

*We hear, but do we listen?*

---

Nurses' voices from Ontario



Linda McGillis Hall, RN, PhD

Diana Kiesners

Funded by The Ontario Ministry of  
Health and Long Term Care

FEBRUARY 2004

# *We hear, but do we listen?*

---

## Nurses' voices from Ontario

**ABSTRACT** These narratives were conducted with hospital nurses already participating in an Ontario-wide research study, designed to provide support and assistance to hospitals as they addressed work life issues for nurses in an attempt to create quality work environments. The eight semi-structured interviews in this study examined areas identified as major nursing workplace issues such as workload, nursing leadership, education, scheduling, respect, rewards and safety, as well as to elicit other possible areas of concern. Issues of retention and recruitment were also explored by asking nurses why they stayed in their profession, and what might make them leave.



### **Acknowledgements**

We gratefully acknowledge the Ontario Ministry of Health and Long-Term Care for their support of this research. The opinions reported in this book are those of nurses in Ontario as described to the research staff involved in this study. No endorsement by the Ontario Ministry of Health and Long-Term Care is intended or should be inferred.

We would also like to acknowledge the contribution of the Research Officer, Leah Pink.

Finally, we would like to thank Ontario's nurses, in particular those who took the time to participate in this study.

*We hear, but do we listen?*  
Nurses' voices from Ontario

Linda McGillis Hall, RN, PhD.  
Assistant Professor, Faculty of Nursing;  
New Investigator, Canadian Institutes of Health Research;  
Co-Investigaor, Nursing Health Services Research Unit (NHSRU);  
University of Toronto, Toronto, Ontario CANADA  
T 416 978-2869  
F 416 978-8222  
email: l.mcgillishall@utoronto.ca  
web: [www.nursing.utoronto.ca/l.mcgillishall/](http://www.nursing.utoronto.ca/l.mcgillishall/)

Funded by: The Ontario Ministry of Health  
and Long Term Care

Copyright © 2004  
ISBN 0-7727-3607-3

## TABLE OF CONTENTS

---

5	FOREWORD
7	INTRODUCTION
9	METHOD
9	Subjects
9	Location
10	Scheduling
10	Structure of interviews
11	Analysis
13	RESULTS
13	Acuity
14	Workload and understaffing
17	Multitasking
17	Workload measurement
18	Staff mix
19	Scheduling
20	Shift work
21	Rewards
21	<i>Financial</i>
22	<i>Structure of pay increases</i>
23	<i>Appreciation</i>
24	<i>Sense of helping; of making a difference</i>
24	<i>Challenged</i>
24	Respect
24	<i>Respect from the institution or management</i>
25	<i>Respect from patients</i>
26	<i>Respect from relatives</i>
27	<i>Respect from doctors</i>
28	<i>Respect from other nurses</i>
29	<i>Respect from government</i>
29	Availability of, and access to, nursing leadership
31	Educational opportunities and career mobility

## TABLE OF CONTENTS

---

<b>32</b>	Safety and injury
<b>34</b>	Time consuming tasks (and systems that cost time needlessly)
<b>36</b>	Equipment and supplies
<b>37</b>	Level of patient care
<b>39</b>	Absenteeism
<b>39</b>	Retention, recruitment and turnover
<b>42</b>	Increasingly technological nature of nursing care
<b>43</b>	Student supervision and preceptorship
<b>44</b>	Public perception or misperception of nurses and the role of media
<b>44</b>	Why nursing?
<b>45</b>	What keeps you in nursing?
<b>46</b>	What would make you leave nursing?
<b>46</b>	Children, family and childcare
<b>47</b>	Orientation and training for new nurses
<b>47</b>	Entry to practice
<b>48</b>	Allocation of health care funds
<b>48</b>	Change and instability
<b>49</b>	Is anyone listening?
<b>49</b>	The need to get involved
<b>50</b>	INTERVIEWS
<b>50</b>	Interview 1
<b>55</b>	Interview 2
<b>63</b>	Interview 3
<b>72</b>	Interview 4
<b>82</b>	Interview 5
<b>90</b>	Interview 6
<b>98</b>	Interview 7
<b>106</b>	Interview 8
<b>112</b>	CONCLUSION
<b>113</b>	REFERENCES
<b>114</b>	APPENDIX A
<b>115</b>	APPENDIX B

It is always a privilege to listen to the voices of nurses as they describe their work with patients and their lives in our hospitals. I call it a privilege because it allows us to see nurses work from the inside, from the perspective of those doing the work, and that perspective is a very personal one reflecting the dreams, frustrations and feelings of those nurses. The problem is that we have been listening to these stories for a number of years and in a number of forms and I'm not sure we are really hearing the messages clearly. Even more troubling is that if we are hearing nurses, we haven't responded, either because we can't seem to figure out how to respond or worse because we don't think we need to – at least not in a systematic and system-wide way. I should be clear that when I say we, I mean all of those who must listen, administrators, educators, policymakers and the public.

About ten years ago, I, Dyanne Semogas and Jennifer Blythe wrote a monograph about nurses' worklife. That monograph, *Towards an understanding of nurses' lives: Gender, power, and control*, was published at what we thought was the height of the "quality of nursing worklife crisis" and discussed the crisis with a focus on nurses as women and control over work as key issues facing nurses in the 1990s. These eight 2003 stories are painfully reminiscent of that earlier work. The two themes of control over work and managing the dual job career (home and hospital) are as compelling today as they were in 1994. These eight stories, with all of the limitations clearly identified in the text, tell us that the considerable turmoil and dramatic change in health care and health care delivery that have occurred over the past ten years have left nurses feeling more stressed, overworked and disillusioned with the workplace; the restructuring and reorganizing that promised more efficiency and greater effectiveness have eliminated the infrastructure and the human and material resources that nurses need to deliver quality care. And yet these nurses remain in nursing, remain in their jobs and continue to hold out the hope that they will be able to provide their patients with the care they need and deserve. Their ambivalence is powerful – *I love it and hate it; I'd quit in a minute and I'd do it again*; but their loyalty to their patients and to their colleagues is equally powerful.

These nurses, and the many other voices reflected in numerous research studies, have much to tell us about what nurses need in order to provide quality care – and we listen very carefully to the evidence of the challenges nurses face and the strategies required to retain and recruit nurses for today and for the future. These are stories about the inability to control one's work, one's schedule and one's practice. They are stories about never feeling you've done what you want to, ought to and know should be done. They are stories about being a woman in a women's profession but in a work environment that still pays little attention to the double shift. These are also stories about how hard the work is, physically, emotionally and spiritually and how it gets harder as nurses get older.

The voices are loud and the stories are clear. So why can't we really hear the voices? Why does it seem so difficult to make the required changes? Are the voices we hear irrational? Is it just too expensive? I would like to believe that after over forty years in nursing, I know the answers. Of course I don't. But I do know the following.

To respond to nurses' voices is to respond to patients' voices. These nurses' "wants" were all directed to enabling them to provide more and better patient care. To invest in the infrastructure nurses need – more support personnel, more and better equipment, healthy and safe environments – is to invest in patient care. We don't need more reorganizing and different models of delivery – we need to listen to and invest in those who are doing the delivering.

The design of nurses' work must change. The work of nurses must reflect their age, their dual responsibilities, their diverse abilities and interests, and most importantly their professionalism. Even though the stories sent very similar messages, the diversity and uniqueness of each of the nurses was overwhelming. At the risk of overusing an old cliché, *A nurse is not a nurse, is not a nurse*. Flexibility in scheduling, hours of work, shifts and places of work must become a priority. Being able to pick up a child at school or go to the kindergarten concert is not a privilege! It is not easy to organize the work of hundreds (and in some institutions, thousands) of nurses, but unless we try to give nurses more control over their work, we risk losing the ones we have now and the ones we want to recruit for the future. And that will be very bad for patient care.

It is time to hear the voices.

*Gail Donner, Ph D., RN*  
Professor Emeritus, Faculty of Nursing  
University of Toronto

## INTRODUCTION

---

In its 2002 final report, *Our Health, Our Future*, the Canadian Nursing Advisory Committee identified an urgent need to improve the working conditions of Canadian nurses. It warned that an aging population of nurses combined with a lack of new graduates signified a significant nursing shortage, a serious concern for a health care system in which nurses constitute one third of the workforce. The quality of nursing work life affects not only the recruitment and retention of nurses but also outcomes for patients, the system and families. The Committee indicated a number of crucial work life issues and made recommendations to help avert the health care crisis that could result if these issues go unaddressed (Advisory Committee on Healthy Human Resources, 2002).

The eight interviews presented here were conducted with hospital nurses already participating in an Ontario-wide research study, the Development and Testing of Quality Work Environments in Nursing (or QWEN). QWEN is an intervention study that developed out of concern for the effects of reorganization of health care in Ontario on nurses' work environment. It was designed to provide support and assistance to hospitals as they addressed work life issues for nurses in an attempt to create quality work environments. A quality practice setting was defined here as "one in which client needs are met within the quality framework mandated by the organization and where nurses are supported by strong organizational attributes to meet standards of practice" (College of Nurses of Ontario Quality Assurance Program, 2000).

As an adjunct to the larger study, semi-structured interviews were conducted with one nurse from each of the eight Ontario sites involved in QWEN. The nurses were asked to describe in their own words issues of importance to them in their working lives – "what it's like to be a nurse in today's work environment." The intent was to provide an opportunity for nurses to speak out about work life issues of importance to them; to obtain their valuation of designated working life issues; to discover other areas of developing concern; and to listen to their recommendations for needed change – to acquire, in effect, a snapshot of a health care system in transformation from the perspective of the nurse. The result is a descriptive document structured around a series of work life narratives, related in the nurses' own words.

The burnout of experienced nurses and the difficulty of recruiting new ones are at least partially due to a stressful and undesirable work environment. Many factors conspire to create stressful work conditions for nurses, among them: "heavy workloads, long hours, low professional status, difficult relations in the workplace, difficulty in carrying out professional roles, and a variety of workplace hazards" (Baumann et al, 2001, p. 1). Work life factors are interrelated in complex and intricate ways. Increased acuity, complexity and intensity of patient care combined with downsized nursing leadership have led to increased workload, while this in turn has resulted in decreased satisfaction and nursing morale, increased absenteeism and reduced quality of patient care (Advisory Committee on Healthy Human Resources, 2002). In effect, no single factor exists independently of the rest; tug on a string and the whole garment begins to unravel.

When Greenglass and Burke (2001) investigated the effects of hospital restructuring on nurses they found that the most significant and consistent predictor of stress among nurses in hospitals being downsized was workload. “The greater the nurse’s workload as a result of changes in the hospital,” the authors found, “the greater the impact of restructuring and the greater the nurse’s emotional exhaustion, cynicism, depression, and anxiety” (p. 104). Decreased job satisfaction, professional efficacy, and job security were also related to increased workload. Restructuring has also been found to have a greater, more negative effect on younger nurses, a finding with severe potential implications for both retention and recruitment (Burke & Greenglass, 2000).

Nurses believe that patients’ well-being and safety are increasingly jeopardized by deterioration of nurses’ working conditions (Nicklin & McVeety, 2002; Keddy, Gregor, Foster, & Denny, 1998). When patient care must be compromised because nurses don’t have enough time to achieve quality outcomes, job satisfaction and morale also suffer. These may be connected with high levels of absenteeism (Zboril-Benson, 2002). While intended to address issues of workload, workload measurement systems can in fact exacerbate them. As early as 1990, a large proportion of staff nurses were reported to feel that workload measurement tools did not capture true workload, and many found them too time-consuming (Cockerill & O’Brien-Pallas, 1990).

Restructuring and increased workload are also related to high levels of absenteeism among nurses. In one study, nearly 25% of 2,000 respondents reported that they had seriously considered leaving nursing; of these, half cited overwork and stress as their main reasons. Another 15.6% cited disillusion with nursing. High job dissatisfaction, full-time work, twelve-hour shifts and working in an acute care setting were also predictors of absence. This suggests that twelve-hour shifts may not be practicable in the present health care work environment, particularly for older nurses. When nurses were asked for a solution to the problem of absenteeism, provision of adequate staffing levels was the most common response (Zboril-Benson, 2002).

While a nursing shortage may result in short-term bargaining power for nurses, this power is highly market dependent and therefore liable to fluctuate. Some nurses have tended to advocate for themselves by leaving an undesirable work environment. Canadian nurses have most often migrated to the United States, but some have also gone to Britain or Saudi Arabia. Signing bonuses, educational support and full-time work are all incentives that can create a drain of Canadian nurses going abroad (Heitlinger, 2003). Frustrated with change, or lack of it, in the Canadian health care work environment, nurses have been voting with their feet.

The eight semi-structured interviews in this study were designed to examine areas identified as major nursing workplace issues such as workload, nursing leadership, education, scheduling, respect, rewards and safety, as well as to elicit other possible areas of concern. Issues of retention and recruitment were also explored by asking nurses why they stayed in their profession, and what might make them leave.

## METHOD

---

A semi-structured interview format was selected as most appropriate for the purposes of the study. The aim was to develop a descriptive document containing a series of narratives. It was hoped that the limitations of the small sample size would be offset by the richness of the data and the insights it yielded (Bowling, 1997) and that the responses of the interviewees might suggest areas of further investigation.

### Subjects

Interviews were conducted with one nurse from each institution involved in the QWEN study who had indicated willingness to discuss the work environment of nurses today with an interviewer. Names of possible interviewees were collected and provided to the study by QWEN on-site facilitators for each institution. The potential interviewees were contacted by telephone. They were informed of the purpose of the interviews and asked if they were still willing to be interviewed.

All of the nurses who expressed willingness to participate in these interviews were female. Responses to some issues might differ for male nurses but an exploration of this was unfortunately not within the scope of the study. The interviews were approximately one hour long. Almost all of the nurses were interviewed on their own time, which was limited.

The subjects were employed in either Medical or Surgical units in their respective institutions and presented a wide range of nursing experience: from nine months to 40 years. The range of experience was a fortuitous artefact that helped demonstrate how the concerns of nurses might develop throughout their careers. The compelling issues of nursing do not necessarily remain throughout a nursing career, just as the issues of recruitment and those of retention, though they may overlap, are not necessarily identical. Decreasing the physical stresses that cause injury to many experienced nurses will not necessarily attract more young applicants; neither will improvements related exclusively to compensation, education or career mobility address all of the work-related problems that force some older nurses from their jobs. In addition, as Letvak (2001) suggests, the cyclical nature of women's work may put them at a disadvantage in a hierarchically structured system; the requirements of family and children may also divert their career paths from a linear progression.

Seven of the nurses interviewed were employed full-time, though most had worked part-time at one point or another in their careers. One currently worked part-time, a situation that suited her lifestyle. Seven were RNs (Registered Nurses) while one subject was a Registered Practical Nurse.

### Location

Whenever possible interviews were conducted at the health care institution where the subject worked, both for the convenience of the nurses and to put them at ease by being interviewed on "home turf." Interview rooms were booked at their institutions so that the interviews would take place in privacy and would not be interrupted by work matters. In extrapolation of Marrow's (1996) comment that empirical research findings can take on an unreal character when that research is conducted away from the clinical setting, it was felt that proximity to the work environment might make it easier for subjects to connect with and discuss work life issues even when they were not on duty.

In fact only five of the eight interviews ultimately took place onsite as an outbreak of SARS in the course of the study caused some hospitals to be closed to visitors. The first five interviews were completed before the SARS (Severe Acute Respiratory Syndrome) outbreak; at the time of the sixth, SARS was still confined to Toronto region hospitals but concern was beginning to be felt in other regions of Ontario. The seventh and eighth interviews were conducted by telephone as those hospitals had been closed to visitors. In addition, one nurse indicated that she preferred to be interviewed by telephone and her wishes were accommodated.

### **Scheduling**

For the onsite interviews nurses were generally interviewed on their own time, before or after their shifts or in one case before an evening class. Only one nurse was able to schedule a meeting during her work day. The telephone interviews were conducted in the evening or on days off with the nurses situated in their homes.

### **Structure of interviews**

Interviews were semi-structured in that the interviewer to some extent guided the interview by asking open-ended questions related to the topics of interest (Bowling, 1997). Nurses were asked to talk about any issues related to their work lives that were important to them and that would help to illuminate “what it’s like to be a nurse in today’s work environment.” Specific areas of interest were derived from categories established as important to nurses by the Nursing Advisory Committee (2002). Some of the concepts and categories were therefore pre-established, while others emerged from the interviews and are discussed later in this document.

As the intent in the qualitative research interview is to discover “the interviewee’s own framework of meanings” (Britten, 2000, p. 13), the concepts and variables under study may change in the course of interviewing. As Britten (2000) describes them, semi-structured interviews are characterized by structural looseness. Open-ended questions indicate the area or areas of interest, which the interviewer or interviewee may explore or diverge from. It should be remembered that observed behaviour may differ from reported behaviour – that is, what people say they do in interviews is not necessarily what they are seen to do. This important caveat aside, the information yielded in this type of interview may be extraordinarily rich in contextual detail and meaning.

Various techniques have been recommended for conducting qualitative research interviews. According to Britten (2000), the interviewer should begin with questions that are easy for the interviewee to answer and move toward difficult or sensitive issues in the course of the interview. Cohen and Manion (1989) found a “funnel” approach to be useful, in which the interview begins with a wide focus and gradually becomes more specific. Price (2002) stated that, though it is important not to force data or shape it according to research or other paradigms, entirely undirected interviews often produced results that were relatively superficial. He suggested that probes be structured at three levels of inquiry: action, knowledge and philosophy. Questions should be formed according to their level of anticipated intrusion, descriptions of action being assumed within this framework to be the least invasive and philosophical questions – those concerned with beliefs, values and feelings – the most. Knowledge-based questions are best asked in the middle of the interview. This “laddered” technique was used when possible and when probes appeared necessary.

Unless a topic had already established itself during pre-interview conversation, the interviews generally began with: “Has anything happened recently in your working life that made a big impression on you or that you’d like to talk about to start off?” This sometimes served to create a concrete opening for the discussion, though on occasion the subject was unable to think of any particular event. Anecdotes often emerged later, triggered by other areas of discussion. The questions “Why do you think you have stayed in nursing?” and “What do you think would make you leave nursing?” were generally asked towards the end of the interview (unless there was a clear opening earlier for such a question) because they are more attitudinal or belief-oriented questions and could therefore be perceived as more threatening. Appendix A provides a list of questions and topics covered.

According to Britten (2000), “qualitative interviewers try to be interactive and sensitive to the language and concepts used by the interviewee, and they try to keep the agenda flexible. They aim to be below the surface of the topic being discussed, explore what people say in as much detail as possible, and uncover new areas or ideas that were not anticipated at the outset of the research” (p. 13). To this end, the interviews were conducted in as colloquial a manner as possible. Technical language was not discouraged but explanations of any technical terms or procedures were requested. Instructions (Appendix B) and questions (Appendix A) were not read verbatim but relayed in a more spontaneous manner in the hope of creating a more relaxed environment. In most, though not all, cases, this was effective. The interviews were tape recorded and the nurses were informed that their identities would be protected. They were told that they should not worry about a logical progression of ideas as their interviews would be edited for coherence and grammar and that they could return to previous questions at any point in the interview. They could veer off-topic if they wished to elaborate on issues raised earlier in the interview. It was hoped that more profound data would be obtained if self-presentation was not a cause for concern to the interviewees. Some sharing of personal information by the interviewer was seen as legitimate to redress any perceived power differential and to make subjects more comfortable. Interviewees were told that they could stop the interview or interrupt taping at any time to ask questions or take a break.

Following the interview, subjects were asked whether they wished any details or portions of the interview deleted. Every attempt was made to ensure that the subjects were satisfied with the outcome and course of the interviews, and to ascertain that they had no reservations about what had been discussed. They were told that if any such reservations arose at any time following the interviews they should not hesitate to call the interviewer to discuss them, and that if there was any part of the discussion they wished excluded from the study their wishes would be honoured.

## **Analysis**

The transcripts were analysed with reference to the topic areas established before the interviews and new categories that arose in the course of interviewing. The transcripts were then edited into a single-person narrative. Where necessary, grammar was corrected and some statements reordered with an eye to coherence and to preserve the dignity of the respondents. Care was taken to maintain the nurses’ viewpoints and the balance of their arguments – to maintain their emphasis, their words. The narrative approach was chosen because it “stresses the importance of the story the respondent has to tell.... Data need to be presented so that

their richness is not lost” (Bowling, 1997, p. 349). It was therefore considered important to present the narratives in near-entirety as well as in excerpted form. Issues of identity and control over self-identity are also involved when dealing with personal narrative. Interviewees’ narratives are intimately connected with their sense of individual identity and “when participants lose control over how their narratives are interpreted and generalized upon, they also risk losing control over self-identity” (Richards & Schwartz, 2002, p. 136). The parameters of respondents’ lives cannot but inform their attitudes to nursing issues. Younger nurses do not report physical strain as often as older nurses. A nurse who is part-time because she also runs a business has a different attitude towards part-time work than someone who seeks full-time employment in nursing and cannot get it. Without context, these responses become less meaningful, perhaps even misleading.

Narrative structure can also be helpful when a particular incident or day becomes emblematic for a nurse of the whole work environment or direction of nursing worklife. For one nurse, it was a particular shift that encapsulated the desperation she was feeling. To excerpt too much in such an instance could reduce the integrity of the documents and deny in some way the very heart of the nurses’ experience.

Nurses’ names were changed as well as the names of health care institutions; details of geographical location were usually removed. Where any specific characteristics appear it is with the express permission of the nurses who participated. Unfortunately it is not always possible to predict which details, or even speech mannerisms, may make participants identifiable (Richards & Schwartz, 2002). The presentation of entire narratives would tend to increase the probability of recognition. For that reason, interviewees were asked at the end of each interview about any details that might be identifying and asked whether they wished them to be excluded. They were also told that if they changed their minds or thought of such details after the interview, they could and should call the interviewer so that these could be excluded.

## RESULTS

As might be expected from their age range and variable years of experience, the nurses interviewed differed somewhat in their responses. However, certain issues surfaced again and again. Some were predictable, such as issues of workload, understaffing and patient acuity. Others were less expected, such as the extent to which decreased quality of patient care seemed to affect job satisfaction for most respondents. Some nurses who were extremely unhappy with the direction of nursing and health care in Canada nevertheless expressed a sense of vocation, feeling that nursing was still the best profession for them. Dissatisfaction with work life characteristics ranged from extreme to slight. Even the most positive respondents found room for improvement in their work environment.

### Acuity

The factor reported by all eight nurses as a major cause of stress in their working lives was patient acuity. Patients were sicker; they presented with multiple conditions rather than just one:

I think the major source of stress for nurses is that patients are sicker nowadays. Patients are not coming in with just COPD, for example. They're coming in with COPD and congestive heart failure and kidney failure – you know, every system is going. So that's a lot of time for a nurse because you're not just focussing on one area. You're focussing on every area and acuity has gone way up there. And there are that many more procedures. And paperwork (see Interview 2).

Whereas a nurse might once have been required to care for three very sick patients out of six in a shift, now all six could be critical or “fresh post-op.” Less critically ill patients who would once have been hospitalized are often dealt with on an out-patient basis, raising the average acuity of those patients found in hospital.

They come in and they're really, really sick. It's hard because if you've got four patients and they're all really acute then you're running around trying to make sure everything is done whereas if you've got at least one patient who can manage a little bit on their own or do something for themselves, then it's not so bad (see Interview 4).

In addition, the patient population (as well as the nursing population) is ageing: “And our patients are getting older. As well as their medical problems, now they're recovering from surgery so their other problems are compounded” (see Interview 7).

Issues of acuity are of course connected with workload, which is itself influenced by nurse-patient ratio and staff mix. However, it is striking that of all the factors considered in the interviews, increased acuity was the one agreed upon as major by all respondents. In general, the patients are sicker, the nurses are fewer, and the result is increased stress and sometimes injury.

Although acuity is agreed to have been on the rise for some time, nurse-patient ratios often have not reflected this increase:

The acuity is high, very high. You have very ill patients. We are the only active Medical floor in the hospital. It's a sort of almost step-down from ICU or a step-up to ICU, whichever. So you do have very ill patients. The acuity has been increasing over the years with no extra staff (see Interview 8).

We have a lot of really sick patients right now but our nurse-patient ratio doesn't change. If you have four patients, you might have two that are really sick and two that are less sick. They're all sick, but their acuity levels will be different. A four-patient workload with varied levels might not be as difficult as a four-patient workload where the acuity for all four is at the highest level. In general, the acuity is probably increasing (see Interview 1).

### **Workload and understaffing**

Workload was also reported to be extremely high and appeared, even to the minimally experienced, to be increasing:

I haven't been a nurse for that long, but a lot of people seem to be saying the same things – that it's too hard or that people are staying later at work because they didn't have time to finish everything during the day (see Interview 1).

A nurse with 21 years of work experience felt that the increase in workload was accelerating:

It's amazing but I just don't think anything has been as bad as it has been in the last five years. I'm trying to think of why that is and all I can think of is just that people are getting older; they need more help with activities of daily living, like just washing, dressing and walking because of physical infirmities. We have so many more machines attached to people nowadays. I really do think that we had better staffing in the past" (see Interview 5).

Depending on the nurse and the institution, workload might be rated from somewhat stressful to so crushingly high that interviewees were considering leaving their institutions or jobs because of it. One nurse repeatedly used the word "frantic" to describe her work situation. To an interviewee who had been a nurse for 40 years, the effects of current nursing workload on the profession were overwhelming:

You go home every day knowing you haven't completed your job. There is no way that you can finish your workload. You have to decide on what is most important and hopefully what is left isn't and wasn't that important because there is just too much for the workload, for the amount of nurses. The hospitals have cut and cut. You are portering and you are lifting, you are taking on the job of the orderly. You are everything (see Interview 8).

The majority of nurses reported extreme physical exhaustion at the end of shift and the sense of having been on the run throughout.

Because of increases in patient acuity, nurse-patient ratio was not necessarily an accurate predictor of workload. As one nurse explained, "I used to be able to handle four or five [patients], even six, at St. Gertrude's quite nicely because usually several of them were going home or they weren't that sick, but when you have six that are sick..." (see Interview 3). No matter how hard or how long nurses worked, there didn't seem to be enough hours in the day to handle the workload. Some nurses reported missing breaks and/or meals on a frequent basis: "Lots of times we don't take an afternoon break – that's almost non-existent – and a supper break. We don't take care of ourselves break-wise because we want to get out on time" (see Interview 5). The lack of respite could be extreme:

Quite often I work shifts with very little break. I have even worked twelve-hour shifts with no break, especially on the midnight. You could not leave the floor. I sit there and eat my sandwich while I'm charting and you hardly have time to go to the washroom" (see Interview 7).

Furthermore, the nurse may be held responsible for not being able to manage her time in this unmanageable situation: “they say it’s your fault – that if you need to go for break, you should go for break. But, you know, you go for break but you still have your work to do when you get back” (see Interview 7). One nurse said she knew that if she took her breaks she would have to work overtime in order to get her work done. She felt, however, that “it’s better to work the overtime. I know I feel better if I go and take 20 minutes and sit down” (see Interview 3). Some thought their health was being affected.

I think that nursing is affecting everybody’s health with the length of the shifts, the stress, the physical demand of the night shifts. It has to take a toll on someone’s life. I just have a nurse’s back and am emotionally exhausted every day. I come home and I think, “Now tomorrow when I go back I will be positive,” but it takes me five minutes on the floor and I’m back in the same boat I was before. Because situations do not change (see Interview 8).

The stress and burnout of excessive workload could be accompanied by high levels of absenteeism. Because it was often difficult to replace staff on short notice and because some institutions had the practice of replacing the second sick call on a shift but not the first, absenteeism further increased the workload for the remaining nurses and, in a circular manner, contributed to their stress and potential absenteeism. When acuity was high and workload was at a critical level, the practice of not replacing the first sick call placed a terrible burden on the nurses who were present: “When somebody calls in sick they don’t replace and that’s just brutal. They don’t replace the first sick call. The second they try to replace but when you’re working with the bare minimum...” (see Interview 7). If there was a second sick call – if two nurses were absent – the unit would begin calling around to try to find a replacement nurse. However, this wasn’t always possible; casual and part-time pools might be already over-used and replacement staff simply not available. Even if a replacement could be found, there was a sometimes lengthy period of time during which nurses had to deal with an inadequate nurse-patient ratio. Nurses might end up staying at work for extra hours, even though they had already worked a full twelve-hour shift.

A part-time nurse who was frequently called in to replace absent staff said:

When you come in, it’s nothing for the Ward Clerk or the Resource Nurse to have called ten to twelve people and got ‘nos’. Just this week there were two night shifts where they went short because they weren’t able to replace anybody....

What you do is you put that you’re available on your days off. If you put that you’re not available they’re not supposed to call you but they sometimes do because they’re so desperate. If you put that you’re available you’ll get called every day to go in every shift of every day. If you said yes before, they will keep calling you because they’re always very busy and always very desperate (see Interview 3).

For one nurse, a contentious issue was trying to balance her duties as Charge Nurse and her patient load, a balance that was easier to achieve on some days than on others:

On some days it doesn’t work at all, because I still have a patient assignment even though I’m the Charge Nurse. I have three. Sometimes that’s hard if there’s stuff going on because you’re striving to look after your patients and there’s other stuff going on and you feel like you’re being torn (see Interview 2).

High workload and the resultant stress were also linked in some nurses' minds with both nurse and patient safety – when nurses were rushing around, accidents were more likely to occur and nurses were more likely to injure themselves.

Workload as an issue is affected by acuity, absenteeism and understaffing. It in turn affects stress levels, perceived quality of patient care, absenteeism and possibly risk of injury to nurses. Often understaffing is a budgetary issue, but some institutions are finding it difficult to recruit nurses even when they actively seek them. It's impossible to overestimate the importance of workload as a factor in the working lives of nurses. Some felt that even talking about other factors served to obscure the importance of this central issue:

I think a lot of people would be happier even not talking about money. I think it's the workload. It's the workload that is getting to everybody these days. It's the sheer mental stress that is involved. You come home and you bring it home with you and you're just exhausted because of the workload. You bring the tiredness home, the stress levels home (see Interview 8).

I think workload is everything, work environment is everything. I've stuck with it as long as I have because of the people and the work environment I had. This is very stressful, what's here. You'd always have a day where you had a stressful day, that's part of nursing, but you shouldn't have to work 150% every day. It gets to the point where you can't even say hello. You should be able to breathe. You should be able to do it at a natural pace instead of always being pressured and pushed and that's what's happening here (see Interview 3).

We need porters, we need RNs, we need more RNs and RPNs to create a pool so that when we have sick people we don't have to come in on our days off, which we're doing, and so that when we ask for a vacation day we can get it, which we are being denied. This summer looks really, really bad. You are just told that you have been denied because there's nobody to replace you.... We have been told to come in when we're sick because there's nobody to replace us (see Interview 8).

The absence or insufficiency of non-nursing staff such as porters interacted with and created other problems for nursing staff:

We don't have enough time to get all the diagnostic tests done during the week so they're being done on Saturday and Sunday. But we don't have the portering staff to take them down so the nurse takes the patient down on Saturday and Sunday for CAT scans. Legally there has to be at least one nurse in the X-ray Department during a CAT scan, if there isn't one scheduled to work. The X-ray Department has complained bitterly to the nursing staff to try and get more staff down there to cover this. It takes a whole hour to give an injection of the dye – there's a risk, right? So you end up going down for a whole hour with this patient. On a Saturday or Sunday! So you're missing from the floor. Somebody else is covering your patients (see Interview 6).

Usually there's a porter available, but not always on shifts. Sometimes in the recovery room we have to go pick up the patient if the recovery room nurse can't leave. Then two of us will have to go (see Interview 3).

A patient going for a CAT scan, a patient going to minor OR for a procedure, a patient going to the OR, a patient being transferred to ICU, anything like this that might need a porter, there isn't a porter (see Interview 8).

With porters in short supply, in some institutions volunteers are helping with transport. However, their participation is limited; the nurse still has to “get the person onto the stretcher – [volunteers] aren’t allowed to do that because of insurance” (see Interview 5).

The requirements of the unit were not necessarily reflected in the staff mix:

On weekends we’re still doing x-ray stuff, we’re still sending up to the OR, just like Monday to Friday, but we’re down one nurse and we don’t have a desk clerk after 3:00. So a new patient comes in. You’re putting the chart together, which has got a lot of documentation, ordering the reqs, phoning – maybe we need an ECG because we know that there is going to be OR time in about two hours. So then you’ve got to phone the RT to do the ECG because there’s no ECG Tech. The nurse is now answering the phone to the relatives, putting the charts together, trying to look after the same amount of patients. Weekends are not fun (see Interview 6).

It was often reported that technology had actually increased nurses’ workload:

We have morphine pumps, epidural lines, femoral lines, so you’re doing vital signs frequently. For post-op, on a PCA (patient controlled analgesia) pump, you have to do vitals every hour for twelve hours.... For five years we’ve had PCA pumps, patient-controlled analgesia. To change the rate of the cartridge now takes two nurses. There are *so* many problems with the pumps that for accountability – holy smokes! They haven’t saved anything (see Interview 6).

One nurse said that she knew extra staffing was the solution but also knew that funds didn’t exist to implement it, causing her to feel hopeless about the whole situation:

But if I were to say what the solution is, once again it comes down to more staffing. And I know that’s not going to happen because, the way it is now, we don’t even have the funding to complete the new hospital (see Interview 5).

### **Multitasking**

The pressures of time and workload meant that nurses were constantly multitasking, doubling and tripling up on activities, performing diagnostic functions while carrying out routine tasks:

You have to start asking questions right off the bat. While you’re bathing them: “Okay, who do you live with? Where do you live? How are you getting home? What do you know?” Because you have to. You don’t have time to say, “Okay, now we’ll discuss your ileostomy.” While you’re making the bed you’re saying “Oh, the ostomy nurse – do you know if she’s booked to come in on Tuesday to discuss the types of prosthetics that you’re going to need and give you the forms for the doctor to sign to have it paid for?” (see Interview 6).

### **Workload measurement**

Some nurses expressed dissatisfaction with these tools and with paperwork in general, particularly when they did not result in any action taken on their behalf or when hospital management used them to further burden nurses:

And that’s why some people at work now are getting very frustrated about doing GRASP. They feel, “What does it really matter?” Because we feel that this is just something the hospital instituted as part of accreditation so they could get funding – not necessarily so that it would help our workload. And that is really what it comes down to now in our workplace. We just feel we’re doing a lot of paperwork that doesn’t really help us out in the long run” (see Interview 5).

One nurse who logged 24 patient care hours in a single shift wondered if anyone noticed: “I often wonder why we’re doing these things. Does anyone ever look at that and say, ‘Wow, better not let that happen again!’” (see Interview 3). They suspected that most technologies presented to them as labour-saving devices actually increased workload and were used as an excuse to reduce staffing or to introduce other organizational economies.

Now we have very expensive monitors because you have to be doing vital signs every 15 minutes for a couple of hours. So you’re in there all the time, it’s almost one-on-one nursing care. But you don’t have one-on-one staff (see Interview 6).

There was also a perception that aspects of the nursing experience could not be captured or quantified in this way: “You can’t really explain on a piece of paper why it took you so long today to do things” (see Interview 1).

### **Staff Mix**

There was little uniformity in staffing combinations across institutions. Some were moving toward or had recently adopted an all-RN staff mix; some employed a combination of RNs and RPNs (Registered Practical Nurse), or of RNs and PCAs (Patient Care Assistant). The various combinations made it very difficult to make comparisons across hospitals as the different types of staff affected different aspects of nursing workload in different ways. In addition, there was a wide range of patient-nurse ratios.

The absence of certain types of staff was keenly felt by nurses in hospitals where they were scarce. Unit clerks were considered very desirable but these were often only available on day shifts. Porters seemed always in short supply and it fell to nurses to provide time-consuming and arduous transport:

We need desk clerks, and two orderlies on days for doing the transporting. Not only for transport, but for getting the patients – the heavy ones – in and out of bed and stuff like that. You have to wait to get help all the time (see Interview 6).

We do our own transport. If it’s a sick patient, we go with the patient. If they’re going for a test or procedure we have to accompany them, with a porter as well. If a patient is coming from our step-down onto our floor and we have to move quickly because of a sick patient coming from somewhere else, we nurses will move the bed ourselves (see Interview 2).

On the whole, those nurses whose hospitals were moving toward or beginning to adopt an all-RN staff mix didn’t mind the idea or were cautiously optimistic about it. While RPNs were considered helpful and professional, RNs assumed responsibility for the RPNs patients as least so far as medications went, so that some RNs said they preferred to perform total care but with a lower patient-nurse ratio:

When I first came and there were the RPNs and they had their patient load and you were responsible for the meds only, technically you were still responsible for them. If anything critical happened to their patients you were still responsible. So if you had your six or seven patients and they had six or seven patients, plus you were doing their meds, you were actually twelve for the day (see Interview 2).

As one nurse said in an institution where the RPNs were all being moved to another hospital, “I don’t mind the complete care, it’s just I can’t do it for that many people” (see Interview 7).

As for the non-nursing tasks that would necessarily devolve to them, “we were doing them anyway. I was doing the baths, I was doing the vitals. I was doing the Glucometers, getting the patients up to the bathroom. Everybody worked, whoever was available” (see Interview 7). Some said that they were able to assess patients while bathing or performing other mundane tasks.

In terms of doing everything – well, at least you’re getting to know the patients too ... Even the basics – the bowel movements – you’re there, and while you’re doing it you can check their skin. While you’re doing their bath you’re checking for oedema. You can do a lot of assessment that way (see Interview 7).

Where nurses were accustomed to working with RPNs they usually looked upon the situation favourably:

Our RPNs are excellent. I don’t have a problem with the staff mix that we have. I wouldn’t want to see it changed. The RNs are of course able to do the epidurals and the things that the RPNs aren’t able to do. As I say, the girls we have are very experienced and very good at what they do (see Interview 3).

Orderlies were also sorely missed, both for help in transport and for physical support when nurses needed it. One nurse spoke of an elderly patient who was nevertheless strong enough to hold off the female nurses:

There are no orderlies any more so you’re pretty well on your own unless you have a male nurse working on the unit. We have two at present – both part-time, so they’re not there all the time. We rely on each other for help (see Interview 4).

Some nurses would appreciate any kind of additional help, particularly with time-consuming tasks that do not require a nurse:

I think it would be nice actually to have health care aides just because I think there are a lot of little things that they could do that would make your day go more smoothly. I’d rather have seven people to look after in terms of their overall health if health care aides could help with the bath and do all the little things that are time-consuming (see Interview 1).

## Scheduling

Scheduling was reported to be a major worklife issue by more than half of the nurses interviewed and was often cited as a reason why nurses might choose to go to the United States rather than work in Canada (the perception being that self-scheduling was more often available to nurses in the U.S.):

The nurses who go to the States get more say about their scheduling. They can pick their shifts. They can say when they’re available. They have self-scheduling, a lot of those hospitals (see Interview 7).

Generally nurses stated satisfaction with master schedules in which they could indicate preferred rotations: “Our unit, we’re just starting a master rotation. Our management in our area look at making staff happy. If staff are happy, staff work better, staff aren’t so stressed out” (see Interview 2). Unhappiness was expressed when there was difficulty trading shifts or getting time off (to go to a conference or attend to family matters):

I think that self-scheduling would help a lot. Getting time off is really, really hard here. Because there’s no staff. We have four part-time and one was on a sick leave and the other three were

scheduled to work that day. And you can't switch shifts. Switching is really too hard. In order for me to switch a day I would have to work six or seven in a row and so would the person I'd switch with. And that's just too much when they are really hard physical days. So, it's hard to get time off and even when people do make special requests they're denied (see Interview 7).

In the worst case scenario, the nurses on a unit were not only denied self-scheduling but were told they couldn't take vacations unless they could find another nurse to trade with them (see Interview 8). Absence of flexibility also meant that some nurses were denied the possibility of obtaining further education while working in their institutions (see Interviews 7 and 6). Long days or nights made it difficult to pursue any kind of further education: "It's very difficult with twelve-hour shifts to do ongoing learning. You have to rearrange your shifts and that. So mostly people will do like computer, distance learning – just at-home stuff" (see Interview 5).

### Shift work

There was also little sense of control over the types of shifts worked. One nurse changed units, attempting to move from a twelve to an eight-hour shift, but found herself thwarted:

I was working a twelve-hour shift in Intensive Care and there was an eight-hour position, full-time, available and I took it to get away from twelve-hour shifts. But then of course my full-time [position] went to twelve (see Interview 8).

Shift work was sometimes considered an inevitable downside of nursing, one that couldn't really be eliminated. Some nurses preferred eight-hour shifts; some reported that younger nurses might prefer twelve because of the increased number of days off.

When I first started nursing I loved the twelve-hour shifts because I thought, "Well, this is great because I'll have more days off," and I seemed to be able to go on less sleep. But now that I'm older – 47 now – I really wouldn't mind an eight-hour shift Monday to Friday (see Interview 7).

Most didn't like working nights, though the youngest nurse interviewed said she had no problem with nights if she could have enough time to adjust to the change from days to nights. As might be predicted, there was a general sense that night shifts were more difficult for older than for younger nurses.

Nights were considered difficult for a variety of reasons:

Nights are busy because there's a lot of paperwork. It's a critical area. We have morphine pumps, epidural lines, femoral lines, so you're doing vital signs frequently. For post-op, on a PCA pump, you have to do vitals every hour for twelve hours. That's fairly often because you've still got five to seven patients on evenings. You've also got dressings and packings and pain stuff and antibiotics at 6:00 and sleeping pills and antibiotics at 10:00. And just pulling them up and changing the diapers and emptying the colostomy – whatever. Nights are as busy as days for a variety of reasons. You have less staff doing the same amount of work. Not as many ORs, but you can have some. You have admissions so you have to clear the bed and all the rest (see Interview 6).

A Charge Nurse who had worked in her institution for 13 years said, "I don't like nights per se. I think as you get older nights get harder and harder to do" (see Interview 2). One nurse coveted a regular, nine to five schedule so much that she left nursing for administrative work. However

she found it impossible to adjust to the very predictability she had sought and returned to nursing with the realization that the variety of shift work could also be a plus:

As much as I complain about it, I like to have the split up of time. If I had to come in all days I think that would just kill me. And if I had to go all evenings that too would kill me (see Interview 4).

Shift work means that families must juggle child care and other family responsibilities. In some cases night shifts are desirable so that spouses can spell each other, though this may also place incalculable stress on relationships:

I once did four years of permanent nights because of my family. I was only working three days a week and my husband had three days off so I could do nights and he could do days. We managed. We always worked opposite shifts. He would start at 6:00 and I would start at 3:30, because he'd be home at 2:30 and I'd leave home at a quarter to 3:00 (see Interview 6).

## Rewards

### Financial

Most nurses identified their main workplace concerns as non-monetary:

I'm happy with my pay. I think I get paid well. I don't have any issues with my pay at all, but mind you I'm at the top of the ladder right now. No, I just wish I didn't have to work non-stop for it when I get there (see Interview 5).

The pay is good, that's fine. I have no complaint with my salary. But the workload and the pressure are astronomical. People don't want to work overtime because they're already tired. It doesn't matter that the hospital will pay you overtime – you're dead (see Interview 6).

Even for those who declared themselves to be happy with their pay, there was a sense that they couldn't be paid enough for the kind of pace they were expected to keep up:

I do feel that I earn every cent that I make, if that makes any sense. I certainly feel that I am worth what I make and many days I feel maybe I deserve more because of the effort I put out and the responsibility I take (see Interview 8).

Others thought that, given the responsibilities of nurses and the critical nature of their work, they should be making more money than those in professions whose outcomes were less crucial:

It was nice to start at the wage that I started at. But when you compare it with other jobs – they're getting this much, and I'm dealing with people whose lives are in my hands. When you compare the salaries you think, "This doesn't make sense. Why am I getting paid either the same as or less than somebody who's not dealing with people's lives?" (see Interview 1).

Everybody has a purpose and a job and I don't knock anybody's profession, but when you can compare my job to a plumber's job or an electrician's job or a factory worker's job – I am in charge of people's lives. And when you look at it that way and because of our increased responsibility, I think we're worth a lot more than what we get (see Interview 2).

Inadequacies in compensation were perceived in various areas. One nurse thought that there should be more of a shift differential and that "the pay should be higher to cover the fact that you're working more weekends"; also that increased benefits and vacation time could be used as incentives (see Interview 6). Another thought that nurses working in different areas should not necessarily receive the same compensation:

Since I have worked in ER and I have worked in ICU, I find that perhaps paying a nurse working in a long-term setting as much as she is making in ICU, that's something to look at. A nurse working in ICU has educated herself more in order to get in that position (see Interview 8).

Some thought that nurses should be better compensated because of the increased responsibilities and complexity of their jobs. The single RPN interviewed felt that the increased scope of practice of RPNs in her institution should be reflected in their pay. Also problematic for RPNs was the fact that their wages were contracted with individual institutions with the result that RPNs in other regions and even other institutions within the same region might earn as much as a few dollars an hour more or less. Many interviewees thought that material compensation was a major reason why nurses might leave to work in the U.S. This would tend to support the opinion of one nurse that, while it is often claimed that money isn't an issue, it is in fact important both in itself and as a symbol of recognition: "They *say* money isn't important, but listening to people on the unit you realize that money *is* important – and recognition of a job well done" (see Interview 4).

### **Structure of pay increases**

Opinions were divided as to the structure of pay increases for nurses. Some felt that the standard nine-stage series of increments was adequate and provided incentive for nurses to remain in nursing. A junior nurse felt that the current structure of increases provided incentive to nurses "because you'll reach that maximum after, let's say, eight to ten years. That's pretty good considering there are a lot of other places where you'll stay at the same salary for a longer period of time." And yet it sometimes wasn't sufficient in view of the immediate experience of workload and patient acuity: "Sometimes you don't think it's enough of one when you're in the situation itself – it's like, "I don't get paid enough for this!" (see Interview 1).

Another nurse felt that the difference in pay between the bottom and top levels wasn't sufficient but that there were non-financial ways to address this:

The last contract, if you were at the top – if you had 25 years seniority – then you got an extra week with pay. That was new. So that's more vacation time with pay. That's an incentive. You now have almost the same vacation time as teachers! You have seven weeks (see Interview 6).

One (senior) nurse suggested that, because beginning nurses in her institution were frequently thrown into positions of responsibility with little preparation, they should be paid at the same level as senior nurses performing the same work: "If you're doing the same job as somebody else, no matter how long you've been here, you should be paid the same. So waiting nine years to get to the top level I don't think is correct" (see Interview 7). Another nurse who had long ago reached the top of her pay scale jokingly complained that there was nothing to look forward to: "It's good for the people who are climbing up, but once you're sitting on top it's like, 'I want something! Give me something more!'" (see Interview 2).

A part-time nurse said that she wasn't unhappy with her pay but that "as a part-timer it's always been difficult without benefits" (see Interview 3). Given the large number of hours she worked, she felt that some type of reasonably priced benefits package should be available to her. Instead she was obliged to purchase them from her husband's professional association.

## Appreciation

Appreciation as expressed by patients, superiors, doctors and other staff was viewed as one of the potential rewards of nursing. Appreciation and expressions of it were in some instances related to respect for nurses. One nurse perceived respect to be one of the rewards of a nursing career:

a lot of people respect you for being a nurse and that's a reward in itself. When you tell them, "I'm a nurse," they say, "Oh really? That's so great!" ... People say it takes a certain type of person to be a nurse. It makes you feel good. You get the same thing from patients and families when you're helping them and things turn out, because they thank you (see Interview 1).

Perhaps because they received so little of it, all forms of appreciation were valued by nurses. As one nurse said, people were more likely in all situations to express dissatisfaction than appreciation, particularly when it was associated with a notion of service (see Interview 7).

It's nice when people acknowledge you. It's nice when someone has been a patient and they send like a basket of fruit or something and say you've done good nursing care. It's nice when you see a letter written up in the newspaper about the good care that they've gotten. That's very nice (see Interview 5).

Where acknowledgement was not forthcoming, it was missed. One nurse longed for some type of evaluation:

You do receive acknowledgement the odd time. But I think maybe there could be more evaluation so you know where you stand. There's always that unknown: "What are they really thinking?" I don't know, I've never had an evaluation since I've been here. I think I had maybe one evaluation in 27 years. You do receive verbal validation the odd time but I think it should be more of an ongoing ... I think people need to be told, "Oh yeah, that was good" (see Interview 7).

However, appreciation was not a sufficient reward when workload reached a particularly acute peak:

I had a lot of gratitude from the patients – they said, "Wow, thank you so much," and "You did so much even though you were so busy." And normally that gets me through. When someone pats you on the back you think, "You know what? I made a difference today." But it wasn't like that. It was too overwhelming to even feel good about what I had done because I knew there was a lot more that I could have done or would have liked to have done (see Interview 3).

One institution was reported to emphasize acknowledgement and feedback at all levels:

We get a lot of peer feedback from the doctors. If there was a crisis and we all worked really well together they'll thank you and our managers will also. Anytime we do something good they'll send us a note or they'll come and talk to us personally. We have gotten notes from other floors – you know: "Thank you for moving quickly to get this patient over." In April or May we have a staff recognition and you can nominate different staff for an award, someone who you think is contributing well to the hospital (see Interview 2).

Others seemed to have few systems in place for making sure that messages of appreciation were sent and received:

Sometimes “thank you” would be sufficient. When good things happen, say “Thank you” – don’t just jump on the bad things and say, “Well, we got a letter.” Most of the time you hear about the bad things, but you hardly ever hear when the patients or the family write and say nice things about you. You just hear about the bad things – what you didn’t do or what somebody complained about (see Interview 4).

At worst, a nurse in one institution felt utterly unacknowledged and neglected both by patients and her institution:

The patients don’t really acknowledge us going above and beyond in the work we do. I don’t think that the hospital knows. Or maybe they know, but I don’t feel that they care. I don’t find that they make things easier in any way (see Interview 3).

Good working relationships were considered supremely valuable where they existed. In addition, one nurse said that humour and fun were essential in her workplace:

There are problems like there are going to be anywhere, but we try to work it out and we always have a lot of fun. That’s one rule on our floor. We laugh a lot. We have a lot of humour and smiling and chatting – you have to – and when somebody’s not having a good day, we know they’re not having a good day. You know, if they want us to stay clear we stay clear, and if not, we’re there for support (see Interview 2).

### **Sense of helping; of making a difference**

The sense of having succeeded in helping patients was often reported to be both personally and professionally rewarding:

If I had to pick a single thing that was most important to me about being a nurse it would be coming to work and having a really ill patient and, after nursing that patient, seeing that patient go home. That’s my reward. Sometimes it’s nice, the thank you, but you don’t expect thank you. When I see them go home, I feel good about that (see Interview 4).

### **Challenged**

Even in the absence of other types of reward and in a difficult work situation, a sense of challenge motivated one nurse:

But I like the challenge. Every day is different. You may think that you know what you had yesterday, but you don’t. Things happen every day. So it’s exciting, it’s a challenge – never boring, never (see Interview 6).

### **Respect**

One nurse felt that disrespect for nurses was the norm and was demonstrated at all levels: “You get disrespect from patients, from their families, and from the physicians and sometimes from your coworkers” (see Interview 7).

### **Respect from the institution or management**

Whether or not attention was paid to nursing needs or opinions varied with the institution. The majority of nurses felt strongly that their voices were not heard or were disregarded. Only one

nurse felt that her institution was committed to dealing with the needs and opinions of all staff, nurses included; she attributed this to a change of management and management style in the hospital:

They're listening to us where before we didn't feel they were. They're taking more of a nursing opinion. We're still short-staffed and we're still overworked, but it seems like they're trying a little harder. Our CEO holds meetings and "town hall" meetings with the whole hospital every three or four months. It doesn't matter if it's nursing-related or a different area of the hospital, everyone knows what's going on. And people seem more accessible to us. We see our management much more often (see Interview 2).

One nurse reported that nursing needs and priorities were given short shrift by both the Pharmacy and X-ray departments in her institution. She felt that nursing needs received no priority: "That's why I feel we aren't really listened to – that our concerns aren't really important to them" (see Interview 3).

Some felt that they received little sympathy from a management that virtually ignored their needs:

I just don't feel that there's enough compassion from the people higher up. I really feel like we are front-line workers and when it comes down to it, for all the talk – "Yes, we know that we need more nurses on the floor and, yes, we know that your work load is heavy" – when it comes to the end of the day, a bed is just a bed and it doesn't really matter how heavy your assignment is. That bed is going to get filled whether there is staff or not (see Interview 5).

When one hospital was closed to visitors during the 2003 SARS outbreak in Ontario, its already overworked nurses were further burdened by a public announcement that although visiting was no longer permitted, relatives of patients could call the hospital anytime to find out about patients. No arrangements were made to supply the additional staff that this would require. In general, consultation with nurses about management decisions was often cursory: "We nurses are supposedly given feedback, but this is a done deal. Whether we like this or not we're told it's going to happen" (see Interview 5). "You get e-mail after e-mail about these sorts of things," another nurse said, "This is what we're going to do and why" (see Interview 3).

### **Respect from patients**

Patients were generally but not always appreciative of the challenges nurses faced and aware of their excessively high workload:

I've never had a patient angry about the amount of care that they're receiving or not receiving. I think as a whole most people see that you're running and they don't ask, or they may ask and they realize that they have to wait for the little extras that they're not automatically given (see Interview 3).

Older patients could be less understanding because, as one nurse suggested, "they don't realize or maybe they're not as perceptive of what is going on around them" (see Interview 3) or because of dementia: "Sometimes the patients aren't mentally with you. That can be an issue. We've had a few lately, their language was so coarse and so vulgar" (see Interview 6). Staffing changes and change in general may be difficult for the elderly to cope with: "Some of the older patients – they're still looking for the white dress and cap still. They don't know who

the nurses are unless you've introduced yourself and then most of the time they forget because there's such a turnover" (see Interview 2).

Sometimes, however, when the workload was exceedingly high, even appreciation expressed by patients did not improve the situation, either because the nurse was too busy to properly register their thanks, or because the workload was so high that she did not feel in control of her patient load or able to keep track of her patients' basic condition.

### **Respect from relatives**

Relatives are generally perceived to be less appreciative and respectful of nurses, perhaps because they do not witness the entire working day and often arrive when nurses are charting, leaving them with the erroneous impression that nurses spend most of their day sitting down. Nurses sometimes express mixed feelings about "demanding" relatives, feeling on the one hand that they are right to insist on the best for their relatives, but on the other that they should be aware that nursing care has been affected by cutbacks:

You know how you have people and they have family and you think, "Oh, no, here comes the family again." Well, in one way they're right – they *should* demand the best. They should demand conferences with caregivers to know what's going on. And in some ways I think: "Haven't you heard? There's a shortage. What, do you think it's not going to affect you?" Sometimes they're more demanding than the patients because I think it makes them feel better and because they know that their loved ones should be taken care of maybe better (see Interview 7).

Relatives and other visitors were reported to be frequently abusive, sometimes because of factors beyond the control of nurses or doctors. Frustrations about the level of patient care were frequently vented on nurses:

Often patients' families will get upset: "How come they're not washed? How come they're still in bed? How come ...." But, you know, it's just not possible because of other things that have happened. It's difficult. You don't want to tell them, "Well, I don't have time for your mom or dad." It's not that. You have to try to explain that you have another patient who required a little bit more attention today and that you will get to it, but that time hasn't allowed it to happen (see Interview 1).

One nurse of long standing felt that respect for nurses by relatives and other visitors had declined and that nurses were held to be responsible for any number of things beyond their control:

It's not like it used to be years ago where you had visiting hours and the people came in and sat there and showed a little respect for the fact that you were trying to do the best you could for their family member. They come in these days and they are sitting on your shoulder ready to jump at you with anything. With regard to why you did this and why you didn't do that and why isn't the doctor there and what is the medication you're giving and why are you giving that and you are the reason that Dad has got worse (see Interview 8).

Still, some relatives were sympathetic and some even helped to provide care: "You try to explain to them that you're really sorry but you just haven't gotten to it yet. Most of them are understanding and some will actually offer to do it for you" (see Interview 1).

## Respect from doctors

Though the interviewees were reluctant to generalize in this regard, there was some sense that younger doctors might view the nursing role more positively than older doctors: “With younger people it’s often more like a team: ‘Well, what do you think?’ Some people will actually ask for your input on things, which is nice, whereas others don’t really bother with what you have to say” (see Interview 1).

As far as the doctors go, that really is individual. We have a couple of old timers who can be quite abrupt and give you difficulty if you call them for something. The new guys coming in, I find them much better. You know, they’re a little bit more up to date as far as how you handle people (see Interview 3).

Cultural differences could also determine doctors’ attitudes towards nurses:

The residents, they come and go. Sometimes there are cultural differences – say, if they’re not used to dealing with women. It’s really a big issue. People who are here for training. They probably haven’t worked with women until they came here to do their residency in thoracics so it’s kind of a culture shock for them. Well, you have arrogant ones who are nasty, sure you do, and for the patient’s benefit you have to deal with them. And that’s it and you tell them what you have to do. As I told one new nurse, the worst they can do is yell at you and – so what? Forget about it (see Interview 6).

Sometimes the degree of respect accorded to nurses varied from unit to unit within the institution. One nurse preferred working on a Medical floor to a Surgical one because she found the doctors more communicative and respectful. Another felt that although doctors paid lip service to respecting the nursing role, their true motivations were more self-serving:

As much as doctors say they respect what we have to do, when it comes down to it, all they really want to do is get their surgeries in, fill the beds, and it doesn’t matter how busy I am. He wants *that* surgery in *that* bed. There might be a bed available on another floor, but they want them all on our floor because then they won’t have to move around as much (see Interview 5).

Moreover, in this instance the doctors got their way:

When it came to SARS they were upset that they weren’t getting their surgeries in because that was their bread and butter. They wanted those surgeries back and they pushed and pushed until they got it (see Interview 5).

A Charge Nurse had experienced little in the way of disrespect from doctors but thought that this might have been due to her own personality:

I get right in there. I introduce myself. I want to know who everybody is. I have certain standards for doctors and they know that! The new residents who come – they’re introduced to me and the doctors who have gotten to know me will say “You’d best be on your toes and respect her because she knows what she’s talking about. So if she wants you to do something, really listen to her because she is trying to tell you something” (see Interview 2).

## Respect from other nurses

Interpersonal relationships between nurses were as complex as might be expected in such a pressured and demanding workplace. Generally however there was a sense that, in spite of interpersonal difficulties, colleagues could be relied upon to pitch in:

But even though we might have our differences, the next day you come in and it's all forgotten .... Even if they're angry with you or you've done something to upset somebody, if you're having a hard day – if something happened to one of your patients or something's happening to you – everybody is going to be there. They come: "Can I help you?" They're not talking to you, but they'll help you" (see Interview 4).

Though interpersonal friction was not uncommon, the cooperation of nurses with each other was also reported as a great workplace satisfaction. One nurse said that "for the most part the people I work with are a great bunch" (see Interview 5); another that:

I love the group of people I work with, the other RNs and RPNs. If I were to change, that would be one of the hardest things because they're excellent people and there's a lot of respect and a lot of sharing of knowledge when there's time" (see Interview 3).

RNs' attitudes towards RPNs were cited as problematic by a few nurses. Some RNs felt the need to check up on RPNs' work in a way that one RN described as "insulting." This may have been partially due to the different – and sometimes fluctuating – scopes of practice of RPNs within and between hospitals; also of the RNs' sense that they, the RNs, were accountable for anything that happened to all patients, even if it was another health professional who actually provided the care. RNs who were unfamiliar with working alongside RPNs were perhaps less comfortable with sharing patient care, while RNs with experience working with RPNs found it easier to rely on their expertise:

It's just knowing where the division of labour is and letting them do what they're trained to do. Some people feel like they have to check up on the RPN. Well, they don't have to. That's just a personal thing. So I do find that – you know what? – it might be helpful for us if we did have RPNs working down the hall (see Interview 5).

Although there were some reports that older nurses were not kind to younger ones ("They always say nurses eat their young. Have you ever heard that one? Oh, they're brutal. Really, they're not kind to younger nurses" [see Interview 7]), in other institutions, the opposite seemed to be the case. It was lamented that there was no longer enough time for the kind of informal mentorship that might have occurred years ago:

We help out the younger nurses when we can. I don't think there's the time that there was when I first graduated. The nurses, they definitely took you under their wing and just showed you what needed to be done. There was never any worry about asking a stupid question or not knowing something, and that's the attitude we have I think. But there isn't the time to say, "Okay, run through whatever the procedure is, would you like me to go with you?" You don't have that luxury any more (see Interview 3).

Stress was suggested as a reason why nurses might find themselves in conflict with each other, as in one incident in which an interviewee reported that two nurses in her institution were involved in a physical altercation, an event that was deeply upsetting to their coworkers:

We've had meetings in the last couple of weeks with the other nurses to talk about what happened. One of the nurses suggested, "Do you guys think that it might be a reflection of

how busy and how stressed that we are that it came to that?" Obviously, no matter what, it shouldn't happen, but because of the acuity, people get frustrated and stressed and it can come out in the wrong way (see Interview 1).

Nurses could be supportive of each other as well, particularly when they had worked together for a long time:

There's a certain amount of companionship working with other women. You get to know what they're doing and they know what you're doing and you support each other ... I work on a unit where the staff have been there a long time. We're pretty much all senior, so that we know each other quite well (see Interview 6).

Sometimes it was relationships with other nurses that made the job bearable:

Luckily I knew one person on that floor and she put me with her. Thank God I had her, because she was great... We weren't such good friends to begin with but she was just really good and that's what saved me. Without that support I don't know if I would have stayed (see Interview 7).

### **Respect from government**

Nurses expressed substantial scepticism about governmental promises of workplace improvements:

At a government level, there are a lot of promises. One in general is that there is going to be money and there are going to be nurses. But where is the money and where are they going to get the nurses? The nurses that are in the degree courses right now are not going to be out there for another four or five years and what are they going to do in the meantime? They're going to lose half of the nurses that they have right now before that five years is up. Because generally, as I said, they are scaring them out the doors (see Interview 8).

Other sources of distrust were the provision of erroneous statistics ("They pay a lot of lip service to, you know, 'We have more nurses.' But then you read your ONA or your magazine and it says 'Actually, this isn't true.' You know how they play with figures to make it look better" [see Interview 7]); restructuring that didn't make sense or was not cost-effective; or plans for new buildings that didn't materialize, leaving nurses stranded in temporary locations working with inadequate equipment and supplies.

### **Availability of, and access to, nursing leadership**

Nursing leadership often seemed under-invested, over-burdened or unavailable. Though frequently viewed as well intentioned, Nurse Managers were seen as having too many responsibilities and too little control to make desirable changes:

our nursing leadership have so many other things to attend to that they can't be on the floor all the time. They not only have to oversee us as nurses but, because they're management (like the nursing unit administrator), they have other responsibilities, meetings to attend – things that mean they're not always available if you need to speak with them (see Interview 1).

Their administrative responsibilities were seen as detracting from their availability in regard to issues of patient care:

We have a coordinator on pretty well every floor but she is not specifically patient-oriented. She does payroll, she does meetings, she does other things, but we need someone to speak to about patient care; we need someone to take over if we have to have someone speak to a family member that they want to direct their questions to other than ourselves, which we do not have the time sometimes. And when they are gone at meetings all the time there is nobody (see Interview 8).

One nurse reported that her unit was without a Nurse Manager for a long time because no one wanted to work there:

It's known as being a very busy place and no one really wanted to take on the load. So for a long time we were without leadership. And you know, we seemed to sort of run along the same as we run now with leadership! (see Interview 5).

However, some institutions seemed to be reinvesting in nursing leadership: "They got rid of our Head Nurses with the first set of cutbacks many years ago. Every floor used to have a Head Nurse and then, when they downsized, they downsized too much. And then we upsized a little bit" (see Interview 2). The newly increased numbers facilitated accessibility:

I think now we're starting to see a little bit more of a trend for our nursing leadership to be around, just lately. To be accessible. Actually I think they're increasing. Our Unit Manager now is going to have just our floor instead of two floors. I think some responsibilities are being taken away. I think they spent so much of their time doing scheduling and doing non-nursing things and coming to bed meetings, and on and on, that they weren't so involved with the staff (see Interview 7).

Many aspects of nurses' working lives seemed dependent upon having a Head Nurse who was willing to go to bat for her nurses, to fight for additional staffing, funding for education, or equipment. One nurse felt that burdening nursing supervisors or managers with budgetary responsibilities made them less able to advocate for nurses and for patients:

In the past a lot of the Head Nurses ... were mostly very pro-nursing and pro-nurse and pro-patient and not business managers. That's what you want, somebody who is pro-nurse and pro-patient – you know, not the budget so much (see Interview 6).

The support of a Head Nurse or Chief Nursing Officer could mean the difference between being heard and being ignored:

As an RPN you're not always vocal and people don't always listen to you. Being on Council at least your voice will be heard. If nothing happens, at least it's heard. When I first joined I don't think they really took me seriously. But then some sort of conversation came up and I had the opportunity to have some input. Then everybody sort of sat up and took notice. Well, people were sort of trying to have me not talk and the Chief Nursing Officer said: "Wait a minute, let's hear what she has to say" (see Interview 4).

While supportive supervisors might be a great boon to the nurses who worked under them, even the best managers were not always able to provide the help their units needed:

The workload has fluctuated with the staffing levels that the Nurse Manager is able to fight for us to have. It's my feeling that she's always doing her best to get us the most that she can.

When we began here of course we were all very stressed and we were having five and six of the high acuity patients (see Interview 3).

In that case the Nurse Manager was able to obtain extra staff, though she explained to her staff that the change might be contingent on reduced levels of absenteeism:

That's when she tried to get the extra staff because, "I know everyone's really tired, I know what's happening and I'm attempting to show that your overtime is going to go down and that your sick time is going to go down if we can provide you with more people." I don't know if she succeeded in showing them that, but we still went back to less people (see Interview 3).

### **Educational opportunities and career mobility**

The nurses' awareness of the availability of support for continuing education was for the most part vague. In fairness, most of those interviewed were not currently considering a return to school; information about funding and other institutional support for education might have been readily available if nurses were actually seeking it. However, there was some sense that, while institutions might encourage continuing education for nurses in theory, in reality there was little financial support and it was difficult for nurses to get time off:

I wanted to go on a conference – and I am going, finally. But you have to find someone to work for you. You have to practically beg them to give you the time off to go. It is going to be paid for, but it is a bit of a struggle here (see Interview 3).

Some hospitals offered financial aid but most nurses were vague about the specifics. Few if any offered time off to pursue educational goals. One nurse pointed out that a reason for the lack of support was that if nurses were given time off for continuing education it created additional staffing problems for already understaffed units. In effect, if nurses were learning, they couldn't be nursing at the same time. The same nurse stated that lack of support for education was identified as one of the primary complaints in her hospital's staff surveys and that this problem was currently being addressed:

If you give people time off to get better educated in their field, we're running short of nurses. It's difficult. They've improved that now. We didn't have the casual worker. We now have the casual worker. We have a weekend worker now, so people can go to school Monday to Friday if they want and be the weekend worker. They've brought that kind of stuff back to us (see Interview 2).

According to the RPN interviewed there were substantially fewer educational opportunities for RPNs than for RNs but further education was not necessarily impossible:

For RPNs – I guess you've got to take initiative like myself and go out and take the courses or the workshops and then bring the certificates and say, "Hey, I can do this. I've got interest in this. Can you allow me to do it?" (see Interview 4).

In this case further education was achieved on an informal basis that was not institutionally acknowledged and that depended upon the goodwill of the nursing supervisor: "My manager has been pretty good because she knows I have an interest. She has allowed me" (see Interview 4).

The one interviewee who was engaged in post-RN education at the time of her interview had received a bursary from her hospital to help pay for a university course and was studying part-

time: “As of 2003, they’ll pay \$1,500 a semester. So in other words, they’d like you to finish your degree if you can. You take courses on your own time” (see Interview 6).

One nurse flatly stated that there was no support whatsoever forthcoming from her institution for educational purposes; nurses were expected to make their own arrangements to cover shifts, and they were not permitted to draw upon the part-time pool:

You can apply for assistance from the hospital, financial or in terms of time, but the chances are you’re not going to get it. If I wanted to, say, go to a learning seminar or something I would have to find someone else to work my shifts for me. And right now we’re not even encouraged to pull from the part-time pool. It’s more like trying to switch shifts with someone instead of giving the part-timers shifts because the Nurse Manager wants the part-timers available for sick calls (see Interview 5).

Nurses desire education and training and several expressed an interest in pursuing it but thought they would not receive institutional support. Some institutions did not even provide quite basic forms of training:

I find that we’re really hungry for more education. It would be wonderful. Now you don’t even get CPR. I mean, the factories get paid CPR! I know they’re different, they’re private and they’re funded much differently but still it’s pretty bad when the hospital doesn’t provide CPR, I think (see Interview 7).

Notions of career mobility and of institutional support or lack of support were also vague and anecdotal. Some nurses mentioned a single staff member who might or might not have been helped with career development by the institution, but most often these seemed to have acted on their own initiative:

I mean, we’ve got a girl who has been working part-time on our floor, went away to do her Masters and is now back on our floor, but she wasn’t ever accommodated from our floor for her to go ahead and do her Masters. It was her own time and money. She came back seasonal, in the summer. She wasn’t working part-time (see Interview 5).

Family considerations have acted as a curb to career goals. One interviewee had turned down an offered promotion because her family was too young, then accepted it at a later date. For nurses with families, the availability of childcare could determine whether or not they could take advantage of educational opportunities. This is another area in which the unavailability of “24/7” daycare would be a major drawback.

### **Safety and injury**

When nurses were asked about safety, most thought first of patient safety. A certain amount of nurse injury seemed to be accepted as normal, such as senile patients hitting out or patients with drug reactions becoming aggressive. Though not all nurses had been hit, all were aware that it had happened to coworkers. Several nurses seem to regard nurse injury at the hands of patients or relatives as a commonplace of the job and were matter-of-fact about injuries sustained. One thought the problem was so systemic that a Nurses’ Week should be devoted to nurse abuse: “Whether we are hit, pinched, scratched, bit, spit on, thrown something at – I mean you get it all. Today my lady wanted to bite me. My patient tried to bite me!” (see Interview 2). It seemed to occur so often that nurses saw such events as unremarkable. Patients with dementia or in reaction to medication could be particularly dangerous:

I've been punched in the stomach. I've been slapped in the face. My uniform has been slightly ripped. Patients with dementia, once they keep seeing you for a while they get to know you. They have to see your face constantly and once they recognize that face they will allow you to do certain things to them. But initially when they come in – most of them come in from the nursing hospital or from a home – they don't recognize you and they get very aggressive (see Interview 4).

I did get hit once, very hard. A patient just swung and hit me in the stomach. It was somebody who was just kind of out of control and we tried to settle him. I think as far as what was going on with him, he was a patient who was in a step-down unit and he was just out of it, really not himself. I don't know whether it was the medication. I just happened to go in to help and we were trying to get him into a chair to get him away from that step-down environment because they're all sick in there and he was creating – he just got his hand loose and whacked. It could have been anyone, I'm sure he wasn't even aiming. He was just flinging. But there are those hazards (see Interview 7).

It was not only patients who could become aggressive. Several nurses reported incidents with abusive visitors or relatives, some of them violent:

And nurses have been shoved, pushed by family members. We had a nurse that was thrown against a wall recently, just because she was in the wrong place at the wrong time. The family member was very unhappy with certain things and she happened to be there. In that situation, you pretty well just get out of the way. There is Security in the hospital and you can have someone removed if they are being a problem, but families are not easy to deal with these days (see Interview 8).

There were no reports of physical violence from doctors, though in two cases verbal abuse was indicated.

Lifting was a more commonly reported source of injury. The difficulty of calling porters or being in a rush could cause nurses to ignore their own safety:

But you're always yanking people up in bed or helping them out, or you're changing diapers. Some of the elderly ones who are a little demented too are fighting with you a bit. They're rigid, you're trying to get them over, and a lot of times you don't have someone handy to help you. So you do try to do it yourself, but you shouldn't (see Interview 7).

This could lead to injury, as when one nurse failed to raise a bed rail or another tried to lift a heavy patient without assistance. The long-term repercussions of the latter incident eventually forced the nurse to leave bedside nursing for less physically demanding work. Even those nurses who hadn't sustained injuries all knew of other nurses who had:

I haven't been physically hurt but I'm tired. I see a chiropractor regularly and maybe that keeps me in tune. Ah, yeah, the lifting. But I'm a fairly strong person anyway because of what I do outside of my job. Certainly I know of several people who have had back problems. More older nurses (see Interview 3).

Workplace safety is greatly compromised – greatly compromised – because you don't have the staff to help with the lifting, you don't have the equipment because there is not enough finances to buy this equipment. Safety is very much an issue (see Interview 8).

High workload and stressful work conditions could lead to carelessness about safety for nurses who were trying to get too much done. Furthermore, nurses were trained to think more in terms of patient safety than their own:

Sometimes when you're in such a rush or trying to get things done or maybe there is an emergency, you tend to forget about certain safety things. Like you lean over the bed rail instead of putting the rail down and putting the bed up. There's always a chance you hurt yourself that way, like your back or your shoulders. Last year I was off because of injury to my back and shoulders. I didn't do the side rail thing and the patient was aggressive; I was leaning over and trying to help. There were a few of us in there and the patient was getting combative and we were trying to get them stable in the bed. At that point you're not thinking of safety for yourself, you're just thinking of safety for the patient (see Interview 4).

This experience caused the injured nurse to emphasize safety to her preceptorship students: "I kept saying to the students: 'Watch your back.' It was a way of passing on what I've learned. 'Make sure that you don't hurt yourself'" (see Interview 4).

Nurses who sustained injury could become more safety-conscious as a result, becoming more likely to seek help with lifting or other potentially compromising activities. After suffering a severe injury, one nurse said:

I had a patient from ICU the last day I worked. He was 260 pounds and about 6'2", and the nurse from ICU and the orderly thought, "Well, we'll just pull him across." I said, "No, I think we'll get the transfer board and we'll get another nurse and I will instruct you on how to do this." So we rolled him over and put the board underneath. If you pull the sheets you can put a board in, and then the patient just slides on. It takes away half of the body weight, but I had four people too. The patient couldn't even lift his hand. I thought, "I'm not going to be a patient again!" (see Interview 6).

### **Time consuming tasks (and systems that cost time needlessly)**

Poorly designed systems within the hospital were considered to be unnecessarily time consuming and onerous. These were extremely irksome to the nurses but in most cases their institutions showed little inclination to make changes. Problems in interaction with the pharmaceutical department seemed to be particularly common. These might involve cumbersome procedures for reporting and rectifying incorrect dosages or missing medications, the necessity of writing up and faxing orders for meds, or Pharmacy's reluctance to supply additional meds. Mentioned more than once was a discontinuity between the use of brand names and generic drug names in doctors' orders and pharmacy documents, causing nurses to spend a great deal of time looking up drug names in order to ensure that the correct medication had been provided.

Meds are changing. I'm forever looking things up now. I make sure I have my little book, my Davis Drugs book, with me so I can check on things. The hospital is trying to save money by using generics and the names are all changing. You know, "Is this really what I think it is?" So I have to look it up real quick. It just takes time (see Interview 6).

Systems for distribution and administration of medicines varied in efficiency across hospitals.

Pharmacy brings up our medications and they are *not* in blister packs. They are individual bottles and we dispense that way. As far as intravenous medication, we have the mini-bags and we put our own antibiotics in them. They are not pre-poured or mini-bags aren't ready

when they come to the floor. Drips, morphine drips, whatever you want, heparin drips – all of this is prepared by us on the floor. Taking a lot of time. I think it's a combination of things because you are taking orders, transcribing orders, giving out medications, running here, running there, starting IVs, taking care of codes – you're doing everything when there's not very many on the floor. That's what you do (see Interview 8).

Sometimes physical characteristics of the unit exacerbated problems. Time might be spent picking up medications at the opposite end of the floor.

I think that part of it may be physical layout. I know we seem to be walking long distances. The way our place is laid out, there are two long wings and a utility room where you get your supplies at the middle (see Interview 5).

Other interdepartmental complaints included inconvenient scheduling of patient tests requiring several nurses for patient transport (see Interview 3); the requirement of a nurse's presence during lengthy waits for a patient's tests, resulting in very few nurses left on the floor (see Interview 6); and the failure of physiotherapists to return patients to bed so that nurses were left to wonder whether to call them to come back or try to get the patients back in bed themselves (see Interview 1). One nurse felt that the convenience of all other hospital departments took precedence over nursing requirements (see Interview 7). One cited too much paperwork (see Interview 2), but also said it was all necessary so that it was found to be impossible to reduce it. The problem was exacerbated, she felt, because nurses were trained to record their observations in written format: "We have tick sheets that are just diet, mobility, skin, bathing, elimination, safety – but we still go back and chart because most of us have been taught to chart, chart, chart" (see Interview 2).

Running around looking for missing equipment and waiting for other nurses to be finished with equipment were also cited as time-consuming and burdensome:

It's little things like running for supplies. We don't seem to have enough supplies so you have to go to other units to borrow. Things as simple as urinals, sometimes, that you just don't have enough of – basins, kidney basins. You borrow because, if you've got a patient who needs it, you're going to need it. You have to find one from one of the other units. Looking around for supplies during a day, I might spend a good 45 minutes when it comes down to it, just running and looking for stuff (see Interview 5).

Equipment and pumps that required frequent vital signs cost a great deal in nurses' time, as did actions that had to be interrupted and later resumed:

As you're pouring them, you see: "Oh, that's missing." So you have to call Pharmacy and get them to deliver it for you. By the time you check to see if it's come up – you have an hour leeway let's say for medication but it's always difficult, there are all these little things that will come up in between that delay everything. People are calling for a bedpan or they interrupt something that you might be doing with another patient (see Interview 1).

An ageing patient population meant additional tasks for nurses:

There are also dressings to change and if the patients are incontinent that's something that you have to deal with throughout the day. So that takes up a lot of time as well, and repositioning the patients. They're in bed all day so you have to keep going in and changing them from side to side, usually about every two to three hours (see Interview 1).

Telephone calls could be extremely frustrating to the nurses whose work they disrupted, particularly when SARS had resulted in many hospitals being closed to visitors. Often the calls came from relatives inquiring about the status of the very patients whose care was interrupted so that the nurse could answer the phone. Sometimes the calls were from other departments of the hospital. As one nurse described it:

For example, if we're having to discharge patients or move patients around or get patients into our step-down and it's not moving as quickly as another floor or Emerge wants us to move, that's where usually we get management involved. I'll phone over and say, "You know, they've phoned twelve times in an hour. They know we're busy. We're moving as fast as we can. We're only the staff that are on – we're moving as fast as we can." There's always lots of phone calls that take you away from important work (see Interview 2).

Visitors were generally viewed as being time-consuming. During the temporary closure of many Ontario hospitals to visitors due to SARS, many of the nurses confessed that their workload was considerably lightened by the absence of visitors, though correspondingly more time was spent answering queries about patients on the telephone.

### **Equipment and supplies**

Reports of insufficient or inadequate equipment were endemic. Large amounts of nursing time were devoted to hunting down, waiting for or borrowing equipment or supplies, sometimes quite basic ones. One nurse said her unit needed new beds "because we still have to crank the beds on our unit" (see Interview 4).

What would make our lives better here would be new equipment. Oh, we need new equipment. Somebody win the lottery and give us some money for some equipment, please! At times you're looking for a recliner or some sort of chair for a patient who's restless so you can put them at the desk, put them in an area where somebody can keep an eye on them, and there's nothing. Or if there is, it's broken (see Interview 4).

Another nurse who had moved to a new location as part of restructuring estimated that she might spend 45 minutes a day chasing down needed equipment. She was surprised to find her new institution less well equipped than the previous one:

When I moved over to the [hospital] I'm at now I was amazed because some of the IV pumps at the new place were older models we had retired years ago. Even supplies – we seemed to have lots of supplies on the carts at the previous place (see Interview 5).

Because some procedures were performed at the same time each day for all patients, having to wait to use equipment caused a disruption of the nursing routine.

We only have two machines [to check blood sugar], so you don't usually get one right away. You're waiting for somebody else to be done, so it delays you.... You don't actually get to do it when you'd like to or when you have the time to do it because you don't have the equipment at your disposal. You spend time looking for it (see Interview 1).

In some types of unit the shortages of specialized equipment bordered on the bizarre. For example, a respirology nurse reported that there were no tracheotomy kits in her unit – staff had to borrow them from Intensive Care. A nurse from another respirology unit said that while funds were being expended on building, in her unit:

you're fighting for an oximeter. Really, we should have that in every squadron. And the Glucometer machines always seem to be acting up. It's a constant fight with equipment being broken. On our floor we don't have even one automated blood pressure machine! We use manual (see Interview 7).

Understaffing and high workload exacerbated the problems of insufficient and deteriorating equipment: "We're very hard on equipment. We drop things and bop things around. I think it's in our madness rushing around because we're in a hurry" (see Interview 5).

### **Level of patient care**

The level of patient care nurses were able to provide was a significant work life issue for many nurses. Nurses were unhappy about being unable to provide the level of care that they considered adequate. There was little time to communicate with patients:

You know, what's rewarding about nursing is talking to people and helping them. That's how you find out things that maybe you weren't aware of that will help with the care you're giving them. I think that's a big part of it. But it's so busy now, you can't always give all the care that you would want to give (see Interview 1).

I wish I were allowed to work at a more relaxed pace. That I had more time to go in and chat with my patients rather than being so task-oriented all the time. Because I really do think that emotional bond is important.... I would just like to have more time to do teaching and to be able to have that chat with them" (see Interview 5).

Patient education was regarded as a crucial aspect of patient care and one nearly impossible to find time for.

Let's say they're a new diabetic for whatever reason ... You have to make sure that you get the doctor's order to Diabetic Education and that they know what the supplies are and that they practice. You have to make sure that they're doing it when you're not doing it anymore and that they're ready to function independently outside of the building, right? That they're not having to leave the hospital unprepared (see Interview 6).

Two nurses reported that basic hygiene and housekeeping – "beds and baths" – were becoming compromised because of lack of time and overwhelming nursing workload. The nurses' time was completely taken up with more critical issues.

It just seems that you're supposed to give less actual care to the patients in order to get just the safety issues done. It doesn't feel good. We've been told, not that bathing isn't necessary, but just to cover the very basics (see Interview 3).

But making patients comfortable and relaxed by cleaning them up, as one nurse explained, was an important precondition to their successful therapy and healing:

One man was very sick and, even though he had had a post-op wash, he had a bit of blood here and there, a little bit of urine here and there. I couldn't *not* wash him and then ask him to walk and do the deep breathing, the coughing and all the exercises that I wanted him to do in order to get better because I had to make him feel good first (see Interview 3).

At extreme levels of workload and stress each aspect of patient care became onerous and fraught for the nurse who was trying to fit everything in:

Even walking a post-op patient becomes a chore because of the time frame. And that shouldn't be, because it's so important, and the deep breathing and coughing and all the things that we do with them. Trying to fit it all in is a real chore. And it's really difficult to feel that pressure and go in and be very laid back. Because if you're showing: "C'mon let's go," then that post-op patient is going to be tensed up and uncomfortable. You have to be relaxed with them. It's very difficult to come from: "You need to do this, this, this and this," as you come out of the room, and then go back in and be calm and relaxed. Looking calm and serene on the outside is becoming much more difficult here" (see Interview 3).

Nurses were frustrated at being denied a sense of completion with regard to patient care or, indeed, to any given task. For some it was simply a question of feeling they had done a good job, had completed their care according to their own standards. A nurse who came to hospital nursing after working in Community Health compared the levels of care:

In the community you're one on one and in the hospital you're like 50 on one. You can never finish a task. In the community you went in and you did what you had to do and you really didn't leave until it was completed or the patients were set for that moment. You did everything you needed to do. Here at the hospital, you never feel like you ever finish a task. You just prioritize and finish what you have to at that moment (see Interview 7).

"Actually sometimes I'm embarrassed that hospital patients are not getting the care they should," the same nurse concluded. Her workload was so extreme that after a shift "you kind of pray that you've done everything, because you're flying constantly" (see Interview 7).

Sometimes patients felt apologetic about asking for help from nurses they know are already overburdened:

They read the papers, they know what's going on. The first thing they'll say, a lot of them, is, "I'm so sorry for bothering you. I know you're busy." So then you have to say, "No, I'm here for you. I'm yours. So what can I do for you?" (see Interview 2).

Or the patients saw first hand how overwhelmed their nurses were:

they feel really badly because their nurse is running around like a chicken with her head cut off. "Oh, poor old so and so. She was really running yesterday." They don't want to ring the buzzer and that's not what it's all about. "You know, if you need help," I tell them, "push the buzzer, because it's the squeaky wheel that gets the grease here. If you don't buzz for me, I won't know" (see Interview 5).

Some nurses believed that policies and procedures at their institution were being instituted solely for financial reasons: "It's all money. I don't believe that it's patient care. I believe that's a money-based thing" (see Interview 5).

## Absenteeism

Absenteeism was generally reported to be high, due not only to illness and injury but also to stress, and sometimes because nurses needed to stay home to look after sick children. Each absence placed additional stress on the remaining nurses.

Several nurses felt that at least some absenteeism in their institution was due to issues other than illness. One nurse felt that:

As at every hospital, sick time has always been an issue. That's your number one thing. They try to replace every absence, depending on staffing. It all depends on staffing. A lot of us think that, yes, there is valid sick time but there is a lot that isn't valid sick time. They're actually slowly starting a new program to see what we can do about that. I think it's mostly stress time. I think more people just need to take some days off (see Interview 2).

Another nurse also felt that her working life was impacted by absenteeism that was not necessarily illness-related:

We have a very high rate of absenteeism – there might be three off during a week. People seem to call in sick for things that aren't really related to them. Women who have children call in sick because their children are sick and they have to take care of them – which I understand. I don't have children myself, so I'm not begrudging them that. Although some days..." (see Interview 5).

However, institutional attempts to categorize and deal with absenteeism could be contentious. Some caused much unhappiness and resentment:

if you were off so many days it was so many points, and if you were off so many more days that was so many more points, and then you were given a warning. Usually if you had more than three, four, five days, then you were flagged. These were quarterly setups. The reason it didn't go over and the reason it was looked down on by the nurses is because we found that they weren't even looking into the reason why you were off. People had been flagged and they'd been off for surgery or people had been flagged and their husbands had died and people had been flagged and on and on and on and on until it was totally ridiculous. And this drops the morale in the hospital very much (see Interview 8).

## Retention, recruitment and turnover

High rates of turnover were associated by interviewees with a number of factors, including stressful working conditions, inflexible scheduling, the absence of institutional support for educational advancement, or a combination of these. "We have a high rate of turnover. People just leave because they just don't like it – because it's too busy, it's too heavy, and they just go elsewhere," one nurse said (see Interview 5). Another, who felt that her unit was a positive workplace, admitted that it nevertheless had high turnover and speculated that it had to do with a relative lack of educational incentives. A lot of students, she said, "consolidated" in her unit:

They really like it and they further their educations, like take the Critical Care course. It costs money and most people will leave and try to get into ICU because if you get into ICU you don't have to pay for the last part of the program. And that's how we think we're losing our staff quite quickly, because most of our staff are going to ICU (see Interview 2).

This created a difficult situation for the senior staff who remained and had to absorb the effects of turnover.

For us “old folks” who have been here forever it’s hard because you have a lot of responsibility. When you bring in new people – because mostly our floor gets new people who are graduating or a new grad who has come from another institution and hasn’t worked there very long – you put a lot of time and effort into training them and helping them out (see Interview 2).

Several nurses said they stayed at their current institutions because of seniority, which earned them a number of advantages ranging from the tangible benefit of vacation time (“I’ve got four weeks holiday and I don’t think I want to give that up to start at two again.”) to the intangible benefits of familiarity (“I know the institution, I’m on committees, I’m making myself known. You go in the hall and you know people. Even if they don’t know your name they know your face” [see Interview 4]). Sometimes it was a case of “the devil you know.”

However, for a combination of reasons at least two interviewees had decided to make a change. One had experienced a series of bad shifts while the other realized that her work situation in her present unit was only going to deteriorate and that she herself would have to take steps if her working life was to improve:

I guess I’ve stayed because I just don’t like to quit. I don’t like to say that it’s gotten the best of me. I like to think that I can handle it. But recently it’s come to me that I can’t change the way things are there no matter how hard I try. But what I can change is my work situation and I’ve got my eyes peeled now for when a posting comes up in Intensive Care full-time. I’m going to apply for it because I realize I’m just beating my head against a rock (see Interview 5).

It was acknowledged that many younger nurses left Canada to go to the United States:

Everybody is leaving constantly. It’s all you hear, all the time. They are always leaving for the States. As much as they say it’s not happening, they still are. There are more opportunities for advancement over there. They get what they want, they have the shifts they want and then, the younger ones, they make the money. On this side of the border you make \$20 and on that side of the border you make \$20 US. And it takes nine years I believe to get up to the top level (see Interview 7).

A major reason given for why nurses might leave for the States was the periodic unavailability of full-time work in Canada: “They offer a lot of incentives for people to go down there. Most nurses when they graduate want full-time. That’s the goal for nearly everyone” (see Interview 2). In addition, there was a perception that nurses in the States had more autonomy with respect to their working schedules, that they:

get more say about their scheduling, quite a few of them, especially the ones who go contingent. They can pick their shifts. They can say when they’re available. They have self-scheduling, a lot of those hospitals. I’m not saying everything is perfectly roses over there. But the education is paid” (see Interview 7).

Career advancement, training opportunities and better orientation were other reasons why young nurses might go south:

But for a younger person I don’t think there’s the career advancement here that they could get in the States. There just seem to be more opportunities for them there” (see Interview 7).

A lot of the girls who go to the States, they'll get months of orientation and mentorship. But [here] on the floor they just get thrown into it and ... a lot of yelling" (see Interview 7).

There was a sense that the provision of educational opportunities could make an institution or unit attractive and promote retention – "At the moment I would stay in this institution, more specifically in labour and delivery because they have the best program. For that I would stay here" (see Interview 1) – and that the absence of those opportunities could lead to higher turnover.

Older nurses were considering early retirement because of excessive workload, lack of nursing leadership and lack of holidays:

Nurses have left, or are just counting the seconds until they're gone. Especially senior staff. It's just that heavy, you know? Everything is going back to the nurse. So how do we make it so people want to go into nursing? We need more nursing staff and I don't know where it's going to come from (see Interview 6).

Between lack of staff, lack of coordinators to talk to, lack of holidays, lack of being able to get time off when you're sick – the morale has really dropped quite a bit. Right now anyone who can retire – it's looking very good (see Interview 8).

Fears about declining health due to the physical demands of the job were another incentive to retire:

I've been in it a long time and I probably am coming to the end in another few years. I enjoy it. Physically I am a well person, but I feel that it is wearing on me and I may come to an end sooner if things don't improve. I don't want it to make me older before my time and it probably will do that if I continue working at the pace I am working now (see Interview 8).

Of the nurses interviewed, several said they would take early retirement; one was leaving bedside nursing because of injury; and several mentioned plans to leave the acute care setting. With this kind of attrition it seems likely that, in a best case scenario, only young nurses will be left working in acute care. At worst, there will be no one willing to do it. In an area in which it is critically important that experienced and committed individuals participate in patient care, conditions seem designed to ensure just the opposite. "I just can't see myself running around at age 65 at the rate that I'm going now, you know? It's not gonna happen" (see Interview 5).

Nursing was thought to be less attractive to younger people than other professions with commensurate salaries, making recruitment more and more difficult:

Say physiotherapy. It's a four-year university course and the pay is equal to nursing, so why would you not? Teaching is opening up. That's a nice job. It's good pay, you know, nice vacation and every weekend off. That would be the ideal job (see Interview 6).

A nurse who entered the profession when there were not many choices available to women felt that, with many more vocational options available to women, nursing was simply not an attractive proposition any longer – particularly given the large investment of education and time.

if you go to high school graduations you will see that there's not many people opting for nursing. There are so many different opportunities now than when we all came out. When I graduated from high school usually it was a teacher, secretary or nurse, but now there are

just so many opportunities and there's so much that's negative about nursing. And now you want people to go four years. Four years! I mean, you could do so much (see Interview 7).

The reasons to leave seemed more compelling than the reasons to stay. One nurse thought that, with the inevitable attrition and projected deficit of new nurses, younger people needed to be encouraged to enter the field. She suggested a sort of public relations campaign waged by senior nurses at schools and colleges:

They do need nurses but the way that health care is going I don't know if the young ones are going to stay here when they can go to the States and have it so much easier. They're closing beds, they're closing hospitals, they're downsizing and cutting back on nurses – then discovering they need them and that they've gone south of the border. We're going to need nurses, a whole lot of them. We've got to make sure we encourage the ones who are supposed to be coming in. I think what nurses should do is go to colleges that have health programs and encourage people to come and be nurses; to stay in it. Like a speaker for a day. The kids have career days at school. Maybe they could do something like that because we're really going to need nurses. The ones who are here, like myself, are getting dilapidated and getting old. So they are going to need somebody to come in and take over, you know? (see Interview 4).

### **Increasingly technological nature of nursing care**

Several nurses complained that the time-consuming aspects of technological innovation were rarely taken into account by institutional management when making changes that affected nursing:

You know what it is? It's more and more machines. I love technology, that's fine, but the more machines and tubes you have hanging off people, the longer it takes to get them up and moving. We have to get people up walking in the halls two to three times a day as part of the post-op routine. So you've got all these tubes to disconnect, lines to take care of, things to measure – you know, just maintaining this person with all these tubes. So by adding another line to the mix you're just adding more checks and balances that I have to be checking on (see Interview 5).

Technology was often represented to nurses by management as labour- or time-saving when in fact the opposite was the case:

They instituted these epidural lines and it's supposed to be saving the nursing staff time. It's not. The vital signs, the side effects ... You've got to be checking and checking and checking and that takes lots of time. It's supposed to save time because you're not mixing it ... but with epidural lines in the back, the Fentanyl can drift – it can go out of the spaces in the vertebra in your back. It can suppress respiration ... Then you have a major calamity that's taking you away from your other five patients. So it hasn't saved anything" (see Interview 6).

One nurse, when she learned that patients with epidural lines were going to be added to her floor, decided to leave her job:

Here we hardly have time to do what we're doing and now they're going to institute something that's going to cause us more work. I just found it very frustrating and I thought, "You know what? If I'm going to be dealing with epidurals on the floor, I might as well go to an Intensive Care unit where my patient load is less (see Interview 5).

## Student supervision and preceptorship

Preceptorship and the supervision or mentorship of students became a fragile and endangered part of the nursing role as workload and other workplace pressures on nurses increased. Swamped with work and responsibilities, many nurses simply could not find the additional time to perform teaching and supervisory functions.

Some nurses nevertheless felt the need to pass on what they had learned and accepted the responsibilities of preceptorship. An RPN who had returned to nursing after experimenting with another profession adopted the preceptorship role, feeling that it was important to transmit to younger nurses practical information they might not have learned in school. As well as emphasizing the importance of safety procedures, she made sure they had the opportunity to witness potentially stressful nursing situations in order that they be prepared to face them: "If there's a Code I always say to them, 'Go and see what's happening so you can be a little bit prepared'" (see Interview 4).

But other nurses felt their workload was already too high:

A lot of the older nurses now are losing patience. They haven't time to be training or mentoring. Or they choose not to mentor people. They just want to come in. "Just let me come and do my shift and don't tax my brain with having to mentor anybody and be responsible for anybody (see Interview 4).

Accountability was a major issue with regard to monitoring students. Responsibility for students' training and supervision, some believed, was being offloaded from educational institutions:

I am still very unsure as to where the responsibility lies and it makes me very nervous when I have to go along with a student. People will not even take a student because of this. We have asked, they have told us that the college is responsible. We have been told that that is taken care of. But what is most upsetting is that I am trying to do my job shorthanded as it is and am trying to teach that student. Where is her teacher? I am not being paid to teach. I am being paid to work shorthanded as it is and I am doing the best I can. Where is her teacher and why aren't there more? (see Interview 8).

As well as the sense that the nursing role was being stretched to accommodate other, non-nursing responsibilities, having to work with a student slowed down procedures to the point that a nurse might not be able to get through her daily workload.

When I was being trained and I was being taught medicine I had my teachers from my school behind me. Now, on a floor, where I myself am giving out medicines to 25 people and I have to do it the best I can, sometimes it takes me a terrific amount of time because of the extent of the medicines and the type I'm giving. And all of a sudden I'm given a student to watch, which takes her three times as long as it would me, and medicines are not being given on time. The student is getting anxious. I'm getting very anxious because I would like to know who is responsible if she makes a mistake and there is no teacher to be found. They apparently do not have enough teachers to do this type of training any more. The courses are not set up the best, as far as I can see. They don't know where their teachers are half the time. Or the teachers who are coming along with them are people who have not worked in a hospital setting in the last five to eight years because they are totally baffled by the speed and the acuity and the need to get things done at a more rapid pace than they are used to" (see Interview 8).

## Public perception or misperception of nurses and the role of media

Blame for the increasing demands of the public and their misconceptions about the health care system was often laid at the door of the media. Patients and their families gathered information and formed impressions of the health care system by watching television and surfing the Internet. These sources could spawn public misconceptions about nursing roles and could encourage a confrontational attitude in patients and their families:

There was an article I think about a year ago in the newspaper written by a doctor, but it was a doctor who taught in the States. It said something like: “Don’t let them tell you about visiting hours. There’s no such thing. Don’t let them ask you to leave the room if they’re doing any care, you have the right to stay and watch. And come in pairs so one of you can advocate at the desk and one can be in the room to make sure things are being done.” I think a lot of people took that literally and a lot of them do come in pairs and they do come to the desk with their backs up and they do demand a lot of immediate action (see Interview 4).

In addition, because much of the information on television and the Internet was American, patients might assume that the Canadian medical system operated in the same way:

And a lot of them have been on the Internet and read a lot of things, mostly American. So they think it works the same way here in Canada too. The system is different, you know. And they watch a lot of ER on TV, and ER is not reality as far as I’m concerned (see Interview 4).

Despite the professionalization of nursing, old stereotypes persisted:

I think a lot of people still don’t see us as professionals. You’re just a nurse, right? ... Doctors are considered the top people. “I don’t want to talk to you, I want to talk to the doctor...” (see Interview 1).

## Why nursing?

A variety of reasons were given for why the interviewees went into nursing. Some of the older nurses said they chose nursing because it, along with teaching and secretarial work, was one of few acceptable careers for women at the time:

That was way back in the time when you either became a nurse or a secretary and nursing always appealed to me. I don’t know, I guess I just liked to look after people. It seems to be my nature and I have always liked nursing. I have never wanted to do anything else (see Interview 8).

One nurse thought her choice might have been influenced by a liking for science. Many seemed to feel a sense of vocation, of wanting to help people. An RPN who left nursing only to return after a few months of a new career was told by her husband, “This is your calling. Why do you run from it? Stay with it” (see Interview 4). Even the nurses who were most disappointed in their jobs still felt they were well-suited to the caring aspects of their careers.

At least two connected their choice of nursing as a career with caring for, or loss of, loved ones early in life: “I lost my father when I was young and I think that had a lot to do with my decision. I just wanted to help people” (see Interview 1). A nurse who declared herself very happy with her choice of profession said:

My favourite thing about working here is the patients. I’ve wanted to be a nurse since I was two. I’ve looked after sick people in my family and I knew that this – I mean, I love my job. You hear other people going, “Oh geez... I wouldn’t do it again!” I would. I would in a heartbeat (see Interview 2).

## What keeps you in nursing?

The reasons some nurses gave for staying in nursing also reflected a sometimes passionate, sometimes beleaguered sense of vocation:

When I come here I give them my all. I try to work over and above. I try my best because I always think that person lying in the bed could be my relative, could be my husband, could be my father, could be my mother, and what would I want for somebody to be doing to them, if it was them. So that's the way I approach it and, you know, that's the way you *have* to because sometimes you're having one hell of a day. And then you have to stop and think, "What would I want for my relatives?" So that sort of pulls you back. It's the care that keeps me in nursing (see Interview 4).

A sense of meaning, of having made a difference, could be a major factor in keeping nurses at the bedside:

What keeps me in nursing is to know that I've made a difference. To try and get the greatest amount of help for whatever the problem is. To make sure the patients get the care they need and that they're prepared for what they need to do when they leave. There's the *after*, you know. To make sure that they're educated and they know where to get their supplies and know how to do what they're going to need to do – whether it's a new ileostomy or just using their inspirimeter properly after they've left the hospital (see Interview 6).

The years spent on nursing education and the absence of skills suitable to other occupations also kept some nurses from leaving even when their jobs had become decidedly arduous: "What has kept me in nursing? I guess part of it is that I've done all this schooling. I'm not really willing to go and retrain for something else" (see Interview 5).

Learning, even the informal day-to-day process of learning on the job, made the job bearable for one nurse and to some extent validated her change from community to hospital nursing:

Since I came to the Medical floor I've learned something every single day... So that's what I like about here and I wouldn't go back. I could have gone back to the community when they did start again. But I thought, there's no going backwards. Things aren't going to be the same. They aren't going to be the way they were and I thought, I have learned an awful lot here, and I like that" (see Interview 7).

The same nurse said in another instance that she wouldn't miss nursing; that if she were financially able, she would leave. However, she later revised herself and said she probably would miss it after all:

I really do enjoy the learning. I must be interested in it. That's what I tend to read too. As much as you'd think you're going to get away from it you tend to read articles on disease, on different things. You do and you think, "Why do I do that?" Because that's what you're interested in (see Interview 7).

## What would make you leave nursing?

Even a beginning nurse who said she intended to stay in nursing for her entire career believed that if anything would make her leave, it would be stress:

Because you can get to a point where you just can't cope anymore – can't cope with everything, with the stresses of the workplace. That's going to make you sick in the end if you can't cope properly with things. It's going to be reflected in your work as well (see Interview 1).

One interviewee was leaving bedside nursing because of an injury that did not permit her to fulfil the physical requirements of her job. Potential physical breakdown was given as a possible reason for leaving by several older nurses:

But if it gets too physical and I just can't do the job, I might have to leave earlier. Some days it was getting pretty bad. You just think, "I can't do this much more." I'm too tired to do anything else. Tired, just chronically tired. So if my legs give out or if it hurts too much to come to work, then I'd have to think about it. But hopefully I plan to work a couple more years (see Interview 7).

Declining standards of patient care were one of the things that would make her consider leaving nursing, one nurse said. It was:

completely the way I feel about coming home and not having finished, not having done my job the way I would like to have done my job. Not having had that extra few minutes to talk to somebody who's had a mastectomy. To feel good about having done the very best I could. And there are safety issues too. When I had those patients, those six patients, what I went home feeling was, I really didn't know at any given time during that shift what the status of every one of my patients was, as far as being okay. I mean, being not critical. And that's really terrifying to me (see Interview 3).

The very idea of leaving the profession was conflicted for some. One nurse thought she probably would not leave nursing but might abandon acute care for some other type of nursing:

I don't think that I would leave nursing. I really do love nursing. I love the patient contact. I like the feeling that I'm helping. What I would leave would be maybe the acute care setting and go into a related field (see Interview 5).

## Children, family and childcare

Family considerations became an issue of working life for most nurses with families. One deferred an offered promotion until her children were older; she stated that she would likely wait to go back to school until her children were finished college.

The absence of child care that accommodated shift work was a major difficulty for nurses with families and particularly those who were single parents:

If we want to encourage people to be nurses and to stay here, I don't know how we're going to get around shift work, because nursing is 24/7. A lot of the younger ones don't like the shift work. Places need to have some sort of child care facility where if you are a young family you could bring your kid and they would be looked after while you're at work. Or have something that is affiliated, an institution that's open 24/7, just like we have to work 24/7.

Most places are nine to five, or day cares are seven to six, something like that. I mean, the rest of the world stops but we have to keep going. People need to realize that we also need somebody to help us with our kids. We are providing care (see Interview 4).

Difficulties were experienced by nurses trying to switch shifts to deal with family issues. As well as making it difficult for nurses to work their shifts, to participate in continuing education and meet the normal requirements of a family life, the lack of available daycare could mean increased absenteeism by nurses whose arrangements for childcare fell through for one reason or another or who needed to stay home with sick children. In this sense, family issues affected even those nurses who did not have children because they had to assume the workload of their absent coworkers.

Family issues sometimes affected a nurse's preference for full-time or part-time work:

When I first started nursing and in between my two children I wanted full-time work. Probably two to three times I was looking and if there had been something available.... I wasn't willing to leave my city at the time, wasn't willing to go anywhere else. Even now there isn't full-time available but that's okay with me right now (see Interview 3).

### **Orientation and training for new nurses**

There was concern among senior nurses about the training and orientation provided for new nurses. Good orientation was seen as valuable by younger nurses as well. One nurse said she chose her hospital because of it: "And they do have a really good orientation program. So that is one of the reasons that I came here as well, because they give you classes and offer about seven weeks of orientation to the unit" (see Interview 1).

Another nurse said she felt her institution's orientation was inadequate: "Then you have new grads and they're nervous. I think the orientation should be longer. I think they're getting a couple of weeks." Sometimes not only was the training too short but the supervision inconsistent and unsystematic:

When new nurses come to the floor, whoever is on and senior is assigned to them. They probably should be assigned to one person or maybe an educator should be going through each thing with them and checking off things – making sure that they've met all the criteria for what needs to be done on that floor. Here it's really kind of hit or miss and they're not all being taught exactly the same. It's confusing for them (see Interview 7).

One nurse reported that new nurses, virtually new grads, were being thrown into situations of responsibility almost immediately upon beginning work; another expressed concern that new nurses were not being adequately prepared.

There was a perception that nurses received more orientation in the United States and it was suggested that this might be one reason why beginning nurses went south.

### **Entry to practice**

Some worried that a degree requirement for entry to practice would create hierarchies among nurses. It was also suggested that it could result in more early retirement among senior nurses:

Senior nurses and staff don't want to have to go back to school. If you've got five more years to finish, would you want to spend that kind of money? You'll never get it back. You'll never

get a job in administration – you're too old. And for new nursing staff – it's another year of education that costs you more money, a bigger student loan. If we had a nursing shortage before, we are looking at a bigger nursing shortage now (see Interview 6).

The same nurse felt that government subsidies to university nursing schools might make a return to school more attractive to nurses.

### **Allocation of health care funds**

Concern was expressed by several nurses at the ways in which health care dollars were being spent, often on new building, when basic supplies and equipment were in short supply: "Here they're using capital funds for building, but we need money too. I'm on a respiratory floor and you're fighting for an oximeter" (see Interview 2).

Sometimes costly restructuring decisions seemed completely illogical to the nurses whose lives they impacted. One nurse had been waiting for years to move into a new building that could not be completed because of cost overruns:

The way they handed out the contract was not a good way. What they did, from my understanding of it, is instead of awarding the building contract for the whole deal for the hospital, they handed it out in increments. They made people bid on it every year or so. When this part of the hospital comes up we'll put up the bid again. As we know things just get more expensive and more expensive. So by doing all these little bids it pushed the price of the hospital up. If they had negotiated with someone in the beginning for the whole thing that would have been cheaper, in my understanding, but they didn't do it that way. So in the end they ran out of money. A hospital that was supposed to be, say for example, \$100 million is now three times that – \$300 million (see Interview 7).

After a long and painful process of restructuring, involving amalgamation, building and the forced migration of staff from one institution to another, one nurse was puzzled that her institution was still providing a kind of care that was supposed to be the province of another institution. Furthermore, money was being spent on more building:

We just finished all this restructuring. Now they're building and moving to make this Rehab thing. It doesn't make a lot of sense when they have buildings across the street or down the road from us, and not five minutes from us. That sort of thing is frustrating to hear. You wonder about the money being spent when you could have more money for an extra nurse, extra staff, and let St. Gertrude's deal with what they were intended to. You know, don't spend money on changing the building (see Interview 3).

### **Change and instability**

The perception of a health care system in perpetual turmoil created a feeling of unease and insecurity for many nurses: "They say that things are more advanced there [in the United States] and of course there's so much turmoil here all the time right now" (see Interview 7). Many nurses tried to gamely soldier on and absorb all the changes but found there were just too many: "There are always changes in life and there are always changes in nursing, but there are so many changes lately that it makes it difficult" (see Interview 3). Furthermore, the rate of change appeared to some to be increasing:

I would say the changes started roughly eight years ago. But in the past three years or so they seem to be just evolving quickly – too quickly. Speeding up, work load enhancing. Physically and emotionally demanding. Lack of staff, lack of enough people in the pool to allow full-time nurses to have time off. Lack of management to talk to, to express your opinions to, to voice differences to and just generally anyone there to listen to you (see Interview 8).

### **Is anyone listening?**

One nurse, speaking of nursing research being conducted, expressed disappointment that no changes were forthcoming as a result of all the information that had been collected. There was a sense that no one was listening, or that it was impossible to convey how acute the situation had become:

We keep getting asked questions and questions and questions.... It's like trying to tell somebody what a different world is like. And answering these questions is not doing any good because they're not getting the true picture (see Interview 8).

In view of all the studies in which nurses have participated and the lack of substantive change resulting from them, nurses may perhaps be forgiven for feeling that all the carefully gathered information might as well have been thrown down a well for all the difference it has made to them. The situation was too extreme, one nurse felt, for outsiders to appreciate: "You can't sit in an office from afar and judge what's happening these days. It is far different, I think, than what anyone can even imagine" (see Interview 8).

### **The need to get involved**

Most of the nurses interviewed were not engaged in any political activity; only one mentioned participation in hospital committees. Although nurses are traditionally not a politically-minded or cohesive group of workers, substantial dissatisfaction with regard to work life issues could foster more active participation – particularly if they can be persuaded by strong nursing leadership that involvement is a benefit and, indeed, a necessity.

Nurses need to be involved in their profession.... People make the generalization: "Whatever I have to say doesn't make a difference." But you have to say it. How do people know how you think if you don't say it? How do you know it's not going to make a difference if you don't say it? So you have to say it. I think coming, leaving and then returning – that sort of brought me to the realization that you have to be out there. You have to advocate for your patient. You have to advocate for the profession. If you don't, then it's your downfall (see Interview 4).

### Interview 1: Long days/A certain type of person

*Gabrielle Signe is a recent graduate who has been a nurse for nine months. At this stage of her career, everything is new; the privileges and limitations of a nursing job stand in sharp contrast to her previous life as a student. She compares the expectations developed in nursing school with the reality of hospital nursing and muses about the dichotomous public attitude toward nurses, characterized on one hand by an exaggerated respect and, on the other, by a perception of nurses as “less than” doctors. Some of the conflicts of the nursing profession are already apparent to her: the struggle for professionalism, recognition and remuneration; a surfeit of daily tasks and insufficient time to perform them. Often essential tasks are completed at the expense of patient communication. “You don’t have the time to sit there and talk to them,” she says. “You know, what’s rewarding about nursing is talking to people and helping them. That’s how you find out things that maybe you weren’t aware of that will help you with the care that you’re giving them.” Barely out of school, she is finding that “nothing is really by the book.”*

When you’re in school they say it’s all about organization – that if you can handle two patients, you can handle four. They teach you how to do things a certain way and everything is supposed to go smoothly. But you don’t have a full patient load as a student so when you’re actually thrown into nursing full-time, it takes you a while to adapt. Things don’t go as smoothly and when you’re starting out it takes longer to do things. You just learn that nothing is really by the book.

I work three days and then I’m off for five; then I work four days and I’m off for two. Twelve-hour shifts, days and nights. We usually get one eight-hour shift every two weeks. I like working the twelve-hour shifts. I also like having the eight-hour shift because it’s kind of a treat. You get to go home early! It only happens once every two weeks. On twelve-hour days it’s dark when you leave in the morning and dark when you get home – you don’t really get to see daylight. So it’s nice when you get to leave at 3:30 and you still have the whole evening ahead of you. I don’t work nights often, though I don’t have a problem with it – I like working nights. But I think for some people it might be difficult. Because of the line [one of several shift rotations] I’m on, I get my days off all in a row. When people work two days and then they’re off for two it might be more difficult because they don’t have as much time to re-adapt to going back on a day shift.

On days we start at 7:30, so we try to get there about ten minutes early. I usually get up at around 6:00. I’ll be at work for 7:20 or 7:30. Then we get our report sheets from the nurses who work nights. If they have anything more specific that they want to let us know then they tell us, but otherwise everything is written on a report sheet. We have some overlap between the two shifts so we sit down from about 7:30 till close to 8:00. That’s just going over the basic information that we need to know for the day on the patient. Medication, and if there’s any special care that they need or issues that arose overnight that we have to look out for during the day.

At 8:00 you make sure everybody’s all right and set them up for breakfast. You do your initial assessment, your vital signs – you know, chest, abdomen. I do a head-to-toe. That might take 15 minutes per patient. There are always going to be little things that make it longer here or

there. You ask them how their night was, if there were any concerns. You set them up for breakfast. Of course if you have diabetics then you have to check their blood sugar. We only have two machines, so you don't usually get one right away. You're waiting for somebody else to be done, so it delays you. Lately for some reason we have an equipment shortage. I don't know why, because we did get extra equipment at one point. It just seems to be disappearing and we don't know where it is. So we're always saying, "Are you done with that?" You don't actually get to do it when you'd like to or when you have the time to do it because you don't have the equipment at your disposal. You spend time looking for it.

About 9:00 we have rounds, the whole interdisciplinary team. The physiotherapist and the speech pathologist and all the doctors are there. Basically they just want to know if there are any issues. You do that for every patient that you have. That can take until about 9:30 to 10:00. It depends on whether they start on time or not.

Then you try to wash everybody. It doesn't always happen! You might get one or two done in the morning. It's physically taxing – sometimes I'll get home and I'm just so drained and so sore. You know, aching, not necessarily because I pulled anything. Sometimes you'll go to lift somebody and realize, hey, you might need an extra hand. I usually try to get another nurse. Or we have a service assistant to help with the lifting if we need help boosting the patients up in the bed. Service assistants are the ones who bring all the meals. They pass out the breakfasts or do the cleaning, but they will also help us boost the patients up. They don't participate in care but a lot of times they help us for breakfast. Sometimes we don't always get there right when the breakfast comes and the patients want to eat so the service assistants will help us and do it if we're not there.

About 10:00 is the usual time for patients' medications. We pass out all the medications. We have separate bins for each patient and all their medications are in there. You hope that they're all there! As you're pouring them, you see: "Oh, that's missing." So you have to call Pharmacy and get them to deliver it for you. By the time you check to see if it's come up – you have an hour leeway let's say for medication but it's always difficult, there are all these little things that will come up in between that delay everything. People are calling for a bedpan or they interrupt something that you might be doing with another patient. You're supposed to go on break actually at about this time, around 10:00 to 10:30. So you might manage about one bath by then.

Then we cover for whoever is on break, so we pick up the extra four patients. That means we're covering for eight patients in a half-hour. We might get another bath done before we have to set the patients up for lunch again, pass out meds again. And then we have to deal with Physio[therapy], or the patients may need to have tests done.

If there are any tests to be done it means transferring patients from the bed to a stretcher, getting somebody to help you. Service assistants take them to Physio, or there's a porter who comes. It depends what test they're getting. The porter comes for certain ones but not for all of them, so it depends. It requires time – most of the time you need more than just two people to transfer a patient. It does take time sometimes to find other people who are available to help you.

For physiotherapy, sometimes they need help getting the patient up. They try to come and see the patients that require physiotherapy to get them up, at least to sit them up in a chair for lunch. What's been happening lately is that often Physio doesn't come back and put them back in bed. Then the question is, do you call them and try to get them back up on the floor to do it, or do you just do it yourself? Because if the patients can't sit any longer they get agitated and frustrated. All they want to do is go back to bed. They might only have a half-hour tolerance that they can handle. It can become a problem. It has been in the last little while. Physio will get them up and sometimes they'll forget to put them back, so then we're stuck doing it, it's something extra that we have to do. It's what physiotherapists are trained for; they might know an easier or a better way to do it. They have the equipment that they need – a lap belt to help pull the patients up or things like that. Sometimes you're not really sure how they got them up and how to get them back into bed. You didn't get them up, so ... how do you get them back in? You don't know how strong they are. You run into problems.

Now it's maybe one-ish so we try to go for lunch. Then at 2:00 is another medication. A lot of people have medication at 2:00, so you do that again and try to get in another bath or two. Often patients' families will get upset: "How come they're not washed? How come they're still in bed? How come ...." But, you know, it's just not possible because of other things that have happened. It's difficult. You don't want to tell them, "Well, I don't have time for your mom or dad." It's not that. You have to try to explain that you have another patient who required a little bit more attention today and that you will get to it, but that time hasn't allowed it to happen. You try to explain to them that you're really sorry but you just haven't gotten to it yet. Most of them are understanding and some will actually offer to do it for you. And some won't. We do appreciate it when they offer because a lot of times we won't get to it until the afternoon. So it's nice for them to help out in that way. There are also dressings to change and if the patients are incontinent that's something that you have to deal with throughout the day. So that takes up a lot of time as well, and repositioning the patients. They're in bed all day so you have to keep going in and changing them from side to side, usually about every two to three hours.

So we're at maybe 3:30 or 4:00. At 4:00 it basically starts all over again. The medication and getting them ready for supper. Probably about 6:00 is the time when you can actually sit down and do your charting. You're supposed to do it routinely during the day. Which is another thing that you're not taught in school – that you won't actually get to do it until 6:00. Maybe some people do it and it may be the way things work in other places – I don't know because I haven't really been in other institutions, except when I was in school. Then I didn't have that four-patient load, so I don't know if I would have had the time to do it. So you try to squeeze that in there and you hope by 6:00 that you're able to chart on everybody.

Then it's time to go home. You have good days and you have bad days. I don't necessarily get everything done that I want to. If I don't have time, say, to give a bath but I've done two out of the four then, because I know I'm going to be there the next day, I'll start with the other two that weren't done. You try to do what you can. I don't like to leave anything for night shift that's supposed to be done on days. And that's another issue, because we do all our blood work as well. We don't have an IV [intravenous] team. It's not a rule that night shift does it, but usually the night shift nurses will start the blood work at about 6:00 in the morning. So you hope when you arrive in the morning at 7:30 that they got it all done. If it wasn't done, that's another thing that you have to add into your day and that you might not necessarily get to right away. And the doctors like to have the results. So ....

As for working late, it doesn't happen that often. I'm usually there, I'd say, until maybe a quarter to eight, eight o'clock. It's happened that I've stayed an extra hour. I've done it maybe five times in a matter of nine months. Sometimes I will come home and complain about something – you know, "My day was so busy ...." But usually I'm able to leave it there and I don't take things personally.

When I decided to go into nursing it was a last-minute decision. There were two opposite routes I was considering. I was thinking of either commerce or nursing – obviously two very different directions, obviously. I lost my father when I was young and I think that had a lot to do with my decision. I just wanted to help people. Also, a lot of people respect you for being a nurse and that's a reward in itself. When you tell them, "I'm a nurse," they say, "Oh really? That's so great!" Or, "I could never do that. Nurses are angels." People say it takes a certain type of person to be a nurse. It makes you feel good. You get the same thing from patients and families when you're helping them and things turn out, because they thank you.

At the moment it's so busy that you don't actually have time to notice when somebody is thanking you for something. You're so preoccupied with other things. You don't have time to sit there and talk to them. You know, what's rewarding about nursing is talking to people and helping them. That's how you find out things that maybe you weren't aware of that will help with the care you're giving them. I think that's a big part of it. But it's so busy now, you can't always give all the care that you would want to give.

We have a lot of really sick patients right now but our nurse-patient ratio doesn't change. If you have four patients, you might have two that are really sick and two that are less sick. They're all sick, but their acuity levels will be different. A four-patient workload with varied levels might not be as difficult as a four-patient workload where the acuity for all four is at the highest level.

In general, the acuity is probably increasing. I haven't been a nurse for that long, but a lot of people seem to be saying the same things – that it's too hard or that people are staying later at work because they didn't have time to finish everything during the day.

I think that our workload is actually pretty okay, considering, but there are different systems depending on the institution you work in. Ours is four to one, there are four patients to one nurse, whereas others might have seven to one but they'll also have health care aides. We don't have any health care aides – it's an all-RN institution. I think it would be nice actually to have health care aides just because I think there are a lot of little things that they could do that would make your day go more smoothly. I'd rather have seven people to look after in terms of their overall health if health care aides could help with the bath and do all the little things that are time-consuming.

We had an event not too long ago, maybe about two weeks ago, where we had two nurses who actually got into a physical ... fight, or dispute. We've had meetings in the last couple of weeks with the other nurses to talk about what happened. One of the nurses suggested, "Do you guys think that it might be a reflection of how busy and how stressed that we are that it came to that?" Obviously, no matter what, it shouldn't happen, but because of the acuity, people get frustrated and stressed and it can come out in the wrong way.

Patients probably feel the effects of increased acuity on some days because you can't always be in there and some people need more care than others. Sometimes you just don't have the time. It's not that you don't want to go in there – you know they need that time, but you can't always provide it. So I think on some days they will feel it. Because if you're stressed and flustered and frazzled because your day is just crazy and all these things are going on, I'm sure that they sense it in the care that they're getting. You know, everything is probably done at a faster pace. Some will be sympathetic – you know, "You guys are so overworked!" Some people will totally understand but there are some people who just don't. On our floor we get a lot of confused people and they don't understand. You know, you're trying to explain something to people you can't reason with, so it makes it difficult.

I think a lot of people still don't see us as professionals. You're just a nurse, right? I know I said earlier that a lot of the time you do get respect, but there's the other thing where a lot of people think of nurses as what they used to be ages ago. Doctors are considered the top people. "I don't want to talk to you, I want to talk to the doctor" – about issues that you could possibly deal with. They think that you don't know anything and the doctors are the people who have all the answers.

That's the one thing that I would like to change. I think it's getting to be more like that. The institution that I work in is a teaching hospital so there are a lot of interns and people who are younger. They're of our mind-set, let's say, and they tend to appreciate us more. They'll ask *us* about some things: "What do you think? Because you're with them all day so you're going to know more than we will." Whereas there are other, maybe older doctors, and I'm not saying – you know, there are some young doctors who think that way too, but we'll have the older doctors who still consider you just a nurse, that you're a servant basically and a servant to them: "I'm telling you to do this, go do it!" With younger people it's often more like a team: "Well, what do you think?" Some people will actually ask for your input on things, which is nice, whereas others don't really bother with what you have to say.

In the beginning, when you're starting out, I found that you get a lot of support from other nurses and doctors because they know you're new. It also depends on the people. I notice some people won't offer as much support as others. That's just something that you learn to deal with. You learn who to go to for support. I'd say overall it's been pretty good, the support that the staff has given me starting out. It's always, you know, "If you need help or you don't know how to do this, come see me." Things like that. But our nursing leadership have so many other things to attend to that they can't be on the floor all the time. They not only have to oversee us as nurses but, because they're management (like the nursing unit administrator), they have other responsibilities, meetings to attend – things that mean they're not always available if you need to speak with them.

For me right now the salary seems good because I'm coming from school, so obviously this is better than working a part-time job while you're studying. It was nice to start at the wage that I started at. But when you compare it with other jobs – they're getting this much, and I'm dealing with people whose lives are in my hands. When you compare the salaries you think, "This doesn't make sense. Why am I getting paid either the same as or less than somebody who's not dealing with people's lives?"

The current range of salary probably provides an incentive for nurses because you'll reach that maximum after, let's say, eight to ten years. That's pretty good considering there are a lot of other places where you'll stay at the same salary for a longer period of time. We know that ours is going up every year. So I think it probably is an incentive. Sometimes you don't think it's enough of one when you're in the situation itself – it's like, "I don't get paid enough for this!"

I think I will probably stay in nursing. Probably not where I am now, but I'm thinking further ahead in what I'm going to do in nursing. So I think it's safe to say that I will stay. Right now I want to branch off more into labour and delivery, because I never did it in school. So I want to find out whether I like it or not, and if I do I think I will probably be going off into Community Health and doing the mother and baby classes that they have. I've also thought of being a Nurse Practitioner. I don't necessarily want to go back to school just yet. At the moment I would stay in this institution, more specifically in labour and delivery because they have the best program. For that I would stay here. And they do have a really good orientation program. So that is one of the reasons that I came here as well, because they give you classes and offer about seven weeks of orientation to the unit.

If anything would make me leave nursing, I think it would probably be stress. Because you can get to a point where you just can't cope anymore – can't cope with everything, with the stresses of the workplace. That's going to make you sick in the end if you can't cope properly with things. It's going to be reflected in your work as well. It takes so much time just to do the little things. At the end of the day you often don't know why you were so busy – and why you're still there! I don't know. You can't really explain on a piece of paper why it took you so long today to do things.

## **Interview 2: Charge Nurse/A Good Day**

*After 13 years at the same institution, Cheryl Durning refers to herself as one of the "old folks" of her hospital. She has recently accepted the position of Charge Nurse on her unit, a job she was offered years earlier but turned down because it would have placed stress on her family. Now that her children are older she has decided to take it. Her new position combines bedside nursing and management; in addition to her duties as Charge Nurse, she still carries a (reduced) patient load. Though her nursing tasks sometimes conflict with her new duties, she says that she enjoys patient contact and considers herself to be a nurse first and foremost.*

*Four years ago her hospital underwent a management shift that she believes resulted in positive changes for the institution and for nurses. She has the sense now that nurses are being listened to, that desired changes are being implemented. Of the interviewees, she is the only one who refers to "fun" as part of her worklife: "That's one rule on our floor. We laugh a lot." She is energetic and articulate and characterizes herself as highly organized and outspoken. When she can afford it, she would like to go back to school to get her degree (she currently holds a diploma). Nurse Practitioner training has always attracted her. She has wanted to be a nurse since she was two years old and would make the same choice again "in a heartbeat." When asked what would make her leave nursing, she says, "Retirement."*

Four years ago we had a management change and it's gotten a lot better around here I think. I *think*. I mean we still have places to go but I think overall morale is a little better. They're listening to us where before we didn't feel they were. They're taking more of a nursing opinion.

We're still short-staffed and we're still overworked, but it seems like they're trying a little harder. Our CEO holds meetings and "town hall" meetings with the whole hospital every three or four months. It doesn't matter if it's nursing-related or a different area of the hospital, everyone knows what's going on. And people seem more accessible to us. We see our management much more often.

We started doing cultural surveys – we have another one coming up. They send a survey to all staff members in the hospital. It's just a questionnaire, anonymous, asking different questions: where we see them, how things are going; what improvements we can make. And they look at that.

I love this hospital. I think it's just a good institution. Every institution has its bad points and its good points, but I enjoy what I do here. I enjoy where I work and I have a good rapport with the doctors. Sometimes it's a little crazy and sometimes we don't always work as a team, but on our floor we sit down and talk with them and we give our feedback. We started having regular meetings and it works well. I just think it's a very good institution, a good learning centre and I enjoy it.

I've been a Charge Nurse for three months. I was asked before and declined. When I turned it down, it was child-related. I live an hour away and the driving back and forth .... My son was older but my daughter was still young and I thought, "I'm not ready for this yet." I wanted it but I thought, "No, I'll wait till she gets a little older." Later I sat down with the family and we all agreed on it because they knew I wanted it. And it's working out quite nicely.

Basically I'm here to foresee any problems that are happening on the floor. I always check out the bed situation on our floor and report it first thing in the morning. If we're having any discharges, are we going to have some open beds? We have a step-down unit on our floor, so I go in and assess those patients. I assign breaks – it's very important that we get out for breaks (sometimes we don't though). Any family situations I try to deal with first before management gets involved. If there are any crises I'm right there. Shift changes, I look after that and just help organize the floor and make it run smoothly. There are problems. There are problems like there are going to be anywhere, but we try to work it out and we always have a lot of fun. That's one rule on our floor. We laugh a lot. We have a lot of humour and smiling and chatting – you have to – and when somebody's not having a good day, we know they're not having a good day. You know, if they want us to stay clear, we stay clear, and if not, we're there for support.

We also have a Nurse Manager. They got rid of our Head Nurses with the first set of cutbacks many years ago. Every floor used to have a Head Nurse and then, when they downsized, they downsized too much. And then we upsized a little bit. Our Manager looks after two floors and she's right in the middle between us. She's just outside this door and I have regular access to her. I have her pager, I have her office number and if it's a problem that I can't deal with I phone her and she'll come and deal with it. And some problems I look at are not my problems. I've always told the people that I work with, "My first job is a nurse and this is what I'm here for." Some of the other stuff, to me that's management's job. They know I won't look after that stuff because it's not my job.

I don't think I had any transitional problems. At 3:00 when I leave, a twelve-hour girl takes charge for four hours. Then the girls coming on at night, there's someone in charge for them. They don't do a lot of the stuff that I do in the day, but I was used to it. I'm very organized. I have a name on the floor because I'm so organized; everything has to run smoothly. So it

hasn't been difficult at all. Getting to know every team again – because I know pretty well all the girls but you get set with your own team, and knowing how they work and just getting to know everybody again has been quite fun actually.

In our master rotation we have four different groups. The first group is a Monday, Tuesday, Friday, Saturday, Sunday and then the following week is the Wednesday, Thursday. And that's two weeks of days and then they flip to two weeks of nights. There's eight girls on each side of that. The eight-hour girls do five days, two evenings, and then they come back two evenings and then switch off to days, with a couple of days in between. The part-time – that's a rotation that we're just starting. It went by seniority and there were nine lines, I believe, that were up. People got to pick a line that would go with their family life and that they'd like.

Previously you were just put in the shifts at random. Now there's room for people to pick up shifts because, when you're on a twelve-hour shift, every 16 weeks you get a week off (or it would be too many hours at the end of the year). So then the part-timers pick up those shifts and there are more available spaces. If the twelve-hour nurses want a vacation day they can get it and they can get somebody to work for them. So then these part-time girls, they have their assigned shifts so that they can plan their family life too, knowing that if they want to pick stuff up, they'll write on the schedule: "Available for Monday, Tuesday, Wednesday." That way we know if they're available.

I don't like nights per se. I think as you get older nights get harder and harder to do. Most of our nurses have twelve-hour shifts in this hospital. We do have some eight-hour shifts. I'm an eight-hour, but I came from a twelve-hour. I was a twelve-hour person. Our unit, we're just starting a master rotation. Our management in our area look at making staff happy. If staff are happy, staff work better, staff aren't so stressed out. Our manager is very accommodating for us.

As at every hospital, sick time has always been an issue. That's your number one thing. They try to replace every absence, depending on staffing. It all depends on staffing. A lot of us think that, yes, there is valid sick time but there is a lot that isn't valid sick time. They're actually slowly starting a new program to see what we can do about that. I think it's mostly stress time. I think more people just need to take some days off.

We have a new form. We don't totally agree with the form because sometimes you are off sick for a reason and we all know that if we're off for a reason we call our manager and we bring in a doctor's note but now they're asking that if you're off any three consecutive shifts you have to have a doctor's note. The unions aren't agreeing with this. Partly they ask some information that we don't think is the hospital's business. They might revisit the sheet and revamp it. I don't know; that's up to them. But I think it's a good thing because we've been complaining so much. People are taking sick time who really don't need sick time. We know they're not sick and there are abusers of sick time everywhere. So this will help because when these people take the sick time and it's not actual sick time it always affects your floor because then you're short and it becomes very stressful. So they're trying to do that.

On our floor we actually have a very high turnover, the reason being because we have students who come and consolidate here. They really like it and they further their educations, like take the Critical Care course. It costs money and most people will leave and try to get into ICU because if you get into ICU you don't have to pay for the last part of the program. And that's how we think we're losing our staff quite quickly, because most of our staff are going to ICU.

I know that there's a lot of information out there about support for education, and you can get money back. But if these people get hired in ICU then they don't have to pay that money. So I think they think, "Okay, I'll get hired there." Maybe we'll see them again and maybe we won't; maybe they won't come back. That's one big problem on our floor. You spend a lot of time educating people on our floor. We acquire a lot of skills. I really think that people who are hired should be assigned to a floor at least for a couple of years. Because a lot of these people are just new grads and I think sometimes they leave and may not totally have the whole picture at hand.

For us "old folks" who have been here forever it's hard because you have a lot of responsibility. When you bring in new people – because mostly our floor gets new people who are graduating or a new grad who has come from another institution and hasn't worked there very long – you put a lot of time and effort into training them and helping them out. Sometimes we call ourselves "the older nurses." We're not old, but it can be very stressful.

We're generally good at voicing our feelings. We have a Clinical Instructor on our floor so any problems that we have, we write down and she'll address them, or we'll address them personally to the new people if we see them. We try to do that first and then if it's more of a skills issue we'll send our CI with them and usually the CI will check in with them, talk with them or maybe even buddy up with them for a few hours or for a day. Because sometimes a person perceives themselves as doing okay, and you think they're doing okay, but actually they've missed some steps along the way. Nursing has changed so much that it's – boom, boom, boom! – very fast. You have to really get your skills up and get quick. These new people, it takes time to get good assessment skills. That's just natural, I think. So, some of that, and on our floor we have more critical patients so you have to be on top of your toes.

I think that generally nurses receive respect here but there are always cases when they don't. I think it's on an individual basis. If we're seeking information, if we think maybe we should be doing something, especially when the doctors are just new to the hospital and they're not sure what to do, and we're trying to push them – that takes a little time and can be frustrating because you've been here for so long and you know the process and you know where we're going. That can be frustrating but in general it's pretty good.

We get a lot of peer feedback from the doctors. If there was a crisis and we all worked really well together they'll thank you and our managers will also. Anytime we do something good they'll send us a note or they'll come and talk to us personally. We have gotten notes from other floors – you know: "Thank you for moving quickly to get this patient over." In April or May we have a staff recognition and you can nominate different staff for an award, someone who you think is contributing well to the hospital.

From patients, you hear a lot of positive and negative, but I think on our floor we probably hear 95% positive. They read the papers, they know what's going on. The first thing they'll say, a lot of them, is, "I'm so sorry for bothering you. I know you're busy." So then you have to say, "No, I'm here for you. I'm yours. So what can I do for you?" But then on the other end of the spectrum you have the very demanding patient who rings the bell to move their Kleenex from point A to point B when they can do it. That's *very* frustrating. And then you leave the room and they ring again to move something else or to do something else.

I think generally everybody works in their own area and everybody has their own skill and everybody thinks they're the busiest place in the hospital – but that's natural. For example, if we're having to discharge patients or move patients around or get patients into our step-down and it's not moving as quickly as another floor or Emerge wants us to move, that's where usually we get management involved. I'll phone over and say, "You know, they've phoned twelve times in an hour. They know we're busy. We're moving as fast as we can. We're only the staff that are on – we're moving as fast as we can." They have to understand that. We don't have an extra pair of hands or, in ICU, we don't have a doctor readily available or an extra pair of hands that can help. So sometimes that can be a problem, because no one really knows what each other's area is like. Because you think you're the busiest area.

If we're having a real problem I will phone my manager and she will phone the manager downstairs. Or sometimes another floor will actually phone our management and then management will come over and I'll say, "If they'd stop calling me 50 times and getting me to the phone...." You know, a lot of phone calls. There's always lots of phone calls that take you away from important work. That can be frustrating.

We do our own transport. If it's a sick patient, we go with the patient. If they're going for a test or procedure we have to accompany them, with a porter as well. If a patient is coming from our step-down onto our floor and we have to move quickly because of a sick patient coming from somewhere else, we nurses will move the bed ourselves. We're RNs and PCAs. When I started it was RNs and RPNs and then we moved to RNs and PCAs. A PCA is a Personal Care Assistant. They're responsible for baths and feeding, toileting – just the personal care. When I first came and there were the RPNs and they had their patient load and you were responsible for the meds only. Technically you were still responsible for them. If anything critical happened to their patients you were still responsible. So if you had your 6 or 7 patients and they had 6 or 7 patients, plus you were doing their meds, you were actually twelve for the day.

This way it's good. They help us out with the transfers and the bathing and that lowers your load. On days our ratio is five or six patients per nurse and on nights it's nine. On some days it doesn't work at all, because I still have a patient assignment even though I'm the Charge Nurse. I have three. Sometimes that's hard if there's stuff going on because you're striving to look after your patients and there's other stuff going on and you feel like you're being torn.

There's discussion about the Charge Nurses having assignments. In some areas of the hospital the Charge Nurses don't have assignments. It's all a bed issue, how many beds you have on the floor. I don't know who makes the decision that, "Yes, this floor can have patients with their Charge Nurses and this floor can't." Mind you, I really like the patient contact. But some days you wish you didn't have any patients to get some of the stuff done that you need to get done. Because if you do have crises on the floor or if there's problems in the family – I go to a lot of family meetings and we're trying to get things organized – that takes you away. So some days it would work out quite nicely if you didn't.

I always think there's room for improvement. I have seen improvement in the hospital and I like where I work, but there are days when I say, "Oh, I've just got to get out of here!" It can be stressful. I think there's always room for improvement.

I think the major source of stress for nurses is that patients are sicker nowadays. Patients are not coming in with just COPD [chronic obstructive pulmonary disease], for example. They're coming in with COPD and congestive heart failure and kidney failure – you know, every system is going. So that's a lot of time for a nurse because you're not just focussing on one area. You're focussing on every area and acuity has gone way up there. And there are that many more procedures. And paperwork.

There's way too much paperwork in the hospital, I think. We just did a survey of all the paperwork on our floor for nurses and doctors. There's a lot of paperwork, but none of it we can get rid of. Every bit of paperwork has a reason why it's being done. Actually the doctors brought this up to us: "We have a lot of paperwork." So we said, "Well we do too!"

We had one of our nurses on modified and we had her survey all our paperwork on the floor – every test, every procedure. Everything has a piece of paper. If you just had one piece of paper with a bunch of tests on it, it would be quite easy but you have your STAT [urgent] blood work and your regular blood work, and then you have your ECGs [electrocardiogram]. For example, Echo[cardiogram]s should be able to go on an ECG form. And then you have report sheets and the charting – we chart a lot. Even though we have tick sheets and charting, we write a lot. A lot is doubled, probably.

We have clerks and that's very helpful. They help out a tremendous amount. We've never measured the amount of time that goes into paperwork – that would mean another form or another survey to do! I couldn't even give a time. It all varies with what's going on with your patient. The more that's going on with the patient, the more you're charting, double or triple. We've changed our sheets, our paperwork – not recently, it's been a few years – to try to accommodate stuff but we still find that nurses like to chart everything. We have tick sheets that are just diet, mobility, skin, bathing, elimination, safety – but we still go back and chart because most of us have been taught to chart, chart, chart. So you're doing your ticks, but you still go back and write something about that area. Even though you have ticked it, you feel like you have to chart everything.

When I went to school, you wrote everything down. It's in our heads that we really need to write clear notes. You don't feel comfortable with a tick form. Yes, it's a quick glance to see if a patient has gone to the washroom. If there are problems then we do stars and you know to look for a specific problem in their note. But generally a head to toe assessment's a lot nicer and then as the day goes on just writing what's happening. When you're in school you're taught not to call your patient "the appendix" or "the tonsillectomy" – you refer to your patients as your patients. So maybe it has something to do with that.

I would like to computerize systems here. Hopefully one day we'll get there, because I think they'd be great. Those portable computers – I don't know what they're called, but it would be nice. I always say, "I wish I could have a recorder to say how my day is and somebody could type it up and I could read it and sign it." That would be heaven for me! I would love that.

There's a lot of encouragement of people to achieve higher education. We have newspapers in the hospital and bulletins that come out just to remind you that there are services that can help you with the money for education. One of our complaints last year, going back to our cultural survey, was not getting the time off to go back to school. Then, you couldn't get the time off.

At all. They didn't pay any portion of it; there was no encouragement whatsoever. It was one of the things that was brought up on the cultural survey. That was because we had such a nursing shortage. If you give people time off to get better educated in their field, we're running short of nurses. It's difficult. They've improved that now. We didn't have the casual worker. We now have the casual worker. We have a weekend worker now, so people can go to school Monday to Friday if they want and be the weekend worker. They've brought that kind of stuff back to us.

Now, whether these people are going back to school on their own, I don't know, but there are different ways in the hospital that you can apply for different kinds of money. There are nursing funds and different funds that you can apply for – and hopefully get. We don't have a system like, "Okay, I want to go back to school. Can you please give me some money?" It's not that easy.

I would love to go back to school. I don't have my degree in nursing; I'm just a diploma nurse. I would like to go back and get my degree. But financially right now I just can't do it. I have a son who's heading to college soon. I can apply for stuff here which I know I can do, but then can I survive not working? I'm hoping one day I can. I'm eager right now. I've been talking about it a lot. I've been really talking about it a lot at home, because they know that I'd like to go back. I'm hoping it could happen within the next few years, even just starting off with a course – because you can go to school part-time. I wouldn't quit work, I don't think, and then go full-time for two years to get my degree. I wouldn't do that.

Many years ago when they first brought in the Nurse Practitioner, that was my goal in nursing. They've brought a lot of websites out now on it. I just haven't had time to sit and really read through it and see. Because of the doctor shortage as well now, because they're all moving into the States too, it might be a good time.

When you compare our country to another country like the States, they offer a lot. They offer a lot of incentives for people to go down there. Most nurses when they graduate want full-time. That's the goal for nearly everyone. Most nurses want full-time work and there wasn't full-time work. I was part-time when I started. When I wanted to be full-time I had it, it was there. Then things started happening and we started getting a bit more money and a bit more nursing positions that were full-time. But I don't know why the nurses don't come back here. I really don't understand that. That's in my mind right now. When we're such in a nursing crisis in Ontario, I can't comprehend why these nurses, Canadian nurses, aren't coming back to Canada. Because I don't think we're getting a lot back.

Maybe they're paying more in the U.S., but if you look at the environment, I still think we have a way better health care system. There's still room for improvement but I think it's a lot better here. If you've gone down there and let's say you've gotten some post-education that you wanted – maybe that's why you went down there, or for the full-time job – I'm pretty sure that you can get a full-time job in Ontario now.

I think at the beginning it was the full-time work and the education and the perks. If you're a new grad and you want a full-time job and they're saying, "Come here and we'll help you get your degree and give you \$10,000 signing" – for someone who has a loan, that looks very nice. That looks very nice. But I still can't comprehend why they stay there and don't come back. I can't figure that one out. That question still bothers me.

I know people who have gone. I know people who have come back, but a lot more have stayed. I've lost some contact with them so I don't know ... Some people go for the experience – the traveling nurse. Single people like to do that. When people come back, their reason is: poor health care system. They don't like the health care system down there. In some of the areas that they've gone to there are unsafe working conditions. I don't really know why. They just said that compared to here they felt very unsafe there practicing as a nurse.

If you're running short-staffed and if the acuity is high and you're racing from one person to another, of course you're trying to think ahead and you're thinking back ... that's probably when most of your errors happen, whether it be a medication error or a fall from a patient. You don't want it to feel like an assembly line because that's not what we do but there's days that you feel like it's just an assembly line, when you're just going from one to another.

As for nurse safety – I always said the theme of Nurses' Week one year has to be the abuse of nurses. Because we take certainly a lot of abuse from patients and family. Whether we are hit, pinched, scratched, bit, spit on, thrown something at – I mean you get it all. Today my lady wanted to bite me. My patient tried to bite me! And sometimes when you're looking at the family situation, you can understand – it's their loved one that is sick. But sometimes they forget that there are lots of people here who are sick. So you get yelled at a lot and I don't think that's necessary. I mean, we're doing our best and that's what we'll tell them.

Sometimes I'll pull them out of the room and talk to them. If that doesn't work, that's where I call my manager and she'll come over and talk. Because maybe they haven't told us everything, all their concerns. And then we see if we can get anybody else, any of the other resources to help out. Sometimes it's just that they're maybe angry with the diagnosis and so we'll get Pastoral Care involved. Or some people just really don't understand the health care system. Some people don't understand the jobs of nurses. Some of the older patients – they're still looking for the white dress and cap still. They don't know who the nurses are unless you've introduced yourself and then most of the time they forget because there's such a turnover.

But I've said for years that they have to focus a Nurses' Week on nurses' safety, to let the public know what we go through. Because a lot of people don't know. I know nurses who have been injured. Most of it's a hit or a kick, which isn't very nice. I don't know of anyone I can think offhand that it's ruined their whole career, like they're out now. But it happens regularly and I just wish there was something out there to help us because there really isn't. You have to be very professional when you're a nurse and you have to watch what you say and do. That's as it should be. However, there is nothing out there to help us. A Nurses' Week focussing on the abuse of nurses might make the public aware. Maybe if ONA brought public awareness of the abuse that we take every day it might have people think. We've called police in before.

I respect everybody. Everybody has a purpose and a job and I don't knock anybody's profession, but when you can compare my job to a plumber's job or an electrician's job or a factory worker's job – I am in charge of people's lives. And when you look at it that way and because of our increased responsibility, I think we're worth a lot more than what we get. I've really never thought of a price. But a plumber can be called and get paid \$50 bucks on the spot just for coming to your house and that's to look at a pipe! You know?

I think the way nurses' pay increases are structured is okay. We have a raise coming up next week that we're all looking forward to. It's the last phase of our contract. Our raise comes April 1st so we're all quite looking forward to our next level. We used to have nine levels and now we have eight levels. I think when you start you strive to get as high as you can get. I've been at the high level for quite a few years, so you're just sitting there and you're not getting the yearly raises like everybody else is – unless it's a contract which will mean more negotiating, and then you're waiting. But once you get to the top you just sit there and watch everybody else climb behind you. It's good for the people who are climbing up, but once you're sitting on top it's like, "I want something! Give me something more!"

Nursing was pretty much what I expected when I started out. It's just our roles have increased, I think. We're doing a lot more than nurses used to do. I think more is expected of us. So in that way it's changed. You're not just the nurse who gave the meds and washed the patients. We do a lot more for the patient and really the team approach has changed. It used to be, "You're a doctor, I'm a nurse," and far apart.

When I first started I wouldn't say this was so, but that's probably my personality. I get right in there. I introduce myself. I want to know who everybody is. I have certain standards for doctors and they know that! The new residents who come – they're introduced to me and the doctors who have gotten to know me will say "You'd best be on your toes and respect her because she knows what she's talking about. So if she wants you to do something, really listen to her because she is trying to tell you something."

My favourite thing about working here is the patients. I've wanted to be a nurse since I was two. I've looked after sick people in my family and I knew that this – I mean, I love my job. You hear other people going, "Oh geez... I wouldn't do it again!" I would. I would in a heartbeat. I was with my Director last week and we were talking about the 19 million on Super 7 and who was going to win, her or me. We both lost. But I said I wouldn't quit work. I wouldn't quit because I love what I do and even when I'm at home and have some days off and take some vacation days, I'm very antsy to get back to work.

We're lucky today. Knock on wood, it's been a good day. A good day is no crises. That's a good day, everything is running smoothly. You have your plan and everybody's plan is going nicely with no glitches in it. That's a good day.

### **Interview 3: Part-time/Friday**

*Rose Travis is a part-time nurse in a small urban centre. At different times in her career she has sought but been unable to find full-time employment in her area. Now, however, she runs a family farm with her husband and is satisfied with her part-time status. A year and a half ago, she and her colleagues were transferred to their present site from another hospital as part of a restructuring of health services. She is unhappy with what she considers the diminished quality of patient care since the move. In spite of widespread discontent on the part of the nurses, turnover in her institution is relatively low, perhaps partly because of limited employment opportunities in the region. She and her fellow nurses have worked together a long time, first in her previous institution and now in the current, larger one. Their cooperative working relationship is one of the major factors that ameliorate the difficult work situation and make it possible for her to continue nursing. However, she is uncertain whether she can work under the present conditions and is considering a move to another hospital. She has been a nurse for 15 years.*

I had the worst shift of my nursing career last shift I worked. It was awful. We do those patient care hours, workload measurement, and I approximated mine quickly. I had six patients and I had 24 patient care hours [the equivalent of a double shift] for my shift. I often wonder why we're doing these things. Does anyone ever look at that and say, "Wow, better not let that happen again!" I mean, certainly everybody was aware from the Head Nurse to the Resource Nurse of what was happening, but there were only so many hands that day.

I had two students helping me. They take some of the workload off you, but they were very new students and you still have to be responsible for those patients and answer their questions. So I didn't find that any help really. Everyone I work with is really great – everyone could see I was in the worst situation of the day so they all kind of gather together and help you. But it wasn't do-able that day and I've never felt so ... I've had three or four shifts in a row like that and I just found that overwhelming. After 15 years of nursing, I'm really bothered by it and not sure what I want to do about it.

My workload, since I moved from St. Gertrude's, has increased. The patients are sicker. It just seems that you're supposed to give less actual care to the patients in order to get just the safety issues done. It doesn't feel good. We've been told, not that bathing isn't necessary, but just to cover the very basics. One man was very sick and, even though he had had a post-op wash, he had a bit of blood here and there, a little bit of urine here and there. I couldn't *not* wash him and then ask him to walk and do the deep breathing, the coughing and all the exercises that I wanted him to do in order to get better because I had to make him feel good first. I also like to do a head to toe assessment while I'm doing my bed bath. I did manage to get it done, but I was pressured the whole day. I find that's really changed from when I moved from St. Gertrude's. We were always busy there but the level of care we are able to give now is not the same. It doesn't feel good. It doesn't feel good to the patients.

I work both days and nights, twelve-hour shifts. We have a large unit; it's Surgical. We work on 36 to 38 beds. There are other units that are smaller. I know the girls who work on the floor above us have 24 beds and there's less stress because there's less confusion. So I might look into that. And after the week I've had, I'm thinking of looking at a different hospital in the area, a smaller community hospital. I just felt really bad about my shifts. I had a lot of gratitude from the patients – they said, "Wow, thank you so much," and "You did so much even though you were so busy." And normally that gets me through. When someone pats you on the back you think, "You know what? I made a difference today." But it wasn't like that. It was too overwhelming to even feel good about what I had done because I knew there was a lot more that I could have done or would have liked to have done. So that's where I'm at right now.

I talked about it with my husband and I'm just sort of open right now and looking at what I want to do. When we moved over from St. Gertrude's I said I would give it a year before I made any decisions because we were all very stressed about moving over. We've gone through stages on the floor where things were terrible. And then the staffing level would change because our Head Nurse is really good and she's very supportive of us and she was able to get us more staff, so things went better for a while. There are always changes in life and there are always changes in nursing, but there are so many changes lately that it makes it difficult.

Usually I have four to five patients. This day I had six. It seems that more and more day shifts you're having five to six as opposed to four to five. It really makes a difference, especially when six patients are sick and not going home. Six were sick. I used to be able to handle four or five, even six, at St. Gertrude's quite nicely because usually several of them were going home or they weren't that sick, but when you have six that are sick...

Staffing is always an issue at our hospital. Quite often there's a sick call and then they use the part-time staff, which I am, to call in. I usually work about 36 hours one week and 24 the next. It averages out to five twelve-hour shifts in two weeks. Also they have a casual list which is very small. I don't pick up a lot of extra shifts because of my lifestyle – I'm not able to. I'm happy with the hours that I have. When you come in, it's nothing for the Ward Clerk or the Resource Nurse to have called ten to twelve people and got Nos. Just this week there were two night shifts where they went short because they weren't able to replace anybody.

There have been a lot of changes around that. It depends on the budget it seems. For a while we had what the Head Nurse called extra staffing when she was able to get us that extra staff member but if there was a sick call we weren't to replace them. If there are two sick calls of course you replace one. But now I think we're at a baseline low so you have to replace everyone – or try to replace if you can. Lots of times there'll be a nurse who's done twelve hours who will work four more hours because they can't get someone until say 11:00 at night. I mean, after twelve hours that's enough for me. I can't do any more and I just can't imagine how they do. But they do sometimes.

When I first started nursing and in between my two children I wanted full-time work. Probably two to three times I was looking and if there had been something available.... I wasn't willing to leave my city at the time, wasn't willing to go anywhere else. Even now there isn't full-time available but that's okay with me right now.

Even the part-time is pre-arranged, pre-booked. It's all pre-booked. It's only if they need somebody because of a sick call – which is almost a daily event. What you do is you put that you're available on your days off. If you put that you're not available they're not supposed to call you but they sometimes do because they're so desperate. If you put that you're available you'll get called every day to go in every shift of every day. If you said yes before, they will keep calling you because they're always very busy and always very desperate. So, yeah, my time is booked and I usually don't pick up a whole lot extra, but it's the same with the full-time. Now we have a nurse on our floor who is doing the scheduling and she has been pretty good about it, as opposed to the Head Nurse doing it. You put in your request and she tries her best. We have a master schedule – even the part-timers – so you can predict where you're going to be. If there's vacation, they'll add extra into your shifts that you've already booked.

I like the master schedule. How they did it was they had different lines and you could say, "I prefer not to work Sunday," so I work an extra Saturday. I find that quite good, the way we do it. At this particular hospital what happened over March break was terrible because they didn't have enough staff. I worked a lot over March break. The staffing was, I think, a contributing factor to the way my shifts went. Twelve people were allowed to take a holiday on March break. I think that was a mistake because when they called people there was no one home. But ideally, I think it's pretty good. The nurse in charge of the schedule makes the schedule and then the Head Nurse approves it.

I find my Head Nurse quite supportive. I think she tries her best. She's in meetings quite a bit but I think if I needed to speak to her I could certainly reach her. And then we have two full-time Resource Nurses. They're not always on the desk or in charge but some of the other full-timers are. Certainly they're available on a day shift for the full twelve hours. The workload has fluctuated with the staffing levels that the Nurse Manager is able to fight for us to have. It's my feeling that she's always doing her best to get us the most that she can. When we began here of course we were all very stressed and we were having five and six of the high acuity patients. And then there was a period of probably about six months when we had the extra staffing and we had four to five patients and on night shifts we've had up to ten. I remember one particular shift, I had seven fresh post-op and three were only a day or two old. That was another bad shift but went more smoothly than Friday went. What's happened now is that we've got five on nights and one less on day shifts. So the night shift seems to go better because you'll have maybe seven, whereas on days you could have six and it's not a whole lot different than the night shift.

We have usually one to two RPNs. There is some covering to do for their interventions as well. That day I wasn't covering anybody but there's usually one on night shift. There's one RPN to four RNs and on days I believe there are two RPNs. I believe there are six or seven Resource Nurses. Our RPNs are excellent. I don't have a problem with the staff mix that we have. I wouldn't want to see it changed. The RNs are of course able to do the epidurals and the things that the RPNs aren't able to do. As I say, the girls we have are very experienced and very good at what they do.

I love the group of people I work with, the other RNs and RPNs. If I were to change, that would be one of the hardest things because they're excellent people and there's a lot of respect and a lot of sharing of knowledge when there's time. As far as the doctors go, that really is individual. We have a couple of old timers who can be quite abrupt and give you difficulty if you call them for something. The new guys coming in, I find them much better. You know, they're a little bit more up to date as far as how you handle people.

I've never had a patient angry about the amount of care that they're receiving or not receiving. I think as a whole most people see that you're running and they don't ask, or they may ask and they realize that they have to wait for the little extras that they're not automatically given. Sometimes the older people aren't as understanding, I think, because they don't realize or maybe they're not as perceptive of what is going on around them.

With relatives, again, I've personally never had a problem. I have seen that happen on the floor – people come out and they're very angry. You know, "My mother needs this" or "My mother needs that." I have a couple of times had to go in after and they've been angry about one nurse or another. You just do the best you can and let them know that you're going to do the best you can. I've never had a problem that way with patients. I've been fortunate.

I can think of one man who was very angry with us about his wife. She had a fall. She had had surgery and she wasn't totally confused but she had a lot of short term memory problems. And she did fall and he was very angry. I wonder if that sort of thing would happen less if there were, you know, more eyes, more hands. He was really angry with the staff in general. He was a fairly controlling person anyway and I think felt sort of helpless when he was at the hospital with his wife. I know he was very angry when she fell and he was very abrupt and I guess used

foul language with the staff. They were there for a long time, I think two months, which is not usual on our floor at all. I happen to think of that, but I don't see any violence happen. I see frustration. People are constantly frustrated. Nurses are certainly constantly frustrated. I'm not alone, I don't believe, in the way I feel.

I haven't been physically hurt but I'm tired. I see a chiropractor regularly and maybe that keeps me in tune. Ah, yeah, the lifting. But I'm a fairly strong person anyway because of what I do outside of my job. Certainly I know of several people who have had back problems. More older nurses and, again, I think it shows in absenteeism. In fact our Head Nurse said that in a meeting. That's when she tried to get the extra staff because, "I know everyone's really tired, I know what's happening and I'm attempting to show that your overtime is going to go down and that your sick time is going to go down if we can provide you with more people." I don't know if she succeeded in showing them that, but we still went back to less people.

I'm not unhappy with the wage that I make. As a part-timer it's always been difficult without benefits. You get more money *in lieu* of benefits. My husband is self-employed so that was difficult, but through his association we have gone ahead and got benefits. But I think it's too bad, especially given the number of hours I work, that there isn't something available. There is now, but it's a fairly large amount of money. It's better with my husband's association, so we went that way. As far as that, I think that's all okay. It's more about the amount of work I have to do. The amount of breaks I miss.

I usually try very hard to take breaks because, unless I have to do something after work, I feel it's better to work the overtime. I know I feel better if I go and take 20 minutes and sit down. And things aren't going on around you. So usually I get my breaks but that particular day... Now they've changed a lot, with our breaks. Before we used to have three half-hour breaks and they go in locked shifts of two and two – half the nurses and then the other half of the nurses. Well, it's too busy a floor to do that and so now they've got it going in threes. But in order to fit in all the coffee breaks, it's a 15-minute break in the morning and you're supposed to take 15 minutes in the afternoon. The reality is the 15 minutes isn't happening in the afternoon. It's hard enough to get away the first time, let alone get away the second time. I don't think that anybody gets the afternoon break at all. But that's something new and we're working on that as a floor, on what's the best way to do it. I know there's a staff meeting coming up about it. As a whole it's better when a third of the nurses are gone off the floor as opposed to half, as far as being the one left behind and dealing with it goes.

I sometimes miss meals, particularly supper break. It's the latest in the day and by then it's, "I'm going to get out in time" or "I'm not going to get out in time." And the problem with that particular break is that the hospital says your supper break isn't paid so if you miss it you don't get paid for that. So you're certainly further ahead to go to supper and then take your overtime and then that's paid. But certainly there are circumstances, if you have to transfer someone to ICU or whatever – you just don't go to supper, do you? Usually there's a porter available, but not always on shifts. Sometimes in the recovery room we have to go pick up the patient if the recovery room nurse can't leave. Then two of us will have to go.

The patients don't really acknowledge us going above and beyond in the work we do. I don't think that the hospital knows. Or maybe they know, but I don't feel that they care. I don't find that they make things easier in any way. There's always a committee in the hospital to deal with

any little problem and it never seems to get anywhere positively. I've never been on a committee; everything I know is hearsay as far as that goes. But I think that nurses aren't really listened to – that they go and they state their problems and it doesn't go much further than that.

Pharmacy, for example. Everything is very controlled. Everything except for your Tylenols and that. But Ancef is given to every third patient on the floor. They send it down and if the doctor wants three doses, you'll get a box of three doses. Well, then along comes the next patient and they might need a dose STAT. Then you have to wait for Pharmacy or go and fax them or telephone them. They prefer to be faxed with the STAT order. Then you have to wait for the tube.

Our floor is very large so we're down at one end. You're trying to get the STAT dose, so usually you'll take from somebody else. Pharmacy get very upset with us for doing that sort of thing. We're great stashers. We try very hard to have a little stash cart of extra meds. You put in a couple extra Ancef in or antibiotics. IV antibiotics are the main thing because you like to get them started when the patient needs them. Pharmacy knows about this now and they've come along and taken them off of every cart. You feel like that's a slap in the face. They said, "They're getting too outdated." Well, I know for a fact they're not getting outdated. That's just an excuse. They said, "We're going to give you a bigger stash for your med room so there'll be two or three little bottles in there." But nobody refills that on a regular basis. We're supposed to go through them on night shift and tell them what we need. Well, that's just another job that we don't have time for. And if the patient refill day is Friday, they'll give you exactly the number you need until Friday. If a pills flies on the floor then you're short. So now you have to call them or fax them and this is all very time consuming. I just find that their needs are more important than the needs of the nurses on the floor who actually give the care to the patient. Pharmacy is a big one as far as not making our job easier.

Another thing that happened with Pharmacy is the re-orders. Say heparin. The heparin, if it's outdated, it falls off the MAR sheet – our Medication Administration Record. That comes from Pharmacy every night and you're to check it with the previous MARs and then the orders to make sure it's correct. If there's a heparin, say, it would fall off the MAR because it's outdated, so it wouldn't show up on your sheet. The nurse then has to re-order it or get it for 24 hours or get the doctor to. Anyway, there were a lot of times when it would be there for 8:00 in the morning because it was outdated for the 8:00 dose at night. It would get missed, is what was happening. The heparin was getting missed and instead of automatically re-ordering it or just putting in the time and "please get it re-ordered," it was getting missed. So I wrote in, "Put in the time so it doesn't get missed." We were asked to make a sheet over it, and so I did. Nothing ever happened about that. It continues to be a problem.

Or the doctor will write Ancef and Pharmacy will write Cephalosporin. Well, I know that that's Ancef, but what we were taught in school was that if the doctor writes Ancef, you write Ancef. You don't write Cephalosporin. Tylenol, you write Tylenol. That's fine with the common drugs, but Pharmacy will take a common name that the doctor writes and they'll write it on the MAR a different way. I asked them, "Can you not put both names down there?" Because I've spent many a time in the *CPS* [Compendium Of Pharmaceuticals And Specialties] looking it up to make sure it's the same. It's time-consuming for us. I may know that drug by the generic name, but I may not know it by the other name. I went to a pharmacist and he said, "Well, I'll look into it." That's why I feel we aren't really listened to – that our concerns aren't really important to them.

It's the same thing with X-ray. They would come at coffee break time to get all our fresh post-op knees and hips onto a stretcher, which takes two to three nurses, and take them off to X-ray. That was the time they chose, invariably. Our Head Nurse went to a meeting about that: "Can we not do it another time?" I think the answer was that it was more important that the outpatients got seen first and that our patients weren't as important on the floor because they were here anyway. So that was the time that the porters could come and that was the timing and there would be no change in that. So we had to change. And they still come. I mean, 10:00 in the morning isn't the best time to have three nurses go put people on stretchers. You're just sort of getting into your day, trying to get your walks done and your people bathed and that sort of thing.

From my experience here and from the way things are dealt with, it's a question of hierarchy. We really are on the bottom. I'm not sure why, because if they make our jobs easier the patients are going to be cared for better and there will be less complications. Even walking a post-op patient becomes a chore because of the time frame. And that shouldn't be, because it's so important, and the deep breathing and coughing and all the things that we do with them. Trying to fit it all in is a real chore. And it's really difficult to feel that pressure and go in and be very laid back. Because if you're showing: "C'mon let's go," then that post-op patient is going to be tensed up and uncomfortable. You have to be relaxed with them. It's very difficult to come from: "You need to do this, this, this and this," as you come out of the room, and then go back in and be calm and relaxed. Looking calm and serene on the outside is becoming much more difficult here.

I'm still working here because of the nurses I've worked with for 15 years; because I've learned so much from them. They are so knowledgeable. They pull together when there's a problem. Even though we have an influx of a lot of new staff – some went to the other floor and some went to our floor – we've been able to keep that alive, the teamwork: "You need a hand? Okay, let's go." For a while that wasn't happening. I think we were all so stressed over the amalgamation – we were like, "Okay, we have blinders on. This is what I have to do and you do your ...." But it's back and it's rubbed off on the new people. The friendliness and the way we take care of people I think overall is really good and I like that. Part of it for sure is having worked together for so long. It's just knowing if there is a crisis, I know so-and-so is on and is going to be there for me on Friday. If it wasn't for Elsa – she was like my little saviour on that day and I knew that would happen. Another nurse that I work with, she knew what was happening and she was over and helped out as much as she was able to. That's sort of what keeps you here.

Relationships between the nurses who have been here longer and the new people who come in have been really good, surprisingly so. It takes certainly I would say six months for everybody to get to know you. So I think for the first six months or so it was difficult because new staff are usually younger and they're more easily integrated. They follow the lead of the older nurses whereas these are older nurses with experience. So there were differences but it worked out really nicely.

We help out the younger nurses when we can. I don't think there's the time that there was when I first graduated. The nurses, they definitely took you under their wing and just showed you what needed to be done. There was never any worry about asking a stupid question or not knowing something, and that's the attitude we have I think. But there isn't the time to say, "Okay, run through whatever the procedure is, would you like me to go with you?" You don't have that luxury any more.

I think it's fair to say our turnover is not that high. I was at St. Gertrude's for almost 13 and a half years and I was the youngest one on the floor. So I'm not sure if that's just because people just really stuck with it. It's hard to say with the new ones that are here, if they'll stay. They certainly seem to. There's a couple who are going to move on to an OR course and go that route. Other than the new grads who have been hired on after 15 years I'm the youngest on our mutual floors. Surprisingly.

I think that the hospital does encourage career mobility for nurses. I can think of our Resource Nurse who has been helped along to move from her position. They provide time off. But that's, again, our Head Nurse, as opposed to anyone further up. I think she's getting some financial help there but I'm not 100% sure.

They usually have a lot of pamphlets about courses that are available. I know one nurse who's going to get her degree and that's encouraged. I think that you can apply for financial support. I haven't myself; I've only gone to the day courses. You know, I haven't thought it was worthwhile but to be honest I'm not sure if it's available. They certainly are always putting up the pamphlets if there's a conference or any local thing that's happening, which I think is really good because then you can kind of: "Okay, which one looks good, guys?" And two or three of us will go. I like that.

What would make me leave nursing is completely the way I feel about coming home and not having finished, not having done my job the way I would like to have done my job. Not having had that extra few minutes to talk to somebody who's had a mastectomy. To feel good about having done the very best I could. And there are safety issues too. When I had those patients, those six patients, what I went home feeling was, I really didn't know at any given time during that shift what the status of every one of my patients was, as far as being okay. I mean, being not critical. And that's really terrifying to me. At the very least you should be able to know that everyone's stable, and I didn't feel that way on Friday. That sort of thing, if that continues, that will make me leave for sure. I can't do that, not feel good about my job. I've always found nursing very rewarding up until this point, until we moved. I think that you felt you made a difference to somebody's hospital stay and their illness getting a step towards better. That's why I like surgery because for the most part people are very ill and they get better. It makes you feel good and it's nice to see that. Even cancer patients, if you can help them through that difficult time, that's very rewarding.

The reality now is very different. I was very happy where I was. St. Gertrude's didn't have an Emergency so it was all elective surgery. Part of the problem on our floor now is that it's so large and there's Emergency. If you have an empty bed or you send someone home you know it's going to be filled before the bed gets cold.

The number of nurses per patient is definitely a factor. The size of our floor is definitely a factor because you have one Ward Clerk, you have one Resource Nurse for 38 when they're not blocked in. Sometimes they're not blocked. When we're in gridlock, which is usually the case, and then upstairs they have 24, and they have one Ward Clerk, one Resource Nurse. So there's less hubbub. I have done some shifts up there for call-in and it's generally better but it's still not what it was at St. Gertrude's. So I think that the patients are sicker. We used to look after cataract patients and they don't stay now. Now you may have two or three bowel resections and a hip and a knee replacement. That's a lot. Before, there used to be two or three people going

on discharge and then you'd have three fresh people. You can deal with that on a day shift, or where you'd have eight patients on nights and maybe three of them had surgery today, but the rest were reasonably stable.

I think the government has been pressured into doing some good things and I think that needs to continue. They pay a lot of lip service to, you know, "We have more nurses." But then you read your *ONA* [Ontario Nurses Association] or your magazine and it says "Actually, this isn't true." You know how they play with figures to make it look better. I think that's not a good thing.

But then, the restructuring – I don't think it was necessarily a bad thing that happened with St. Gertrude's. If they really feel that we could do it all in one building and save money that way, okay. St. Gertrude's is long-term care now. I'm not a political person, so I don't really understand how we got Rehab beds here when they're the Rehab facility. I'm not sure how that happened. An example of what would happen – we got these Rehab beds but we didn't have any physical structure for them yet. So they put six on our floor and six on another floor. What they would do is put in whoever to fill the beds to show the Ministry. You'd have a fresh hip in there – that's Rehab! Or you'd have somebody who is confused, who I wouldn't consider to be a Rehab patient.

That whole thing created a lot of work for us. We had a patient over here, and maybe he would be three or four days post-op. Okay, so that's a legitimate Rehab patient. So now you have to move that patient across the hall, because that's the designated Rehab bed. You move your patient across the hall but you're over here. So you choose either to keep that patient across the hall, which is a lot of traveling, or you can have someone new – probably fresh. That's been happening. Now they've got the Rehab facilities starting within a month or two. The Rehab beds are going to be moved from us. But the thing is – they had no extra physio. Why did they even get that when the Rehab facility and the Physio and everything is supposed to be over at St. Gertrude's? It confuses me how this hospital got that. I don't have a lot of faith in the political system that allowed us to receive that if that wasn't really what was intended.

We just finished all this restructuring. Now they're building and moving to make this Rehab thing. It doesn't make a lot of sense when they have buildings across the street or down the road from us, and not five minutes from us. That sort of thing is frustrating to hear. You wonder about the money being spent when you could have more money for an extra nurse, extra staff, and let St. Gertrude's deal with what they were intended to. You know, don't spend money on changing the building.

You get e-mail after e-mail about these sorts of things, "This is what we're going to do and why." Why can't you have a floating bed for a Rehab bed then? Why make us move – that's a lot of work, you know, to move a patient over and all their stuff. Because maybe their family member isn't there and then they have their TV hooked up, so then you have to go run over and make sure their TV gets hooked up.

I think workload is everything, work environment is everything. I've stuck with it as long as I have because of the people and the work environment I had. This is very stressful, what's here. You'd always have a day where you had a stressful day, that's part of nursing, but you shouldn't have to work 150% every day. It gets to the point where you can't even say hello. You should be able to breathe. You should be able to do it at a natural pace instead of always being pressured and pushed and that's what's happening here. I'm not usually one to speak out but I thought, "You know what? Maybe I do have something to say."

#### Interview 4: Over and Above/Making a Difference

*Catherine Massey has more than 20 years of experience as a Registered Practical Nurse, or RPN. Recently, longing for a “nine to five” job and a less gruelling work schedule, she left hospital nursing to pursue a different career path. She trained as an administrative assistant and studied international business at a community college. After three months of work in her new field, however, she missed nursing. She found the regular hours of her new job, the main reason for her career change, confining, and the office work environment stifling. Since her return to nursing she has approached her job in a new way, seeking out opportunities for learning, and sitting on Nursing Council and other committees at her hospital. Within her scope of practice and with the support of her nursing supervisor she has become a specialist in wound care; she also participates in her hospital’s mentorship program. At the time of this interview she was preparing to run as a candidate for the College of Nurses. She was not elected but regards the experience as a positive one and plans to run again in three years.*

I work days and evenings, from 7:00 a.m. to 3:00 p.m. or 3:00 p.m. to 11:00 p.m. I rotate – two weeks of days followed by two weeks of evenings, five-day weeks. Sometimes I like the rotation, sometimes I don’t; it comes and goes. When I’m on days it’s hard for me to get up but it’s good going home at 3:00 o’clock. When I’m on evenings it’s good to sleep in but then it’s hard coming home at night because I get home about midnight. As much as I complain about it, I like to have the split-up of time. If I had to come in all days I think that would just kill me. And if I had to go all evenings that too would kill me. Plus my husband doesn’t sleep until I get home and then he has to get up at 5:30 in the morning. If he does sleep it’s not a restful sleep; he’s waiting and listening for me to come in, so when I’m on evenings it’s really hard on him. He keeps saying to me, “When are these evenings going to be over?”

Shift work is difficult for the whole family because you don’t see the kids, you can’t help them with their homework. I think they’re used to it by now but every once in a while they’ll get me up in the morning to sign papers. I’m thinking: “You could have had this signed last night,” you know? But they wake me up. They want *me* to sign it. They don’t want my husband to sign it – they want me to sign it. So they get me up in the morning and then I have to sign it. I guess that’s their way of saying hello to me, you know – making sure I’m still there, keeping track.

If we want to encourage people to be nurses and to stay here, I don’t know how we’re going to get around shift work, because nursing is 24/7. A lot of the younger ones don’t like the shift work. Places need to have some sort of child care facility where if you are a young family you could bring your kid and they would be looked after while you’re at work. Or have something that is affiliated, an institution that’s open 24/7, just like we have to work 24/7. Most places are nine to five, or day cares are seven to six, something like that. I mean, the rest of the world stops but we have to keep going. People need to realize that we also need somebody to help us with our kids. We are providing care.

I’ve been both fortunate and unfortunate in that regard. There was a lady who baby-sat right in my building. I worked one shift – the evening shift – so I would be home with the kids in the day and then my ex-husband would pick them up in the evening. They were babysat for a short period of time and then he would have them. When I left him I had a really hard time. I moved to the west end of the city and I was working in the east. I had to get up around 3:00 or 4:00 in the morning, make my way to the babysitter, drop my kids off and then make my way to work. When I got an apartment in the east end I found a lady who baby-sat for me and was willing to

keep them overnight. When I was on evenings she would bathe them. She didn't mind. Instead of waking them up in the night when I got home, she would keep them overnight. Then I would pick them up in the morning and bring them back in the afternoon. So I was fortunate that way. And then when I met my present husband and he worked permanent days. So if I was on days then she would keep them and if I was on evenings he would pick them up for me.

But not everybody is fortunate enough to have relatively close people who can take care. And day care is so expensive these days. So most of your pay cheque would go into mortgage or rent, or into day care. So I think that will be an issue too. The younger ones coming, they want to know who is going to look after their kids.

When I started nursing I worked at an institution with the elderly. I enjoyed that. I really did enjoy it but I wanted to get away because I thought, "Oh my back's getting sore, my shoulders are getting sore." From the lifting. Then I went to Orthopedics and sure enough they were there! And I thought, "Okay, I'll go to Medicine," and they're there too. So I just can't seem to get away from it. Most of the time we have an older patient population because we have a few nursing homes around the area. I just think of them as somebody's parents. You know, how would I want my parents to be treated? I try my best to do the best possible I can for them. Even if they are beating you up.

When they're aggressive that's very difficult. And they are *so strong!* A hundred years and over and they're pulling you in bed with them because they're so strong. I can't believe it! What are we feeding them? I remember we had this patient, she was 101 or so – strong as ever. I couldn't believe how strong she was. She was able to grab our hands and hold us off. In that situation, you can ring the bell and somebody will come and help you. There are no orderlies any more so you're pretty well on your own unless you have a male nurse working on the unit. We have two at present – both part-time, so they're not there all the time. We rely on each other for help.

So that's the way the patients are – very strong. We give wonderful care! They can beat us up at the end of the day. I've been punched in the stomach. I've been slapped in the face. My uniform has been slightly ripped. Patients with dementia, once they keep seeing you for a while they get to know you. They have to see your face constantly and once they recognize that face they will allow you to do certain things to them. But initially when they come in – most of them come in from the nursing hospital or from a home – they don't recognize you and they get very aggressive.

But once they get to know you, then they will allow you to do things for them. We had a patient, she was here for seven months and her husband was caring for her. She had Alzheimer's and at first she was very aggressive and didn't want us to touch her. But once she got to recognize your face, she would see you. Sometimes her husband would come and take her walking and if she saw you come in – big smile! – she would smile at you and wave. So she recognized you after a while. And then she would go with you, whereas before she wouldn't go anywhere with you. I used to take her on walks and I would visit some of the units I used to work on. At first she would grab me and say, "C'mon!" – she was ready to leave. But once I'd taken her a couple of times and she recognized some of the nurses and they talked to her, then she would stay for a bit. But then she doesn't want to stay too long because she knows that's not where she is supposed to be. So she'll grab my hand: "Let's get going now."

And some, they are very aggressive and the most we can do is we can put mitts on their hands. The mitts, they've got padded mesh on the outside, sort of like a boxer's glove but padded and light. You just put those on their hands so they don't hit you or do any damage to themselves. Because sometimes they tend to want to pull the IV out and pull the Foley [catheter] out and pull any medical intervention out. You can't restrain people. You'd have to get a doctor's order, the family has to be in agreement and it's only for a short period. Days of restraints are over. You've got to take the battle. The policy now of this institution is that once you have a patient who is combative or wandering, you can't restrain them. We have to get a sitter. So we bring someone in from an agency who sits with that person.

The patients are getting a lot heavier. Heavier to lift, and heavier in the sense that they require more care. They come in and they're really, really sick. It's hard because if you've got four patients and they're all really acute then you're running around trying to make sure everything is done whereas if you've got at least one patient who can manage a little bit on their own or do something for themselves, then it's not so bad. But I've noticed that over the past year or so patients are a lot sicker.

When I came to Medical two to three years ago it was a big adjustment. After I had settled in I started to notice the acuity. I came from Orthopedics, so it's a lot different. Those patients *choose* to have surgery, most of them, so they come in and they're pretty well medically stable. They just have their surgery and then they go home. It was difficult for me to change to a unit where the patients are so sick. Sometimes you're not quite sure what's wrong with them – you have to go in blind – and then later you find out you could have been exposed to something. I don't really feel in danger very often. I'm pretty well, not sickly, except for the aches and pains of working in nursing for 20 years. Other than that I feel, so far, okay. We've had people who came in with TB and by the time it was diagnosed we had all been exposed. But we were okay.

I take my own precautions. If somebody comes in with something that is not yet diagnosed I make sure I protect myself because I've got to go home to my family.... Sometimes when you're in such a rush or trying to get things done or maybe there is an emergency, you tend to forget about certain safety things. Like you lean over the bed rail instead of putting the rail down and putting the bed up. There's always a chance you hurt yourself that way, like your back or your shoulders. Last year I was off because of injury to my back and shoulders. I didn't do the side rail thing and the patient was aggressive; I was leaning over and trying to help. There were a few of us in there and the patient was getting combative and we were trying to get them stable in the bed. At that point you're not thinking of safety for yourself, you're just thinking of safety for the patient. So I'm not quite sure how I did it, how it happened, but when I got home at the end of the night to unwind and have a shower, I just felt it. I was in agony.

I was off for about a week or ten days and then I came back. I tried to come back modified while I was doing therapy. Before three months I was back on track. I became a preceptor then, I took a student, so it became a little bit easier on me physically. That was another way for me of reinforcing safety issues because I kept saying to the students: "Watch your back." It was a way of passing on what I've learned. "Make sure that you don't hurt yourself."

I do a lot of preceptorship. I haven't been a preceptor this rotation, but the last two rotations I was. I do a lot with the students when they come on the floor. A lot of, "Watch your back, make sure the bed is up," that kind of thing. I would like to think that I am easily approachable

and able to convey my “wealth of knowledge” to the new ones coming. Believe me, they need it! A lot of them come and they’re nurses but they haven’t experienced what nursing is really like on the floor. Especially on the Medical unit – it’s busy, heavy, and anything can happen at any time. You could be walking out the door and all of a sudden you’ve got a Code and you’ve got to turn back, that kind of thing. If there’s a Code I always say to them, “Go and see what’s happening so you can be a little bit prepared.” In Orthopedics we hardly ever had Codes. You get more Codes in Medicine than you do in Orthopedics. It’s scary for a student.

I was scared during my first Code. I was in the room when it happened and the doctor wanted me to get all these things for him. I was a floater [casual staff member who “floats” from unit to unit as required] at the time so I didn’t have a clue about the set-up of the unit. So I froze for a while and then one of the other girls said, “I’ll show you.” So they came and they were running with me while we went and got all the stuff. It was really scary.

Some things are already on the crash cart but you still have to get other things. If the chart’s not there you have to go bring the chart. And the crash cart only has selected things. If they want IV bags, or whatever, you have to run and get them. Then the team comes and they’ve got everything from the Cardiac Unit that comes with the big cart. They pretty well have everything. If they want specimens you have to call down to the lab and make sure the specimens get there STAT, that kind of thing. It’s good for the students because they can see the process. Sometimes you have to make sure you get the patient right on the bed. They have to be just so, so that the team can get in behind. So you have to move the bed out. Sometimes the students don’t know you have to do all these things. So if they see it and process it then if it happens they know at least some of what to do. They don’t have to stand there looking like a bump on a log.

A lot of the older nurses now are losing patience. They haven’t time to be training or mentoring. Or they choose not to mentor people. They just want to come in. “Just let me come and do my shift and don’t tax my brain with having to mentor anybody and be responsible for anybody.” So a lot of them choose not to help. There was an incident on our unit I was really angered by. There was an experienced nurse who was on and then there was a younger nurse who was on and the experienced nurse said to put the younger one in charge. I mean, she had no experience at the desk, she has nothing to fall back in, no kind of experience at all. I felt I could have done a better job at the desk because as an RPN I have all these years experience, I’ve seen a lot of things and I could probably manage, but they chose to put her at the desk. And then they wouldn’t help her but just walked away and left her. She had to come to us – to the RPNs who were experienced – and ask us, “How does this go? Help me with this. Can you help me decipher what the doctor’s orders say?” I don’t think there is anything more negative than the bickering and fighting among us. But even though we might have our differences, the next day you come in and it’s all forgotten. You come in and it’s: “Hi, how are you doing?” It doesn’t linger on. Nobody sits and plots and plans for you. Even if they’re angry with you or you’ve done something to upset somebody, if you’re having a hard day – if something happened to one of your patients or something’s happening to you – everybody is going to be there. They come: “Can I help you?” They’re not talking to you, but they’ll help you.

I try to stay within my scope of practice and I always explain myself to the patient or the family. Most of the time they’ve been receptive when I explain to them, “Okay, I’m not trying to be rude. I know this is your relative, but in my professional opinion this is how I think things

should happen.” And most of the time they are pretty good, once you talk to them on a level where you’re not sounding like, “Okay, I’m taking over,” or “I’m the big boss and you’ve got to listen to me.” The College of Nurses doesn’t agree with touching because it could be construed as aggression or something else but when a person is angry and you reach out your hand and even touch them on the back of their hand, I find it calms them.

I had an incident one night where someone we thought was a relative was very abusive to one of the younger staff. The patient was very nice, but this person was very rude, swearing at the staff. The patient had said something to her about the IV and all of a sudden the visitor was very upset. She came to the desk. We said we were aware of the issue, that we had called the IV nurse and she was going to be coming. “You just have to wait for the IV nurse to get there because she’s the only one in hospital and she has to make the rounds. People in Emerge take precedence.” And I went back. Apparently the younger nurse was in the hall and the visitor said the “F-word” to her. She said, “You come and do this *now*. I want it dealt with.” And then she said this place was like a barn and it treated the patients like animals, like cattle. I heard the commotion in the hall. I went down and I said, “So how can I help you?” And she said, “I want that fixed now.” And the patient recognized me and she called my name – she said, “I want to talk to you.” I said, “Well, let me talk to this lady first.” Anyway, we were talking and she was getting really loud and obnoxious with me. So I just reached out and I held her hand and I said, “You know, we’re not here to hurt anybody. We’re trying to do our job.” And I said, “It’s not right for you to come and swear at us like this, you know?” She said to me, “But I’m really angry.” I said, “I realize you’re angry because of what you said. And I’m sure you’ve never seen us treat patients like that.” “No, I haven’t,” she said, “but I’m really angry.” And I said, “Well, why are you angry?” Apparently she’d had a bad experience in the hospital – not necessarily our hospital, but *a* hospital, and she told me that the patient lived on her own and she was just looking out for her best interests. “Well, I understand all of that,” I said, “but this is not the way you speak to people. You can’t talk to people like that. You have to come and you have to talk to us.” I said, “We are also human, you know?” By that time she had calmed down and I had let go of her hand and then she hugged me. The patient called my name and said, “She’s not my relative. She’s just some visitor that came to see me.” I thought, “All of this and you’re not even a relative!”

By then the patient had called her sister and her sister was on the phone, crying. She said to me, “You nurses have been so nice to my sister. I hope this doesn’t make a difference in the way you treat her.” I said, “Why would it?” But she was just *so* apologetic for this other person. I said to the visitor, “Visiting hours were over a couple of hours ago. I’m being nice by letting you stay. If you’re going to treat us and talk to us like that, I think you should really go.” So she said, “Okay,” and she left after that and apologized before she left. I think the patient told her to come and apologize to us, so she came to the desk and apologized for her behaviour. But I understood it once I started talking to her to find out why she was so angry, I understood there was something else involved. But I probably wouldn’t have found that out if I hadn’t reached out and touched her. If I had just got my back up and walked out of the room, then I wouldn’t have found that out.

I think the media have a lot to do with how patients’ relatives react when they come into hospital. There was an article I think about a year ago in the newspaper written by a doctor, but it was a doctor who taught in the States. It said something like: “Don’t let them tell you about visiting hours. There’s no such thing. Don’t let them ask you to leave the room if they’re doing

any care, you have the right to stay and watch. And come in pairs so one of you can advocate at the desk and one can be in the room to make sure things are being done.” I think a lot of people took that literally and a lot of them do come in pairs and they do come to the desk with their backs up and they do demand a lot of immediate action. It’s stuff that could be dealt with but it’s not always necessary to be aggressive. Sometimes I can understand the aggression and sometimes, yes, things need to be done right away. But there are times when it doesn’t need to be done right away – it can wait till morning. It’s not a life or death situation. But they don’t see it that way. And a lot of them have been on the Internet and read a lot of things, mostly American. So they think it works the same way here in Canada too. The system is different, you know. And they watch a lot of ER on TV, and ER is not reality as far as I’m concerned.

We had a man who wanted to go into the observation place to watch the surgery of his wife. I said to him, “Well, you are either going to go into the OR with the patient or you’re going to wait outside. “No,” he says, “I know there is a room up there where you can look down and see the surgery going on.” I said, “Nooooo.” He says, “I saw it on TV!” So I said, “That is TV, that’s not reality. Not here. Maybe in other teaching hospitals, but not here.” He didn’t believe us so the doctor had to explain to him. He didn’t really believe the doctor either. He went away still believing that we were gypping him. So the doctor told him he was welcome to get dressed and scrubbed and come in to the OR to see the surgery. If the doctors agree, you can scrub and go in. Of course he didn’t, because he would have fainted. So he decided not to.

I always wanted to be a nurse to look after and care for people. I just find that within me. Though actually I attempted to get away from nursing, just before I moved to the Medical unit. I did an administrative assistant’s course – a glorified name for a secretary. Then I went to college and I did a year and a half of international business and I got a job in an office. I worked there for about three months and then I couldn’t take it anymore. I was out of my realm, out of my comfort zone. Nursing was my comfort zone.

I had always wanted a Monday to Friday job, nine to five. And the nine to five was killing me because I craved that day off during the week that I didn’t have. I got up later, I grant you, but when it came three o’clock I felt I should be going home. And working till five, six o’clock in the evening and then getting home at seven – that just threw me right off. It was just horrendous. I couldn’t believe it. My husband kept saying, “But this is what you wanted. You wanted a Monday to Friday, nine to five. You kept saying, ‘This is what I want.’ You took the course and spent all that money!” I’d been like the patient’s relatives, watching TV and thinking it was going to be glorious. You know, I was going to get paid this exorbitant amount of money. Actually it was less. I was making more money part-time nursing than I was making full-time at the office.

So I came back after three months. That’s when I decided to do preceptorship and get on committees. I’m even more patient and tolerant with relatives when they come. You know, I don’t get so upset anymore. But I did try to run away. My husband said to me, “This is your calling. Why do you run from it? Stay with it.”

If I had to pick a single thing that was most important to me about being a nurse it would be coming to work and having a really ill patient and, after nursing that patient, seeing that patient go home. That’s my reward. Sometimes it’s nice, the thank you, but you don’t expect thank you. When I see them go home, I feel good about that.

When I come here I give them my all. I try to work over and above. I try my best because I always think that person lying in the bed could be my relative, could be my husband, could be my father, could be my mother, and what would I want for somebody to be doing to them, if it was them. So that's the way I approach it and, you know, that's the way you *have* to because sometimes you're having one hell of a day. And then you have to stop and think, "What would I want for my relatives?" So that sort of pulls you back. It's the care that keeps me in nursing.

Another thing I do now is I sit on Nursing Council at the hospital. I started last year. I felt I needed to have a voice. As an RPN you're not always vocal and people don't always listen to you. Being on Council at least your voice will be heard. If nothing happens, at least it's heard. When I first joined I don't think they really took me seriously. But then some sort of conversation came up and I had the opportunity to have some input. Then everybody sort of sat up and took notice. Well, people were sort of trying to have me not talk and the Chief Nursing Officer said: "Wait a minute, let's hear what she has to say."

I'm also one of the wound care experts on the unit. I go around and look at them and see what can be done before it gets really bad so that we have to go to wound treatments. Sometimes I say, "Well, okay, put this dressing on for now," like the Tegaderm™ or Allevyn™ or whatever. Tegaderm™ is sort of like a Duoderm®, but it's more pliable and it can stay on for seven days and it's not as hard on the skin as the Duoderm®. I can put that on or Allevyn™ if it's required. We just hired a stoma nurse, so she will come and take a look and say, "Okay, then this is what we need or what we don't need." But initially they can call me.

To become a wound care expert I went to every possible wound conference I could go to. I went on my own and then I told the [Nursing] Manager. And then, because RPNs in this facility don't do Stage 3 and Stage 4 wounds, or packing, I made the effort myself and attended KCI [Kinetic Concepts, Inc.] who do the VAC dressings. So when there's a VAC dressing I am a specialist. A VAC dressing is a vacuum assisted closure of a wound. A vacuum is placed and it sucks all of the exudate out of the wound and promotes healing. So I went ahead and I did those workshops on my own. Then I brought my manager the certificates, so now I'm allowed to do those dressings when they come on the floor.

There aren't a lot of courses offered for the RPNs but for the RNs there's a lot of stuff offered. For RPNs – I guess you've got to take initiative like myself and go out and take the courses or the workshops and then bring the certificates and say, "Hey, I can do this. I've got interest in this. Can you allow me to do it?" My Manager has been pretty good because she knows I have an interest. She has allowed me.

Our Manager's in charge of only one unit, so that's pretty good. Once you tell her that you have an interest she might say, "Okay." Whenever we have a VAC dressing on the unit she says, "Okay" – whenever I'm on, she assigns me to that patient so I can do the dressing. Then if there are any air mattresses or special beds needed, she will say to me, "Well, what do you think? Go look at the dressing and assess the patient. Come back and tell me what type of bed you think we should order." When it comes to wounds a lot of the girls come and call me to look at them, so in that way I guess they acknowledge my expertise. Not all the time, but some of the time they do. The Clinician – she knows a lot of the stuff that I do because I'm also on committees with her so she's aware of what I'm capable of.

I'm on also on the Retention and Recruitment Committee. I was on the Preceptor Committee but I turned that over to one of my coworkers. For recruitment and retention one of the major issues for younger nurses is shift work. They find it very difficult. They *say* money isn't important, but listening to people on the unit you realize that money *is* important – and recognition of a job well done. Sometimes “thank you” would be sufficient. When good things happen, say “Thank you” – don't just jump on the bad things and say, “Well, we got a letter.” Most of the time you hear about the bad things, but you hardly ever hear when the patients or the family write and say nice things about you. You just hear about the bad things – what you didn't do or what somebody complained about.

At Christmas our Manager bakes everybody cakes and during Nurses' Week she buys everybody plants. And then she writes little notes about whatever you have done. Like for me, she was talking about my committees and so on. Some other people buy their staff cards or pens or keepsakes, something like that. It makes it a little bit more personal, rather than, “Okay, I'm your boss, you come to work...” And the institution, they have things for Nurses' Week. Now the two sites are together so they rotate events between the two sites.

Nurses, especially from the RN side, they say that that they can get bonuses – like for working on Christmas or bonuses for staying. A lot of them, they've got years put in and they figure that if they get a bonus for that ... They're not asking for a lot, maybe \$500. It would be good. I can't speak for the RNs because I'm not quite sure how much they make but for the RPNs, now that they've increased our scope of practice here at this institution, we feel that we need to be compensated for the skill that we're using. I mean, it's not bad. But one student was inquiring about our hourly wage – she had apparently done a survey and researched other places and there are a lot of places out there where RPNs are making more money than we are. That was both in Toronto and going out west, I think. It all depends on the union, on how your union fights for you. And how much the institution is willing to pay. So I was really surprised because the student was saying to me that one institution was making at least three to four more bucks an hour than we were, and I thought, “Hey...”

I have too many years in this institution to make a change. I'm in my 13th year here so to start over – I've got four weeks holiday and I don't think I want to give that up to start at two again. That keeps me coming back, I'm telling you! And then I'm thinking you might get the money, you might get the hourly pay, but I'm not sure in the long run how it would be. At least here I've got seniority. I know the institution, I'm on committees, I'm making myself known. You go in the hall and you know people. Even if they don't know your name they know your face. For me, I'm getting too old to start over, you know?

They do need nurses but the way that health care is going I don't know if the young ones are going to stay here when they can go to the States and have it so much easier. They're closing beds, they're closing hospitals, they're downsizing and cutting back on nurses – then discovering they need them and that they've gone south of the border. We're going to need nurses, a whole lot of them. We've got to make sure we encourage the ones who are supposed to be coming in. I think what nurses should do is go to colleges that have health programs and encourage people to come and be nurses; to stay in it. Like a speaker for a day. The kids have career days at school. Maybe they could do something like that because we're really going to need nurses. The ones who are here, like myself, are getting dilapidated and getting old. So they are going to need somebody to come in and take over, you know?

What would make our lives better here would be new equipment. Oh, we need new equipment. Somebody win the lottery and give us some money for some equipment, please! At times you're looking for a recliner or some sort of chair for a patient who's restless so you can put them at the desk, put them in an area where somebody can keep an eye on them, and there's nothing. Or if there is, it's broken.

And beds – we need new beds. If I win the lottery, that's the first thing I'm buying – no, I take that back! We need new beds because we still have to crank the beds on our unit. That helps with the back and the shoulder injuries – all that cranking. We have a step-down unit on our unit – a step-down from ICU to our unit and then out to our floor – so if they are heavy.... We had a patient who was about 500 lbs. They came from ICU to the step-down unit to the floor. That makes it really heavy. There's not much new equipment that has come in. We're still using the same equipment as ten or 15 years ago. I don't know if it's the budget or what, but it seems like the Surgical floor has better equipment. I don't know, maybe people donate more than to Medical. Do they have a bigger budget, or what is it? Because most of the Surgical floors have – new beds! – and I don't.

I think the public perception of nursing is distorted, the way they perceive you. The first thing they say to you is, "You're getting paid to do this." In the newspaper it says you are supposed to be making \$50,000. So they all assume that everybody's making \$50,000: "I'm paying you fifty thousand, you're not doing a good job." I get really angered by that. We pay these baseball stars, these sports people, millions of dollars to do nothing and nobody complains about it. But they come to hospital and you don't run fast enough with a glass of water – "I'm paying you!" They want service. They just think that nurses are glorified maids.

They haven't got a clue about what nursing is. And when people who don't have a clue come into hospital and they realize they don't have a clue – by the end of the day they're saying to us, "We could never do what you do and thank you so much for doing it because we could never do it." It's good to hear. Those are the ones who are observant and notice what you do and how hard you work, as opposed to those ones who come in with a chip on their shoulder and want hotel service.

Like I said, a lot of the medical TV programs are from the States and in the States you've got to pay, you know? But patients think that it should be the same. You see soap operas and they have a private room, they have a couch, they have TV, they have stereo, they have all these flowers. People just think that those things should be there. They think that nurses are being paid to do nothing. One friend of mine says, "You sit at the desk all day." I said, "Excuse me? When do I get to sit at any desk?" He says, "Every time I come to visit you." I said, "And notice what I'm doing. I have a chart in front of me and I'm trying to chart in a hurry at the end of the day. Come in the morning when I'm run off my feet." But they have this perception that we're getting paid \$50,000 to do nothing.

I think it's because it's women. We need more men. If there were more men, first of all the attitudes of the public would change. Once we get them in they can go and talk to the patient. It doesn't matter what they say to the patient or the relatives – they're gods! The little old ladies just love the guys, especially if they are cute. We had one male nurse on our unit. The patient was dying so he approached a relative about comfort measures. He explained to the

relative, and she said she would think about it. And he said, "I'll call the doctor and make arrangements and you can let us know what you decide." Well, she came to the desk in the night. "I was talking to that nice young doctor," she said, "and he promised to get my sister something for comfort, and I just wanted to know how that was going to work?" And we're trying to figure what nice young doctor she was talking about. Then we realized it was him and we were all chuckling. She held him in the highest esteem.

We've got to get out there and let it be known. I don't understand why people can't accept nurses. Why is it so hard for them to accept you and allow you to do your job without double questioning you because you're a woman? We have struggled so long and so hard. Why should we need men to come to relieve us? Why? I mean, we as a society – why can't we accept women as doing something? We can't. It has to be a "man" thing. It's like the doctor is God. The doctor is not here – we're here, you know?

I'm not sure how it's going to work out but this coming election I'll be up for a College of Nurses Committee Member. I'm a candidate. So I'll have to see how it goes. I think the results are due back in June. I haven't been doing a very good job of campaigning! The President of our union is an RPN, so I told her and she's excited. I gave her some flyers. She's going to pass them around in the area. I've also been telling RPNs as I see them. I also have to give it to the Chief Nursing Officer. It's supposed to be in the nursing newsletter that they have here for the hospital. For the election, the packages are out the end of February. So at the beginning of March, I guess they'll be received in the mail and you can get out there and vote.

If I'm elected, I'm not quite sure what committee I'll be on. They choose the committee. It would only be about one day a month, something like that, which means I have some prep time. It would be good in the sense that there would be nurses right there at the College of Nurses who are focussed like I am on patient care and on continuing ed for other nurses. And for the nurses who work at the institution and/or in the area that voted me in, they've got someone they can call and get information or ask any questions. So hopefully we can schedule around it. The days I have to be down there, maybe I can take an off-day or a leave day or something. I spoke to my manager and she's all excited. "Wow," she says, "I know you'll do well there!" So we'll see how it goes. I'm hoping it will be something that will be interesting. Being on Council here and then going there for those meetings would be really good.

Nurses need to be involved in their profession. A lot of us – I mean, I was one of them too – for years you go through the motions: "I just come for the paycheque." You come in and you get the paycheque and you go home. You know – "Don't get me involved in any committee, don't get me involved in anything other than work." People make the generalization: "Whatever I have to say doesn't make a difference." But you have to say it. How do people know how you think if you don't say it? How do you know it's not going to make a difference if you don't say it? So you have to say it. I think coming, leaving and then returning – that sort of brought me to the realization that you have to be out there. You have to advocate for your patient. You have to advocate for the profession. If you don't, then it's your downfall.

## Interview 5: A few more people down the hall/Part of the solution

*Phyllis Vlasik has been a nurse for 21 years. She moved to her current institution from another local hospital five years ago as part of an amalgamation plan. "It's change, nobody likes it, but eventually we are all going to be moving over to the other facility so why not do it now?" she reasoned. According to the plan, all staff were to be moved to a newly-built facility within two years. That was three years ago. Since then, she has been making the best of inadequate temporary facilities. Even the equipment is older than what she used to discard at her previous institution. Her unit is routinely short-staffed; though the staffing looks adequate "on paper," in fact many staff are on sick leave, Workers' Compensation or maternity leave. The absence of replacement staff makes it impossible for the hospital to support educational advancement for its nurses.*

*She genuinely loves nursing and wants to be "part of the solution" but it has recently been brought home to her that the planned changes in her unit are going to be negative ones for the nurses. "I guess I've stayed because I just don't like to quit. I don't like to say that it's gotten the best of me. I like to think that I can handle it. But recently it's come to me that I can't change the way things are there no matter how hard I try. But what I can change is my work situation...."*

I just don't feel that there's enough compassion from the people higher up. I really feel like we are front-line workers and when it comes down to it, for all the talk – "Yes, we know that we need more nurses on the floor and, yes, we know that your work load is heavy" – when it comes to the end of the day, a bed is just a bed and it doesn't really matter how heavy your assignment is. That bed is going to get filled whether there is staff or not.

We're doing something at work called GRASP® [nursing workload measurement]. We do a check list of different things that our patients need and add up how many points they have – a "four" would be a heavy patient and a "one" would be a light patient. If my assignment has five patients that are, say, "threes" and somebody ends up going home sick and there's no one to replace – they aren't going to shut down beds and say we can't admit anymore. When it comes down to it, that bed is going to be filled no matter how busy I am. And that's why some people at work now are getting very frustrated about doing GRASP. They feel, "What does it really matter?" Because we feel that this is just something the hospital instituted as part of accreditation so they could get funding – not necessarily so that it would help our workload. And that is really what it comes down to now in our workplace. We just feel we're doing a lot of paperwork that doesn't really help us out in the long run. I understand the hospital needs money to run – sure. And I understand that they have to do some type of accounting to show the government why they need the money. I think it's just the way things are.

In our hospital the equipment is archaic. Lots of times we're running for supplies. We don't have supplies. We don't even have paid porters; we have volunteers. I think it all comes down to money and I really don't know what the answer is. I wish I did. The famous saying is, "Don't be part of the problem; try to be part of the solution." But if I were to say what the solution is, once again it comes down to more staffing. And I know that's not going to happen because, the way it is now, we don't even have the funding to complete the new hospital.

Increasing our budget might help so that they would hire more staff – but that brings us to another point that I find puzzling. Right now our Nurse Manager isn't really looking to hire any more part-time staff, thinking that we have enough staffing. But when someone goes home ill and they call around to find someone to come in, there is no one. We've got people off on sick

leave and people off on Workers' Comp, people off on maternity leave. On paper it looks as if we have enough staff, but when it comes down to actually calling in people there's no one who is willing to come in. So I would like to see a larger pool of bodies to pull from.

For a long time on the unit that I worked on we did not have a Nurse Manager because no one wanted to come to our unit. It's the Surgical unit. It's known as being a very busy place and no one really wanted to take on the load. So for a long time we were without leadership. And you know, we seemed to sort of run along the same as we run now with leadership!

I mean, the Nurse Manager is accessible and she will listen to you. Her office is right on our floor. She's been our Nurse Manager for less than a year. She is a very nice person. I like her but I just get the feeling that her hands are tied and it all comes back down to budget.

It's very strange. In our city there were three main hospitals. Five years ago I switched over to the one that I'm presently working at. We were supposed to be amalgamating, so all the surgery moved over to the hospital that I am presently at with the understanding that within two years – and this was three years ago – we would all be moved over to one facility. It was on a volunteer basis. Twelve of us had to come over because they were moving General Surgery to one building and I thought, "Well, you know what? It's change, nobody likes it, but eventually we are all going to be moving over to the other facility so why not do it now?" So I did it on a volunteer basis.

When I moved over to the one I'm at now I was amazed because some of the IV pumps at the new place were older models we had retired years ago. Even supplies – we seemed to have lots of supplies on the carts at the previous place. I thought, "How can this be? If we are all supposed to be the same system, how could one hospital have more?" And indeed it did. It just seemed that there were more supplies and numerous things at the place I had been. Go figure. I don't know how that happens.

The regional hospital has handled the funds. The way they handed out the contract was not a good way. What they did, from my understanding of it, is instead of awarding the building contract for the whole deal for the hospital, they handed it out in increments. They made people bid on it every year or so. When this part of the hospital comes up we'll put up the bid again. As we know things just get more expensive and more expensive. So by doing all these little bids it pushed the price of the hospital up. If they had negotiated with someone in the beginning for the whole thing that would have been cheaper, in my understanding, but they didn't do it that way. So in the end they ran out of money. A hospital that was supposed to be, say for example, \$100 million is now three times that – \$300 million.

I guess I've stayed because I just don't like to quit. I don't like to say that it's gotten the best of me. I like to think that I can handle it. But recently it's come to me that I can't change the way things are there no matter how hard I try. But what I can change is my work situation and I've got my eyes peeled now for when a posting comes up in Intensive Care full-time. I'm going to apply for it because I realize I'm just beating my head against a rock.

Recently they developed a team called Pain Management. A nurse like myself – but she's also been a Nurse Manager at one point and has had dealings with administration – goes around with an anaesthetist – and he changes from day to day, week to week. We have patients on patient-controlled analgesic morphine pumps for post-op pain. We've had these instituted for, say, two years and we never had this team before.

But now we have this team that goes around and assesses whether or not the patient's pain is being controlled and what they can do if they're going to increase the lock-out times. A lock out time would be say six minutes. Six minutes later the patient can push again, but he can't get anything in between. He's locked out for six minutes. So they will decide what parameters they're going to change on the pump, if they're going to augment it with Acetaminophen every four hours or whatever.

So they go around and assess this. And I thought, "Oh well, you know... whatever." *Then* I find out that this is only because they now have plans to some time in the future put patients with epidurals on our floor. And I thought, "Well, isn't that special! Here we hardly have time to do what we're doing and now they're going to institute something that's going to cause us more work." I just found it very frustrating and I thought, "You know what? If I'm going to be dealing with epidurals on the floor, I might as well go to an Intensive Care unit where my patient load is less. The patients I know are a little bit sicker but I think I can handle, you know, one to two patients as opposed to four to five patients."

You know what it is? It's more and more machines. I love technology, that's fine, but the more machines and tubes you have hanging off people, the longer it takes to get them up and moving. We have to get people up walking in the halls two to three times a day as part of the post-op routine. So you've got all these tubes to disconnect, lines to take care of, things to measure – you know, just maintaining this person with all these tubes. So by adding another line to the mix you're just adding more checks and balances that I have to be checking on. And our patients are getting older. As well as their medical problems, now they're recovering from surgery so their other problems are compounded.

Our patient load is about one to four. We have a very high rate of absenteeism – there might be three off during a week. People seem to call in sick for things that aren't really related to them. Women who have children call in sick because their children are sick and they have to take care of them – which I understand. I don't have children myself, so I'm not begrudging them that. Although some days....

We all do twelve-hour days, except we have a Nurse Leader who's at the desk and does orders and deals with the doctors. She just does an eight-hour shift. I think people, when they're not feeling really up to par, if they've had a busy day – this is just my opinion, mind you – just say, "Oh, what the hell, I'm calling in sick today." I know instances where someone who has had a really bad day and has to come back the next day calls in sick, and they didn't seem sick. But who's to prove it?

I graduated in 1982, so this will be 21 years for me. It's amazing but I just don't think anything has been as bad as it has been in the last five years. I'm trying to think of why that is and all I can think of is just that people are getting older; they need more help with activities of daily living, like just washing, dressing and walking because of physical infirmities. We have so many more machines attached to people nowadays. I really do think that we had better staffing in the past.

I think that part of it may be physical layout. I know we seem to be walking long distances. The way our place is laid out, there are two long wings and a utility room where you get your supplies at the middle. Even when I worked five years ago at the other institution we had a supply room on each wing. We still had to go to the main nurses' desk to get medications and

stuff, so that hasn't changed. Even our nursing station, that's archaic too. Our narcotics drawer, instead of having a push combination lock, we have keys and the keys are always going missing. People are taking them home. It's just something else you end up having to do, counting the keys, looking for the keys, phoning people at home, "Do you have the key? Where's the key?"

It's little things like running for supplies. We don't seem to have enough supplies so you have to go to other units to borrow. Things as simple as urinals, sometimes, that you just don't have enough of – basins, kidney basins. You borrow because, if you've got a patient who needs it, you're going to need it. You have to find one from one of the other units. Looking around for supplies during a day, I might spend a good 45 minutes when it comes down to it, just running and looking for stuff.

Everybody is supposed to have an oxygen saturation done on them in the morning. They just put their finger on a little device and it measures how much oxygen they have in their system. And there's one – one device for everybody to try to grab to get their patients done. And that's something everybody has to do at the same time. I can't see that they would be that expensive. Normally we are supposed to have one for each hall and even that's not very much, but half the time the one is broken. We're very hard on equipment. We drop things and bop things around. I think it's in our madness rushing around because we're in a hurry. Lots of times we don't take an afternoon break – that's almost non-existent – and a supper break. We don't take care of ourselves break-wise because we want to get out on time.

I work both days and nights. We tend to work more days than nights because more people are required on days than nights, as the schedule goes. I think it's about a 60:30 split of days to nights. I like both, myself, because, like anything, a change is good. I just don't like to get mired in the routine.

When I first started nursing I loved the twelve-hour shifts because I thought, "Well, this is great because I'll have more days off," and I seemed to be able to go on less sleep. But now that I'm older – 47 now – I really wouldn't mind an eight-hour shift Monday to Friday. But that's not going to happen, unless you get into a Public Health setting or something. Because even if you worked the eight-hour shifts you would be working a rotation, I think. I haven't worked eight-hour shifts forever, when you work sometimes ten in a row – that's the way the rotation goes. In the Acute Care setting, you don't have the five-on/two-off rotation – it doesn't really occur.

I don't find that injury is an issue for me. I think I may have called in sick more when I was younger than I do now. I haven't called in sick for over a year now. I think maybe it's in my constitution that I really just don't get that sick. I might have a snuffle or something but I'll go in to work. I guess it's because I feel, unless I'm really having to drag myself in, that I'm not really sick. Whereas some people might think, "Oh, okay, my throat is sore. I'll stay home." Well, that's not an option for me, just because my throat is sore to stay home.

We're fortunate in that we don't have any active cases of SARS. It's affected the daily routine because now when we come in in the morning we have to sign a release. It's a little questionnaire that has three questions on it. And then if you answered yes to any of the three questions they take your temperature and, depending on what your temperature is, they'll go on to a farther pathway. You're supposed to pick up a paper when you leave work and then fill

it out in the morning before you come into work and hand it in at the front desk. There are people with masks and gowns and gloves taking the papers.

The only people allowed to visit were people like mothers of kids on Peds, families on Peds, or of people who were dying or in critical condition, mostly Intensive Care people. But now they're opening it up a bit. So for people who have been in the hospital and are probably going to be here for another few weeks, they're allowing one family member to come in and see them. But you know what? It makes it a lot better without the visitors. It sounds really cruel, but it's true. A lot of time goes to dealing with visitors.

And because of the physical layout of our floor, when you come off the elevators, that's our unit. There's Pediatrics down one far wing and there's Intensive Care down another far wing. So when people come to the desk they are looking for their relatives from Pediatrics, from Intensive Care or whatever, and they are always at that front desk. They're asking for this or that or, you know, their mother who's been in surgery, how is she doing? When is she getting out? So that means you have to make a phone call to a recovery room and find out how their mother is. People who you'd think would be directed from the switchboard to the right unit just end up off the elevators and looking at us. Or maybe when people are in times of stress they don't process the information. Maybe switchboard said, "Get off the elevator and go down the hall." But they don't remember that. They just remember when they get off the elevator to ask us.

Phone calls constantly, which are even worse now. The phone calls are maddening. With SARS, because people aren't allowed to visit as much, I heard that our CEO recently told the public, "Don't be afraid to phone. You can call anytime to find out how your family is doing." And *boy*, I wish I had a redirect button on our phone! So there you are down the hall taking care of so-and-so's mother and they're on the phone wanting you to tell them how she's doing. Well, you're in the middle of a dressing, and they just don't seem to understand. Because they were told that they can phone at any time!

I guess in an ideal world what I would like to see is just a few more people on down the hall. I mean, as a euphemism for more staff. They were playing around with the idea of having RPNs on the floor. We're all RNs and that didn't go over very big with some people. I was kind of averse to it myself, I must admit, because I thought, "Oh, well, big deal. What's that going to help?"

But I have worked with RPNs now. Even though we're a Surgical floor, we also get Medical patients. That's another problem – off-service patients. Because if the beds are empty and we have a 24-hour Emerge – you know, if they need a bed and there are no beds [in Emerge], they're going to come to our unit whether they're our service or not. So, for a while we had another wing where we tried to put mostly the Medical patients so we could keep the surgicals all in one part. So we had RPNs working on that floor. Well, what happened was our staffing got so bad that we had to close that wing because we no longer had the staffing, but we had RPNs who were working on that unit. Now they're working with us until they get a job in another place, and it is helpful because there's morning care. I find it is helpful. It's just knowing where the division of labour is and letting them do what they're trained to do. Some people feel like they have to check up on the RPN. Well, they don't have to. That's just a personal thing. So I do find that – you know what? – it might be helpful for us if we did have RPNs working down the hall.

When we had RPNs upstairs we had a mix of Surgical patients. They were doing chest assessments, they were doing physical assessment and listening to lung sounds. They were okay with that because they had a little course that they were taught by one of the Nurse Educators and it was great. Mind you, I've worked with others in the past, I've worked in places where they weren't even allowed to insert a Foley catheter – but now their scope has changed. So that certainly helps us. They still aren't allowed to give medications or do deep packings. They can do superficial dressings. And then it comes down to personalities too. Working with someone else – I think a big problem with the RPNs is that some RNs feel like they are “better than,” and this gets conveyed to the RPN so it makes for a poor working relationship. So you really have to know how to work *with* someone and not just give them orders.

It means delegating well and trusting them when they do something. You don't go behind them and check up on their work because that's an insult. I think that some of the RNs on our floor had some difficulty with that. But that is probably the answer for our floor – to increase staffing by implementing maybe an additional RPN down each wing. I think that would really help. And I think that it would be cost effective as well.

There are so many non-nursing things that we do. Like I said, we porter people. We have these volunteers who come up, bless their hearts, and they will come to the room with the stretcher. But I've got to get the person onto the stretcher – they aren't allowed to do that because of insurance or whatever. Because, you know, they are just volunteers, right? And things like that. If I need to transfuse someone I have to run down to the lab to pick up the blood and come back with it. It really is a lot of running. Some days my feet just burn from running, up and down, up and down, back and forth, back and forth.

We've got an ice machine that keeps breaking every other day. And then they have the gall to have this nurse walk around that they're paying now for pain control, you know? I see money being diverted other ways and I just think, “We were doing fine without this before, but I know why you're doing this. It's because you want to take people that are in Intensive Care or Special Care just because they've got an epidural and put them on the floor.” And, yes, of course it's more expensive to keep the patient in Special Care or Intensive Care than it is on the floor. So I know exactly where that's coming from. It's all money. I don't believe that it's patient care. I believe that's a money-based thing.

We nurses are supposedly given feedback, but this is a done deal. Whether we like this or not we're told it's going to happen. This is something that I heard in the works about two years ago, about epidurals coming to the floor, and I got a good chuckle out of it then. I thought, “Oh yeah!” And now, about a month ago when this position was instituted, and I'm thinking, “Oh, my God. You know what? It's time to go, Phyllis, because this is going to happen whether you like it or not.”

I thought I could handle anything, but now I understand that I don't have to handle it. I don't think that I would leave nursing. I really do love nursing. I love the patient contact. I like the feeling that I'm helping. What I would leave would be maybe the acute care setting and go into a related field. I've got my degree, right? So I could do Public Health or Occupational Health or something, which is what I plan to do. That's one thing that I've changed my mind about in the last year or so when I've seen things just getting progressively busier and busier. I've decided I am going to take my early retirement. I am certainly not going to stay in the acute care setting.

I just can't see myself running around at age 65 at the rate that I'm going now, you know? It's not gonna happen. My plans are – and plans can change – to work until I'm 55 in the hospital that I'm at (or if, God forbid, we move to the new facility, that one); to get Intensive Care nursing experience under my belt. That would be another seven years I have to go before retirement and with the knowledge that I've gained then I plan to do something in a nursing-related field. I don't know what, but it won't be in the acute care setting. It's too busy and it takes up too much of my life. I find that when I work a twelve-hour shift now I'll want to sleep for at least twelve hours, just to recharge. And then you still have to do all your regular daily business that you don't get done on the other days.

I just get very tired, very tired, and lately people have been saying, "My God, Phyllis you look tired." It's because I don't sleep that well and I'm 47 so I guess I'm going through a menopausal thing where I only sleep two hours and then I wake up and I go back to sleep ... I'm just getting tired and that's it.

I look forward to training for Intensive Care. Our nursing education [in this hospital] is really lacking. I don't know what they've got them doing most days, the Nurse Educators. Recently a few colleagues of mine were involved in the Quality Work Environments in Nursing Study where we instituted teaching to our colleagues about tracheotomies and PICC [peripherally inserted central catheter] lines and central lines. We made the plan of care and did the teaching to our colleagues and provided the in-services because we felt we had more of a grasp on it than the educator who was available. She might be able to read off the paper what we've done but we have the practical knowledge because we just don't see her on the floor.

It's very difficult with twelve-hour shifts to do ongoing learning. You have to rearrange your shifts and that. So mostly people will do like computer, distance learning – just at-home stuff. I think that Laurentian University now has part of a nursing degree online, I believe they're instituting it.

You can apply for assistance from the hospital, financial or in terms of time, but the chances are you're not going to get it. If I wanted to, say, go to a learning seminar or something I would have to find someone else to work my shifts for me. And right now we're not even encouraged to pull from the part-time pool. It's more like trying to switch shifts with someone instead of giving the part-timers shifts because the Nurse Manager wants the part-timers available for sick calls.

Just for our floor right now, the nurses feel like they do enough learning on the floor, day to day. I do it for quality assurance just because that's who I am but a lot of the girls think, "You know what? I work my ass off on the floor and I'll be damned if on my spare time I'm going to go do some extra learning." And I know where they're coming from. I mean, they've got families. I don't necessarily agree with it, but that's where they are. They just feel that they're giving too much of their time as it is to the hospital.

Our floor, it wouldn't be a good place for anyone who wanted to go back to school. I mean, we've got a girl who has been working part-time on our floor, went away to do her Masters and is now back on our floor, but she wasn't ever accommodated from our floor for her to go ahead and do her Masters. It was her own time and money. She came back seasonal, in the summer. She wasn't working part-time.

Respect among nurses is a touchy issue because I know that there are people currently on our floor who just aren't up to par. Not necessarily newer grads. Some of them have come from other settings like Occupational Health or Home Care and just don't seem to do all they could be doing down the hall. I don't know if this is just women or nurses in general; people will talk about people behind their back, but no one will actually come up and address the person, right? Because it's hard to confront someone. There is a real cliquishness to working on our floor. We have a high rate of turnover. People leave because they just don't like it – because it's too busy, it's too heavy, and they just go elsewhere.

As much as doctors say they respect what we have to do, when it comes down to it all they really want to do is get their surgeries in, fill the beds, and it doesn't matter how busy I am. He wants *that* surgery in *that* bed. There might be a bed available on another floor, but they want them all on our floor because then they won't have to move around as much. Some doctors – there's a newer doctor I have in mind particularly – don't respect our opinions. When we say that a wound is looking like it's getting infected, he'll get very defensive and will wait until it actually eviscerates or whatever before he'll address it, and then say that no one told him. Some of the older doctors, they understand the plight but they have their own interests at heart. When it came to SARS they were upset that they weren't getting their surgeries in because that was their bread and butter. They wanted those surgeries back and they pushed and pushed until they got it.

So most of them are civil to us and there are a few that you can even joke around with, but there's no real camaraderie. Where there is, I know, in the Special Care Unit with the Intensivists and in the Emergency – there's more of a team. It's not present on the floor.

I'm happy with my pay. I think I get paid well. I don't have any issues with my pay at all, but mind you I'm at the top of the ladder right now. No, I just wish I didn't have to work non-stop for it when I get there. I wish I were allowed to work at a more relaxed pace. That I had more time to go in and chat with my patients rather than being so task-oriented all the time. Because I really do think that emotional bond is important. I know that there are people who hang out at the nursing station instead of being down the hall when they've got a few minutes. I would just like to have more time to do teaching and to be able to have that chat with them, you know? But otherwise, pay-wise, I think it's fine.

Some of the patients, I know they've made comments to me that they never see the nurses around. Or they feel really badly because their nurse is running around like a chicken with her head cut off. "Oh, poor old so and so. She was really running yesterday." They don't want to ring the buzzer and that's not what it's all about. "You know, if you need help," I tell them, "push the buzzer, because it's the squeaky wheel that gets the grease here. If you don't buzz for me, I won't know."

It's nice when people acknowledge you. It's nice when someone has been a patient and they send like a basket of fruit or something and say you've done good nursing care. It's nice when you see a letter written up in the newspaper about the good care that they've gotten. That's very nice. There is a hospital newsletter that sometimes prints things like that.

I always wanted to into a profession where I was self sufficient. And like I said, the pay is good. I feel that I'm doing something worthwhile. What has kept me in nursing? I guess part of it is that I've done all this schooling. I'm not really willing to go and retrain for something else. And what would I retrain for? I don't know. Maybe I could be a rock star or something?

I just feel really badly that I just don't see a solution for the problem as it exists on our unit other than increased staffing – which I really don't think it going to happen because of the way funding is. Because for the most part the people I work with are a great bunch. You see people's spirits sagging when the patients keep coming and coming from surgeries and you just can't keep your head above water. It's really frustrating because we all know that the answer is more staffing but we all know deep in our hearts that it's not going to happen. So I just wish, if and when the new hospital comes about, that the physical layout will be better and that they will have more services organized so that we can concentrate on nursing duties rather than non-nursing duties. Like I said, I really wish I had an answer and, like I said, I just don't see an answer other than staffing. Which is money – and we all know how hard that is to come by.

### **Interview 6: Giving it push/One more nurse**

*Brenda O'Connor was hurt lifting a patient four months ago, an injury that reactivated aches and pains from a car accident some years ago and resulted in two numb fingers and neck pain. A period of medical leave was followed by a month of desk work. Acupuncture helped with the pain; her physiotherapy began the day before she was due to return to work. Fortunately, she says, she works in a unit which doesn't require a great deal of patient lifting.*

*Back at work now, she is taking an evening course, part of a post-RN degree offered on-site at her hospital by a local university. Ultimately it will enable her to leave bedside nursing, which is no longer possible for her because of its physical demands and her injury. The second Tuesday of each month she serves on her institution's Professional Development committee. In 1996 she was laid off twice in one year.*

*She was interviewed on her own time, having agreed to come in early before her night course. When asked if she had a spare hour in her working day when she could be interviewed, she laughed. "There are no spare hours," she said.*

The first day it happened I thought, "I can't be having a coronary. I'm only 48. I have to take my kids to my mother's for the weekend so I can go to work Saturday and Sunday. I have no time for this." So I went into major denial. I sat at the desk and charted and everybody thought, well, that I was just charting, right? About 20 minutes later the chest pain going down my left arm subsided and I thought, "Thank God!"

But again I felt this crushing chest pain going down the left arm. This time it was horrendous and I couldn't breathe anymore. The staff saw me slump over the desk so they put me on oxygen. They took me to Emerge where I had an ECG and ended up being admitted for coronary insufficiency.

But that wasn't what was wrong. The first two sets of cardiac enzymes came back negative. I was in a telemetry unit on a monitor. I had tremendous pain in my arm and it felt like a crushing weight on my chest. I was on oxygen, but after the second set of enzymes came back negative I lay there thinking, "What could have caused this? Why would I have this left-sided chest pain?" And they gave me Nitrol and all the rest.

It wasn't until the middle of the night that I thought, "Why would the pain in my arm be so severe that I couldn't use it?" Six years ago I had been in a car accident that resulted in left-sided neck pain, so I asked the cardiologist, "Do you think I could have a neck injury?" And he said, "Well, I'll order the x-rays." I tried to get onto the table for them to take the x-ray and when I turned my neck I lost the use of my body and collapsed on the floor. They put me on a board, blocked my head and strapped my neck and body to the board. This time they lifted me on the x-ray table and took the x-rays.

It turned out I had a bad fracture of my neck from the previous accident. It had collapsed when I lifted a patient.

I was off work for three or four months. When I went back to work I still hadn't recovered full use of my left arm and my fingers were a bit numb, but it resolved. Hopefully I'll be able to leave bedside nursing and go to work at the Assessment Centre soon. I have enough education and a lot of seniority. That's just the way it is, you know? I've been doing bedside nursing for ... it'll be 32 years soon. I graduated in 1970. I really like it, but I have to get out because of the physical injury. I've had paralysis twice now. These three fingers are still numb from last October and this section of my arm is like a piece of wood. I'm three-quarters of the way through my post-RN degree program at Ryerson. That will give me more options and choices to get out of bedside nursing if I can.

The course I'm taking tonight is part of a university program but it's offered here, on-site. I won a scholarship from the hospital – \$1,000, which covers two credits. Which is fine, that's money I didn't have to put out. Most of the time my institution is supportive, though to be honest it depends who the Unit Administrator is. There's some more funding for education as of this year. Last year it was \$750. They'd pay for 50% of courses, up to a total of \$750. As of 2003, they'll pay \$1,500 a semester. So in other words, they'd like you to finish your degree if you can. You take courses on your own time.

I work mostly twelve-hour shifts. It's very heavy, it's frantic. I come in 15 minutes early so I can get a report from the night shift before I hear the tape, which is the official report. It's smart, you get to look at your assignment. You have a look at the board and the night staff will tell you this, this and this. It's a benefit. So you come in a little early and that helps.

You look at the assignment, and then you look at the OR [operating room] list right beside it so you know when your patients are leaving you. And then you look right below it for the posting of times for x-ray and diagnostic imaging lists. Then you go into Report and you write everything down – in case you don't have time to get back to the Kardex in a hurry. Half the time you don't even get to sit through a report because the patients are on call for the OR – because our floor is a major Surgical unit. So patients come in in the middle of the night. They'll be booked for the OR and they can go anytime. Sometimes we have Gyne patients too, and it's the same with them – they would go on call too. You just get up and go get the chart, look for pre-op orders, go and look at the patient, do the vitals and put them on a stretcher and make sure everything is there. You send them up to the OR and then you check the linen and make sure you have towels and facecloths for everybody. You go to the meds cart and make sure there was no [med prescribed for] 8:00. You've missed that now because it's a quarter to nine. It's frantic.

We cover each other's patients for breaks. One girl went on her break and gave me a report on her patients, so I had a diagnosis and a faint idea, but I hadn't seen any of them. The orderly comes running down and says, "Brenda! Brenda! This patient is seizing! Get in here!" So I ran down the hall, put the oxygen on, took the vital signs. Then I ran back to the desk because I thought, "I'm going to need somebody fast." I put a STAT call through: "I need help now!" The nurse whose patient it was came off break. We got a doctor to come and see the patient and we gave her IV Valium but it didn't work. The doctor's grabbing the chart because he doesn't know this patient either – it's not his service.

We found out it was a reaction to the morphine drip. I had never seen this before, but it was a side effect. Patients can get hallucinations and bad dreams and anxiety from morphine sometimes, but *grand mal* seizures? Holy smokes! So the doctor said, "You get me the Dilantin." I opened a crash cart, gave him the Dilantin. He gave it push, so the seizures decreased. He stopped the drip. The patient was terminally ill and the day before the gerontologist had ordered a morphine drip. She wasn't expected to live and this was a comfort measure. But when the doctor looked at the chart, he saw that kidney function was very, very decreased, so the patient wasn't excreting the morphine. It took about an hour to solve the problem. The doctor was there the whole time. In an hour he said, "That's what too much morphine looks like."

And that's the way most days go.

The patients are quite acute. I work in the chest unit, Respiriology, which is now combined with General Medicine. So patients can be trachs, but they can have other things, maybe trauma from a car accident. We no longer have an Acute Care Unit, so ICU patients come to us. We get quite a variety of very serious patients.

We don't have enough time to get all the diagnostic tests done during the week so they're being done on Saturday and Sunday. But we don't have the portering staff to take them down so the nurse takes the patient down on Saturday and Sunday for CAT scans. Legally there has to be at least one nurse in the X-ray Department during a CAT scan, if there isn't one scheduled to work. The X-ray Department has complained bitterly to the nursing staff to try and get more staff down there to cover this. It takes a whole hour to give an injection of the dye – there's a risk, right? So you end up going down for a whole hour with this patient. On a Saturday or Sunday! So you're missing from the floor. Somebody else is covering your patients.

About a year and a half ago when my unit administrator was new she interviewed all the staff and asked, what's the number one thing you need? *One more nurse on Saturday or Sunday!* Because, in the type of unit we're in, it's seven days a week. On weekends we're still doing x-ray stuff, we're still sending up to the OR, just like Monday to Friday, but we're down one nurse and we don't have a desk clerk after 3:00. So a new patient comes in. You're putting the chart together, which has got a lot of documentation, ordering the reqs, phoning – maybe we need an ECG because we know that there is going to be OR time in about two hours. So then you've got to phone the RT [radiologic technologist] to do the ECG because there's no ECG tech. The nurse is now answering the phone to the relatives, putting the charts together, trying to look after the same amount of patients. Weekends are *not* fun.

If you can't get us another nurse, get a desk clerk, somebody to answer the phone for relatives. It's the non-nursing stuff that takes time. We're an all-RN staff, so whatever needs to be done,

we do it. We have an orderly who can transport, but a lot of times you end up going. We have evening desk clerks until 8:30 from Monday to Friday, but in our unit we get patients coming down from ICU at 7:30 at night. Then their families come too. It's not like the place shuts down early. It doesn't, it just runs constantly. I mean, our patients complain that it's noisy because you have stretchers in the nights. We haven't got enough pumps so some nurses pump pushing a pole with big wheels down the hallway and it's noisy.

Nights are busy because there's a lot of paperwork. It's a critical area. We have morphine pumps, epidural lines, femoral lines, so you're doing vital signs frequently. For post-op, on a PCA pump, you have to do vitals every hour for twelve hours. That's fairly often because you've still got five to seven patients on evenings. You've also got dressings and packings and pain stuff and antibiotics at 6:00 and sleeping pills and antibiotics at 10:00. And just pulling them up and changing the diapers and emptying the colostomy – whatever. Nights are as busy as days for a variety of reasons. You have less staff doing the same amount of work. Not as many ORs, but you can have some. You have admissions so you have to clear the bed and all the rest.

I prefer days. I once did four years of permanent nights, because of my family. I was only working three days a week and my husband had three days off so I could do nights and he could do days. We managed. We always worked opposite shifts. He would start at 6:00 and I would start at 3:30, because he'd be home at 2:30 and I'd leave home at a quarter to 3:00. He only had one weekend in five off. I had a good Head Nurse. I explained to her that we weren't even going to get the same weekend off when he had his one in five. She gave me the time sheets and had me mark off the days that he was off. I would give up one of my weekends so I could hit his fifth weekend. And then we put in a request – so there was no change in pay, no overtime, right? This way it didn't cost the hospital money. It was great. Our new administrator is more flexible than she used to be. Now she'll negotiate. So as long as it's a senior for a senior and the shift is covered – and you show up – you can switch. Before, she didn't want so many switches. It's usually just that somebody has to drive their son to the airport for the evening, or whatever, so you cover the evening.

In the past a lot of the Head Nurses were single and that meant that they were mostly very pro-nursing and pro-nurse and pro-patient and not business managers. That's what you want, somebody who is pro-nurse and pro-patient – you know, not the budget so much. We used to have a Head Nurse five years ago, if you want the ideal. She would come in at 7:00 – a half-hour early – and ask the night staff which patients were problems. Then she would help the doctors when they came to do rounds. When they saw their patients, and there were three teams and three services, she would fax requisitions and handle things for half an hour while we got Report. It was great. She was very supportive of the nursing staff. Then, about 8:30 or so, after about an hour and a half of the shift, she would go to her meetings and things.

Our new unit administrator got a lot more supplies and organized them. She put in shelving units in this one room right to the ceiling, labeled everything, put in bins. One staff meeting I said, "We don't have any trach kits" – for cleaning trachs. And she said, "What? This is Respiriology – what do you mean you don't have any trach kits?" I said, "I borrowed one from ICU, which is five floors up," and she said, "You have *got* to be kidding!" Anyhow, she picked up the phone right away and said, "I need trach kits – I have two trachs on the floor." "You've got it!" It saves nursing time if we have some of everything.

We have a unit dose for Pharmacy now. We used to have a pharmacist on the floor which helped because they had a cart that was locked and they had extra stores, so you could get the meds right away. You didn't have to wait two hours or worry about whether you're going to get it in time for the next dose. Now it's quite the juggling act. You come on and you count the narcotics at 3:30 and think, "I only have one more morphine PCA, oh rats!" So then you phone Pharmacy and then you have to go down in person and pick it up because you're the RN – you have to sign for it – and it's in the basement! When I get new orders I rip them off and fax them to Pharmacy immediately, before I transcribe the order – you know, fax it because I want to make sure I get them before 8:30. After that, I'd have to go get a key and go to another floor and sign them out.

They instituted these epidural lines and it's supposed to be saving the nursing staff time. It's not. The vital signs, the side effects – it's horrendous. You've got to be checking and checking and checking and that takes lots of time. It's supposed to save time because you're not mixing it, because it's in a constant dosage ordered by the anaesthetist, right? But with epidural lines in the back, the Fentanyl can drift – it can go out of the spaces in the vertebra in your back. It can suppress respiration – that's a big one. Anything below eight and you have to shut it off and phone the anaesthetist immediately because you're looking at major respiratory depression and that has to be reversed right away. Then you have a major calamity that's taking you away from your other five patients. So it hasn't saved anything.

They're using more PICC lines, which is a pushed-up IV tubing that allows you to run several kinds of solutions at the same time. These are inserted in X-ray, but it means that the nurse is drawing all the blood samples for daily blood work or every 4 hours. Instead of having the blood tech do it, the nurse is doing it, and there's a whole protocol for that. You have to take a class for it and get certified – it's just more and more work and we don't have that kind of staff.

For five years we've had PCA pumps, patient-controlled analgesia. To change the rate of the cartridge now takes two nurses. There are *so* many problems with the pumps that for accountability – holy smokes! They haven't saved anything. Now we have very expensive monitors because you have to be doing these vital signs every 15 minutes periodically for a couple of hours. So you're in there all the time. It's almost one-on-one nursing care, but you don't have one-on-one staff.

It's gotten much more stressful now there's more accent on accountability. Accountability is fine, but if you don't lighten up the load .... Meds are changing. I'm forever looking things up now. I make sure I have my little book, my Davis Drugs [Guide for Nurses] book, with me so I can check on things. The hospital is trying to save money by using generics and the names are all changing. You know, "Is this really what I think it is?" So I have to look it up real quick. It just takes time. It's too stressful right now. The workload is too heavy.

When my injury recurred in late October I ended up doing data input for a month. It was sure a whole lot easier than hauling patients – pushing them on stretchers and stuff. I had a patient from ICU the last day I worked. He was 260 pounds and about 6'2", and the nurse from ICU and the orderly thought, "Well, we'll just pull him across." I said, "No, I think we'll get the transfer board and we'll get another nurse and I will instruct you on how to do this." So we rolled him over and put the board underneath. If you pull the sheets you can put a board in, and then the patient just slides on. It takes away half of the body weight, but I had four people too. The patient couldn't even lift his hand. I thought, "I'm not going to be a patient again!"

What keeps me in nursing is to know that I've made a difference. To try and get the greatest amount of help for whatever the problem is. To make sure the patients get the care they need and that they're prepared for what they need to do when they leave. There's the *after*, you know. To make sure that they're educated and they know where to get their supplies and know how to do what they're going to need to do – whether it's a new ileostomy or just using their spirometer properly after they've left the hospital.

Because quite often it's a big battle if you start asking questions and the patient doesn't really understand. Let's say they're a new diabetic for whatever reason and it's all new to them. You have to make sure that you get the doctor's order to Diabetic Education and that they know what the supplies are and that they practice. You have to make sure that they're doing it when you're not doing it anymore and that they're ready to function independently outside of the building, right? That they're not having to leave the hospital unprepared.

Not having time to do that is part of the stress. You have to start asking questions right off the bat. While you're bathing them: "Okay, who do you live with? Where do you live? How are you getting home? What do you know?" Because you have to. You don't have time to say, "Okay, now we'll discuss your ileostomy." While you're making the bed you're saying "Oh, the ostomy nurse – do you know if she's booked to come in on Tuesday to discuss the types of prosthetics that you're going to need and give you the forms for the doctor to sign to have it paid for?" You also have to make sure that they're ready.

Right off the bat you look at the diagnosis and you think, okay, what kind of questions do you need to ask? Or you need to find out about what's going to happen later – just a whole lot of things. Some of our patients are from up north and there isn't lots of physio up north. You can go to Orangeville and there's no post-op physio. We have a good physio department, so they'll give them diagrams and make sure they've got everything.

Because there's been a lot of publicity I think people really do understand now how short-staffed we are. I work at a good hospital where the patients really appreciate you ... well, maybe more than 50% appreciate you. It's very individual. The residents, they come and go. Sometimes there are cultural differences – say, if they're not used to dealing with women. It's really a big issue. People who are here for training. They probably haven't worked with women until they came here to do their residency in thoracics so it's kind of a culture shock for them. Well, you have arrogant ones who are nasty, sure you do, and for the patient's benefit you have to deal with them. And that's it and you tell them what you have to do. As I told one new nurse, the worst they can do is yell at you and – so what? Forget about it.

Sometimes the patients aren't mentally with you. That can be an issue. We've had a few lately, their language was so coarse and so vulgar. So you deal with it, right? The deal is that you only have them two days in a row and then you don't see them again. You get a change of assignment – they're as much as you can tolerate. You don't have them the whole time that they're there. You can't. It wouldn't be fair.

There's a certain amount of companionship working with other women. You get to know what they're doing and they know what you're doing and you support each other. Alice wants to go up north to work and she needed four days off in a row to do the Pediatrics specialty course. She can't afford to take time off, so we negotiated when she'd replace it so she could go to

school and not lose money. Or kids have hockey games and so-and-so needs Saturday night, so everybody pitches in. I work on a unit where the staff have been there a long time. We're pretty much *all* senior, so that we know each other quite well.

With new nurses, you quickly figure out why they are in the job – whether they're in it for the money or for the satisfaction and doing a good job as a nurse. Whether they count the minutes till they leave – “This is my coffee break and I don't care.” It's very individual. Most people don't stay in nursing unless they like it. Because there's too much shift work, you work too many holidays, there's a lot of stress.

But I like the challenge. Every day is different. You may think that you know what you had yesterday, but you don't. Things happen every day. So it's exciting, it's a challenge – never boring, never.

Entry-to-practice now being a degree is going to create a problem. Senior nurses and staff don't want to have to go back to school. If you've got five more years to finish, would you want to spend that kind of money? You'll never get it back. You'll never get a job in administration – you're too old. And for new nursing staff – it's another year of education that costs you more money, a bigger student loan. If we had a nursing shortage before, we are looking at a bigger nursing shortage now.

The solution? I don't know. More subsidies to the universities? They're not funded adequately.

If the government doesn't support the university financially, then it's transferred to the students who have to take out the loans. And they can't afford it – it would take forever to pay it back. At Ryerson last year at graduation time there were recruiters from the States offering \$7,000. That was just to go! To pay for your transfer to the States. If you have a student loan and you've just graduated, \$7,000 looks really good.

I don't know how to promote nursing to people. If you're going to go to community college or university, financially your benefits are better in other jobs. Say physiotherapy. It's a four-year university course and the pay is equal to nursing, so why would you not? Teaching is opening up. That's a nice job. It's good pay, you know, nice vacation and every weekend off. That would be the ideal job. I was going to go into history. I was accepted at York and I was going to do Honours History, to teach. My father was a nursing supervisor and all his life he said, “Don't be a nurse.” But my parents were quite happy when I did, so it was okay.

There should be more of a shift differential for nurses. The pay should be higher to cover the fact that you're working more weekends. Also, the difference in pay isn't much between the top and the bottom, from first to ninth level. The last contract, if you were at the top – if you had 25 years' seniority – then you got an extra week with pay. That was new. So that's more vacation time with pay. That's an incentive. You now have almost the same vacation time as teachers! You have seven weeks.

But we don't seem to win. We got our new contract. For glasses we've gone from \$150 to \$200 now. But then management increased the cost of being in the plan. The contract was accepted and then three weeks later this notice came out from management saying that it would be monitored with a view to increasing your monthly payments, deductions from your pay. So we didn't win.

With the new contract starting next year, it would be I think April of this year, 2003, they'll pay 50% of dentures and 50% of crowns, with a limit. So the benefits are better. That's an incentive because people have children. Braces are astronomically expensive. Our hospital increasing funding for university; that's an incentive to go back. The difference of \$1,500 per semester as opposed to \$750 for the whole year – that's quite the increase.

The other thing is that it's hard to get time off. You know, it's hard to juggle the work at home and your timesheet and still stay full-time and keep your benefits and all that. Because you've made the day care and you're organizing the cooking, driving to Guides, doing swimming lessons and everything else.

We need desk clerks, and two orderlies on days for doing the transporting. Not only for transport, but for getting the patients – the heavy ones – in and out of bed and stuff like that. You have to wait to get help all the time. The auxiliary staff could help do more things. We need more staff in general. In my unit, on days you have four patients – now we're going towards five most of the time. That's another thing! I'm a senior member of the staff, right? So I always have five. And how about you're in charge every once in a while, on evenings, overnights? So the demands increase with seniority. It's 50 cents an hour shift differential, but you're just running. You're troubleshooting everywhere.

People are burned out. The pay is good, that's fine. I have no complaint with my salary. But the workload and the pressure are astronomical. People don't want to work overtime because they're already tired. It doesn't matter that the hospital will pay you overtime – you're *dead*. You've already done twelve hours, and then it ends up as 14 because you came in early and you're staying late. It accumulates. You can't do this – you know, running like a MASH [Medical Army Surgical Hospital] unit – all the time.

Nurses have left, or are just counting the seconds until they're gone. Especially senior staff. It's just that heavy, you know? Everything is going back to the nurse. So how do we make it so people want to go into nursing? We need more nursing staff and I don't know where it's going to come from.

## Interview 7: Return to hospital nursing

*Linda O'Connor has nursed for 30 years, 27 of them in Community Health. When her employer, the Victorian Order of Nurses, lost the contract for community nursing in her region, she and the other nurses employed by VON were thrown out of work. "So I sat at home for a couple of months trying to figure out what to do and after all that time came back to the hospital. It was very traumatic." Hospital nursing had changed a great deal since her training and the patient population had become more acute. So much was unfamiliar that she felt at a disadvantage even in relation to the new students: "At least they were fresh!" She persevered, eventually moving from a Surgical to a Medical floor in order to obtain shorter (eight-hour) shifts. She has on occasion worked twelve-hour shifts with no break: "You sit there and eat your sandwich while you're charting; you hardly have time to go to the washroom. And you're exhausted. I go home and lie in bed and think: 'I can't physically do this any more.' And you just kind of pray that you've done everything, because you're just flying constantly." She is unhappy about not being able to provide what she considers an acceptable level of care.*

*While she finds hospital nursing more exciting than Community Health, the workload and pace are gruelling, largely because of severe understaffing in her institution. Young people, she feels, have little reason to choose nursing as a profession, and those who do frequently leave for more financially and professionally rewarding positions in the United States. When asked to provide a comparison between hospital nursing and community health nursing she says, "There is no comparison!"*

When I came back to hospital work I was 50. But what do you do? Our jobs were eliminated. Our only options were to go to the other agencies that didn't offer us the same employment package. They wanted split shifts and less wages, more on-call, more weekends. Less vacations. We lost everything. I lost my vacations. I was up to five weeks. You go to a different place and you're right down at the bottom. Now I'm up to three weeks, after three years. The pension – I could have moved it, but I know people have had a hard time with moving from one to the other. They've lost a few years. So what I did was just take it and invest it myself.

You go back at that age, now you're working on midnights. That's very hard, extremely grueling. You're just exhausted. I never sit down, really, unless I'm doing my charting. I don't sit at the desk and talk. I mean, you do try to get your breaks because it's important, but not always do you get them. Almost every time you turn around something else has to be done.

When new nurses come to the floor, whoever is on and senior is assigned to them. They probably should be assigned to one person or maybe an educator should be going through each thing with them and checking off things – making sure that they've met all the criteria for what needs to be done on that floor. Here it's really kind of hit or miss and they're not all being taught exactly the same. It's confusing for them. I didn't get much orientation. Luckily I knew one person on that floor and she put me with her. Thank God I had her, because she was great. She actually came with me to the floor I'm working on now; she came ahead of me and then I came. We weren't such good friends to begin with but she was just really good and that's what saved me. Without that support I don't know if I would have stayed.

In the community you're one on one and in the hospital you're like 50 on one. You can never finish a task. In the community you went in and you did what you had to do and you really didn't leave until it was completed or the patients were set for that moment. You did everything you needed to do. Here at the hospital, you never feel like you ever finish a task. You just prioritize and finish what you have to at that moment. It's very harried.

You prioritize all day, every day, constantly. I think you just do it by experience from being on the floor. You know what you have to get done. For example, say right now I'm working on a respiratory floor. I know by 1:00 I have to have all my work done because Rounds are starting at 1:00. You can't leave anything after that because you have to do orders afterwards and if you want to be done in time you'd better make sure your charting is done and your baths are done and your beddings are done and your vitals are done, all the medications are handed out. You just do it by experience. You know what you have so much time to do and you do it.

I work eight-hour shifts. I did work twelve-hour shifts for two and a half years. Quite often I work shifts with very little break. I have even worked twelve-hour shifts with no break, especially on the midnight. You could not leave the floor. I sit there and eat my sandwich while I'm charting and you hardly have time to go to the washroom. And you're exhausted. I just go home and lie in bed and think: "I can't do this anymore." Just physically. And you kind of pray that you've done everything, because you're flying constantly. I did that for two and a half years.

They say it's your fault – that if you need to go for break, you should go for break. But, you know, you go for break but you still have your work to do when you get back. And, coming from a Community Health environment I was used to meeting the patients' needs before I left. I know sometimes we probably did a little more than we needed to for people. It's hard not to straighten that bed, pull them up – I just can't leave a room unless everything's in order. Actually sometimes I'm embarrassed that hospital patients are not getting the care they should. That's how you feel sometimes, especially when we had patients with Norwalk virus. Oh, my goodness – I just felt embarrassed that I wasn't doing what I needed to do for them. You can only do so much.

I keep saying I'd like to come to a job where it's nice and calm, you can do your job and be happy that you did a good job and still feel that you can go out at night afterwards. You know, at least have dinner. Last night we went out for dinner. Usually it's "No, I don't want to go anywhere! I need to rest."

When I changed from a twelve to an eight-hour shift, all I did was I applied for an eight-hour floor. A Medical floor is not attractive to a lot of people, so that was one thing. A lot of people find it's chronic and they don't want to be there. I was on a Surgical floor. Actually, some girls from the Medical floor moved to a Surgical floor and then a couple of us went to the Medical floor because we wanted the eight-hour shifts. Some of the younger ones, they really like the twelve-hours. A lot of people don't like to be here every day and one day off just doesn't seem to cut it, you know? At least on the weekend you can have two in a row and then you're back Monday to Friday. I did days and nights. Now I do days and evenings. That was another plus for this floor for me. So at least I'm in bed at night.

I've been sick a little more often on this floor. On the other floors you work the twelve hours, then you have a few days off, you recoup. But I don't have to go home and do groceries and take care of little kids. My husband does a lot for me, so I basically can go home and relax. The ones who have to go home and do all that – I just don't know how they can keep it up.

I think the situation had changed since I trained in a hospital; I think it gradually got worse. It seemed like you were always working short. You're always told, "Oh, you just do what you have to do," but really, beds and baths are not a priority. I mean, it needs to be done but it wasn't

something that was hanging over your head. It's just got to the point where you do what you have to do. Well, there is so much that you have to do but you just don't have the time to do it.

Now in the last couple of days it's been quite calm. We've had more staff. We've hired so many fresh RNs that they may be giving them a bit of a break, with less patients. So we all have less patients right now. I came to our floor five months ago and I'm now way up in seniority, probably three or four up. Everybody is leaving constantly. It's all you hear, all the time. They are always leaving for the States. As much as they say it's not happening, they still are. There are more opportunities for advancement over there. They get what they want, they have the shifts they want and then, the younger ones, they make the money. On this side of the border you make \$20 and on that side of the border you make \$20 US [approximately \$29.30 CDN]. And it takes nine years I believe to get up to the top level.

At my stage of the game, I'm not looking for a lot of changes. I just want maybe a few more years. But for a younger person I don't think there's the career advancement here that they could get in the States. There just seem to be more opportunities for them there. I don't work over there so I can't really speak for them. Not everything is perfect over there. I mean, they're overworked too. That's a big thing with nursing. You work unbelievably!

The nurses who go to the States get more say about their scheduling, quite a few of them, especially the ones who go contingent. They can pick their shifts. They can say when they're available. They have self-scheduling, a lot of those hospitals. I'm not saying everything is perfectly roses over there. But the education is paid. Here it's such a hassle. I wanted to go on a conference – and I am going, finally. But you have to find someone to work for you. You have to practically beg them to give you the time off to go. It is going to be paid for, but it is a bit of a struggle here.

I think that self-scheduling would help a lot. Getting time off is really, really hard here. Because there's no staff. We have four part-time and one was on a sick leave and the other three were scheduled to work that day. And you can't switch shifts. Switching is really too hard. In order for me to switch a day I would have to work six or seven in a row and so would the person I'd switch with. And that's just too much when they are really hard physical days. So, it's hard to get time off and even when people do make special requests they're denied. I think they could work a little harder on that. If someone's grandparents are having a 50th anniversary they should be able to arrange the time off if they asked enough in advance. They're being denied these types of things. We have lives, you know? Try to work with us a bit.

Also, we're way behind in technology from what I hear. I know our equipment is terrible. Here they're using capital funds for building, but we need money too. I'm on a respiratory floor and you're fighting for an oximeter. Really, we should have that in every squadron. And the Glucometer machines always seem to be acting up. It's a constant fight with equipment being broken. On our floor we don't have even one automated blood pressure machine! We use manual. Not one automated BP machine, which is kind of bad. So I don't know if they're finding better equipment over there. They say that things are more advanced there and of course there's so much turmoil here all the time right now.

All our RPNs are being let go – they're all being shipped over to the other hospital for Rehab, complex care. This is an acute hospital and that's a chronic hospital. We're supposed to become

an all-RN institution. RNs are supposed to do all the care. I don't mind the complete care, it's just I can't do it for that many people. If you've got a group that's very chronic and they all have something – like we had the Norwalk virus on our floor – four or five patients per nurse is a killer. Even three with Norwalk, it's just too much physically.

I don't know how it's going to work out with all RNs. There's good and bad in everything and, like I say, you're going to have less patients. Before I had nine; now I'll only have four or five maybe. As for the non-nursing tasks, we were doing them anyway. I was doing the baths, I was doing the vitals. I was doing the Glucometers, getting the patients up to the bathroom. Everybody worked, whoever was available. I think it's really nice to work together, to be able to count on your co-workers. In terms of doing everything – well, at least you're getting to know the patients too. I mean, you've got to report. Even the basics – the bowel movements – you're there, and while you're doing it you can check their skin. While you're doing their bath you're checking for oedema. You can do a lot of assessment that way.

On the chronic side of the hall there were nine patients and we had one RN and one RPN – which was very stressful because the RN does all the meds, does all the reporting on everybody to all the doctors. Well, you share the doctors' orders writing them but you always had to co-sign them. If you had to call a doctor, you were calling for nine. So you had to be on top of nine and you reported often. You're responsible. The RPNs were excellent and many moved along; others would only take their four or five patients and that would be it, so it was a stressful thing. Now that they're going with an all-RN staff it's kind of nice in a way because you may only have four patients. But I can see if we get sick calls we're probably going to be asked to do more. Today I had five which really wasn't bad. I could handle that. They weren't chronic, most of them were able to wash. But it all depends on the care too, what you have to do for them.

I think it will probably work. I'm not a Pollyanna, but I hope. I just hope they don't try to cut back on staff. I feel not bad today. I just hope they don't try to make us do more than what we can physically do, like starting with the working short again. That's really awful. When somebody calls in sick they don't replace and that's just brutal. They don't replace the first sick call. The second they try to replace but when you're working with the bare minimum.... We have, let's see, 32 patients and we have four modules – nine in each module on one side, and we each have one RN and one RPN. So on that side there are 18 patients and we have four staff.

Lifting, if I'm unsure I call transporters. I say, "I don't know how this person transferred so I'm calling you." You know, if they're a big person I'd rather have the two guys there. If the patient walks to the chair, fine – the next time I can do it. And pass that information along. But you're always yanking people up in bed or helping them out, or you're changing diapers. Some of the elderly ones who are a little demented too are fighting with you a bit. They're rigid, you're trying to get them over, and a lot of times you don't have someone handy to help you. So you do try to do it yourself, but you shouldn't.

I haven't been injured but people can be, sure they can. So it's just wear and tear. If I had been in here 30 years I'm sure I would feel a lot worse than I do. I've only been here for three years, but I can feel I'm getting varicose veins where I never had them before. At the VON you had time to sit down. You were in the car in between clients, so you had that time and you weren't racing around their house. You usually went in there, you did your treatment and it was one on one. In here, you're constantly on your legs the entire time you're here.

I don't think we deal with any bad chemicals or anything you have to worry about. I think the chemo floors would need to be more concerned, but they're probably quite educated. And you're using your universal precautions. So I don't think safety is a real problem. The only thing with the increased workload is that you're fatigued, there's wear and tear and you can hurt yourself. You can hurt your back more easily if you're exhausted. I don't feel like I'm in danger. I don't work in a Psych ward where you're worried about patients. I did get hit once, very hard. A patient just swung and hit me in the stomach. It was somebody who was just kind of out of control and we tried to settle him. I think as far as what was going on with him, he was a patient who was in a step-down unit and he was just out of it, really not himself. I don't know whether it was the medication. I just happened to go in to help and we were trying to get him into a chair to get him away from that step-down environment because they're all sick in there and he was creating – he just got his hand loose and whacked. It could have been anyone, I'm sure he wasn't even aiming. He was just flinging. But there are those hazards. I just put in an incident report in case anything came up, but I was okay.

I think the pay is okay. I suppose it could be better but I think for the top level it's okay. I think the increments should be eliminated or I think maybe within a year you really should be at top level. If you're doing the same job as somebody else, no matter how long you've been here, you should be paid the same. So waiting nine years to get to the top level I don't think is correct. A lot of the younger ones are going to the States because here they're making I think just a little bit over \$20 to start and you can make the equivalent of \$30 across the border. That's why they're going. And then once they're there, they are learning to like it and they stay there. So I don't really believe that they should wait nine years to get to the top level, not when you expect them to do the same job. And they do expect that. It's not like they're doing half the job or they're working with people who have a lot of experience. A lot of times they're put in charge. Some of these new grads have been in charge on different shifts – mostly midnights – when they've only been here a month or two ... and making the minimum amount. We have a supervisor on afternoons who is excellent, but she goes home around 11:30 or midnight. So the new grads could call their unit manager for support I guess but the unit managers are working the next day, so you're not going to call them every night for your run of the mill. And they can call doctors, but it's not like you can say, "Well, I'll just call and run this by them." No, they don't have that. And yet they're paying them the minimal amount.

I think now we're starting to see a little bit more of a trend for our nursing leadership to be around, just lately. To be accessible. Actually I think they're increasing. Our Unit Manager now is going to have just our floor instead of two floors. I think some responsibilities are being taken away. I think they spent so much of their time doing scheduling and doing non-nursing things and coming to bed meetings, and on and on, that they weren't so involved with the staff. You can't blame them, it's just that they had a lot to do too. But sometimes I think they have too much top level staff and if they had more staff that were actually doing the work it would be nice. It just seems like there's this one here and they have a boss and then there's another boss. I don't know, maybe they're changing now. Unless it's just for now when all these new staff are here that they've become more accessible because these new staff are being thrown into things too quickly. We have one girl on our floor who hardly speaks English. She's lovely, she's probably very good, but it's very difficult to understand her. Then you have new grads and they're nervous. I think the orientation should be longer. I think they're getting a couple of weeks.

I hope things do change because – and you hear this a lot – if you go to high school graduations you will see that there's not many people opting for nursing. There are so many different opportunities now than when we all came out. When I graduated from high school usually it was a teacher, secretary or nurse, but now there are just so many opportunities and there's so much that's negative about nursing. And now you want people to go four years. Four years! I mean, you could do so much.

And a lot of it is disrespect. You get disrespect from patients, from their families, and from the physicians and sometimes from your coworkers. They always say nurses eat their young. Have you ever heard that one? Oh, they're brutal. Really, they're not kind to younger nurses: "Oh, that was so stupid!" They have to have a chance to train and get some experience. I think a lot of the time you're being thrown in on your own and not being mentored properly. A lot of the girls who go to the States, they'll get months of orientation and mentorship. But [here] on the floor they just get thrown into it and ... a lot of yelling. People are afraid to call doctors because they're yelling and families are yelling because they think we're lazy – I mean, just because you're sitting at the desk charting doesn't mean you're not doing something. But it's frustrating. Because you want to be the best. You want to make everybody feel wonderful and it's really hard to take that kind of abuse.

I also think people change when they come into the hospital as patients. They have a different personality once they walk through those doors; it's "Me, me, take care of me."

I don't know why. It's funny. You could have almost a Code going on in the next bed and – "I need some attention here! I need some water!" We were putting an NG [nasogastric tube] down this one lady and we were having a heck of a time – she kept pulling it out. [Her roommate said,] "Well, nobody's helping me over here!" We said, "Well, we're busy right now. We'll be over there..." "Well, I haven't had anybody's attention over here and I need some water!" That's when you say, "And you wonder why people aren't going into nursing!"

I find as a nurse I get more respect on this floor. The Surgical floor was horrible. The Surgical guys were ignorant, obnoxious. They usually yelled. I think sometimes if you ask them something outside their field, it's easier for them to yell at you. Maybe they don't know the answers. I've even had a guy say, "Ah, you know, I'm just a poor dumb surgeon!" The Medical guys, they tend to explain things. Sometimes they're a little snotty. You know everybody has a personality and you can see their different personalities. Some of them like to be the showman, some like to be smart alecks. I like the respiratory staff, I learn from them. I find they are a big plus. Lab, you don't really have much to do with – you know, they're pleasant enough, but I don't really have any working relationship with them other than them coming to the floor. So that's fine. I like the nurses. The RPNs on our floor were excellent. It's really a shame. They were really good.

I think most patients appreciate the care. They can see how hard – but really maybe their expectations should be higher for themselves. I don't think they need someone in there handing them water and pushing their bed up for them when they can do all these things themselves but there are things that really.... When you have a proper staff you can look at your labs and you can do a proper assessment and you can ask the doctor appropriate questions. It's going to help in the long run. It maybe gets them out of there sooner. Like, if you're so busy and you get a lady with a Foley for a week you're just too busy to worry about

that. Today I was saying, "Well, let's get this out. Let's get her moving." So it's to their benefit I think to have the proper staff.

Relatives can be – I have mixed feelings about that. You know how you have people and they have family and you think, "Oh, no, here comes the family again..." Well, in one way they're right – they *should* demand the best. They should demand conferences with caregivers to know what's going on. And in some ways I think: "Haven't you heard? There's a shortage. What, do you think it's not going to affect you?" Sometimes they're more demanding than the patients because I think it makes them feel better and because they know that their loved ones should be taken care of maybe better.

You do receive acknowledgement the odd time. But I think maybe there could be more evaluation so you know where you stand. There's always that unknown: "What are they really thinking?" I don't know, I've never had an evaluation since I've been here. I think I had maybe one evaluation in 27 years at VON. You do receive verbal validation the odd time but I think it should be more of an ongoing ... I think people need to be told, "Oh yeah, that was good." I think people don't even think of it. It's easier to complain about something than to compliment. Don't you find that with anything? Even if you went into a store, I think people tend to complain more than they would say, "Oh, yeah, that was really great service." I think in general they should do it a little bit more.

I think it would be nice if the hospital would listen to their staff and get their input into what needs to be done. I'd like to see a little more confidentiality – we're giving reports and there's no door on back rooms. I'd like to see a little more concern with trying to be more confidential with reporting. I'd like to really see more education offered. You know, staff would go on their own time if they weren't exhausted from working, if education was provided. You could bring people into the hospital here for a few hours and teach. I find that we're really hungry for more education. It would be wonderful. Now you don't even get CPR. I mean, the factories get paid CPR! I know they're different, they're private and they're funded much differently but still it's pretty bad when the hospital doesn't provide CPR, I think.

VON was totally different in that we did a lot of palliative and that was very interesting and we were educated pretty well at the VON. They seemed to have more opportunities for us. Not to say that they paid for it but still we had more opportunities. Then again I don't really miss doing palliative. That's hard! I don't want to do that forever. It's sad, especially in the community. I had my own area and three patients died – one every week for three weeks. And these are people that I had for a long time. I found that very hard. And also we didn't have any sounding. You didn't have anybody to really hear you. The patients that die, the family gets to grieve and the relatives get to grieve and you get to go on to your next one. And you're only human. I don't know if you get any support here, like counselling or anything. I don't know how they do on the palliative floor, if they do get that close to the patients. They may, because they might be in there for awhile.

It's very isolated in Community Health. The odd time you can try to meet for lunches or something. Some developed friendships, but I didn't tend to – just working relationships really. The social part of hospital nursing is nice, but we don't tend to go out. I think everybody's tired and they're all trying to do so much. A lot of women are trying to run their households. They have kids and they have to work and it's difficult.

I think working at the hospital is more exciting than Community Health, though. Since I came to the Medical floor I've learned something every single day. Especially on the respiratory side because we do Rounds with the doctors every day at 1:00. They can be snotty at times but they do explain things and you're looking at x-rays and listening to them talk. On the Surgical floor you never went with the docs. You didn't have time. You didn't even have enough time to stand there and listen to them, so you weren't really getting that learning experience. So that's what I like about here and I wouldn't go back. I could have gone back to the community when they did start again. But I thought, there's no going backwards. Things aren't going to be the same. They aren't going to be the way they were and I thought, I have learned an awful lot here, and I like that.

When I was off [work], I thought – "I can't do anything else. I mean, I've done this for so long. I don't type. I'm not a teacher. I'm not going back to school at my age to get a different career. I only want to work maybe three more years." So that's what keeps me. Otherwise, I wouldn't miss nursing. No. Only because there's other options that I never even considered. I could have gone into police work or engineering; or I like math. But I didn't even really consider those at that time. That was a long time ago, eh? Like you weren't really seeing women go into.....more the adventuresome women. And I wasn't.

I think I'd like carpentry. I'd like to get a job where you can feel satisfied with a job well done. I think in nursing you don't get much feedback. You never hear "Oh, you did a good job." Today, though, we were doing Rounds and the doctor actually said to one of the nurses, "You're very good." That doesn't happen very often, but it would keep somebody going. I think you're just so worried all the time in nursing: "Oh, I don't know the answer. I didn't get that right." And you can't know everything. The doctors, they don't have a problem saying, "It's not my field." But you feel stupid if you don't have the answers to everything.

If I were financially stable I would leave nursing. Isn't that awful? If I won the lottery, no two weeks notice! But I'd probably miss it. I really do enjoy the learning. I must be interested in it. That's what I tend to read too. As much as you'd think you're going to get away from it you tend to read articles on disease, on different things. You do and you think, "Why do I do that?" Because that's what you're interested in. But if it gets too physical and I just can't do the job, I might have to leave earlier. Some days it was getting pretty bad. You just think, "I can't do this much more." I'm too tired to do anything else. Tired, just chronically tired. So if my legs give out or if it hurts too much to come to work, then I'd have to think about it. But hopefully I plan to work a couple more years.

I think we felt really let down by the government when we lost our jobs at VON. We felt like it was a slap in the face. We felt like we were really set up. They made these RPs, requests for proposals, so that we didn't stand as good a chance as some of the other agencies. And we were a big agency. VON had people who were full-time and they had commitments to their staff and they treated their staff decently. We all just felt like the government just slapped us right in the face. One of the representatives even said, "Well, they'll just pitter-patter over to the other agencies." We felt really let down by our own government – that we were disposable. That you can have a career and you're supposed to feel loyal and then all of a sudden everything's gone. I know it's the American way – the corporate way – but it's really disheartening and it really breeds disloyalty. These people who really feel loyal to their company and to the

institution as a whole, it really changed their attitudes. You think, “Well, they’ll just do it.” And they’re doing it here. Like all these RPNs who have been here for many, many years. They were in Acute Care settings. They specialized in different areas and now they’re sending them over to Rehab and Chronic Care. They don’t value their workers. I was really let down by the government. They do it to the ambulance people too: “Oh, well, this one is hiring you so you know what? Your vacation is wiped out.” It’s really rough.

### **Interview 8: Speeding up/Shorthanded**

*Stella Paskiewicz is close to the end of a nursing career that began 40 years ago. Although she feels well suited to her chosen career she is disappointed in what the job has become. Understaffing in her hospital is so severe that nursing workload has become astronomical. Not only is it nearly impossible for nurses to take their vacations, but, she says, “we have been told to come in when we’re sick because there’s nobody to replace us.” Even when there is no freeze on hiring, the institution seems unable to attract any additional staff at nursing job fairs.*

*She worries about the future of a career that she doesn’t regret choosing but that is now almost unrecognizably different than when she began. Supervising students under these circumstances is difficult and time-consuming, particularly when there don’t seem to be enough teachers available. Stella is concerned about accountability – who is responsible for the students? – and about the future of nursing in view of the fact that “the majority of nurses are all baby boomers. What will happen in any institution when the old ones leave?”*

*Though she enjoys nursing and says it has been a good career for her, she says she may elect to take early retirement to protect her own health: “I don’t want it to make me older before my time and it probably will do that if I continue working at the pace I am working at now.”*

Nursing is not what it used to be. Nursing has come to be a totally different job than I ever entered into many years ago. Every day is a different event; every day is physically and mentally demanding. I don’t recall lately ever coming home without being physically and mentally tired.

I would say the changes started roughly eight years ago. But in the past three years or so they seem to be just evolving quickly – too quickly. Speeding up, workload enhancing. Physically and emotionally demanding. Lack of staff, lack of enough people in the pool to allow full-time nurses to have time off. Lack of management to talk to, to express your opinions to, to voice differences to and just generally anyone there to listen to you.

I graduated in 1963. I have not been full-time all that time. I started and worked three years full-time and had my family and from that time up until 13 years ago I did part-time. Since then I’ve been full-time. That was way back in the time when you either became a nurse or a secretary and nursing always appealed to me. I don’t know, I guess I just liked to look after people. It seems to be my nature and I have always liked nursing. I have never wanted to do anything else. I did enjoy it very much – I shouldn’t say I did, I still do, but I’m very disappointed in what I do these days.

You go home every day knowing you haven’t completed your job. There is no way that you can finish your workload. You have to decide on what is most important and hopefully what is left isn’t and wasn’t that important because there is just too much for the workload, for the amount of nurses. The hospitals have cut and cut. You are portering and you are lifting, you are taking on the job of the orderly. You are everything.

We are RNs and RPNs [in our institution]. There are Registered Practical Nurses and ourselves. They have cut the porters and many, many days there won't be a porter. Of course that takes away from your work time, portering patients around. A patient going for a CAT scan, a patient going to minor OR for a procedure, a patient going to the OR, a patient being transferred to ICU, anything like this that might need a porter, there isn't a porter. Pharmacy brings up our medications and they are *not* in blister packs. They are individual bottles and we dispense that way. As far as intravenous medication, we have the mini-bags and we put our own antibiotics in them. They are not pre-poured or mini-bags aren't ready when they come to the floor. Drips, morphine drips, whatever you want, heparin drips – all of this is prepared by us on the floor. Taking a lot of time. I think it's a combination of things because you are taking orders, transcribing orders, giving out medications, running here, running there, starting IVs, taking care of codes – you're doing everything when there's not very many on the floor. That's what you do.

We have a long Medical floor, an active Medical floor, and one end is longer than the other. It's 45 patients in the whole unit, but at one end, for example, you would have 25 patients. And you have a Med Nurse and you have 4 RPNs for those. Each RPN has about 6 patients each and the Med Nurse is, of course, over all of those patients, where the medications are concerned.

The acuity is high, very high. You have very ill patients. We are the only active Medical floor in the hospital. It's a sort of almost a step-down from ICU or a step-up to ICU, whichever. So you do have very ill patients. The acuity has been increasing over the years with no extra staff.

I think that we need more staff. Of course, they say that there aren't any nurses to be hired. But sometimes they're just not hiring, for whatever reason I don't know. We have been told of late that there was a freeze on hiring, and then at other times we have been told that there aren't any nurses out there. At one point they were looking for nurses and couldn't find any.

They go to the job fairs. They said they were at the job fairs not too long ago but I don't see any extra staff after that point. We here don't seem to show as much encouragement for nurses to stay here, from what I understand. As a country. In the United States, their way is paid and they are helped to find lodgings and there are just many, many things to entice a young one to go off to other places. I think it depends on your make-up. These days are so different and they think differently these days than they used to years ago.

There have been people who have gone to the States in the time I've been here – yes, I have known some to travel. Some to go down to Florida, some to go off to Carolina and a few places. I was just talking to a few students the other day that were on the floor and several of them said that they were heading other places when they were finished. I don't know whether they just want something bigger. Our town is small. That could be the reason. But they don't say that they're going off to Toronto or London or any other place. They say they are going to the States, so something has enticed them to go that way.

I think that the pay is good. Of course, when I started back in 1963 I certainly didn't make the money I'm making today. We have come quite a long ways. I do feel that I earn every cent that I make, if that makes any sense. I certainly feel that I am worth what I make and many days I feel maybe I deserve more because of the effort I put out and the responsibility I take.

I think maybe we shouldn't be all paid alike. Since I have worked in ER and I have worked in ICU, I find that perhaps paying a nurse working in a long-term setting as much as she is making in ICU, that's something to look at. A nurse working in ICU has educated herself more in order to get in that position.

The majority of the people who are on my floor are basically much in the same salary range, by only a few years, and I think that most of us are at about the same level. I don't think honestly I know the range of salary. I think a lot of people would be happier even not talking about money. I think it's the workload. It's the workload that is getting to everybody these days. It's the sheer mental stress that is involved. You come home and you bring it home with you and you're just exhausted because of the workload. You bring the tiredness home, the stress levels home.

I work long days and every two weeks I do nights. Two weeks of days, two weeks of nights and so on. One floor has done self-scheduling because of the complete turmoil they were in. They seem to like that, but then it's a smaller unit. The twelve-hour schedule requires less nurses and there doesn't seem to be at this point anything that we can do about it [in our unit] unless we had extra nurses. If we had extra nurses maybe the scheduling could change. Frankly, I don't know if it would work on our unit because it's a larger unit and it might be more of a conflict because you've got so many different thoughts. Whereas the unit I'm talking about is much smaller – it's Intensive Care.

I traded when I went from part-time to full-time – I took a position. I was working a twelve-hour shift in Intensive Care and there was an eight-hour position, full-time, available and I took it to get away from twelve-hour shifts. But then of course my full-time went to twelve. I didn't save anything there, but it was a Medical floor I had started on years ago and I do like medicine, so that was okay. I think it's a challenge, you know? You've got someone in who's very, very ill and you can see them progress as you do the tests, you do the lab work, you do the medications and it is a challenge. I like it. I've always liked medicine.

You are with the doctors and you're ordering the lab works – you are pretty well everywhere. It isn't that you have different people in different areas – excepting that the lab work is drawn by the lab, of course. But you are in charge of the entire outlook, the entire picture. I'm quite happy with the way it is. We just need extra hands, we need extra help.

We need porters, we need RNs, we need more RNs and RPNs to create a pool so that when we have sick people we don't have to come in on our days off, which we're doing, and so that when we ask for a vacation day we can get it, which we are being denied. This summer looks really, really bad. You are just told that you have been denied because there's nobody to replace you, or sometimes you can trade with another person who might be good enough to trade. If you are on midnights, for example, and there isn't a person to replace you on midnights you could trade to days and then there might be someone in the pool that would do your days, and that's the way we exist. We have been told to come in when we're sick because there's nobody to replace us.

I don't think, considering our workload, that our level of absenteeism is bad. They did at one point hire a specific nurse to monitor sick time who was paid big money to do that. To monitor the sick time in the hospital, that was her job. And as I said, that was a high paying job and she set up a program: if you were off so many days it was so many points, and if you were off so many more days that was so many more points, and then you were given a warning. Usually if

you had more than three, four, five days, then you were flagged. These were quarterly setups. The reason it didn't go over and the reason it was looked down on by the nurses is because we found that they weren't even looking into the reason why you were off. People had been flagged and they'd been off for surgery or people had been flagged and their husbands had died and people had been flagged and on and on and on and on until it was totally ridiculous. And this drops the morale in the hospital very much. Between lack of staff, lack of coordinators to talk to, lack of holidays, lack of being able to get time off when you're sick – the morale has really dropped quite a bit. Right now anyone who can retire, it's looking very good. And ONA and the College and everyone else knows this, that the majority of nurses are all baby boomers. What will happen in any institution when the old ones leave? The young ones will come along and I won't want to be a patient anymore.

When I was being trained and I was being taught medicine I had my teachers from my school behind me. Now, on a floor, where I myself am giving out medicines to 25 people and I have to do it the best I can, sometimes it takes me a terrific amount of time because of the extent of the medicines and the type I'm giving. And all of a sudden I'm given a student to watch, which takes her three times as long as it would me, and medicines are not being given on time. The student is getting anxious. I'm getting very anxious because I would like to know who is responsible if she makes a mistake and there is no teacher to be found. They apparently do not have enough teachers to do this type of training any more. The courses are not set up the best, as far as I can see. They don't know where their teachers are half the time. Or the teachers who are coming along with them are people who have not worked in a hospital setting in the last five to eight years because they are totally baffled by the speed and the acuity and the need to get things done at a more rapid pace than they are used to.

I am still very unsure as to where the responsibility lies and it makes me very nervous when I have to go along with a student. People will not even take a student because of this. We have asked, they have told us that the college is responsible. We have been told that that is taken care of. But what is most upsetting is that I am trying to do my job shorthanded as it is and am trying to teach that student. Where is her teacher? I am not being paid to teach. I am being paid to work shorthanded as it is and I am doing the best I can. Where is her teacher and why aren't there more?

Recently I had a student. I assisted her with her meds and it took me twice as long as it would have myself. Then I usually return to the desk and assist the Charge Nurse because she is backlogged with orders. *She* was supposed to have had a student with her on the desk. So of course, her time was taken up trying to assist this student to learn how to process orders and I couldn't really help her because everything had to be passed through the student. Now there again, she was teaching, I was teaching and on a very rapid paced floor which was only putting us behind and making things sort of chaotic. It's not fair to the students.

We have a coordinator on pretty well every floor but she is not specifically patient-oriented. She does payroll, she does meetings, she does other things, but we need someone to speak to about patient care; we need someone to take over if we have to have someone speak to a family member that they want to direct their questions to other than ourselves. And when they are gone at meetings all the time, there is nobody.

The doctors again are so overloaded, particularly where I work, that you're speaking to the family. You're the doctor, the nurse, the coordinator – the everybody. Patients, I don't have problems with. It's the families who come in. Families are over-educated these days because they have all the information on their computers and they read, they see on TV, they come in and they are full of questions and there's just you to answer. You do the best you can.

It's not like it used to be years ago where you had visiting hours and the people came in and sat there and showed a little respect for the fact that you were trying to do the best you could for their family member. They come in these days and they are sitting on your shoulder ready to jump at you with anything. With regard to why you did this and why you didn't do that and why isn't the doctor there and what is the medication you're giving and why are you giving that and you are the reason that Dad has got worse. And nurses have been shoved, pushed by family members. We had a nurse that was thrown against a wall recently, just because she was in the wrong place at the wrong time. The family member was very unhappy with certain things and she happened to be there. In that situation, you pretty well just get out of the way. There is Security in the hospital and you can have someone removed if they are being a problem, but families are not easy to deal with these days.

I think a lot of people do understand your workload and they have said they could never believe the pace we go at and the load we carry. Others just are self-centered and demanding, you know, and that's the general public these days. Everyone is stressed. The kitchen is stressed. The laundry is stressed. Because we're all at the same level we communicate very well one with another because we understand each other's load.

Most of the doctors understand the load we have. They try to do their best, but their patient load is tremendous. People do express appreciation but – let's say not as much as maybe they should. For what's being done, there's not a lot of recourse back.

I have always liked nursing and I still like it. I might go into nursing again. I think I would understand it's a totally different situation these days than it was when I went into it. I don't know. I just feel badly that something that I truly liked is causing me to think more of retirement because of the pressure it's causing me and wondering whether it's injuring my health. It will eventually. I think that nursing is affecting everybody's health with the length of the shifts, the stress, the physical demand of the night shifts. It has to take a toll on someone's life. I just have a nurse's back and am emotionally exhausted every day. I come home and I think, "Now tomorrow when I go back I will be positive," but it takes me five minutes on the floor and I'm back in the same boat I was before. Because situations do not change.

A survey was done from Toronto. There was a nurse who came here and we were going to try and improve on certain aspects of nursing. We were going to pick one specific thing and try and improve on it. And after the survey was done and we all worked hard on it, it couldn't be done. It couldn't be implemented. And we as nurses said, "Well, maybe that will show the College – the University – whoever is looking into this, that the situation out there is pretty grave when you cannot take something and implement it because of lack of funds, lack of nurses, lack of interest by management." And it really, to me, did show something.

The other thing – we were asked to fill in surveys. We filled them in. I know a lot of people spoke very honestly about a lot of things. We keep getting asked questions and questions and questions, which makes me wonder ... the people who are asking the questions – I'm not wondering, I know – they have not been in hospital settings for the last eight years or they wouldn't be asking these questions. It's like trying to tell somebody what a different world is like. And answering these questions is not doing any good because they're not getting the true picture. Nursing is different these days and it's hard work.

I don't know whether more people have to come right into the workplace and see what actually is going on. You can't sit in an office from afar and judge what's happening these days. It is far different, I think, than what anyone can even imagine. And what the answer is I really don't know. I wish I did because it might change my feeling about the future. I just like to think that I could go to work and do my job and enjoy it like I have and know that on my day off, I could have my day off, and know that I can give care to the patients that I should be giving, or total care that I should be giving and not coming home thinking that I could have done a lot more and didn't have time.

I think that a lot of times management's hands are tied. From the funding, yes, and I think maybe they are trying to do something that is impossible to do. I think that's why they're busy all the time at meetings and trying to pull something out of a hat that's not there.

At a government level, there are a lot of promises. One in general is that there is going to be money and there are going to be nurses. But where is the money and where are they going to get the nurses? The nurses that are in the degree courses right now are not going to be out there for another four or five years and what are they going to do in the meantime? They're going to lose half of the nurses that they have right now before that five years is up. Because generally, as I said, they are scaring them out the doors.

I just think that people who want to be nurses, people who like nursing like I do, would be just as happy where they are today if there *was just more help*. If we could have more staff. Where the staff is coming from, I don't know. We've stopped these nursing schools from producing and there was a long period of time when we didn't produce nurses, then a lot of them that did come out of school went other places. Well, we're kind of in a crisis right now.

Workplace safety is greatly compromised – greatly compromised – because you don't have the staff to help with the lifting, you don't have the equipment because there are not enough finances to buy this equipment. Safety is very much an issue.

I've been in it a long time and I probably am coming to the end in another few years. I enjoy it. Physically I am a well person, but I feel that it is wearing on me and I may come to an end sooner if things don't improve. I don't want it to make me older before my time and it probably will do that if I continue working at the pace I am working now. I just want to do what part I can to improve on something that has been a good career for me. I really believe in nursing and I have really liked nursing and I am just disappointed at the situation that we are in right now.

## CONCLUSION

---

In spite of considerable research and frequent promises of change, the eight interviews in this study indicate that little has improved in the work life of nurses. The conditions under which nurses work have, if anything, deteriorated. High patient acuity and overwhelming workload head the list of factors that make nursing an increasingly difficult profession and a less than attractive option for new graduates in search of a career. These and many other issues must be addressed if a looming nursing shortage and further degradation of the health care system are to be avoided.

Although acuity and workload were the issues most commonly reported by the eight nurses interviewed, these were accompanied by a host of other problems: inflexible scheduling, abuse from both patients and relatives, lack of respect from all sectors, high potential for injury, insufficient or out-dated equipment, lack of access to nursing leadership, lack of educational opportunities, unsatisfactory hospital systems or physical layouts, absenteeism, inadequate training and orientation, and poor levels of patient care. These factors all contributed to the desperation expressed by many nurses, several of whom stated that they could foresee leaving nursing or taking early retirement because of overwhelming stress or physical breakdown.

It is important to find ways to retain senior nurses, who are now being driven to early retirement by the extreme physical and emotional demands of hospital nursing. Younger nurses, too, are subject to the negative effects of restructuring, cutbacks and instability. Nurses must be reassured that their concerns will be addressed; that they will not shortly fall off the political or institutional agenda; and that they will be considered active participants in the development of the health care picture in Ontario. Hospitals must aggressively solicit nursing opinion and be seen to respond to it promptly and with goodwill. Nurses must not feel they are at the low end of the hospital totem pole and that their wishes and needs are the last to be considered after every other interest group has been served. According to these interviews, only one of eight institutions canvassed was successfully soliciting nursing opinion, by creating an explicit policy of “town hall” meetings and staff surveys.

Almost all of the nurses interviewed said that they chose nursing because they wanted to help people. If they were thinking of leaving nursing, it was often because they could not provide a level of care that seemed to them adequate. Other reasons given for choosing nursing as a career included family history of illness, early experience in care giving, and a desire to be perceived as caring. Given the role that expressed altruism seems to play in choosing to become a nurse, it should not be surprising that decreased levels of patient care significantly impair nurses’ work satisfaction. The need of nurses to provide care may be an underemphasized factor in both the recruitment and retention of nurses.

Further research into many aspects of nursing work life and job satisfaction is necessary and should be ongoing, particularly as rapid technological development alters the nursing landscape almost from day to day. However, research findings must lead to real change, or cynicism and alienation will be the result. One nurse complained that people kept asking all the same questions over and over, but nothing changed. The need for research should not be used as an excuse for inaction. At some point administrations and governments must show their mettle and demonstrate that they are willing to “just do it” – and do it before it’s too late, and we are left with a health care system that is irreparably damaged.

## REFERENCES

- Advisory Committee on Health Human Resources. (2002). *Our health, our future: Creating quality workplaces for Canadian nurses. Final Report of the Canadian Nursing Advisory Committee*. Available from <http://www.hc-sc.gc.ca>
- Baumann, A., O'Brien-Pallas, L.O., Armstrong-Stassen, M., Blythe, J., Bourbonnais, R., Cameron, S., Irvine Doran, D.I., Kerr, M., McGillis Hall, L., Vezina, M., Butt, M., & Ryan, L. (2001). *Commitment and care: The benefits of a healthy workplace for nurses, their patients and the system – A policy synthesis*. Canadian Health Services Foundation & The Change Foundation. Available from [www.chsrf.ca](http://www.chsrf.ca) and [www.changefoundation.ca](http://www.changefoundation.ca)
- Bowling, A. (1997). Unstructured interviewing and focus groups. In *Research methods in health: Investigating health and health services*. Philadelphia: Open University Press, 336-351.
- Britten, N. (2000). Qualitative interviews in health care research. In C. Pope & N. Mays (Eds.), *Qualitative Research in Health Care* (2nd ed.). London: BMJ Books, 11-19.
- Burke, R.J., & Greenglass, E.R. (2000). Hospital Restructuring and Downsizing in Canada: Are Less Experienced Nurses at Risk? *Psychological Reports*, 87(3 Pt. 1), 1013-1021.
- Cockerill, R.W., & O'Brien-Pallas, L.L.(1990). Satisfaction with Nursing Workload Systems: Report of a Survey of Canadian Hospitals – Part A. *Canadian Journal of Nursing Administration*, 3(2), 17-22.
- Cohen, L., & Manion, L. (1994) *Research Methods in Education*. Third edition. London; New York: Routhledge.
- College of Nurses of Ontario Quality Assurance Program (2000). *Building quality practice settings: Practice setting consultation program information guide*. Toronto, ON: College of Nurses of Ontario.
- Greenglass, E.R., & Burke, R.J. (2001). Stress and the effects of hospital restructuring on nurses. *Canadian Journal of Nursing Research*, 33(2), 93-108.
- Heitlinger, A. (2003). The Paradoxical Impact of Health Care Restructuring in Canada on Nursing as a Profession. *International Journal of Health Services*, 33(1), 37-54.
- Keddy, B, Gregor, F., Foster, S., & Denney, D. (1998). Theorizing about nurses' work lives: the personal and professional aftermath of living with healthcare 'reform.' *Nursing Inquiry*, 6, 58-64.
- Letvak, S. (2001). Nurses as working women. *AORN Journal*, 73(3), 675-676, 678, 680-682.
- Marrow, C. (1996). Using qualitative research methods in nursing. *Nursing Standards*, 11(7), 43-45.
- Nicklin, W., & McVeety, J.E. (2002). Canadian Nurses' Perceptions of Patient Safety in Hospitals. *Canadian Journal of Nursing Leadership*, 15(3), 11-21.
- Price, B. (2002). Laddered questions and qualitative data research interviews. *Journal of Advanced Nursing*, 37(3), 273-281.
- Richards, H.M., & Schwartz, L.J. (2002). Ethics of qualitative research: are there special issues for health services research? *Family Practice*, 19(2), 135-139.
- Zboril-Benson, L.R. (2002). Why Nurses Are Calling in Sick: The Impact of Health-Care Restructuring. *Canadian Journal of Nursing Research*, 33(4), 89-107.

### Interview questions and prompts

#### Topic question:

What is your experience of being a nurse in the current work environment?

#### Areas/issues to be explored:

Workload

Nursing leadership

Accessibility to supervisors

Career mobility

Access to continuing education

Scheduling

Respect received from other nurses, staff, doctors, institution and government

Workplace safety (including verbal, physical and sexual threats, from coworkers or patients)

Rewards (wages and recognition)

#### Specific questions:

Has anything happened recently in your working life that made an impression on you or that you'd like to talk about?

Describe any issues related to your work life that are important to you. If possible, provide specific examples from your day/week/career.

Given the difficulties inherent in hospital nursing – why do you do it? What keeps you here? What would make you leave?

#### If interviewee is unresponsive to other questions or prompts:

Could you walk me through a typical day?

### Pre-interview instructions to interviewees

We're going to be talking about what it's like to be a nurse in today's work environment. We want to convey what this is like to people who may not be familiar with a medical setting. Please feel free to mention anecdotes and events from your work life as they occur to you. No detail is too small.

I'll be recording the interview, which will later be transcribed and developed into a narrative document consisting of nurses' voices. Neither your name nor the name of your institution will appear in any publication related to this interview. If we discuss your background or specific information about you, I will ask you afterwards what information should be included in any future publication and what should be left out.

Don't worry about silences on the tape. Just say things as they occur to you. If you think of something that relates to an earlier question, or something we were talking about half an hour ago, just say it. Don't be concerned about making sense or "sounding good" – your interview will be edited later for coherence and grammar.

You may see me taking some notes – these are just to remind me of things I want to ask you about later. If you want to ask me a question or take a break, just tell me to stop the tape.



Faculty of Nursing  
University of Toronto  
50 St. George Street  
Toronto, Ontario M5S 3H4  
[www.nursing.utoronto.ca](http://www.nursing.utoronto.ca)