United Nurses of Alberta

Cynthia Perkins

Calgary, 2007

CP: My name is Cynthia Perkins. I'm a nurse at the Rocky View General Hospital in Calgary. I've been nursing for 45 years this very year, and still at it, semi-retired. Trying to get out the door but it's really hard.

When I say I'm trying to get out the door, up until a year and a half ago I worked full-time permanent afternoon shift. Last September I went to a .68 position and this September I've gone to a .4 position. I'm hoping to completely retire by next year. I do get called a lot. I try to explain to the scheduler that I'm a senior citizen, that if they want me to come into work they'll pay me overtime to come, whether I'm entitled. If they want me in there, that's what they're going do with me. It's a little dicey at home right now because my husband's not used to having me around in the evening, and he thinks he has to entertain me. But we're working it out.

Q: Are there things the union could do to make the process easier?

CP: A better process for me personally is probably to have less a physically demanding part of the job. I've had shoulder surgery. I have back problems. So if I have to do a lot of lifting I pay the price for it; it takes me more than one day to recovery from that. I could do a lot of mentoring. A lot of people come and ask me things. I know the hospital policies; I know the medications, I have a lot of good experience. I'm very good at starting IVs. I get called on a lot for that. So if they could make my job less physically

demanding I might consider it. My husband came up with a very good idea. He thought we should have a round hospital, something like a milking thing, so when you go on they attach them and when they go off they unattach them. So we could have a round hospital and I could sit in my wheelchair and just press the button, and the patient will come around to me and I can do what I have to do and then just carry on.

Q: They used to have something they called an IV nurse.

CP: They did; I've done that in the past.

Q: That wasn't such a bad idea.

CP: No, I thought it was a good idea. I could do IVs and work till I'm 90.

Q: Older nurses aren't being utilized and younger nurses are being driven away.

CP: there are two things happening. Most of the job requirements now are asking for bachelor degrees, bachelor degrees preferred. That puts off a lot of the senior nurses, not that they wouldn't get the job, but it's the fight to do that.

The other thing I really notice is that the new younger grads don't want full-time jobs. First time in the last 2 years I've ever noticed that. Most of them want full-time jobs. What's happening now is that they want a life; they don't want to be working full-time in a constant thing. They want a life; they want long weekends; they want to get vacation. Even the ones on my own unit that have been hired recently into full-time jobs immediately are asking to have their hours reduced. It's a lot of the older seasoned nurses

that are actually still working full-time, in a lot of cases. Particularly when you're coming towards the end of your pensionable years, you want to get that extra little bit of money. But it seems to me it's the senior nurses that are really hanging in there as long as they can. Maybe with the new contract incentives it'll change.

On my unit, the people who are entitled to the extra 2% on their paycheque because they have more than 20 years nursing experience, they call us the wrinklies. I just heard someone else say on their unit they call them the fossils. I think wrinklies has a certain ring to it.

Q: How can younger people be brought into the union?

CP: I think that bringing new people into the union, because when they first start they're really into working. A lot of younger ones are getting married; they're starting families. Usually when people are into their late 30s then they start getting involved and want to know about the union. Maybe they mature. When they're first there, they think they know everything, and they don't understand the history of the union and what has happened since '77 and how they got now what we fought for all those years. It's amazing, because when I was telling someone in 1981 I was making $8.35 an hour as a senior nurse, they just about fell over. The undergraduates make $22 an hour now. It's just unbelievable really.

Q: These things didn't just happen.

CP: People forget. When I started training I trained in a Catholic hospital, which was a real experience to me, not being Catholic. Literally we were slave labour. We staffed the hospital; there was no doubt about that. That didn't change; maybe 10 years after I graduated they closed down the nursing schools and went to colleges or whatever. But the experience we got in nursing schools, working in a hospital nursing school, was invaluable, it really was. You learned to work as a team. The camaraderieship, the teamwork, was unbelievable. It was slave labour: there's no doubt about that but we came out with a lot of practical experience. We could hit the floors running, and do the job. It didn't take a 6 month orientation period or familiarization period to do that.

. . . I would never want to go back to that sort of training. I think the big difference is we learned how to think critically while we're running. People now learn the critical thinking before they actually have to put it into effect: a whole different philosophy.

Q: Those two philosophies could meet.

CP: Yes, we could definitely share all the experience. It's kind of fun at work; they come up to me and say, well you know back in the Stone Age when you did this. They don't believe that we used to sharpen our needles ourselves, and that we didn't use gloves to do cleanup jobs, cold browns they called them. It was just unheard of. But we did scrub, scrub, scrub our hands; that was definitely part of it. It's always a joke at work about the old days, the Stone Age as they call it.

. . . Over the years the patient themselves haven't changed that much. We talk about high acuity. We had high acuity 45 years ago. We were dealing with it differently. We didn't

have the new drugs; we didn't have the equipment. People were in the hospital longer; we established really good relationships with our patients because we had the time to do it then. Now the machines demand so much that you sometimes forget that there's a person behind the machine, that there's somebody there lying in the bed. You're busy; you gotta get this stuff in the computer; you gotta fix this pump; you gotta do this; you gotta do that. But there's someone lying in that bed. Having experienced it myself, you feel isolated being sick and in the hospital. To have that kind of atmosphere isn't really healthy either. There's no one to do it; there's no staff to do it. Everyone is go, go, go from the time you start your shift until you end your shift. It never stops. You don't have time to stop and rub somebody's back; that's almost unheard of now. I do however like to always touch someone when I go in the room – hold their hand or touch them that I'm here, the physical contact. I think it's really important.

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

CP: The role of UNA, in my perception of it over the years, has been with our PRC committees allowing us to express our concerns about safety of the patients, but also in the health and safety committee, the safety of the staff. Over the years I've really seen it come in, with the lifts that we have. Although we don't have enough of them, we do have lifts. In my own hospital we have a transfer team, lift team so to speak. I think that has cut down on the back injuries and shoulder injuries considerably. That has only come through UNA. We go to the committees and say, look at the rate of back injuries; we've gotta do something to prevent this. Look at the patient safety issue; we can't have 3

patients in our TV lounge, and in fact blocking the fire doors. If there's a catastrophe we're in big trouble. On my own unit, from my experience with UNA, I can push the button all the time on my manager. C'mon, we've got to do something about this, we can't carry on like this.

Q: What's UNA's role in structuring the mentoring role?

CP: I don't understand what you're getting at.

. . . It's an ingrained thing. I know what needs to be done but it's difficult for me to explain to these new people why, because their way of thinking is way different than mine. They say to me, well how did you know that? Well I just know it. I've known over the years that something's not right, and I don't know what it is but we need to look into it. Or, why did you do that? Well because number one I've always done it. But why? I don't know why; it's the right thing to do but I don't exactly know why I do it. It's just automatic; it's just there inside me to do it that way.

. . . You can't teach instinct, it's either there or it's not there. I think with experience comes wisdom. There's a saying somewhere--we used to have it on the wall: We get too soon old and too late shmart. Maybe we do, I don't know.

. . . Sometimes it's better for people to think: should I do this or shouldn't I do this, than to bull ahead and do it and then be doing the wrong thing. It's never a bad thing to ask questions or to seek someone's advice. Sometimes when I'm at work there's something happening, and maybe 3 or 4 of us will get together and say, well what do you think?

What should we do with this? With age comes wisdom. The wrinklies seem to have a fair bit of wisdom.

Q: What are some of your memories of UNA?

CP: I worked at the Colonel Belcher Hospital. When I started there it was a DVA hospital. The union was called PIPS. So we didn't join UNA. I think it was 1981 or '82 that the hospital was changed over. That's when I really got involved. I got nominated president when I was on vacation. I had some experience in Ontario also with ONA. There was a lot of stuff that went on from 1981 on; there were strikes and whatever. The best thing that happened was when they actually were closing down the Colonel Belcher Hospital and we were going through this horrific relocation. We went through a lot of personal grief. We felt very badly that we were leaving the old boys; we all called them the old boys, the old veterans, that we were abandoning them. We had been promised by the employer that it would go this way, this is how things would be done, and it didn't happen. I remember getting a call at 6:30 in the morning from one of the units saying, you gotta come in; they just called a meeting. They want us to go to a meeting at 7 o'clock. I said, don't move without me. I called Marilyn Babasore and said, there's something going on Marilyn, I don't know what it is but we gotta get there. That's when we went in and they told this unit they were just being closed. It was like, but you promised us this, and it didn't happen. I think that was where a lot of people really thought that the union was doing something for them. If you're not personally involved in something, you don’t seem to care too much. But as soon as something happens to you,

and you phone the union because you don't have anybody else, that's when it seems to count. So I think for a lot of people they did start getting involved with the union then, because that was really traumatic. When it was time for my own unit to go, they just picked us up literally as a whole unit and moved us into an empty spot at the Rocky View. So they didn't break us up; it wasn't as traumatic for us. They didn't break us up, but we still felt that we were abandoning the old boys. That's when I really started to think, we've gotta get into this. Because when we hit in the '90s when those layoffs started and that bumping started, we had a little bumping room down in the basement of the hospital that we manned 8 hours a day, 7 days a week for 5 months, because of the ripple effect that kept on going and going. I think there again people felt the protection of the union, to know that they weren't just going to be thrown out the door. When all the dominos got there, and in the end when all the dominos got laid down, nobody was out of a job. They were doing different jobs, they weren't maybe where they wanted to be, but they all had a job. I think there again the union really pulled and people realized the strength that was in there, that the employer couldn't just throw them out, that there was a system. I'm sure that the employer, when they agreed to it in the contract, never ever thought that we were going to have a fallout like that. That was really something. But it happened, and that's the way we handled it. That was how it was done.

Q: Any other union memories?

CP: Most of the work that I do with my local is return to works, duty to accommodate and return to works. Very time-consuming. We have a very good RO that we work with,

but a lot of the stuff I do is support. People phone me anytime from 6 in the morning till midnight. These are people that have been off work for a year, whatever. When they're well enough to work we give them lots of support. I go with them to meetings with their manager;, I go with them to meetings with Great West Life or workers' compensation, whatever. They need that support so I attend a lot of those meetings. When we finally get somebody back to work that's been off for 2-1/2 years, 3 years, they're well enough to come to work, that's really satisfying. They really want to be there; they really want to be working. Working with the employer to make that happen is very satisfying. It's also really mentally exhausting; it really is. You listen for an hour on the phone to someone just going around in circles telling you what the problem is. I don't have the answer but I try to say we'll find the answer. We're here to help you; it will happen; it's just baby steps, baby steps, baby steps.

. . . We had a nurse that was returned to work after 4-1/2 years, two liver transplants caused by hepatitis that she got at work. But we got her back into the workforce, she's working pretty well full-time; there are times when she can't, medication things, whatever.

Q: Are there unsafe situations in your workplace?

CP: Definitely overwork. I was saying to my manager the other day that she should not be calling full-time people for overtime. They're already working full out; they need their time off. Call the part-time people first or whatever. If you can't get a casual in, do that. We're using a lot of sick time now, more sick time than I've seen for a while. There's more

irritability with the staff, because they can't get done what they need to do; the push is on. Most of the time my unit is in triple overflow. Triple overflow is not safe. It's in a TV lounge; there's no oxygen in there; it's isolated. There's furniture in there; there's 3 beds in there. If you believe it, they have a doorbell system that if they press the doorbell button in the room, then the doorbell rings a nursing station. It's not safe. We have overcrowding in our hallways; we have stretchers on both hallway. That's not supposed to happen because there's no storage room. We have lifts in the hallways; we have isolation carts. Now that's the big thing. We are really into this MRSA infection rate that isolates patients. I think we have 7 or 8 rooms we use for isolation rooms. There's a cart out in front of every room. So you've got carts, you've got stretchers, you've got IV pumps, you've got blood pressure machines. If we ever had a fire there it would be a disaster. I'm at my manager all the time. I come in the next day and it's all tidied up, and the next day after that it's all back there again because there's no place to put it. You need all that equipment; it's not as though it's excess; we need it. Very dangerous.

Q: What needs to change to improve that situation?

CP: I don't know if they can change the situation now. Well we could not have 3 patients in a TV lounge, to begin with. As far as the stretchers and everything, it just needs the manager to be out there looking at things and saying to the staff, to the auxiliary staff, you have to tidy up this place. We cannot have stuff on both sides of the hallway; it's against the fire regulations. One of my nurses did call the fire marshal. The fire marshal came up, looked around, and said, you can't do this. It was a Friday, and the fire marshal

came on Saturday and reamed out the charge nurse, who didn't even know anything about this whole thing. When the manager came in on Monday, she was really upset because this other person had called the fire marshal. I said, you can't reprimand her for that. She's doing her job; this is not safe. She's thinking of patients' safety. If there was a fire we'd never get anybody out of here. I think you need a real commitment from management to do what they're supposed to be doing, to fix the situation. I have quite a good manager. But it just seems like she doesn't have a lot of control of the situation either.

The whole hospital is in triple overflow. You read stuff in the paper about how they're getting the patients out of the emergency department, the waiting time, blah blah blah. Well they are getting them out, but it's to the detriment of the nursing units, because we have 3 people in overflow. We have 2 patients in a private room that only holds one patient. Pretty soon we'll have damn bunk beds. I don't know.

Q: What's UNA's role in improving the situation?

CP: I think that UNA, to control some of these situations, really needs to work on getting some kind of legislation about nurse-patient ratios. I know they have it in California; I know there's several of the states that have it. That's really what we need. In the movie I just watched it was talking about nurses being elastic bands. Even an elastic band has its stretch point where it snaps, and I think that's what's going to happen with the system. If the employer thinks they can push, push, push, they will continue to do so. You can only look after so many people in a safe manner. You can't be just increasing your workload, increasing your workload, increasing your workload. It's going to take some big disaster

to happen. We have had several that have hit the newspapers that have happened because of short staffing and people trying to do too much. They're honest mistakes, but they're fatal.

There are lots of mistakes. There are lots of medication errors out there that you don't even know that you did it. You think that you gave the right medication, the right dose to the right person, and sometimes you haven't. Fortunately there's no big outcome, but I may never know that I did that. Someone else might pick up that something happened, or it might go completely unnoticed. It will go unnoticed unless there's some kind of adverse effect. That's unfortunate, but that's what happens. But, on the other hand, if the incidents of medication errors are going up and people are reporting them, filling out the sheets, and they're not being used as a punishment for somebody, that's an indication that there's too much going on, the workload is too heavy, that people cannot practice in a safe setting. In my own little unit, the little medication room, if there's 3 people in there it's a crowd. Then someone's calling you and you're distracted, you could very well make some kind of error. You don't know you made it, so you never report it because you're not aware of it. It's a Catch 22. If you do something stupid, something that if you weren't so hassled and busy that you'd never do that, and you report it, then you're punished for it. It's because of all the distractions – the noise, the business, the closeness, the gotta-go gotta-go that's going on.

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

CP: I think that UNA should defend public Medicare. I read the horror stories from United States. I saw Sicko, I know what's going on. I've seen several documentaries on it. I remember my grandmother telling me: my grandmother raised me and my grandmother was 95 when she died. My grandmother was afraid to go to hospitals because she thought it was like going to the poorhouse. When she was having her children or whatever, people had to pay for things. My grandfather was a railroader; he was considered to be pretty well employed. She knew the poor people that couldn't get medication; she knew the women who died after having babies because they had no medical attention. She told me these horror stories, and maybe that was one of the reasons I went into nursing. I just can't see going without Medicare; we need the coverage. We need to have equal Medicare for everybody. Everyone's entitled to the very best care that we can give and they can receive.

[END]