"We Love What We Do"

ONA long-term care nurses share the pride they have in their work, and why they wouldn't want to be anywhere else

When the five Bargaining Unit Presidents on ONA's Nursing Homes Central Negotiating Team talk about why they continue to work in long-term care (LTC), a path none of them originally chose, a common theme quickly emerges: they love their residents and are proud of what they do.

"My residents are like family to me," began Shelley Vandenberg, RN, who worked in a hospital (during nursing school), private nursing and the community before moving to LTC 14 years ago. "I love the interaction. They can tell you so many stories; some talk about the war and struggles they had as children. We get to know them on a personal level because they stay longer. In fact, we've had some residents for more than 20 years."

Sandy Kravets, RN, who has worked in LTC for 38 of her 48 nursing years, wholeheartedly agreed, noting, "we watch our residents' grandchildren grow up. The family brings these babies in their arms, then they are walking, going to school, and before you know it, they've left home."

For residents without families, Judith Wright, RN, who likes to joke she is a 70-year-old nurse in LTC after retiring from a career in the hospital and community sectors, explained that nurses can help fill that gap because "there is a bond with our residents. In hospitals, patients come and go, but we really get to know ours individually. We are their advocates and we want the best for them."

That means going the extra mile, added Mary Clarke, RN, who made the switch to LTC after she lost her full-time hospital hours and bumped into part-time because of government cuts. "I enjoy helping my residents. If I see that one or two like to read, I'll bring in some of my own books so they get a chance to read something different. I love getting a pat on my hand from them."

Jean Kuehl, RN, who held part-time jobs in LTC throughout high school because her mother worked in the sector, can relate, stating, "If my residents are hurting, I can help ease that suffering for the most part. I can make them warm. I can get them something to eat. I can help them find something that's lost. I can help them with social activities. Those little things are all about quality of life. It's about making a real difference in their lives."

> ***« We have nurses go through orientation and say, "how do you do it?" The long-term care sector needs more RNs, bottom line. »***
>
> – Mary Clarke, RN

Judith Wright, RN, Region 1: "We choose to work in long-term care because we feel we make a difference to our residents and their families. We are very dedicated."

Jean Kuehl, RN, Region 4: "People think long-term care nurses just sit at a desk and supervise because these aren't acute patients. Nothing could be further from the truth!"

Shelley Vandenberg, RN, Region 2: "Each one of my residents is a person and I become very attached to them. They are my family and they are loved."

"A Stethoscope and Thermometer"

And, it's that difference that keeps these members in a sector that has come under intense scrutiny over the past year as a result of the Public Inquiry into the Safety and Security of Residents in the Long-Term Care System, which is examining the policies, procedures and oversight of the province's LTC homes. ONA had standing at the inquiry last summer and issued a series of recommendations to Inquiry Commissioner Justice Eileen Gillese to address the shortfalls in the sector.

Saying Good Bye

The best part of working in long-term care for these members – their residents – is also what brings the deepest sorrow.

"We lost quite a few residents last year," said Shelley Vandenberg, RN. "I realize it's very hard on the family, but it's not any easier for us. I cry too, and the families say, 'that shows that you loved our family member.'"

"You do develop relationships with your residents," added Mary Clarke, RN. "They almost become your own grandparents and when they pass away, it's devastating."

Jean Kuehl, RN, agreed, adding "I think that's when our nursing skills really kick in because we try to comfort the family."

The nurses are also able to comfort themselves in the knowledge that they have made their residents' final hours the best they can be.

"Residents are sent to hospital based on their advanced care directive," said Vandenberg. "Do Not Resuscitate does not mean do not treat; if they have pneumonia and would have quality of life, we send them to the hospital or have a nurse practitioner come in. If they had a cardiac event that they are not going to recover from and will not have any quality of life, most family members tell us to keep them comfortable at the home with the people that know and love them the best. It's a wonderful way for them to end their lives, with their nurses around them."

"The inquiry made me think long and hard about what I did today, did I do it according to the Ministry regulations, where is it on the priority scale, what am I going to do about it," said Kuehl. "It's made us fearful and anxious."

She's not the only one. Meeting those regulations, along with the College of Nurses of Ontario (CNO) standards, is a common concern ONA has heard from members who work in a sector the LTC Inquiry heard is woefully understaffed and underfunded. They tell stories of being the only RN on a shift in charge of dozens of residents and a support team of registered practical nurses (RPNs) and personal support workers (PSWs).

"Staffing is the number one issue in long-term care," agreed Wright. "To do a proper assessment can take at least 20 to 30 minutes, and then charting. Nurses deal with residents that become agitated, some of whom suffer from dementia, and documentation needs to be done. Nurses will assist when there is a shortage of RPNs or PSWs, who work so hard. When there is a crisis within a facility, often nurses are called immediately. Nurses will also help with resident care and meds."

"Maybe you have three hours for a

Sandy Kravets, RN, Region 5: "The first day in long-term care, I thought, 'if I make it here a week, that will be it.' Yet, here I am almost 40 years later!"

Mary Clarke, RN, Region 3: "I realized as soon as I moved to long-term care from a hospital that this is where I want to be."

medication pass in the morning and the residents are eating, but you can't do this in the dining room and you can't do that, according to Ministry regulations," Kravets noted. "We've also got a window of time to give them their meds, which is a CNO standard. So, you have all these residents to give meds to, but they don't always just take them. They can't swallow or they spit them out, and some like them crushed or need to take 20 pills one at a time. You can spend a long time with just one resident. If I am not giving meds, the RPN is, but I'm in charge of everything else. We don't have x-rays, MRIs or CAT scans to find out what's wrong with our residents. We have a stethoscope and a thermometer."

"Multiple Health Conditions"

Clark agreed, noting there is a general misconception about the role of LTC nurses.

"There's a stigma associated with working in nursing homes. Yet, we have the same skills as our counterparts, we just use them in different ways. We don't have doctors around all the time like a hospital, so when our residents present with worsening conditions, we do our oscillations and assessments to determine whether it's safe to treat them in the home or if we should send them to a hospital, while communicating with the family throughout."

"People don't realize that our residents have multiple health conditions," added Vandenberg. "Our residents can have eight to 10 diagnoses each. On the weekends, we are also responsible for all other departments, and 99 per cent of the time we are the maintenance person too."

It's no wonder then that attracting new nurses to the sector is no easy feat.

"With the Nursing Graduate Guarantee, new nurses used to have six months for orientation, which did the trick because they had a good handle on everything and were ready to go on their own," Kravets said. "But when a nursing home hires an RN now and they've got five days of orientation for two 12-hour shifts or three eight-hour shifts, they're lost. They tell us, 'I can't believe what you do.' So, they go somewhere else and get paid more with better benefits. Sadly, they haven't had the opportunity to stick around long enough to fully appreciate the benefits of working in this sector."

> ***« Our residents are sometimes up before breakfast. You instinctively know they are looking for a cup of coffee, and you just grab it for them because you also know exactly how they like it – and it makes a whole world of difference. Just a cup of coffee. »***
>
> – Sandy Kravets, RN

"Means the World"

But the nurses are optimistic that will change when Justice Gillese delivers the final LTC Inquiry report, including recommendations, to the Attorney General this summer.

"I hope what comes out of the inquiry is more hours, more nursing care and more funding," said Vandenberg. "They need to make it more appealing for a nurse to work in this sector."

Kuehl agreed, adding, "over the years, we have seen the Sharkey Report [which, in 2008, called for guidelines over the following four years to provide Ontario's LTC residents with up to four hours of care each day] and others call for more staff and more funding, but it just hasn't happened. It needs to happen now."

Until it does, the nurses said they don't have to look far for comfort.

"When you get a thank you from a resident or their family, it makes up for so much – for them to acknowledge and appreciate what we do means the world," said Vandenberg, while Clarke added "a smile from a resident who doesn't typically show any expression makes it all worthwhile."

"I would never go to another sector," concluded Kuehl. "Once I moved to long-term care, I never looked back. I love it."

To read these members' individual stories, along with additional information on the LTC Inquiry and ONA's recommendations, see ona.org/carenow