I do very important service where I work, it's just different and it's not what I had set out to do.

Q: Did you attend additional UNA training courses?

SB: Not necessarily through UNA, but Workers Compensation sent me for a lot of stuff.

Q: Your whole career has been impacted.

SB: Absolutely without a doubt. I was off work for almost a year in total.

Q: Were there any changes in the ward where it happened?

SB: I don't know. I haven't followed up with anybody. Just from previous experience, I doubt it. But I don't know for certain.

Q: Have they changed the security arrangements?

SB: I don't know. I don't think so, because there's just not enough security around to be able to be there all the time.

Q: Would this be an area for improvement to protect nurses?

SB: Well, I think in order to protect the nurses, there has to be more people and the methods that they used for sedation have to be different.

Q: Are there other issues impacting your career and profession?

SB: I have a wonderful family physician who's been very helpful to me. One thing he said to me during all this was, you know, people forget what we do and what we see on a daily basis. I used to work ICU. I used to be on the code team. When I was in ICU I've seen and done things that nobody could ever guess. But the average person doesn't think about what we see on a daily basis and how after 30 years that accumulates. A lot of times you just get to the point, like my family physician said, where you hit a breaking point. You're a human first, and you can only take so much.

Q: Did you experience the events of the '80s and '90s?

SB: I was in nursing school when the strike happened. There was a portion of us that wanted to go picket with the nurses, but we were told in no uncertain terms by the School of Nursing that were not allowed to do that.

Q: They tried to impact your solidarity?

SB: I guess in the grand scheme of things. I don't know if those are the words I would use, but yeah. We were told that we couldn't. For what reason, I don't know.

Q: When you went to work in '89, did you feel impacts of the previous year's strike?

SB: Not that I remember; 1994 absolutely. I had just come back from my first Mat Leave. So I had a 7 1/2 month old and I happened to be pregnant again. I had come back from my Mat Leave part-time. Then when the cutbacks happened in the Klein era, my position got deleted. So I didn't have a job. I had an infant, I was pregnant with my second, and I was the main breadwinner in the family. So then I had to go somewhere else and bump somebody else out of their job, to keep a job. That was hard, just because I felt so bad for that person that I bumped that didn't have a job anymore.

Q: Tell me about the bumping.

SB: What happened was a whole bunch of positions got deleted where I worked, so then we went into a . . .

Q: What department?

SB: I was working General Surgery at the University, and I was a .6. I was full-time but when I came back from my first Maternity Leave I became a part-time. Then we went into somebody's office; UNA and Human Resources had come up with a seniority list right from the top all the way to the bottom. We saw where our name was on the seniority list, and we were able to bump somebody that was below us on the seniority list. So we could pick whatever position we wanted, unless the position needed specific training or something like that. I bumped somebody on one of the medical units, and stayed there.

Q: Did that have any impact on the medical unit you went to?

SB: I don't know where else there was to choose from. I just found one and picked it, because I just needed a job.

Q: Did it cause any friction for you, as a new person to the unit?

SB: The person that I bumped, I ended up working with. She understood. She held no grudges or wasn't angry or anything like that. But I suppose because you're getting rid of somebody – not getting rid of – you're bumping somebody who'd been there for a while and had a relationship with that staff, then yeah. It was a little gray area for a little while.

Q: Any other impacts of that period that you felt? Any staffing shortages?

SB: To be honest, I don't remember. Again, that's something that I've put out of my mind. I don't remember that at all, as far as staffing. I do know that at that point or earlier than that, each hospital had its own board of governors. When they came with Alberta Health Services, then there was a lot of that upper management that either got displaced to other places or I don't know how they handled that. So I don't know what they got rid of as far as upper management. But I do know that a lot of the nurses who were in training at that time who ended up graduating soon after, there was no jobs. A lot of them ended up going to other provinces or to the United States for a few years.

Q: Why weren't there jobs?

SB: Because they cut them. They stopped hiring.

Q: Were the cuts across the board in every department?

SB: Yes, they were across the board.

Q: What about wages and working conditions?

SB: I think at that point it depended upon where you worked. Where I worked, luckily enough, there generally was for the most part enough staffing. Like anything else, there were days where there wasn't. But it was challenging, particularly on the nightshifts.

Q: What would happen?

SB: Just not enough staff. You ran and ran and ran to make sure that things got done, dressings got changed, procedures got done, patients got their medications. Lots of times we wouldn't get our breaks, because we had to make sure that what we needed to do wasn't going to be late or not done.

Q: Did they try to force health aides or others to take up some of your responsibilities?

SB: It was on the backs of nurses. There used to be an IV team at the hospital. So there were groups of nurses that would go and look after things. They got rid of the IV team. So that went onto us to look after IVs. There used to be an ECG team that was available on nights. There still is a team available during the days. So on nights we had to go get that machine and try to find a resident that could do an ECG, because you have to be trained on how to do an ECG. So there's things like that that were put on our shoulders.

Q: Did wages change?

SB: No, just your normal bargaining and that kind of thing. But wherever you fit into the pay scale, no you didn't get any, unless you had special training like a degree or you had a special certificate that would allow you to get an extra little bit for your. But no, those wages were not increased because we were given more responsibilities.

Q: So there was no compensation for the additional responsibilities?

SB: No, because we were just paid according to the pay scale that's within the contract, regardless of what our responsibilities are. Unless, like I said, you had special training or a degree or something like that.

Q: That's another form of rollback.

SB: Yes.

Q: Were shifts impacted?

SB: No, because that was part of the contract. That stayed, because that was in the contract.

Q: Were there any changes in overtime?

SB: I didn't do a lot of overtime and I still don't. At that time I had an infant at home and I was pregnant. So I did very little overtime. There was very little if any mandatory overtime at that time.

Q: During the time you were there, were there any UNA demonstrations?

SB: I don't remember.

Q: You were not involved in any industrial actions. But were there any actions taken by others regarding injuries, etc?

SB: There were a lot of what we call incident reports filled out, a lot of PRCs, which are forms that we fill out when there are issues or things that are going against contract. But if there was anything changed or done because of those, I don't remember.

Q: Did you fill out PRCs yourself?

SB: Yes.

Q: On what grounds?

SB: A lot of it was on staffing and workload and safety, because there just weren't enough people around.

Q: And this was while you were pregnant?

SB: Yes, and even after that too.

Q: Were you expected to do 1.0?

SB: Not at that time.

Q: You were describing additional work.

SB: Additional work on the days I was there.

Q: Although you were at .6, did they try to get you to do a work equivalent of 1.0 by giving you all these additional duties?

SB: I would often get calls from staffing asking me to work extra shifts. The majority of the time I would say no because of childcare.

Q: Were there any industrial actions taken by UNA over the coming years?

SB: That's a good question. I know the concept of staffing and not having enough staff has been an issue that UNA has brought up to the employer thousands of times I'm sure in the last 25 or 26 years. So there are a lot of notices. But to answer that question, that's really hard for me. But I know they definitely were involved in the fact that there just wasn't enough staff around.

Q: Working at Health Link, are you exposed to public abuse?

SB: Oh absolutely, verbal abuse on the telephone. I believe it was in the news or in the media a few days ago saying you've got to be nice and speak nice to people and respect our staff, and abuse will not be tolerated, because there's been three times where the verbal abuse over the

telephone has gotten bad enough where there's been threats to us and they've had to dispatch the police three times. I don't know what those incidents were. I don't know.

Q: Have you had any similar experiences?

SB: Oh yeah. We're told that we give the people one warning. If you continue to speak to me like that, if you continue to treat me like this, disrespect me like this, this is your warning. If they continue, then we just say, I'm sorry, I can't continue this conversation. I'm ending the conversation.

Q: What kind of things?

SB: Swearing, name calling, threats.

Q: Why?

SB: Because we're just not doing, well most of that has been during COVID. A lot of that has to do with the fact that we're just not giving people the answers they want, or that we're not able to do what people are asking us to do. Or people are so frustrated and angry with the restrictions that AHS has that they're taking it out on the nearest person, which happens to be us on the telephone.

Q: You've found an increase?

SB: Since COVID? Absolutely.

Q: There are no filters and barriers between the public and you?

SB: Just the telephone, that's it. We did have an incident, oh gosh this would've been probably back in the late spring. Outside our workplace on the cement was painted "AHS Nazis". There

were a lot of us who were very nervous to go into work, because we didn't know who was going to be around.

Q: Are people aware of your physical location?

SB: I don't think they knew that's where Health Link was. But there are signs outside the building that say AHS. So they know that there's some type of AHS staff in that building.

Q: Where is this located?

SB: In 124th Street Plaza – 102nd and 124th Street. It's not an AHS building; it's a privately owned building, but AHS leases or rents space or whatever. But they have their own buildings further east downtown. But this is a spot that they lease space from.

Q: And that's where Health Link is located?

SB: Yes.

Q: And that's the only place in the city?

SB: Yes. Then there's one in Calgary. There's only two sites – one in Edmonton and one in Calgary.

Q: And you field all the calls that are made to Health Link across the city?

SB: It used to be just Red Deer north up until recently. Now we're changing our system from a telephone-based system to a computer base, where now we're getting calls from all over the province. What they're having to do now is alter a lot of the flowsheets that we follow, because now the flow sheet for every zone is different, flow sheets meaning Public Health, Environmental Health, if there's a call or referral to them, Emergency Department, that kind of thing. So if we have somebody from a rural area that needs to go to an emergency department,

there's a flow sheet that tells us, okay. this emergency likes you to fax and chart. So they're having to revamp a lot of those flowsheets and give us access to more of them, because now we're going to be talking to people all over the province rather than just our area.

Q: That sounds like an increased workload.

SB: It's not an increase in the workload in the sense that we get a call regardless of who it is.

Q: But you're servicing a wider area.

SB: Then there's more that we need to be aware of.

Q: But potentially there could be an increase in the number of calls you're receiving.

SB: Potentially, potentially. But we still only do one call at a time. Once that call's done, you finish and just go talk to somebody else. The call times and waits are getting higher, which means that there's more people waiting. But it doesn't necessarily--like we can only talk to one person at a time. But before COVID and before this started, we'd take a call and sometimes there'd be a bit of time where we wouldn't get a call. But for the last almost two years it's just been one on top of the other.

Q: Do you get any abusive calls related to COVID?

SB: Oh yeah. AHS did hire COVID nurses that for a good period of time were the main ones that handled most of those COVID calls, if people hit the right button when they called. But back in July when numbers started to go down and it looked like things were getting better, a lot of those COVID nurses were nurses that had been displaced or redeployed from other areas, so when the number of cases of COVID went down, it was decided that they didn't need as many of the COVID nurses. So they were sent back or deployed somewhere else. Now that numbers are going up, we as Health Link nurses are getting a lot more of those COVID calls, because there aren’t as many of the COVID nurses. Then there's also a vaccine booking line; all they do is

talk to people and book vaccines. But that's not nursing. Those staff, who are very important, aren't nurses. A lot of them just have some kind of medical administration training or something like that. But they're not medical staff.

Q: That's how the government is handling the current increase in COVID calls.

SB: Yes, which means that unfortunately those that are calling with non-COVID related problems, and some of them very serious, are having to wait and wait and wait longer on the telephones to get assistance.

Q: Is this impacting the service in the hospitals and clinics?

SB: That I don't know, but I do know that with COVID in particular, at Health Link if we look at our protocols and guidelines, if somebody needs to see a doctor within 24 hours, let's say, there are a lot of doctors' offices and a lot of clinics that aren't taking people with certain symptoms right now because of COVID. Their only way to get seen is in an emergency department, so that has definitely impacted the emergency departments.

Q: So then the security in that area, which has not been stepped up, is subject to even greater stress.

SB: Absolutely.

Q: Are there any landmark experiences in your career that particularly stand out, or something you'd never do again?

SB: Oh my gosh, there's probably a lot. As far as something I'd never do again, that's hard to answer because I can't; physically I can't go back into that environment anymore. There's been lots of things, in Health Link, for instance. Before COVID we used to man the Mental Health Helpline. We still get a lot of mental health calls, but not as many as before. What they did during COVID was because we had such increased calls, they developed a specific team to deal

with most of those calls, which was greatly appreciated, AHS did. But we still get the odd one, and part of that Mental Health Helpline is suicide callers. I go home thinking about those at the end of the day.

Q: Are those mostly young people, or across the population?

SB: Mostly young people. Any age, in the grand scheme of things, but most of them definitely I would say would be under 40. That's been my personal experience anyway.

Q: Does it reflect that something's wrong in the system?

SB: A lot of people don't feel that they're getting the assistance that they need, particularly in rural areas. I think mental health is definitely, the understanding and treatment of it, is improving. But I think it still has a long way to go. It's definitely better, don't get me wrong, but there's still a lot of work to be done.

Q: Any other experiences that you'd like to share?

SB: Oh my gosh. I guess one that comes across, in ICU I had a patient that passed. Many patients that passed, unfortunately. But this one particular lady, I didn't even have time to do anything with her before I was trundled off to the next patient that was coming up from emergency. Things like that--you just don't get a decompression time in between patients sometimes. I do remember that one in particular.

Q: Why?

SB: Just because I felt so bad myself that I couldn't spend time with her and her family. I just had to kind of go on to the next thing.

Q: She was obviously in some kind of emergency.

SB: She'd had a stroke. She passed away.

Q: Decompression is important.

SB: We often just don't have time for that. That decompression often comes at home.

Q: So you take your work home, in a way.

SB: I know I do and I think a lot of us do.

Q: Could you describe decompression?

SB: There's been many times when I was doing active care where I came home and just didn't speak to my family. I'd go down to the basement and they would know to leave me alone until I came back upstairs. A lot of it was just spending time on my own just to get over what happened that day or what have you. That's what mostly it was.

Q: Is this on a daily basis?

SB: No.

Q: But it is often?

SB: Yes. It's part of the, I don't know if healing process is the right term.

Q: It sounds like it's a part of nursing.

SB: Yeah, it's really hard to leave your job at home. I admire those who can, but for me in particular it's really hard. I think about it a lot when I'm home – oh maybe I should've done this or maybe I could've done this different or something like that.

Q: Does this lead to additional stress? What does it do to you?

SB: Some days profound anxiety. This kind of stuff for a lot of people, myself included, has a profound effect on my mental health. Luckily enough, I've been able to get the assistance that I need. Things are never going to go away. It's just a matter of learning how to do deal with it and certain tools you can use to deal with that anxiety. But I think for a lot of us, because of things we've seen and experienced, depending upon where we work, it's just really hard to forget some of that stuff.

Q: This is in the work environment?

SB: What happens at work definitely affects my mental health when I'm not at work.

Q: This is across the board?

SB: I think it doesn't matter where you work. The way things are right now, even before COVID – staffing, increased workloads, that just affects you. The more tired you get, that affects your physical health too. Your mental health and your physical health are very intertwined. Your mental health has a profound effect on your physical health also. That's been my experience anyway.

Q: What do you think the future holds for you?

SB: Me in particular, in three more years if I want I can retire with a full pension. So I'm kind of guiding towards that. I think just because of my physical limitations, there isn't a lot of other places I'd be able to work. But I'm happy to stay where I'm at; I like it.

Q: Have you participated in any industrial action with UNA?

SB: No, myself no.

Q: You mentioned there were a lot of landmark experiences that would stay with you the rest of your life.

SB: I think a lot of it is just a culmination, like my family physician said, just a culmination of things that you've seen and experienced over the almost 33 years. They pile up, and if you don't deal with them at the time, then they can become an issue a long time down the road. But to think of one particular incident at this moment, I can't do that.

Q: You mentioned that your training was at a hospital, the Royal Alec.

SB: That was one of the other things that changed in the early '90s, was getting rid of all the hospital-based programs.

Q: What were some benefits of that hospital-based training, and what are the differences between the new system we have now?

SB: I think the hospital-based programs, the training – this is going to come out wrong – more bedside and people-based. Don't get me wrong. There's a lot of wonderful nurses that come out of the degree program, but the focus of the degree program isn't necessarily that now. It's a lot of public health, research, instruction, teaching – so the focus changed. I'm not saying that we're any better than anybody else, but the hospital-based program was definitely focused on patient care, bedside-based.

Q: Is that important to the industry?

SB: Yeah, because we're here to take care of people. You have to know how to deal with that at the bedside. Part of the issue that we're having now is they're trying to bring in more LPNs and less RNs to do a lot of that bedside care, rather than the RNs. So that's an issue. There has to be a certain, what's the word, not percentage, but so many nurses and so many RNs kind of thing. I don't know what the number is. I don't know if it changes from unit to unit. But in our contract

it specifically says that every unit has to have an RN in charge at all times. Unfortunately, that's one of the things in the new contract that they've been trying to get rid of.

Q: So AHS used to be patient-focused but it is no longer?

SB: No, the care is still patient-focused, but I find there's a lot more technology involved – sitting at computers, typing. So I think a lot of that has changed the face of it. Everything's obviously still patient-based, but because of certain budgetary restrictions. . .

Q: Who sets the budgetary restrictions?

SB: AHS. They set the budget. If the provincial government says this is how much money you have and AHS says, okay this is how much money I'm giving you. If we've got less money to do what we need, then we can't do as much.

Q: So it has impacted the service?

SB: Absolutely.

Q: So the percentage that is patient-focused has shifted?

SB: Well, look at the OR wait times before COVID. There were people who were waiting for a new hip and knees for two years because there just wasn't the funding to do all of those operations when people needed them.

Q: So the budgets have been cut. Is it deliberate? Doesn't that undermine the healthcare service?

SB: It does. I don't know if I would say deliberate. I just think that, I don't know, I don't know. I just think we're also dealing with a population that's aging. Without keeping up with that, I think that's made things difficult too, if that makes sense.

Q: Can you talk about the difference in nursing education nowadays, and the recruitment issue?

SB: When we were in training, there was always an instructor there with us on the unit. If we needed to do something, they would help us. They would go through the procedure with us. When we preceptor nursing students now, there isn't always an instructor or a professor around. So a lot of that responsibility is on us to teach them how to do things or guide them through things. I love having nursing students--don't get me wrong. But that's extra work on us, with the new system. I think because it is more academic; I'm trying to think how to say this without coming out wrong. I know they have to have a certain number of bedside hours for their program, and I don't know what that is. But I think because the focus is more textbook-based than patient-based, they're not given the tools that they need and the experience that they need to deal with the kind of things that they see. Most of the knowledge I have comes from experience; it doesn't come from a textbook. I had great training and I learned a lot of things, but the majority of things I know now are because I've done them or I've experienced them, not because I read it in a textbook. That comes from years of experience.

Q: Did you notice a shift between before and after your maternity leave, which is when the cuts were starting to bite?

SB: At that point it seemed that finances were governing a lot of the decisions that were made, rather than what was best for the patient.

Q: How does that impact the patients?

SB: Early in my career I had a lady who was palliative; I remember her. Luckily enough, we were able to sit and spend time with her and with the family. But when your staff is cut back, you can't do that. You can't give that human side of care that you'd like to, because you just don't have time. Sometimes, I'll be honest, there's treatments that aren't done on time or are missed,

medications that are late. People ask for something for pain, and instead of waiting five or ten minutes they're waiting 30 or 40 minutes, because you've got so much other stuff to do.

Q: Has the system of teams doing bedside rounds changed?

SB: I don't know what they do at the bedside anymore. The last time I did bedside would've been 16 years ago, and that was in ICU, and every day we had rounds. But that's a bit of a different situation. I don't know what they do on the wards now. I can't speak to that.

Q: You mentioned the IV team – were you on that team?

SB: No. For instance, when I first graduated at the Alec, there was an IV team that would look after starting IVs central line. So, the big IVs that go in the big veins in people's necks or chests. They would change the tubings; they would look after all of that. When they got rid of the IV team, then IV starts became our responsibility. I guess, if I had to guess, I'd say that would've been probably 1991, '92. I'm not sure.

Q: That's a complex procedure.

SB: Some people say it's easy to start IV, some people it's not. The catheters now have changed. So the IVs now, rather than being metal like they were in the '80s, are plastic. The makeup of them has changed a little bit. But the way you start IVs is the same. Veins are veins.

Q: On the subject of retention, are you seeing other nurses, like yourself, looking toward retirement?

SB: Absolutely. I think overwork, overstress, and underappreciation has a lot to do with that. I know HS appreciates what we do, but we're so tired of being overworked. Particularly with this influx of contract talks and the cutbacks that are trying to be made, I think we're just feeling very undervalued and very underappreciated.

Q: Why are they trying to impose cutbacks at this time?

SB: Money--it's all money-based. They did originally ask for a 3 percent rollback. Things have improved and progressed with those contract negotiations in the last couple of weeks quite a bit. But what the public sees is 3 percent, 3 percent. But what the public doesn't see is okay there was 3 percent, but there were other cutbacks that they were asking for with shift differential and overtime and charge pay and all that stuff that amount, when you add that up, well more than 3 percent cutbacks. Not just that, but one of the things they're still harping on, AHS, is right now in our contract in our rotations we have to have minimum two days off between. Like if we work three or four in a row or whatever, then before our next set of shifts start we have to have minimum two days off. One of the things that AHS is sticking to their guns about is getting rid of that, so no mandatory days off.

Q: What other services has the hospital provided in the past that you no longer see?

SB: Food for many years has not been made or centred in the hospital. It gets made offsite and then sent in; then there's kitchen staff that put that on trays.

Q: So, you do still have a kitchen?

SB: I don't know if there are kitchens on individual units anymore, but there's still in the basement of the hospitals a dietary department where the trays come from that get brought up to the patients. But I don't know what goes on in there anymore.

Q: What about linens?

SB: Oh, linen has been contracted out for year.

Q: How does that impact the service?

SB: Well, if we need something and it hasn't been delivered, we can't get it. If we need more sheets or more uniforms or what have you, if they're not there on site, it's not as if we can just go down there and get it. They only get delivered so much.

Q: So that impacts services during this COVID period.

SB: Oh, it's been like that for a long time though. They started contracting out linen services to K-Bro many years ago, probably in the '90s I would guess.

Q: Are they providing PPE during the COVID period?

SB: Where I work in particular, all we have to wear is masks. We don't have face-to-face patient care. But I can't speak for what's available in some of the units, if they're short or whatever. But we've always had the masks and gloves and cleaning supplies that we've needed.

Q: Do you see a connection between the cuts of the '90s and today?

SB: I think it's worse now. I think it's worse in the sense that for a lot of us, just because we've been around it so long, we're just more tired of it. We're physically exhausted and we're mentally exhausted. So, from that perspective, it's worse. But from a staffing perspective, and again I'm not putting anybody down, but because I think there are more LPNs and less of us, a lot of us are uncomfortable with that. But maybe that's just from not being educated as far as what they can and can't do.

Q: It puts more stress on those responsible.

SB: It absolutely does. Most of the knowledge that I have is just from experience. For anybody, regardless of your title, that ability to do your job better comes with experience. But I think people that have less training – and again I'm not putting any LPNs down, there's a lot of wonderful ones – but I think that change in the number of RNs compared to LPNs has made our

job a bit more difficult. I think we're a lot more stressed. They can do a lot, but because of their restrictions on what they can and can't do, then one of us has to do what they can't do.

END