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MNA focuses on latest industry strategy to avoid ratios, boost reimbursements

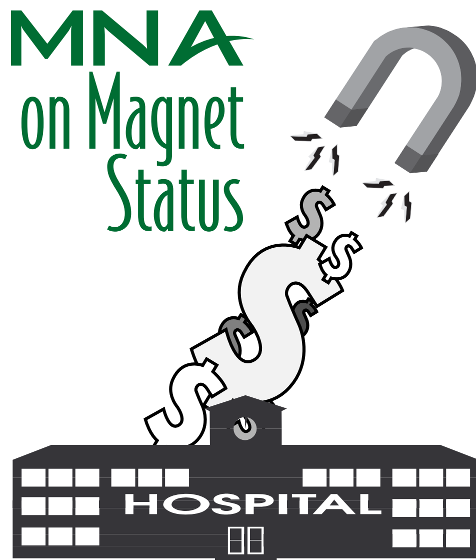
As nursing crisis continues, hospitals turn to Magnet program

By Mary Crotty
Associate Director of Nursing

In the wake of an onslaught of studies and reports detailing deplorable nursing care in hospitals and a massive exodus of nurses who are refusing to work under such conditions, and in the face of a growing movement by nurses, the public and legislators for the imposition of mandated RN-to-patient ratios to correct these deficiencies, the hospital industry has increasingly turned to a voluntary "JCAHO-like" process of accreditation and validation of its nursing programs. This designation, known as "Magnet recognition" has been around for years, but more recently has been embraced by hospital and nursing administrators as a means of boosting public confidence in their nursing care, improving retention of its nursing staff and, perhaps more importantly, increasing its reimbursement for services by the federal government and private insurers.

Here in Massachusetts, two hospitals—Massachusetts General Hospital and Winchester Hospital—have achieved "Magnet recognition," and a number of other hospitals are involved in the process of seeking recognition. Hospitals formally seeking recognition where the nurses are represented by the MNA include Jordan Hospital, Dana Farber, Caritas Norwood, Newton-Wellesley and Northeast Health System *(see associated story on Page 10 for details of Northeast Health Systems' pursuit of Magnet status)*.

In response to this activity, many MNA members have asked for information about this program: what it is, what it means for nurses, and more importantly, for information on its viability as an approach to addressing the problems nurses face in their practice and in their workplace. For unionized nurses, where the union is the primary vehicle for addressing concerns of nurses, nurses have questioned if and how the Magnet program can be incorporated into the labor-management process.



"We have real concerns about the legitimacy of the Magnet program, especially in light of the fact that it is yet another expensive, consultant-driven process that is being used to give the illusion of nurse empowerment," said Karen Higgins, RN and MNA president. "The fact that Magnet status is being used as a public relations gimmick to avoid providing safe staffing levels and that it is trading on the public's trust in nursing as a vehicle for marketing have raised concerns among our members and the Board of Directors."

The MNA's Board of Directors started an extensive evaluation of the Magnet program and its impact on nursing in general and MNA members in particular. This issue of the *Massachusetts Nurse* is devoted to an initial and detailed backgrounder on the Magnet program for our members. In the coming weeks, the Board will be finalizing and producing an official position statement on the program. In this issue you will find a history of the Magnet program; an analysis of how the Magnet program and unions match up; and a first-hand account of one MNA bargaining unit's experience with the Magnet process.

What is a 'Magnet' hospital?

In the early 1980s, in reaction to pressure to resolve a nation-wide nurse staffing crisis, the American Academy of Nurses (AAN) identified a number of hospitals that demonstrated a better-than-average ability to attract and retain professional nurses. They also studied factors associated with higher staff retention rates. The term "Magnet" came into popular

*See **Magnet**, Page 12*

Government report finds JCAHO more 'lap dog' than 'watch dog'

By David Schildmeier

As hospitals continue to promote their "quality care" based on accreditation by the Joint Commission on Accreditation of Health Care Organizations (JCAHO), the Government Accounting Office (GAO) has released a report that found that JCAHO regularly failed to identify "serious deficiencies" at hospitals—problems later found by state inspectors that could "potentially compromise patients' safety."

In response to the GAO report, a bipartisan group of lawmakers introduced a bill under which Medicare could restrict or remove the authority of JCAHO to accredit hospitals.

"Congress expects the Joint Commission to be a watchdog," said Sen. Charles E. Grassley, an Iowa Republican and one of the bill's sponsors. "It looks like the Joint Commission is instead a lap dog."

JCAHO is a private nonprofit organization that has been granted the authority to ensure that health care organizations meet the patient care and safety standards that are required in order to receive Medicare payments—a monetary figure that totals more than $109 billion annually. Here in Massachusetts, the Department of Public Health accepts JCAHO accreditations, which occurs every three years, as deeming a hospital "safe." The DPH will only investigate the quality of care at a facility after something terrible has occurred.

The organization has long been criticized for its lax system of oversight, and in 1999 a Department of Health and Human Services report issued a scathing indictment of the JCAHO process of accreditation, saying it failed in its mandate to protect the safety of patients and was too closely aligned with the industry it was charged with overseeing.

Nurses are among those who have long criticized JCAHO and the system of oversight for the hospital industry as a complete joke and an utter failure.

"Every front-line nurse knows that JCAHO is a total joke," said Karen Higgins, RN. "The hospitals are given notice of pending surveys, and they spend months preparing to get ready. Staffing always improves around the time of a JCAHO visit, and it goes right back to normal (usually bad) immediately after. What good is a voluntary system?"

The credibility of a voluntary process of accreditation takes on added significance for nurses as many hospitals are moving to the "Magnet Program," which is a JCAHO-like process that was created by ANA and that applies a similar process to nursing.

Based on a survey of 500 hospitals inspected by JCAHO between 2000 and 2002, the report found that the organization failed to identify 167 of the 241 deficiencies state inspectors later found at the facilities, or 69 percent of the total. Deficiencies that JCAHO failed to identify included a Texas hospital that failed to manage a serious infection control problem; a California hospital that had no system to ensure sterilization of medical instruments; and a another Texas hospital that administered medication without a

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Safe RN Staffing Starts at the Ballot Box

Vote

Tuesday, Nov. 2

See Page 6–7 for details.

For the latest developments impacting nurses, visit the MNA Web site, *www.massnurses.org*

Nurses' guide to single-payer reform

Incremental approaches to solving the health care crisis won't work

3 failing prototypes

By Peggy O'Malley

In reading newspapers or reviewing any policy initiatives that address covering the uninsured, you often see a number of approaches. Of all of them, only single payer guarantees truly universal coverage that assures high quality, affordable care for all.

All other approaches are "incremental." They include these three prototypes:

1. *Expansion of Medicaid and Children's Health Insurance Plans along with new tax credits (usable only for health insurance) provided to moderate income individuals to enable them to purchase private insurance.*
2. *"Employer mandate" combined with expanded Medicaid for the unemployed. A variation to the employer mandate is a "pay or play" requirement whereby employers who choose not to provide insurance would have to pay a payroll tax instead to cover the costs of their employees' coverage through the public program.*
3. *"Individual mandate" with new tax credits, again usable only for buying health insurance.*

In its comprehensive report, "Insuring America's Health," the Institute of Medicine concluded, "…further efforts to gradually expand coverage through incremental reforms are unlikely to succeed."

Why? Because incremental reform leaves the current system of private insurance—with all of its administrative complexity—intact. In fact, the incremental approaches provide a bonanza to insurance companies. Because of that, expansion of coverage will cause higher costs and/or lower quality while still leaving millions uninsured.

Soon you are likely to hear about a full scale effort for Massachusetts to adopt the "pay or play," or employer mandate, plan. We've found that the following article, written for the members of the California Nurses Association by its executive director, Rose Ann DeMoro, gives a clear explanation of the inherent problems with such a "pay or play" scheme.

Pay or play—a useless diversion

By Rose Ann DeMoro
Executive Director, California Nurses Assn.

At a moment when the public response to the present managed care system of delivering health care services ranges between apprehension and disgust, and support grows for doing something really meaningful to change the situation, along comes something with the catchy title: "pay or play."

Pay or play is simply a rehash of the notion that we are entitled to all the health care we can afford. As another health insurance scheme its most distinguishing feature is that it is not universal health care. That is, it's a counter to the principles of a "single payer" health care arrangement. Rather than challenging the dominant role of the insurance companies and health maintenance organizations in determining who receives health care and how it is delivered, it perpetuates it. Even worse, pay or play will most assuredly accelerate a process already underway under the HMOs' reign—that is, the creation of a multi-tiered health care system guaranteeing that that those with the lowest incomes will receive inferior care.

The basic idea here is that all employers would be required to offer health insurance to their employees ("play") or pay a tax into a government fund that will provide a health plan to uninsured people. As embodied in legislation currently before the California legislature, the government would cover only uninsured people who are employed.

The employer mandate has been praised by the leaders of some unions in California and elsewhere for expanding the existing method of job-based health coverage, the primary source of health benefits in the U.S. Actually, health care through insurance linked to employment has been the Achilles heel of health care in our country. Five decades or so ago when the labor movements of most of the rest of the industrialized world were campaigning for and winning universal health care, we settled for insurance linked to employment. For many, coverage was secured as part of union contracts. Left out, for the most part, were many of those employed by small employers and the unemployed. The limitations of the system are now being underscored by the existence of 42 million people in the country with no insurance and the rush of employers to shift more of the financial burden onto workers or to pull out of the system altogether.

A quick look shows that the "play or pay" employer mandate offers much less than meets the eye—to employees, retirees, the unemployed and even to many employers. For instance:

- Employers are mandated to offer health plans to their employees, but the individual employee may not be able to afford the deductibles or the co-pays for the plan his or her family needs.
- No protection is provided at a time when many employers are reducing benefits, increasing co-pays, or dropping coverage for employees altogether. A Bureau of National Affairs survey in January found that higher deductibles are a bargaining goal for 43 percent of employers with such provisions, and 17 percent without deductibles intend to introduce them.
- The multi-tiered marketplace of insurance plans—the very opposite of a single standard of care—pushes the least advantaged workers into the lowest tier, into underinsurance, into lesser quality care.
- Employees will have to guess and gamble which plan is best for themselves and their families (if it even covers dependents): a plan that pays routine expenses but quickly maxes out on total coverage, or a plan that drains money from the employee's pocket in return for major medical protection in the event of highly expensive treatment.
- Employees who lose their jobs lose their coverage, too. When and if the employee finds a new job, his/her physician or other health care providers may not be available through the new employer's plan.
- For employees in unions, the exact terms of benefits remain an element of collective bargaining. The employer still whipsaws employees between wage gains and health coverage.
- The multiplicity of health plans and the expanded demand for health insurance continue to eat up precious dollars in administrative duplication and competitive marketing.
- If retirees are left out of the mandate, they are left with no coverage beyond Medicare, which has huge gaps, such as prescription drug coverage.
- Rising unemployment throws more people out of their employer coverage, forcing them to rely on programs such as Medicaid, which is currently facing cutbacks due to state budget deficits.
- Small employers in particular face high cost and administrative hurdles arranging coverage for their employees.

The barebones nature of a program financed by employer taxes cannot provide full coverage to vast numbers of people. A number of them wind up in emergency rooms— the most expensive way of delivering care. Thus, the problem of "uncompensated care" remains, resulting in continued cost shifting by hospitals and other providers and raising the prices charged to more generous employers.

An employer mandate does nothing to control skyrocketing health care costs. According to a survey by Mercer Human Resources Consulting, premiums for job-based health coverage increased by an average of 14.7 percent in 2002, and are expected to go up another 14 percent in 2003.

An employer mandate leaves the failing and corrupt health care industry intact. It does nothing to crack down on corporations like Tenet Health care that have been alleged to exploit and defraud the current reimbursement structure. It does not crack down on HMOs that have dropped millions of seniors from Medicare plans. It does not challenge the pharmaceutical industry, which chooses only to develop medications that produce the most income or government subsidies.

An employer mandate fails to resolve systemic problems of today's health care. It does not rectify abuses by HMOs that have prompted a grassroots rebellion and demands for fundamental change. Play or pay does nothing to improve the deteriorating patient care conditions in hospitals and nursing homes or to protect patients from unsafe staffing and medical errors. It offers no plan for reversing the growing closures of hospitals and emergency rooms. It is another band-aid to be applied to a discredited and dysfunctional system. It is intended to sidetrack the growing public embrace of the idea of universal, comprehensive health care for all. ■

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"Your insurance company is in Chapter 11. We're going to need that liver back"

President's message

President's address to the membership at the 2004 MNA Annual Convention

The following is the address that Karen Higgins, RN and MNA president, gave at the annual business meeting on Oct. 7 during this year's MNA convention.

Since our last convention, the Board of Directors convened 11 times for regularly scheduled meetings. The Board continues to work to make MNA the premier nursing organization in Massachusetts by working for and responding to the needs of our members. Our mission remains focused, with the following purpose:

- Protect and promote the profession of nursing.
- Accept and embrace the nurse's role as a patient advocate.
- Promote the access of quality health care for all.
- Protect the health and safety of nurses in all work settings.
- Enhance and promote the economic, health and general welfare of nurses.
- Promote the education of nurses, fostering clinical experience and activism on behalf of their patients and practice.
- Provide and respect workplace democracy for all eligible nurses who desire to exercise their right.
- Work in solidarity with any and all nurses who share these values for the survival of nursing locally and nationally.

Our primary goal this year again remained the passage of RN-to-patient ratio legislation. With all of you, as well as all the departments, structural units and Regional Councils, we did get our bill favorably reported out from The Joint Health Care Committee. With all of your phone calls and post cards and political activism we pushed forward against what was thought to be immovable forces to get our amendment into the Senate budget and very close to becoming part of the state budget. We made it over so many hurdles, but we are not finished. Together we will get this bill passed. You, the members, have made it clear that this remains a priority and we remain committed and will not stop until we have safe staffing legislation.

Karen Higgins

We continue to work on addressing issues that affect us as nurses and the patients we care for, such as workplace violence, and are looking at ways to be proactive in reducing and/or preventing workplace violence. We are continuing to keep abreast of bio-terrorism preparedness and the many other issues of health and safety that affect us every day. This includes a growing focus on the prevention of back injuries for nurses.

Knowing that we are strongest when working in coalition with other groups with similar interests and goals, the MNA has forged strong bonds with our allies for quality health care and social justice for all. More than 70 organizations belong to the Coalition to Protect Massachusetts Patients, a group we formed to help promote and pass safe staffing legislation. We continue our commitment to MassCare, an equally large coalition of groups seeking single payer health care reform, as well as work with the Jobs With Justice coalition, which has made health care a key issue over the past year. As seniors are a natural ally of nurses, we have worked closely with the Mass. Senior Action Council to win affordable prescription drug coverage for seniors. And, working with all of these groups and coalitions, we were part of the successful campaign to pass the initial vote of placing a question on the 2006 ballot that would make universal health care a right to all under our state constitution.

We are now having annual Chair Summits to reach out to the local unit chairs to bring them together to set up the goals they want, meet any needs they have, and to discuss issues of concern. It is also a forum to be able to educate and address issues of both labor and nursing practice that are before us. We are also in the first phase of getting the labor institute started and plan to expand this comprehensive education program with members' input.

We are transitioning from Districts to Regional Councils. This will give every local bargaining unit an opportunity to work and build relationships with other local bargaining units, as well as local legislators and community leaders to build the support they need during difficult contract negotiations, threats of hospital closures and any other issues facing members to better advocate for the patients we care for. This will also be a place where the bargaining units and members within those Regions can use their Regional funding towards issues and programs that are directed at meeting their local needs. I encourage all the local bargaining units to get one of their members to represent them on their Regional Council.

I would like to thank all those involved in this transition for their hard work and commitment to making the Regional Councils reflect and respond to the needs of the members and bargaining units they represent.

We continue to watch managed care and the free market industry model decimate health care in Massachusetts. We are continuing to see our members struggle to maintain safe work places and maintain safe practice and fight to advocate for patients. They fight to ensure the rights for all their members and this Association continues to do everything it can to support every bargaining unit's right to fair and equitable contract. I congratulate all of you who have struggled long hours, days and months to make sure that both nurses and patients are taken care of and a fair contract was reached. We realize that it is not just settling a contract, but the continuous need to enforce it that is never ending. In response we have been increasing our staff to better able to assist our local bargaining units. We are also increasing programs to support these efforts.

As the nursing workforce ages, a key part of our support for bargaining units in the coming year will be to work toward guaranteeing a dignified future and secure retirement for our members through the negotiation of landmark language on retiree health and pension benefits through incorporation of Taft-Hartley plans jointly governed by the MNA with multiple employers.

We continue to work with our Unit 7 e-board and members who are under continuous assault fighting state budget cuts. These cuts are having devastating affects on those who are under state care and are dependent on the services that are provided by our Unit 7 health care professionals. They are fighting to keep resources and facilities open to those they care for and at the same time are being downsized, positions are being cut, and mandatory overtime is increasing.

All of this is putting both patients and staff at risk and to top it all off they are public sector employees and cannot strike. They are in contract negotiations now and the governor is seeking more than 40 proposals that if accepted, would remove nearly every union right of our public sector workforce.

The state's treatment of our public sector members is a disgrace, and the MNA will continue to support and assist Unit 7 in their fight to care for their patients and make sure patients are safe, and that they retain each and every right they have fought so hard to attain.

We will expand our support for all nurses' efforts to unionize believing this makes us a stronger and more effective force on health care issues and better able to advocate for both patients and nurses. Believing this, we continue to support an organizing department to be able to accomplish this. We will remain active on the national front, working with other independent nursing groups with the same core values on frontline nursing issues at a national level. We recognize the need to have a presence in Washington and do so through the AARN making sure that the over 80,000 frontline nurses represented are heard at a national level.

These are just some of the MNA's activities over the past year, and I believe they are reflective of what our members asked of us. But as we complete the first 100 years of caring for the commonwealth, I believe the nurses and the association need to also think of the future. We need to think of what we want to accomplish and where we believe we should be as an organization.

I thank all of you for your hard work advocating for safe patient care and fighting for the future of nursing. You are making sure frontline nurses and health professionals are being heard and seen as leaders in health care and because of all of you we will have safe staffing ratios in Massachusetts. As your elected leaders we will continue to work on behalf of all of you. ■

Health premiums rising

According to a benchmark study by the Henry J. Kaiser Family Foundation and the Health Research and Education Trust, employers' health premiums rose 11.2 percent this year—a statistic that reinforces voters' concerns about the U.S. health care system. This marks the fourth consecutive year that premiums have risen more than 10 percent.

Premiums for family coverage have soared by 59 percent since 2000, to $9,950 this year—far more than inflation or average wage increases.

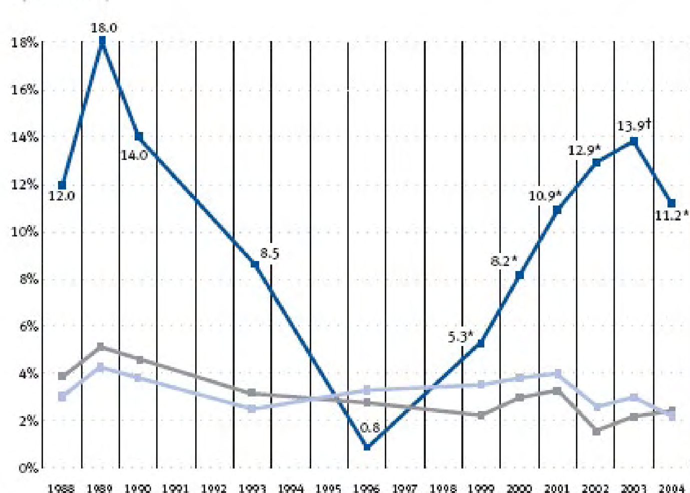
"It's these out-of-pocket costs that are driving voter concern in this election," said Drew Altman, Kaiser's president. The study's findings were released Sept. 9.

Particularly hard hit are small employers: only 63 percent offer health insurance, significantly fewer than in 2001.

Healthcare analysts and economists said neither major party candidate is directly addressing spiraling premiums, which require taking on drug companies and healthcare organizations.

"Healthcare premiums are one of the major issues affecting a real decline in people's standard of living," said Heather Boushey, an economist at the Center for Economic and Policy Research, a Washington think tank. "With wages down and health costs up, workers are getting it from a number of different ends right now."

Source: "Health premiums jump 11.2%" by Kimberly Blanton, Boston Globe; September 10, 2004.



Labor Relations News

Problem puts patients, staff and local community in jeopardy

Survey finds Taunton State Hospital staff believe management is dangerously understaffing the hospital

A recent survey of nurses and health professionals at Taunton State Hospital (TSH) found that a shocking 97 percent report staffing conditions that are dangerous, risking the safety of patients and staff as a result; nearly 90 percent report working conditions that prevent them from providing care up to their professional standards; and nearly 80 percent report that they have/are considering leaving the facility because of the unsafe conditions.

After more than a year's worth of meetings with nursing administration and management at TSH regarding the issue of understaffing and its impact on patient safety, nurses and health professionals represented by the MNA recently announced the results of an in-hospital survey that aimed to better gauge exactly how pervasive the issue of understaffing has become, and how it is impacting the safety of TSH patients, staff and the larger Taunton community as a result. In addition, they recently completed a petition drive that yielded hundreds of signatures from TSH employees. The petition—which called for the administration at Taunton to provide safe and consistent RN-to-patient ratios, as well as appropriate numbers of LPNs and mental-health workers in order to end the dangerous conditions that patients, nurses and professionals face on a daily basis—was delivered to TSH administrators in late September.

Michael McCarthy, RN and chairperson for the MNA at Taunton stated that, "If TSH management maintains its current staffing practices, they run the risk of leaving room for a major mistake to be made. The potential for disaster is there. For example, understaffing contributes to the inability of RNs to adequately assess patients for changes in mental status, or behaviors that indicate what safety interventions are needed."

More than 75 percent of those RNs who received the anonymous survey responded. Key results included:

- 97 percent of respondents believe that management is dangerously understaffing the hospital, risking the safety of patients and staff as a result.
- 95 percent believe that staffing levels have been chronically inadequate for the last two years.
- 89 percent felt as though their working conditions force them to provide a level of care that is below their professional standards.
- 100 percent said that they do not feel that they have sufficient time to provide the level of care that their patients require.
- 92 percent said that they do not feel supported by the nursing department at TSH.
- 78 percent said that they have seriously considered leaving TSH.
- 54 percent had been the victim of physical abuse at TSH.
- And a shocking ***97 percent*** of respondents know of a co-worker who has been the victim of on-the-job violence.

According to the most recent medical research, this chronic understaffing is guaranteed to have an overwhelmingly negative impact on patient safety. In fact, survey results alluded to this happening at TSH already—with most respondents reporting that they have seen a marked increase in the number of patient assaults on staff; patient self-injuries; re-admissions; and medication errors in the last two years.

Concern for the patients, concern for the community

"Taunton State Hospital is meant to provide services and care to a population of patients that has acute mental health needs and require a high level of attention and care," said Jesse Hill, an RN and vice chairperson for the MNA unit at Taunton, as well as a recent recipient of a 2004 Employee Performance Recognition Award from the Department of Mental Health. "In addition, we know that any mental health facility is best able to provide these types of services when it has appropriate RN-staffing levels along with appropriate levels of support staff. If things were done right, there would be consistency in staffing levels on a day-to-day basis. But this is not what is happening at Taunton. Staffing is unpredictable at best, and it is often unsafe."

According to Hill, this also puts another population at risk: the greater Taunton community as a whole. "One of the unique things about TSH is that there are a significant number of forensic (court-involved) patients being treated here. In these situations, the issue of understaffing takes on even more importance."

"We've discussed all of these issues with key TSH administrators numerous times over the last year," said Bill Fyfe, an RN at Taunton State and president of the executive board representing health care professionals employed by the commonwealth, "and we hoped to have made more progress on them by now. But, to some extent, administration says that they are bound by the budgetary constraints placed upon them by the Department of Mental Health. If that's the case, then TSH is part of something even bigger that is in need of urgent repair. And until that happens some of our state's most at-risk citizens will continue to suffer the consequences."

"Unless something is done and done quickly to improve conditions at this facility, we are very fearful that something could go seriously wrong at this facility—a facility that cares for some of the region's most severely mentally ill patients, including forensic patients," added Fyfe. "We have been trying to work with management to convince them to fix these conditions, but they have failed to address our concerns."

Nurses at TSH say that the survey results are compounded by the fact that TSH has seen a dramatic and disturbing turnover rate in its nursing staff since the issue of understaffing became so pervasive. In fact, one informal evaluation showed that approximately 50 MNA-represented registered nurses have left TSH in the last four years—with about 30 of these nurses leaving in the last 12 months.

'What we have is the equivalent of a mass exodus of nurses from Taunton State," said Ellen Farley, an RN and the membership chairperson for the MNA at Taunton."

"Because conditions are so unbearable, nurses are leaving the hospital in droves" added Karen Coughlin, an RN and the bargaining unit's secretary. "And we're ready to consider as many options as possible in order to make it known to administration and DMH that the conditions that have led to this exodus cannot continue." ■

MNA on Beacon Hill

DiMasi replaces Finneran

New speaker elected in House of Representatives

Massachusetts House Speaker Thomas Finneran announced last month that he would resign as speaker to accept a position in the private sector. Finneran will remain a member of the House throughout the remainder of this year.

Legislators voted to elect Rep. Salvatore DiMasi, D-Boston, who has been House Majority Leader for the past three years as the new speaker. For the last three years, DiMasi has been the House majority leader, acting as Finneran's second in command and vote counter when the Democrats needed to ensure a victory on the House floor. DiMasi is viewed as more progressive on social issues, health care and human services than Finneran and has vowed to have a House of Representatives that is more open and accessible.

MNA will be seeking the support of the new speaker as we push forward in the coming legislative session with our policy agenda, advocating on behalf of safe patient care. DiMasi will be in a much more visible public role, as the face of the 160-member House of Representatives, with the responsibility of negotiating with Senate President Robert E. Travaglini and Governor Mitt Romney, a Republican. ■

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MNA
Massachusetts Nurses Association

NLRB rules in favor of MNA in unfair labor practices by Baystate Health, Franklin Medical Center

The National Labor Relations Board (NLRB), Region 1, recently issued a complaint supporting charges of unfair labor practices filed by the MNA against Franklin Medical Center, Baystate Health Systems, and Baystate Visiting Nurses Association and Hospice. The complaints charge that Baystate Health Systems violated the National Labor Relations Act (NLRA) by relocating visiting and hospice registered nurses from Franklin Medical Center (FMC) to another location and by denying the nurses their right to be part of the MNA and to work under the MNA/FMC union contract.

The NLRB issued a complaint on all the of the MNA's consolidated charges; has recommended that Baystate and its affiliates recognize the MNA union contract and remedy its unfair labor practices; and has scheduled a hearing relating to these matters before an administrative law judge on Oct. 18, 2004.

The MNA filed unfair labor charges against a unit of Baystate Medical Systems in Springfield and Franklin Medical Center (FMC) in Greenfield. when they eliminated the hospital's visiting nurse and hospice units. The FMC-based units included approximately 20 registered nurses, all of whom were protected by a collective bargaining agreement that had been negotiated on their behalf by the MNA.

Near the time that FMC announced the closure of the unit, it also announced that its parent company—Baystate Health Systems (BHS)—would relocate them to a new office in Sunderland; that BHS would combine these MNA-affiliated nurses with those from another (non-unionized) Baystate Hospital (Mary Lane Hospital); and that it would provide the *same* level of services to the *same* patient populations in order to guarantee quality care to patients whose well being depended on the care of visiting/hospice nurses.

While preparing to transition to the Sunderland location though, the nurses from FMC were made aware of a unique fact that seemed to affect only them as unionized employees: that their MNA/FMC contract would not be recognized by Baystate at the new Sunderland location, and that they would lose all their associated benefits and rights as a result. Meanwhile, nurses from Mary Lane Hospital were transitioning to the Sunderland office with all of their benefits and seniority levels intact—a move that clearly reflected unfair labor practices for the nurses and MNA alike.

"Hospice nurses do what we do because we love it passionately and because we're able to help patients at a time when they need a really unique level of care," said Janice Fisk, a hospice RN and the former bargaining unit representative for the hospice group prior to its removal from FMC. "That is why more than 90 percent of the nurses in this unit moved to the new Sunderland location. But doing so wasn't always an easy decision."

"Many of those nurses gave up 12-plus years of seniority, which, for some, meant losing hours of accumulated sick time and weeks worth of vacation," added Joanne Calloon, an RN and co-chair of the FMC bargaining unit. "For others it meant taking an hourly pay cut that was significant enough that they needed to take on more days per week. And often the changes meant that some nurses were no longer eligible for certain benefits. It was frustrating because they had all of these things protected when they were at FMC, which is owned by BHS. But now that they're doing the *same* job for the *same* patients via another BHS-owned facility, they're no longer protected by their negotiated contract. What's even more frustrating though is that the non-unionized nurses who moved to the Sunderland office from other facilities arrived with their benefits and seniority levels intact."

This discrepancy in treatment/recognition led the NLRB to evaluate the operations and services of BHS and FMC, as well as other pertinent affiliates, and it was determined that they "constitute a single-integrated business enterprise and a single employer." As a result, the FMC bargaining unit "constitutes a unit appropriate for the purposes of collective bargaining."

The NLRB also said in its recent ruling that "the respondents (BHS, FMC, etc.) granted preference in terms and conditions of employment at its Sunderland facility only to its employees who did not engage in union activities or belong to the FMC unit." In addition, the NLRB ruled that the previously outlined conduct was and is "inherently destructive of the rights guaranteed" to union employees.

"Based on this level on conduct, BHS—with full support from FMC—has been interfering with, restraining, and coercing employees in the exercise of the rights guaranteed under their contract," added Shirley Astle, the MNA Associate Director who works with the unit at FMC. "It's a union-busting effort in its most pure form."

For Elaine Lemieux, RN and the former bargaining unit representative for the VNA group prior to its removal from FMC, the decision by BHS to alienate its unionized nurses represents something even more unnerving: the potential loss of excellent, dedicated nurses. "When this situation started to develop, my colleagues decided that the thing we needed to do first was to protect our patients. We didn't even want them to sense the tiniest blip in service. We're proud to say that we've succeeded, but it's disconcerting to know that BHS and FMC would do this now—during a terrible and overwhelming nursing crisis, when it's hard to find and retain good nurses. This is how a medical facility loses its high-quality staff." ■

Judi Smith Goguen recognized by Cental Mass. AFL-CIO Labor Council

Judi Smith Goguen, RN and MNA committee member of her bargaining unit at UMass University Campus in Worcester, was recently honored by the Central Massachusetts AFL-CIO at the organization's annual Labor Day Breakfast on Sept. 6.

Goguen was awarded the Father Joseph J. Pijanowski Labor Chaplain Award, which is given each year to someone in the local labor community in honor of an individual who, because of his/her commitment to and involvement in the labor movement, is helping to alleviate workplace injustices in the central Massachusetts community.

The mission of the Central Massachusetts AFL-CIO is to provide a voice for working men and women in Massachusetts and to see that the concerns of working families are realized in legislation and public policy. They achieve this by:

- Organizing grassroots political action to push for adoption of worker-friendly initiatives and policies on a national, state and local level.
- Recruiting and supporting candidates who champion working families and a pro- active working family's agenda.
- Supporting economic development strategies for local public investment that create jobs while establishing worker friendly community standards such as living wages, responsible employer ordinances and project labor agreements.
- Mobilizing against anti-union employers and for community issues thru Street Heat the AFL-CIO s mobilization machine.
- Hosting forums and events to educate union members and the community about worker-related issues and legislation.

By uniting the labor movement and mobilizing in communities, the councils—with support from advocates like the MNA's Smith Goguen—play a critical role not only in local and regional matters, but also in statewide and national issues. ■

A cartoonist's view

Member Training

MNA Regions 2 and 3 have scheduled training sessions for all their unit stewards.

Topics to be covered will include:

- The role of the steward
- Recognizing and filing grievances
- Interpreting the contract
- Weingarten Rights
- Past practice

Region 2 Wednesday, Oct. 27, 6-9 p.m.
Region 2 Office, 193 W. Boylston St., Suite E, W. Boylston

Region 3 Tuesday, Oct. 26, Noon - 2 p.m. & 6-8 p.m.
Region 3 Office, 449 Route 130, Suite 6, Sandwich

- A meal will be provided at the training
- Participants are encouraged to bring a copy of their contract

For more information or to register* contact Joe Twarog, the MNA's Associate Director of Labor Education and Training, at 800-882-2056, x757.

** Please note that attendees must register at least one week in advance.*

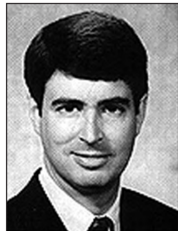
An RN's voter guide to Election 2004

On Tuesday, Nov. 2 voters across Massachusetts will go to the polls to vote in the elections for president, members of Congress and members of our state Legislature. Some on these candidates on the ballot support safe RN staffing legislation and other issues important to staff nurses, and some of these candidates don't. To better assist you, we have created "An RN's Voter Guide to Election 2004." This guide reviews the positions legislators have taken on Safe RN Staffing legislation, highlights some key supporters of RN issues and reviews those candidates who have been endorsed by the Massachusetts Nurses Association.

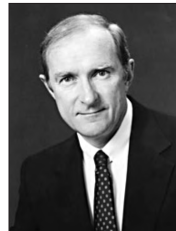
Safe staffing starts at the ballot box

Support these MNA-endorsed legislative candidates

Senate incumbents



Robert Antonioni
Worcester & Middlesex



Stephen Brewer
Worcester, Hampden, Hampshire & Franklin

Hariette Chandler
1st Worcester

Susan Fargo
3rd Middlesex

Robert Havern
4th Middlesex

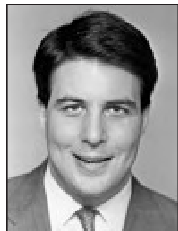
Therese Murray
Plymouth & Barnstable

Robert O'Leary
Cape & Islands

Marc Pacheco
1st Plymouth & Bristol

Pam Resor
Middlesex & Worcester

Bruce Tarr
1st Essex & Middlesex



Richard Tisei
Middlesex & Essex

Susan Tucker
2nd Essex & Middlesex

Marian Walsh
Suffolk & Norfolk

Senate open seats/ challengers

Edward Augustus
2nd Worcester

Angus Mcuilken
Norfolk, Bristol & Middlesex

Karen Spilka
2nd Middlesex and Norfolk

James Timilty
Bristol & Norfolk

House incumbents

Demetrius Atsalis
Hyannis
2nd Barnstable

Jennifer Callahan
Sutton
18th Worcester

Christine Canavan
Brockton
10th Plymouth

Mark Carron
Southbridge
6th Worcester

Michael Costello
Newburyport
1st Essex

Joseph Driscoll
Braintree
5th Norfolk

James Eldridge
Acton
37th Middlesex

Barry Finegold
Andover
7th Essex

David Flynn
Bridgewater
8th Plymouth

William Galvin
Canton
6th Norfolk

Anne M. Gobi
Spencer
5th Worcester

Shirley Gomes
Harwich
4th Barnstable

Mary Grant
Beverly
6th Essex

Patricia Haddad
Somerset
5th Bristol

David Linsky
Natick
5th Middlesex

Barbara L'Italien
Andover
18th Essex

Thomas O'Brien
Kingston
12th Plymouth

Susan Pope
Wayland
13th Middlesex

Thomas Stanley
Waltham
9th Middlesex

Kathleen Teahan
Whitman
7th Plymouth

Joseph Wagner
Chicopee
8th Hampden

House open seats/ challengers

Jennifer Flanagan
Leominster
4th Worcester

Brian Geoghegan
North Attleboro
14th Bristol

Jack McFeeley
Wrentham
9th Norfolk

Other MNA endorsed candidates include:

Senate

Steven Baddour, Methuen
Robert Creedon, Brockton
Cynthia Creem, Newton
Steven Tolman, Allston/Brighton

House

Cory Atkins, Concord
Ruth Balser, Newton
Deborah Blumer, Framingham
Gale Candaras, Wilbraham
Geraldine Creedon, Brockton
Robert DeLeo, Winthrop
Mark Falzone, Saugus
Michael Festa, Melrose
John Fresolo, Worcester
Emile Goguen, Fitchburg
Patricia Jehlen, Somerville
Jay Kaufman, Lexington
Peter Kocot, Northampton
Stephen Kulik, Worthington
James Marzilli, Arlington
Harold Naughton, Clinton
Matt Patrick, Falmouth
Anne Paulsen, Belmont
Joyce Spiliotis, Peabody
Ellen Story, Amherst
Ben Swan, Springfield
Timothy Toomey, Cambridge
Martin Walsh, Boston
Steven Walsh, Lynn
Alice Wolf, Cambridge
Denis Guyer, Dalton *(open seat)*
Patrick Natale, Woburn *(open seat)*

Election 2004: Where do your state legislators stand on safe RN staffing?

Tuesday, Nov. 2 is the next step towards the passage of safe RN staffing legislation. RNs must get out and vote for those who have supported our issues. To help you, included below is a chart to show where your state legislators stand on safe RN staffing. Things to consider while reviewing the chart before you cast your vote include:

1. Is your legislator a co-sponsor of the quality patient care/safe RN staffing legislation?
2. Did your legislator sponsor an amendment to the state budget to insert the safe RN staffing bill to the state budget?

Name	Safe RN staffing bill co-sponsor	Safe staffing budget amendment sponsor
Senators		
Robert Antonioni	Yes	Yes
Steven A. Baddour	Yes	Yes
Jarrett T. Barrios	Yes	Yes
Frederick Berry	No	No
Stephen Brewer	Yes	Yes
Scott Brown	No	No
Harriette Chandler	Yes	Yes
Robert S. Creedon Jr.	Yes	Yes
Cynthia Creem	Yes	Yes
Susan Fargo	Yes	Yes
Guy Glodis	Yes	Yes
Jack Hart	Yes	Yes
Robert Havern	No	Yes
Robert Hedlund	Yes	Yes
Brian Joyce	Yes	Yes
Michael Knapik	Yes	Yes
Brian Lees	No	No
Thomas M. McGee	No	Yes
Joan Menard	No	No
Mark Montigny	No	Yes
Richard Moore	No	No
Michael Morrissey	No	No
Therese Murray	No	No
Andrea Nuciforo Jr.	No	No
Robert O'Leary	No	Yes
Marc Pacheco	Yes	Yes
Steven Panagiotakos	No	No
Pamela Resor	Yes	Yes
Stanley Rosenberg	No	No
Charles Shannon	Yes	No
Jo Ann Sprague	Yes	No
Bruce Tarr	Yes	Yes
Richard Tisei	Yes	Yes
Steven Tolman	Yes	Yes
Susan Tucker	Yes	Yes
Marian Walsh	Yes	Yes
Dianne Wilkerson	Yes	No
Representatives		
Cory Atkins	Yes	No
Demetrius Atsalis	Yes	Yes
Bruce J. Ayers	No	No
Ruth B. Balser	Yes	Yes
John Binienda	Yes	Yes
Debby Blumer	Yes	Yes
Daniel E. Bosley	No	No
Garrett Bradley	Yes	No
Arthur Broadhurst	No	No
Stephen Buoniconti*	No	No
Antonio Cabral	No	No
Jennifer M. Callahan	Yes	Yes
Christine Canavan	Yes	No
Gale Candaras	Yes	No
Mark J. Carron	Yes	No
Paul Casey	No	No
Edward Connolly	Yes	Yes
Michael Coppola	No	No
Robert Correia	No	No
Michael A. Costello	Yes	Yes
Robert K. Coughlin	Yes	Yes
Geraldine Creedon	Yes	No
Robert DeLeo	Yes	Yes
Vinny M. deMacedo	No	No
Brian S. Dempsey	No	No
Salvatore DiMasi	No	No
Paul J. Donato	Yes	No
Christopher J. Donelan	No	No
Joseph Driscoll	Yes	Yes
James B. Eldridge	Yes	Yes
Lewis G. Evangelidis	No	No
James Fagan	No	No
Christopher Fallon	No	No
Mark Falzone	Yes	Yes
Robert Fennell	No	No
Michael Festa	Yes	Yes
Barry Finegold	Yes	No
David L. Flynn	Yes	No
Gloria Fox	No	No
John P. Fresolo	Yes	Yes
Paul Frost	No	No
William Galvin	Yes	Yes
Colleen Garry	Yes	No
Susan Williams Gifford	No	No
Anne M. Gobi	Yes	Yes
Emile Goguen	No	Yes
Brian Golden	Yes	Yes
Thomas Golden	Yes	Yes
Shirley Gomes	Yes	No
Mary E. Grant	Yes	Yes
William Greene Jr.	No	No
Patricia Haddad	Yes	Yes
Geoffrey Hall	No	No
Robert Hargraves	No	No
Lida Harkins	Yes	No
Bradford R. Hill	No	No
Reed Hillman	No	No
Kevin Honan	No	No
Donald F. Humason, Jr.	No	No
Frank Hynes	Yes	Yes
Patricia Jehlen	Yes	No
Bradley Jones	No	No
Louis Kafka	Yes	Yes
Michael Kane	No	No
Rachel Kaprielian	Yes	No
Jay Kaufman	Yes	No
Daniel Keenan	No	No
Thomas Kennedy	Yes	No
Kay Khan	No	No
Brian Knuuttila	Yes	Yes
Peter Kocot	Yes	Yes
Robert Koczera	Yes	No
Peter Koutoujian	Yes	No
Paul Kujawski	Yes	Yes
Stephen Kulik	Yes	No
William Lantigua	No	No
Peter Larkin	No	No
James Leary	Yes	Yes
Stephen P. LeDuc	No	No
John Lepper	No	No
David P. Linsky	Yes	Yes
Barbara A. L'Italien	Yes	Yes
Paul LoScocco	Yes	No
Elizabeth Malia	No	Yes
Ronald Mariano	Yes	No
James Marzilli	Yes	Yes
James Miceli	No	No
Charles Murphy	No	No
James M. Murphy	No	No
Kevin Murphy	No	No
David M. Nangle	No	No
Harold Naughton Jr.	No	No
Robert J. Nyman	Yes	No
Thomas O'Brien	Yes	No
Eugene O'Flaherty	No	No
Shirley Owen-Hicks	No	No
Marie Parente	Yes	No
Matthew Patrick	No	No
Anne Paulsen	Yes	No
Vincent Pedone	Yes	Yes
Alice Hanlon Peisch	No	No
Jeffrey Davis Perry	No	No
Douglas Petersen	Yes	No
George Peterson Jr.	No	No
Thomas M. Petrolati	No	No
Anthony Petrucelli	No	No
William Smitty Pignatelli	No	No
Elizabeth A. Poirier	No	No
Karyn Polito	No	No
Susan Pope	Yes	No
John Quinn	No	No
Kathi-Anne Reinstein	Yes	Yes
Cheryl A. Rivera	No	No
Michael Rodrigues	Yes	No
Mary Rogeness	No	No
John Rogers	No	No
Michael F. Rush	Yes	Yes
Byron Rushing	Yes	No
Jeffrey Sanchez	No	No
Angelo Scaccia	No	No
John W. Scibak	No	No
Frank Smizik	Yes	Yes
Theodotre Speliotis	No	No
Robert Spellane	Yes	Yes
Joyce A. Spiliotis	Yes	Yes
Karen Spilka*	Yes	Yes
Marie St. Fleur	No	No
Harriett Stanley	No	No
Thomas Stanley	Yes	No
Ellen Story	Yes	No
William Straus	No	No
David Sullivan	No	No
Benjamin Swan	Yes	No
Kathleen Teahan	Yes	Yes
Walter F. Timilty	Yes	Yes
Stephen Tobin	No	No
Timothy Toomey Jr.	Yes	Yes
David M. Torrisi	No	No
Philip Travis	Yes	No
Eric Turkington	No	No
James Vallee	Yes	Yes
Anthony Verga	Yes	Yes
Joseph Wagner	Yes	No
Brian P. Wallace	Yes	Yes
Patricia Walrath	No	No
Martin Walsh	Yes	Yes
Steven Myles Walsh	Yes	Yes
Daniel K. Webster	No	No
Alice Wolf	Yes	Yes

*running for State Senate

So you think it's safe at work? Notes from the Congress on Health and Safety

Carbon monoxide detector saves lives of MNA staffer and her family

By Evie Bain and Carol Mallia

October and the end of daylight savings time bring the annual reminders to replace the batteries in smoke and carbon monoxide detectors. Late last winter, in the wee hours of a freezing cold January morning, Carol Mallia, RN and associate director in the MNA's department of nursing, learned just how valuable a working carbon monoxide detector really is.

A faint, unfamiliar chirping sound woke Mallia that night, and reluctantly she got out of her warm bed to locate the noise. On her way down the stairs she recalled changing the batteries in the detectors on the first and second floor within the past month when the low battery tone had sounded. But had she remembered the one in the basement? As she slid the detector off the basement ceiling, she fully expected it to read "low battery." Much to her surprise it was flashing *"Go to Fresh Air."*

She recalled that the wood stove had been running all day but knew that it had gone out some time in the night. She also remembered that there was no smoky downdraft odor to indicate a problem. In disbelief she changed the battery, checked the kids and called the non-emergency number of the local fire department. She was fully convinced that this was going to be an embarrassing false alarm.

Within minutes the fire department arrived, with sirens blaring. The firefighters quickly donned heavy coats and full face breathing apparatus. Once in the house, their instruments detected carbon monoxide at a dangerous level on the first floor and Mallia was instructed to evacuate immediately.

Mallia and her husband scooped up their sleeping children, ages 4 and 8; grabbed coats and blankets; and out the door they went. Where would they go in the middle of a winter night? Into the car, of course. Mallia and her husband got the heater going and warmed up their sleepy, and slightly perplexed, children.

Mallia said the real surprise was to realize the extent of the danger they were in and to learn of the precautions that the fire department was taking for *their own* safety while they checked out the house.

And check it out they did. Sure enough, detector instruments noted toxic levels throughout the basement, highest near the wood stove. The first floor levels were in the danger zone and the second floor (where the bed rooms are located) were just mildly elevated. The woodstove in the basement den was identified as the source. Apparently the wood burned out and with the extreme cold temperatures (2 degrees below zero that night), it had created a downdraft of gases.

The firefighters proceeded to ventilate the house with large fans. After 45 minutes of blowing the artic temperatures into the house, they re-checked the levels and gave Mallia and her family the okay to return inside.

The firefighters explained to Mallia that the family was very fortunate. Since carbon monoxide can get into the heating system, it could have circulated throughout the house via their forced hot-air system.

Mallia told us that she made a few changes after that night. She installed an electric carbon monoxide detector with digital level readout and a battery back up. She still uses her wood stove, but ensures it is completely extinguished before going to sleep.

When Mallia shared this story with us at MNA the day after the incident, I asked her if we could write it up for the *Massachusetts Nurse*, since it just might serve to save another reader's family. Mallia was willing to share this story and reminds everyone to replace the batteries in their detectors in the spring and fall; to test the detector as directed; and to call 911 and get out quickly if the detector alarm sounds.

For more information, visit the Department of Fire Services' Web site at www.mass.gov/dfs/index.shtm, *or the CDC's Web site at* www.bt.cdc.gov/disasters/carbonmonoxide.asp ■

Influenza vaccine helps protect you

By Donna Lazorik, RN, MS, CS
Bureau of Communicable Disease Control, Massachusetts DPH

Every year in Massachusetts, an estimated 2,600 people are hospitalized and 800 people die due to complications from influenza—a highly infectious viral disease. Because of their increased exposure to people who are ill, nurses, like other healthcare workers, are more likely than the general public to become infected with influenza. Every year, up to 25 percent of health care workers get the flu.

Everyone who becomes infected with influenza is at risk for complications from the disease, including pneumonia and exacerbation of underlying conditions, such as asthma, diabetes and cardiac disease. Studies have shown that pregnant women with influenza are hospitalized at the same rate as non-pregnant women with high-risk medical conditions. Pregnant women can and should get vaccinated in any trimester.

Infected health care workers can be asymptomatic and still be infectious. Even when symptomatic, many health care workers continue to work. In addition to putting themselves at risk, infected health care workers can bring the influenza virus home to their families, expose their colleagues, and transmit influenza to their vulnerable patients.

Despite the morbidity and mortality associated with influenza and the availability of a safe and effective vaccine, only 36 percent of health care workers get vaccinated every year. The most frequent reasons cited by health care workers for not receiving influenza vaccine ("the vaccine causes the flu" and "they are not at risk for getting the flu")[1] are based on misinformation. When nurses have misconceptions about influenza vaccine for themselves, they are not only denying themselves the protection that the vaccine can provide to them, they also may be providing inaccurate information to their patients.

Influenza vaccination of health care workers is a safety issue for both nurses and their patients. Nurses have a responsibility to be informed and to do what is necessary to protect themselves, their families and their patients. There are many resources to assist nurses in educating themselves about the true risks associated with influenza infection, and the risks and benefits of the influenza vaccine. The Influenza Information icon on the home page of the Massachusetts Department of Public Health's Web site (www.mass.gov/dph) is a link to the most current guidelines and recommendations regarding influenza vaccine.

A Web-based continuing education course, Importance of Vaccinating Health Care Workers Against Influenza, is available at: http://idinchildren.com/monograph/CMEframeset.asp?article=0402/splash.asp&mono=y.

To obtain an Employee Immunization Campaign Tool Kit, call MassPRO at 781-419-2749, or visit the MassPRO Web site at www.masspro.org. ■

1. Steiner M, Vermeulen LC, Mullahy J, Hayney MS. Factors influencing decisions regarding influenza vaccination and treatments: a survey of healthcare workers. *Infect Control Hosp Epidemiol* 2002;23:625.

Health & Safety **Contacts**

For questions, comments or concerns related to health & safety issues, contact:

- **Evie Bain,** *MEd, RN, COHN-S*
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  781-830-5776
  ebain@mnarn.org
- **Christine Pontus,** *MS, RN, COHN-S/CCM*
  Associate Director, Health & Safety
  781-830-5754
  cpontus@mnarn.org

CDC Fact Sheet/**Protect yourself from carbon monoxide poisoning**

Carbon monoxide (CO) is an odorless, colorless gas that can cause sudden illness and death if you breathe it. When power outages occur during emergencies such as hurricanes or winter storms, you may try to use alternative sources of fuel or electricity for heating, cooling, or cooking. CO from these sources can build up in your home, garage, or camper and poison the people and animals inside.

If you are too hot or too cold, or you need to prepare food, don't put yourself and your family at risk—look to friends or a community shelter for help. If you must use an alternative source of fuel or electricity, be sure to use it only outside and away from open windows.

Every year, more than 500 people die from accidental CO poisoning. CO is found in combustion fumes, such as those produced by small gasoline engines, stoves, generators, lanterns, and gas ranges, or by burning charcoal and wood. CO from these sources can build up in enclosed or partially enclosed spaces.

People and animals in these spaces can be poisoned and can die from breathing CO in an enclosed or partially enclosed space.

How to recognize CO poisoning

Exposure to CO can cause loss of consciousness and death. The most common symptoms of CO poisoning are headache, dizziness, weakness, nausea, vomiting, chest pain, and confusion. People who are sleeping or who have been drinking alcohol can die from CO poisoning before ever having symptoms. If you think you may have CO poisoning, consult a health care professional right away.

Important tips

- Never use a gas range or oven to heat a home.
- Never use a charcoal grill, hibachi, lantern, or portable camping stove inside a home, tent, or camper.
- Never run a generator, pressure washer, or any gasoline-powered engine inside a basement, garage, or other enclosed structure, even if the doors or windows are open, unless the equipment is professionally installed and vented. Keep vents and flues free of debris, especially if winds are high. Flying debris can block ventilation lines.
- Never run a motor vehicle, generator, pressure washer, or any gasoline-powered engine outside an open window or door where exhaust can vent into an enclosed area.
- Never leave the motor running in a vehicle parked in an enclosed or partially enclosed space, such as a closed garage.

For more information on carbon monoxide poisoning, visit www.bt.cdc.gov/disasters/carbonmonoxide.asp. ■

What constitutes malpractice?

You know that a charge of professional negligence or malpractice must be backed up by the facts. But did you know that in every lawsuit, the patient's attorney must prove the presence of four elements—duty, breach, cause and harm—to show that the healthcare provider was negligent? Here's a description of each one.

Duty arises when you establish a professional relationship with the patient. Once this relationship is established, you have a duty to deliver the standard of care expected of a nurse. Your duties may include assessing the patient's condition, identifying and reporting changes in her condition, planning appropriate intervention, and questioning doctors' orders with which you're not comfortable.

Your professional competence is based on your knowledge of, and compliance with, professional standards of care, which include your state's practice act, your professional association's standards, and your facility's policies and procedures. You're also expected to be compliant with regulations governing patient rights, confidentiality, and non-discrimination.

Breach means the duty or standard of care was not followed. The patient's attorney must prove that you were negligent–that you failed to use the standard of care a prudent nurse would use under the circumstances.

Cause refers to the role that breach of duty played in the patient suffering harm. Direct cause means that your breach of duty specifically led to the patient being harmed. Proximate cause is less clear-cut. It means that your action was reasonable under the circumstances, and that other factors, including the patient's condition or actions, could have caused the damage independently of your action.

Harm or damages consist of actual physical damage, and the resulting cost of required treatment and lost wages, both present and future. Trauma and emotional stress may constitute additional damages. If the event is so outrageous that the jury and the judge decide additional damages are in order, the court may award punitive damages.

Provided by the NSO; for more information visit www.nso.com.

Journey to Magnet status: An inside look at

By Joe-Ann Fergus
Associate Director of Labor Relations

Today the quest for Magnet status has become a major topic of discussion in many hospitals. For those of us who have been frustrated and saddened by the continued degradation of the profession as nurses have done their best to provide quality care with insufficient resources and with minimal or no support, the promises of the Magnet philosophy seem nothing short of manna from heaven.

Reading the literature about the ANA's Magnet program, the process promises a restoration of respect for the science and art of the nursing profession, with a built-in mechanism to ensure an equal seat at the table for the beleaguered nursing administrator; the emergence of the nurse clinician as a professional whose input and expertise is not only recognized but sought after; as well as the restoration of quality care and staff satisfaction as primary goals for the institution.

But how does the reality of the Magnet process measure up to its advertised promise? In this article I will relate my experience as well as the experiences of nurses at Northeast Hospital Corp. (which comprises Beverly Hospital, Addison Gilbert Hospital and the Hunt Center) over the last two years of our journey through the Magnet process.

I offer the following not as an indictment of hospitals pursuing Magnet status or the Magnet process itself. It would neither be helpful nor fair to do so. Instead, I offer the following reflections and insights in the hope that it will be helpful to those of you who are about to embark on your own journey through the Magnet process. My goal is to inspire real and meaningful dialog among nurses, their nursing administrators and their larger hospital communities in the hope that should your hospital and, as a result, you decide to engage in the process that you do so fully aware and informed of not just the potential gains but the potential pitfalls. In addition, I hope that this article will help prepare you to take a proactive role in recognizing and effectively dealing with those very real problems.

Unions and the Magnet process

There is no doubt that the presence of a union at a hospital aspiring to Magnet status can and has been viewed as an unwelcome complication by some hospital administrators. This outlook seems to be based on the fact that unions empower the nursing staff and level the playing field in a way that necessitates more explanations, more disclosures, more bargaining, more true collaboration in problem solving and more compromises than some institutions are willing or prepared to engage in.

Ironically, although transparency in decision making, staff involvement and true collaboration in problem solving are major hallmarks of a Magnet hospital, these are the hardest goals to achieve because for many institutions they require a dramatic shift in the internal culture. For unionized facilities it also necessitates a commitment to different approaches to conflict management between the hospital and the union.

In my view, given the stated goals of any facility aspiring to Magnet status, the presence of the union should compliment the process—as research has shown that unionized hospitals tend to have better patient outcomes than non-unionized hospitals, primarily because those nurses are already empowered to be stronger advocates for patient care and practice standards. A review of the current hospitals with Magnet designations reveal that a number of them are unionized.

As an advocate for the profession of nursing and its dedicated practitioners, I look hopefully to new ideas and advancements that give prominence to nursing in the hospital hierarchy. When the elected leaders of the bargaining unit and I were approached about this, we were skeptical about the hospital's sincerity but hopeful that it was a signal of a positive development. Two years later it would be great to be able to say that our skepticism was unfounded. In a few instances we can, but as a whole we continue to have difficulty matching the rhetoric of Magnet to the reality on the ground.

The journey to Magnet status in this case has been confused and complicated by an apparent disconnect between nursing administrators, led by the VP of nursing, who consistently communicated and demonstrated a willingness to find collaborative ways of problem solving, and the very senior non-nursing hospital administrators led by the hospital's CEO, who have communicated and demonstrated just as consistently their disdain for the union in general and the elected bargaining unit leadership in particular. The difference between promise and reality is further highlighted by legitimate clinical practice and workplace issues raised by union leaders being consistently dismissed or ignored, while at the same time some in administration have focused an inordinate amount of time and energy on targeting the elected leaders of the bargaining unit for harassment and intimidation as a result of their outspokenness in the pursuit of quality care and protecting clinical practice.

Instead of involving the elected union leaders in conversations on key issues from the outset, we find that issues are presented after plans have been made and set in place, sometimes with negative consequences. This has left us in the position of having to correct problems instead of being in the position to lend additional insight before the problem has occurred, saving time and energy all around. It has also become apparent that in some instances the administration hand picked the staff it chose to provide information and participe. Over time the nursing staff in general has begun to express frustration and some disillusionment with the process, as from their perspective, although their input is solicited, it seems to be negated or ignored even when there appears to be consensus on the commit-
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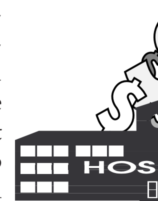


Example of costs of Magnet designation

A 545-bed hospital[1] would incur the following minimum estimated costs for acquiring Magnet designation:

Item	Cost
✦ Appraisal fee (for 500-749 beds)	$39,375
✦ Appraiser honorariums (3 at $1,000 each)	$3,000
✦ Site visit fee ($1,500/day, per appraiser; 3 days)	$13,500
✦ Travel, lodging and related fees	$3,000 – $4,000
✦ Outpatient Magnet designation (if applicable)	$4,500 – $15,000
	$63,375 – $74,875
Additional costs:	
Many facilities use a consultant to guide them through the Magnet process.[2]	Est. $25,000 – 75,000
Staff costs to compile policies and procedures, prepare application materials, and pull documentation together. (2,000 hours at $40 per hour)	Est. $80,000
Total estimated initial costs:	**$168,375-$229,875**
Re-designation fees[3]	50 percent of initial fees

1. *The average number of beds in a Magnet hospital is 545, from "The Magnetic Pull: Recognizing Excellence in Nursing Services," Judith Sadler, Ph.D., RN, Western Michigan University, Bronson School of Nursing, at www.minurses.org/news/general/gen072402magnet.shtml*
2. *ANCC provides consultants, at an additional charge, through its IREC division. From the ANCC Web site: ANCC's Institute for Research, Education, and Consultation (IREC) is the nation's leading institute for research, education, and consultation in nurse credentialing.*
3. *Re-designation required every four years.*

Magnet status: the

By Joe Twarog
Associate Director,
Labor Education and Training

As union members are confronted with the prospect of their hospital engaging in the expense and the process of the Magnet program, many have asked the MNA if and how this process can and should intersect with the role of the union.

While the MNA's Board of Directors finalizes its position on this matter, there are some key points to keep in mind. First of all, any program that impacts employees' working conditions is a union matter—as a matter of law. Therefore, any attempt to modify the working/practice conditions of nurses; any program that purports to seek and utilize staff nurses input; any program that proposes to change policies and practices to boost retention and recruitment of staff **is a union issue**.

MNA

The union must be directly involved at all stages of discussion that relate to a nurse's "wages, hours and working conditions" as defined by the National Labor Relations Act. And any changes contemplated must be bargained with the union.

It is important to note that Magnet, regardless of its purported merits and benefits, if implemented without the input of the union and without the rights and enforceability that a union provides, is yet another consultant-driven process that can circumvent the ability of bargaining unit members to define and protect their practice. Like TQM, Patient Focused Care and all other forms of workplace redesign, the danger of these programs is that they can co-opt staff nurses, providing the illusion of participation, and later, having been co-opted, nurses' participation is used to justify the decisions that are made.

The "participation" most often is another way to control the workforce. Employees enter the process excited and in good faith—expending significant time and effort, only to have their efforts relegated to the level of unenforceable "recommendations."

t the experience of one MNA bargaining unit

tees. This request for appear to be ous. ducing and aging a orative to problem were forced absolutely administra- levels that subjects of assigned to unit counsels s of nurses and managers ocess) without discussion became especially appar- ple. On one unit, a critical tified at different times of their managers agreed that one to ensure appropriate and good clinical practice. solicited and based on the l—and knowing that the table—the staff came up em of call to boost staffing. ff and seemed to solve the l of the staff wanted to par- he plan was supposed to be expected to participate. e more of a problem when porary fix to a temporary ssed in a more permanent t point that the union was n. In presenting the issue to , we were informed that the l staff endorsed. However, it became clear that they ave to sign-up for call" and would prefer not to accept—but they felt that they had no choice. If they did nothing they believed that the patients and the people working shorthanded would be at risk. Furthermore, in discussions with the staff about how they would choose to solve the problem if all options were open to them, they unanimously believed that what was needed was additional staff assigned for the critical times.

Given this additional information, the union representatives returned to the managers and made an additional request for information regarding the situation, including occurrences and staffing. We were able to tackle the problem with a broader scope than the unit staff could because we had access to more information. With the help and input of the staff, we were actually able to negotiate a more comprehensive fix to the problem addressing the needs of both management and the staff without compromising care and forcing staff to work more than they wanted to.

This example actually highlights one of our key areas of concern: how does staff ensure that solutions requiring best practice and the best patient outcomes get serious consideration and implementation? The assumption is that, through the Magnet process of staff-nurse empowerment and an institutional commitment to key nursing issues affecting clinical practice and patient care, safe staffing will be a natural outgrowth. The problem with this assumption is that it relies completely on the will of the management in charge. A Magnet designation comes with no built-in enforcement mechanism—much like JCAHO and its self policing.

Where are we now

Despite these missteps and misgivings, we remain open to the potential transformative nature of the process—and for a while we began to see some hope. We began to believe that although the union and the hospital might have different interests in some areas, we had enough common ground to build on. We began to find areas of true collaboration and areas where we could build trust. This change was credited to the behavior being modeled by the VP of nursing, Janice Bishop, who had begun to explore, create and communicate tangible ways of interacting in a more positive and productive manner despite continued negativity and hostility from others in the hospital hierarchy. Unfortunately, just as we began to believe that nursing administration could and would be empowered to be an equal power at that table, we experienced an abrupt and unexpected change in the hospital's nursing administration. Unfortunately, since beginning this article and the Magnet journey, the VP of nursing who was key to the process and our involvement resigned her position. Since that time we have experienced an unprecedented increase in attacks on the elected bargaining unit leaders, as well as a shift in the forward momentum of collaborative communication and problem solving and a return to an unproductive, adversarial and hostile atmosphere. The result of this is a growing mistrust of the administration and increased skepticism of the effectiveness of the nursing administration.

It also highlights one of our major areas of concern with respect to the Magnet system, which appears to be totally based on the "good will" of an "enlightened" manager to work. What happens when the manager changes? Or the leaders who are committed to the process leave or change their mind? What guarantee is there that the culture created will be maintained? Again we do not need to look too far back in nursing history to see examples of great initiatives spearheaded by innovative nursing leaders that were completely wiped out when the more "budget minded" in the hospital hierarchy felt that innovation and ideals did not serve the bottom line.

Interestingly, this quest has had an unexpected yet positive side effect for the bargaining unit. It has actually motivated the nurses to become more organized and has empowered the membership to become more involved, even if it is to serve as a watchdog over the process. It has also done a lot to shed light on the differences between "perceived participation and power" and "real participation and power." And it has also reinforced the very tangible benefits of the union.

In addition, this pursuit of Magnet status has forced us as a bargaining unit to look at ourselves and our own shortcomings as a group and, as we continue to work, to empower the members to take an active role in shaping their work environment, their clinical practice and their professional development. On the level of labor and management interactions, it has also created more opportunities for interaction. Even if they have not always been positive, they still offer the potential to create opportunities for positive change.

While our particular experience has not been ideal,we have not dismissed out of hand the potential for transformation and change with an administration truly committed to the ideals demonstrated in Magnet institutions. The bargaining unit has taken the position that we will keep an open mind and act in good faith to create a hospital where the ideals of the Magnet system are more than just catchy slogans on posters, banners, billboards or commercials for the hospital to use as part of a marketing campaign.

We believe that we are far from the ideal at this time, but we hold out hope that transformation can come and that we can find more proactive and collaborative ways of reaching our common goals of quality patient care, an informed and empowered nursing professional and a healthy and thriving healthcare institution. Although it is unfortunate that in order to achieve this, hospitals must pay hundreds of thousands of dollars to an outside agency only to learn that the goal was always within their grasp for free and that all it ever required was the will to change and insight enough to see their staff as true partners for success.

We promise to keep you posted. ■

union perspective

Union assessment checklist

Here is a check list of questions you might ask (of yourself and the hospital) in considering Magnet from a union members' perspective.

1. Will the hospital allow the nurse's union to select the nurses who will serve on the nurse practice council?
2. Does Magnet status include a guarantee of safe nurse staffing ratios, a ban on mandatory overtime, inappropriate floating, mandatory on call and other dangerous practices associated with the crisis in nursing care?
3. Does Magnet status afford you as an employee any input and veto authority in the final decision making power in your workplace?
4. Are the decisions made by nurse practice councils final and binding or are they simply recommendations subject to management's approval and implementation?
5. Do you have access to all information and materials (i.e., financial documents, engineering reports, consultant's studies, vendor contracts, merger or restructuring plans, etc.) to make a decision as does hospital management?
6. Is the hospital committed to pay all costs and expenses necessary to implement and maintain resources identified as necessary by the nurse's council for quality patient care?
7. Are there clearly established timelines that the hospital is committed to for implementing decisions made by the nurse's council?
8. Do nurses have full voting rights as equals on decision making boards of the hospital?
9. Is the hospital willing to sign a legally binding document that guarantees nurses a voice in all decisions impacting their work?
10. Has the ANCC guaranteed staff nurse input and approval into any changes of the criteria determining Magnet status prior to any modifications?
11. Are nurses guaranteed a legal right of protection from reprisal for any criticism made of management, within a grievance and arbitration process?
12. Are nurses guaranteed an economic return in their pay and benefits on savings realized or income gained by the hospital as a result of the "Magnet" designation? ■

Professed characteristics of magnet hospitals

- Concern for the patient is paramount
- Have a reputation for quality nursing care as rated by patients
- Nurses identify the hospital as a good place to work and practice professional nursing
- Strong nurse-physician relationships and communication
- High degree of teamwork
- Supportive nurse managers/supervisors
- Staff are more highly-educated
- Staff feel their work has meaning

…JCAHO

From Page 1

physician's orders and gave a double dose of narcotics to an ED patient who later died.

These reports are highly troubling given that they fall on the heals of numerous reports in the most prestigious scientific journals that show patients are suffering greatly and many more are dying because of poor care, particularly due to chronic understaffing at hospitals.

Here in Massachusetts, the DPH reported a 76 percent increase in the number of patient injuries, medication errors and patient complaints in hospitals over the last seven years. A survey of the state's nurses found that two thirds reported an increase in medication errors, and more than half reported an increase in patient injuries, harm to patients and readmissions due to poor care. One in three reported an increase in patient deaths due to poor care.

Yet, nearly all Massachusetts hospitals have glowing reports from JCAHO, and as a result, DPH does nothing to address the problems nurses have so readily identified.

"That is why we need a safe staffing law that makes safe RN-to-patient ratios a condition of licensure," Higgins said. ■

…Magnet

From Page 1

use to refer to hospitals which had these characteristics.[1]

A decade later, in 1994, the American Nurses Credentialing Center (ANCC), which is a subsidiary of the American Nurses Association (ANA), developed a formal Magnet Recognition Program ("Magnet"). The program confers the designation "Magnet Nursing Services Recognition" on hospitals that are able to pass a lengthy credentialing inspection by a team of surveyors—in very similar fashion to JCAHO's (Joint Commission on Accreditation of Healthcare Organizations) inspection and credentialing process.

According to the AANC, as of July 30, 2004, there were more than 100 Magnet-designated facilities in the country. Currently, two hospitals in Massachusetts, Massachusetts General Hospital and Winchester Hospital, have been designated as Magnet facilities, both in late 2003.

Magnet recognition

Magnet evaluation criteria are based on quality indicators and standards of nursing practice as defined in the ANA's *Scope and Standards for Nurse Administrators* (1996). The criteria are similar to JCAHO standards. To obtain Magnet status, health care organizations must apply to the ANCC; submit extensive documentation that demonstrates their compliance with the ANA standards; and undergo an onsite evaluation to verify the information in the documentation submitted and to assess the presence of the "forces of magnetism" within the organization.[2]

Magnet reviewers solicit feedback from a number of sources, including community members; the state board of nursing; state-based consumer organization; state health departments; OSHA; and the National Labor Relations Board. Appraisers may even ask individuals such as taxi drivers and hotel staff near the facility how the facility has contributed to the community.[3] Magnet status is awarded for a four-year period, after which the organization must reapply.

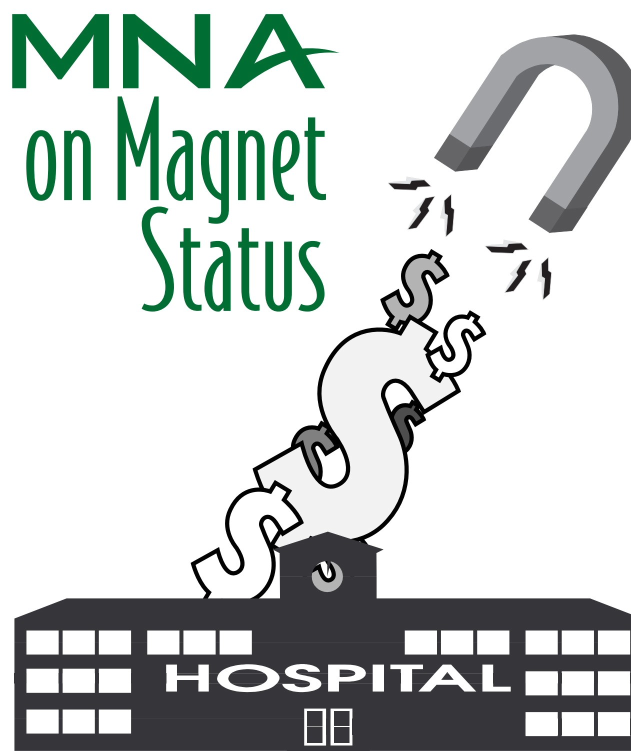
The program is marketed by AANC as a vehicle which can provide the following benefits: enhance nursing care; increase staff morale; attract high quality physicians; reinforce positive collaborative relationships; create a "Magnet culture"; improve patient quality outcomes; enhance nursing recruitment and retention; and provide a competitive advantage for hospitals.[4]

AANC collects a fee from hospitals for its Magnet recognition process. Their fees[5] include an appraisal fee ranging from $9,765 for a hospital with less than 100 beds to $47,250 plus $50 per beds over 950 in large hospitals. A $15,000 fee applies to independent outpatient facilities with a $4,500 added to the inpatient fee if done in conjunction with an inpatient review. Honorariums paid to appraisers are $1,000 each; there are usually at least two appraisers per facility. There is also a site visit fee of $1,500 per day, per appraiser. Site visits usually require two appraisers for two or more full days, but large organizations could require more appraisers and/or more visit days. The travel, lodging and other related expenses for the site visit are paid by the hospital applicant. Re-designation fees are charged upon re-application.

Hospitals seeking Magnet designation will also incur staff costs to assure that policies and procedures within the hospital are adequate to meet designation standards, plus the costs to prepare application materials. In addition, the staff hours required to pull the documentation together are considerable.[6] Jeanette Ives Erickson, RN, MS, senior. Vice president, patient care and chief nurse at Massachusetts General Hospital, indicated to *Nursing Spectrum* that 2,305 pages of written evidence were submitted to AANC by MGH as evidence illustrating the 95 Magnet and core criteria necessary for MGH to gain its September 2003 Magnet designation.[7]

Why we're seeing the emergence of magnet

"Pay for Performance" is the newest trend in hospital reimbursement. It has been called the beginning of the third wave in reimbursement.[8] The previous two Medicare reimbursement schemes were: 1) the original cost-based reimbursement mechanism and 2) the DRG-based prospective-payment system. The DRG system emerged during the Reagan era, with its focus on bringing competition to healthcare and its



view of healthcare as just another business arena. The DRG system restructured hospital finance. Hospitals began to be compensated for saving (or making) money on specific diagnoses, at the expense of less profitable diagnoses, i.e. the acronym DRG, or diagnosis-related groups. The DRG system had the effect of encouraging hospitals to concentrate on the profitability of its various "lines of business," and it inevitably impacted the quality and delivery of care.

The financial reimbursement system is essentially the tail wagging the dog—with the dog being the health care system. Today we see CMS (Centers for Medicare and Medicaid Services, formerly known as HCFA, the Health care Financing Administration) beginning to link Medicare payments directly to *quality of care*, which is viewed as signaling the end to the DRG payment era.[9] CMS is funding pilot projects to tie payments to hospitals to demonstrators of quality.[10] Hospitals that demonstrate efforts to achieve quality (performance) will very shortly see financial rewards for their efforts. This emerging reimbursement system is known as "Pay for Performance."

This coming change in the reimbursement system is fostering the desire of hospitals to gain Magnet designation of their facilities. The linkage to Magnet designation is that organizations including JCAHO, the ANC and others, publicize the correlation between various indicators of quality such as lower mortality rates and shorter lengths of stay with Magnet hospital status.[11] What is clear is that hospitals that can tout having Magnet designation will be far better positioned for reimbursement purposes. And the evolving "Pay for Performance" Medicare payment system will roll out to other payors, if past is prologue. The result is that hospitals have concluded that obtaining Magnet designation will help them secure better reimbursement in coming years.

Hospitals are being nudged in this direction by the federal government and major industry players such as JCAHO. In late July, 2002 Congress passed the "Nurse Reinvestment Act," which included grants to encourage facilities to implement Magnet criteria for excellence in nursing services. Just days after President Bush signed that legislation into law, JCAHO released a report on the nursing shortage that recommended that facilities adopt the characteristics of Magnet hospitals to foster a workplace that empowers and is respectful of nursing staffs.[12]

It is not a stretch to say that the quality of care provided by the current Magnet hospitals is to be commended. Correlations have been found to exist between Magnet designation and positive outcomes for patients and lower nurse turnover.

However, questions surround the motivations to encourage all hospitals to achieve Magnet designation, confusion of cause and effect, and the implications, complexities and underlying dangers related to Magnet and require us to take a deeper look at labor and staffing issues related to Magnet.

Currently, there are no RN-to-patient ratios required for achieving Magnet status. In fact, the AANC is an affiliate of the American Nurses Association, which is also opposed to the concept of specific RN-to-patient ratios.

The similarities between the Magnet approach and JCAHO have also raised concerns among nurses given their experience with the lack of impact JCAHO accreditation has had on the quality of nursing care in hospitals and a number of studies that call the entire process into question.

At best, voluntary accreditation is a snapshot in time of the conditions established at a particular hospital before and during the surveyors' visits. Receiving Magnet status, like JCAHO accreditation, provides no guarantee that those conditions (if they are conducive to quality patient care and a good nurse work environment) will be in place a year or even a month following the awarding of that recognition.

So the question remains: How does this process fit with the real power of nursing unions to have a say in the creation of mutually negotiated and legally enforceable standards and working conditions derived through collective bargaining? *(See related story on page 10.)*

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[1] www.flcenterfornursing.org/research/fcnmagnet.pdf
[2] www.jcaho.org/news+room/press+kits/facts+about+magnet+hospitals.ht
[3] www.nursingworld.org/tan/sepoct02/magnet.htm
[4] www.jcaho.org/news+room/press+kits/facts+about+magnet+hospitals.htm (2004)
[5] Effective April 1, 2003
[6] From a publication of the Minnesota Department of Public Health, December 2001, at www.health.state.mn.us/divs/chs/rhpc/PDFdocs/magnet.pdf
[7] www.nursingspectrum.com/MagazineArticles/article.cfm?AID=10508
[8] www.aishealth.com/Compliance/ResearchTools/RMCCMSLinks.html, Reprinted from the Oct. 10, 2003 issue of *Report On Medicare Compliance*
[9] www.aishealth.com/Compliance/ResearchTools/RMCCMSLinks.html, Reprinted from the Oct.10, 2002 issue of Report On Medicare Compliance.
[10] www.cms.hhs.gov/quality/default.asp?
[11] www.nursingworld.org/ancc/magnet/benes.html
[12] www.nursingworld.org/tan/sepoct02/magnet.htm

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Fall/Winter 2004

Oncology for Nurses

Description This program will increase knowledge in oncology nursing. The content of the program will include an overview of cancer management, tumor physiology and staging, relevant laboratory testing and treatment strategies and safe handling of neoplastic agents. Chemotherapy administration, classification of chemotherapeutic agents, management of toxicities and adverse effects of treatments and oncological emergencies will be discussed. The program will conclude with pain and symptom management, palliative care and an overview of hospice care.

Speaker Marylou Gregory-Lee, MSN, RNCS, OCN, Adult Nurse Practitioner
Date Oct. 27, 2004
Time 8:30 a.m. – 4 p.m. *(Lunch provided)*
Place MNA Headquarters, Canton
Fee MNA members, $125; all others, $150
Contact Hours* Will be provided
MNA Contact Theresa Yannetty, 781-830-5727 or 800-882-2056, x727

Managing Pulmonary Emergencies

Description This program is designed for registered nurses in acute, sub-acute and long-term care settings who want to learn the clinical management of respiratory emergencies. Clinical management of acute respiratory distress will be discussed, as well as the management of chest tubes and tracheotomies. Program will include ABG interpretation and oxygen delivery system safeguards.

Speaker Carol Mallia, RN, MSN
Date Nov. 16, 2004
Time 6:30 – 8:30 p.m.
Place Region 3 office, 449 Route 130, Sandwich
Fee MNA members, free; all others, $25
Contact hours* 2.4
Contact MNA Region 3, 508-888-5774 or 877-888-5774

Clinical Update 2004

A.M. Session **Diabetes: What Nurses Need to Know.** This morning program is designed for nurses from all clinical practice settings and will discuss the pathophysiology and classification of Diabetes Type 1 and 2, nursing implications of blood glucose monitoring, non-pharmacological interventions such as exercise and meal planning, and a discussion of oral pharmacological agents. A comprehensive review of insulin therapy, as well as nursing management of the diabetic patient, will be explored.

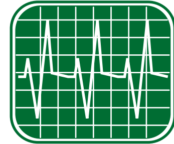
Speaker Ann Miller, MS, RN, CS, CDE
P.M. Session **Cardiac and Pulmonary Pharmacology.** This afternoon program will provide nurses, from all clinical practice settings, with a better understanding of how cardiac and pulmonary medications work. The actions, indications, and nursing considerations will be discussed for the major categories of cardiac and pulmonary medications.

Speaker Carol Mallia, MSN, RN
Date Nov. 18, 2004
Time 8:30 a.m. – Noon: Diabetes: What Nurses Need to Know
12:45 p.m. – 4 p.m.: Cardiac and Pulmonary Pharmacology
8:30 a.m. – 4 p.m.: Combined, all-day program
Place MNA Headquarters, Canton
Fee Per session: MNA members, $65; all others, $95
All day: MNA members, $125; all others, $150
Contact Hours* 3.6 per session
7.2 for the combined, all-day program
Special Note Lunch provided.
MNA Contact Liz Chmielinski, 781-830-5719 or 800-882-2056, x719

Registration information for all C.E. classes is on the next page.

Advanced Dysrhythmia Interpretation

Description This course is designed for nurses who have had a basic course in monitoring patients for cardiac rhythm disturbances and wish to enhance that knowledge base with more complex monitoring of advanced dysrhythmias. The course will describe the EKG changes related to ischemia, injury and infarct. The EKG abnormalities associated with toxic drug levels and electrolyte imbalances will also be described. The course will conclude with an overview of pacemakers and common pacemaker rhythm disturbances.



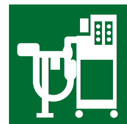
Speaker Carol Mallia, MSN, RN
Date Nov. 30, 2004
Time 5 – 9 p.m. *(Light supper provided)*
Place MNA Headquarters, Canton
Fee MNA members, $45; all others, $65
Contact Hours* 3.2
MNA Contact Theresa Yannetty, 781-830-5727 or 800-882-2056, x727

Psychophysiology of Mind / Body Healing: Placebos and Miracles

Description This program will provide nurses with evidence-based knowledge, in-depth information and insight into the whole person, based on a whole-health concept that is relationship centered.
Speaker Georgianna Donadio, D.C., M.Sc., Ph.D.
Date Dec. 1, 2004
Time 5:30 – 9 p.m. *(Light supper provided)*
Place MNA Headquarters, Canton
Fee MNA members, $65; all others, $95
Contact Hours* Will be provided
MNA Contact Theresa Yannetty, 781-830-5727 or 800-882-2056, x727

Clinical Update 2004

A.M. Session **Cardiac and Pulmonary Emergencies.** This morning program is designed for registered nurses in acute, sub-acute and long-term care settings to learn the clinical management of cardiac and respiratory emergencies. Clinical management of chest pain, brief EKG interpretation and ABG interpretation will be discussed, as well as clinical management of respiratory distress.



Speaker Carol Mallia, MSN, RN
P.M. Session **Cardiac and Pulmonary Pharmacology.** This afternoon program will provide nurses from all clinical practice settings with a better understanding of how cardiac and pulmonary medications work. The actions, indications and nursing considerations will be discussed for the major categories of cardiac and pulmonary medications.

Speaker Carol Mallia, MSN, RN
Dates Dec. 9, 2004
Time 8:45 a.m. – 12 p.m.: Cardiac and Pulmonary Emergencies
12:45 p.m. – 4 p.m.: Cardiac and Pulmonary Pharmacology
8:30 a.m. – 4 p.m.: Combined, all-day program
Place Crowne Plaza, Pittsfield, MA
Fee Per session: MNA members, $15; all others, $15
All day: MNA members, $20; all others, $20
Contact Hours* 3.6 per session
7.2 for the combined, all-day program
Special Notes Lunch provided.
MNA Contact Liz Chmielinski, 781-830-5719 or 800-882-2056, x719

Pulmonary Pharmacology

Description This program will provide nurses from all clinical practice settings with a better understanding of how pulmonary medications work. The actions, indications and nursing considerations for the major categories of pulmonary medications will be discussed.
Speaker Carol Mallia, RN, MSN
Date Jan. 11, 2005
Time 6:30 – 8:30 p.m.
Place Region 3 office, 449 Route 130, Sandwich
Fee MNA members, free; all others, $25
Contact hours* 2.4
Contact MNA Region 3, 508-888-5774 or 877-888-5774

C.E. Course Information

Registration Registration will be processed on a space available basis. Enrollment is limited for all courses.

Payment Payment may be made with MasterCard or Visa by calling the MNA contact person for the program or by mailing a check to MNA, 340 Turnpike St., Canton, MA 02021.

Refunds Refunds are issued up to two weeks before the program date minus a 25% processing fee. No refunds are made less than 14 days before the program's first session or for subsequent sessions of a multi-day program.

Program Cancellation MNA reserves the right to change speakers or cancel programs when registration is insufficient. **In case of inclement weather,** please call the MNA at 781-821-4625 to determine whether a program will run as originally scheduled. Registration and fees will be reimbursed for all cancelled programs.

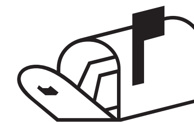
***Contact Hours** Continuing Education Contact Hours for all programs except "Advanced Cardiac Life Support" and "Anatomy of a Legal Nurse Consultant" are provided by the Massachusetts Nurses Association, which is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation. Contact hours for "Advanced Cardiac Life Support" and "Anatomy of a Legal Nurse Consultant" are provided by the Rhode Island State Nurses Association, which is accredited as an approver of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

To successfully complete a program and receive contact hours or a certificate of attendance, you must:

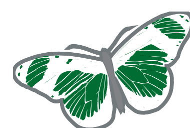
1. **sign in,**
2. **be present for the entire time period of the session and**
3. **complete and submit the evaluation.**

Chemical Sensitivity Scents may trigger responses in those with chemical sensitivity. Participants are requested to avoid wearing scented personal products and refrain from smoking when attending MNA continuing education programs.

Have you moved?



Please notify the MNA of your new address:
800-882-2056, x726



MNA Peer Assistance Program

Help for Nurses with Substance Abuse Problems

- Are you a nurse who is self-prescribing medications for pain, stress or anxiety?
- Are you a nurse who is using alcohol or other drugs to cope with everyday stress?
- Would you appreciate the aid of a nurse who understands recovery and wants to help?

Call the MNA Peer Assistance Program

All information is confidential
781-821-4625, ext. 755
or 800-882-2056 (in Mass only)
www.peerassistance.com

Support Groups for Nurses and Other Health Professionals with Substance Abuse Problems

Below is a list of self-help groups facilitated by volunteer nurses who understand addiction and the recovery process. Many nurses with substance abuse problems find it therapeutic to share their experiences with peers who understand the challenges of addiction in the health care profession.

Boston Metropolitan Area

- Bournewood Hospital, Health Care Professionals Support Group, 300 South St., Brookline. Contact: Donna White, 617-469-0300, x305. Meets: Wednesdays, 7:30–8:30 p.m.
- McLean Hospital, DeMarmeffe Building, Room 116. Contact: LeRoy Kelly, 508-881-3192. Meets: Thursdays, 5:30–6:30 p.m.
- Peer Group Therapy, 1354 Hancock Street, Suite 209, Quincy. Contact: Terri O'Brien, 781-340-0405. Meets: Tuesdays & Wednesdays, 5:30 p.m. & coed Wednesdays, 7 p.m.
- Caritas Good Samaritan Medical Center, Community Conference Room, 235 N. Pearl St., Brockton. Contact: Eleanor O'Flaherty, 508-559-8897. Meets: Fridays, 6:30-7:30 p.m.
- Health Care Professional Support Group, Caritas Norwood Hospital, Norwood. Contact: Jacqueline Sitte, 781-341-2100. Meets: Thursdays, 7–8:30 p.m.

Central Massachusetts

- Professional Nurses Group, UMass Medical Center, 107 Lincoln Street, Worcester. Contacts: Laurie, 508-853-0517; Carole, 978-568-1995. Meets: Mondays, 6–7 p.m.
- Health Care Support Group, UMass School of Medicine, Room 123, Worcester. Contact: Emory, 508-429-9433. Meets: Saturdays, 11 a.m.–noon.

Northern Massachusetts

- Baldpate Hospital, Bungalow 1, Baldpate Road, Georgetown. Facilitator: Joyce Arlen, 978-352-2131, x19. Meets: Tuesdays, 6–7:30 p.m.
- Nurses Recovery Group, Center for Addiction Behavior, 27 Salem Street, Salem. Contact: Jacqueline Lyons, 978-697-2733. Meets: Mondays, 6–7 p.m.
- Partnership Recovery Services, 121 Myrtle Street, Melrose. Contact: Jay O'Neil, 781-979-0262. Meets: Sundays 6:30–7:30 p.m.

Western Massachusetts

- Professionals in Recovery, Baystate VNAH/EAP Building, Room 135, 50 Maple St., Springfield. Contact: Marge Babkiewicz, 413-794-4354. Meets Thursdays, 7:15–8:15 p.m.
- Professional Support Group, Franklin Hospital Lecture Room A, Greenfield. Contacts: Wayne Gavryck, 413-774-2351, Elliott Smolensky, 413-774-2871. Meets: Wednesdays, 7–8 p.m.

Southern Massachusetts

- Professionals Support Group, 76 W. Main St., Suite 306, Hyannis. Contact: Kathy Hoyt, 508-790-1944. Meets: Mondays, 5–6 p.m.
- PRN Group, Pembroke Hospital, 199 Oak Street, Staff Dining Room, Pembroke. Contact: Sharon Day, 508-375-6227. Meets: Tuesdays, 6:30–8 p.m.
- Substance Abuse Support Group, St. Luke's Hospital, New Bedford, 88 Faunce Corner Road. Contact: Michelle, 508-947-5351. Meets: Thursdays, 7–8:30 p.m.

Other Areas

- Maguire Road Group, *for those employed at private health care systems.* Contact: John William, 508-834-7036 Meets: Mondays
- Nurses for Nurses Group, Hartford, Conn. Contacts: Joan, 203-623-3261, Debbie, 203-871-906, Rick, 203-237-1199. Meets: Thursdays, 7–8:30 p.m.
- Nurses Peer Support Group, Ray Conference Center, 345 Blackstone Blvd., Providence, R.I. Contact: Sharon Goldstein, 800-445-1195. Meets: Wednesdays, 6:30–7:30 p.m.
- Nurses Recovery Group, VA Hospital, 5th Floor Lounge, Manchester, N.H. Contacts: Diede M., 603-647-8852, Sandy, 603-666-6482. Meets: Tuesdays, 7–8:30 p.m. ■

Gotta Go Soothe

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During your visit preview our InnSeason Vacation Club, which offers vacation flexibility worldwide.

* Certain criteria apply to this promotional offer. There is no cost or obligation to purchase at the preview. This advertisement is being used for the purpose of soliciting vacation ownership sales. Please note, there are lodging discounts available at selected properties listed above that do not include a preview.

MNA membership dues deductibility 2003

Below is a table showing the amount and percentage of MNA dues that may not be deducted from federal income taxes. Federal law disallows the portion of membership dues used for lobbying expenses.

District	Amount	Percent
Region 1	$17.20	4.9%
Region 2/3	$17.20	5.0%
Region 4	$17.20	4.8%
Region 5	$17.20	4.7%
State Chapter	$19.34	5.2%

Health & Safety At Work

Learn about OSHA requirements for Health and Safety in your hospital

An OSHA 10-hour general industry outreach training with a focus on the health care industry.

This program is being offered in two parts at UMass Memorial Hospital, 119 Belmont Street, Worcester

Part 1: Thursday, Nov. 18, East One - Classroom
Part 2: Thursday, Dec. 16, Knowles Hall
8:30 a.m. to 3:30 p.m.

No charge to MNA members
Fee for all others: $45 for the OSHA Standards textbook

MNA members: For information and to register call Evie Bain at 781-821-4625, x 776 or via e-mail at eviebain@mnarn.org

GBAOHN members: For information and to register call Terry Donahue at 781-784-5158 or via e-mail at tadhfd@comcast.net

Labor Education and Training Survey

The Massachusetts Nurses Association is surveying its membership to identify key areas of interest for member education and training on labor issues. The MNA has dedicated resources to make this a priority for the organization. Please take a few minutes to fill out and return this survey to the MNA.

Check off as many topics that you believe are important for training. Then, to the left of the boxes you checked, list the top five most important topics by numbering them 1 to 5.

____ ☐ Grievance training
____ ☐ The role of the steward
____ ☐ Internal communications: newsletters, phone trees
____ ☐ New employee orientation: contract language
____ ☐ Health and safety
____ ☐ Leadership development: identifying new activists
____ ☐ Unfair labor practices and the National Labor Relations Board
____ ☐ Steward's right to information
____ ☐ Researching the employer
____ ☐ How to run a union meeting
____ ☐ Fair Labor Standards Act: pay, comp time and the new overtime rules
____ ☐ Family and Medical Leave Act/small necessities leave
____ ☐ Drafting contract proposals
____ ☐ Negotiations training
____ ☐ Costing out the contract
____ ☐ Drafting/implementing unit bylaws: officer elections
____ ☐ Unit officer training: understanding Landrum-Griffin
____ ☐ Arbitration: what is it and how does it work
____ ☐ Federal mediation at bargaining
____ ☐ Internal organizing and charting: identifying where members are and how to contact them
____ ☐ Americans with Disabilities Act
____ ☐ Non-discrimination in the workplace
____ ☐ Pressure on the employer and worksite activities
____ ☐ Contract campaigns
____ ☐ Labor history
____ ☐ Other ______________________________

Where would you prefer that training programs occur?

☐ At a local facility near your place of employment
☐ At the Regional office (identify the Region ________)
☐ At the MNA office in Canton
☐ At the worksite itself
☐ Other ___________________

What is the best day and time for such training programs? ______________________________

Mail completed surveys to: MNA, Attn. Joe Twarog, 340 Turnpike St. Canton, MA 02021

MNA

Fenway Community Health is New England's largest provider of outpatient mental health services to Boston's gay, lesbian, bisexual and transgender communities and in addition serves the residents of Boston's Fenway neighborhood. The following position serves as part of a multidisciplinary team in our Mental Health and Addiction Services Department:

CLINICAL NURSE SPECIALIST (Full or Part-time)

The Clinical Nurse Specialist provides psychopharmacological evaluations and medication monitoring to mental health clients receiving outpatient psychotherapy.

Typical duties include performing psychiatric evaluations (including assessing physiological, neurological, and psychopharmacological status) and providing follow up and medication monitoring. Additional duties include providing crisis intervention, participating in case assessment meetings, serving as a resource and liaison to other health care providers, and completing evaluation summaries, progress notes and other required documentation.

Requirements: Clinical Nurse Specialist degree and appropriate license to prescribe medication; related experience; familiarity with the GLBT population. The ability to work harmoniously with diverse individuals is essential. **NOTE:** Full-time or part-time is available.

Fenway offers competitive salaries and has an excellent benefit package that includes health and dental insurance, life and disability insurance, a retirement plan and generous vacation, sick and holiday time.

E-mail cover letter and resume to Jgreen@fenwayhealth.org; fax to 617 859-1250; or mail to Fenway Community Health, 7 Haviland St., Boston, MA 02115, Attention: Human Resources.

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—nurse from Boston

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— nurse from Boston

2 Canton St., Suite 115, Stoughton • 781-344-4999
www.whyweightfitness.com

Clinical Nurse Specialist/ Nurse Practitioner

Stetson School, a residential treatmen program for adolescent sex abusers, seeks a 20-hour Clinical Nurse Specialist or Nurse Practitioner with prescriptive powers and psychiatric experience. Works in collaboration with school psychiatrist. Flexible hours but must include Wednesday. Excellent benefits including health, dental, life, 403-B retirement, and vacation. Cover letter and resume to Kerry Cornwell, Program Director, Stetson School, P.O. Box 309, Barre, MA. AA www.stetsonschool.org

Have you moved?

Please notify the MNA of your new address: 800-882-2056, x726

Benefits Corner

Get lower heating oil prices through the MNA

As a member of the MNA you are eligible to join the Oil Buying Network (OBN), the largest heating oil buying group in the nation. Using its combined buying power, OBN can help you lower your heating oil costs by 10 to 25 percent.

OBN member benefits include:

- Average savings of 10 to 25 cents a gallon
- Deliveries and service from top-rated local heating oil suppliers
- $5 off the regular membership rate of $20
- Conveniences like automatic delivery, budget billing and 24-hour burner service

For more information, call the Oil Buying Network at 1-800-649-7473 or visit www.oilbuyingnetwork.com. ■

Want Safe Staffing? Then Get Political with NursePLAN

If you truly want safe staffing for your patients and your profession, then you need to get political with NursePLAN—the MNA's political action committee (PAC).

NursePLAN is dedicated to raising and contributing funds to political candidates who support the nursing profession, patient safety and quality health care:

- NursePLAN ranked as one of the state's top 20 PACs in 2002.
- Last November, NursePLAN endorsed candidates who were successful in 18 out of 23 state primary races and 51 out of 56 state general election races.
- One MNA-endorsed candidate won by just 12 votes, due in large to the impressive number of nurses who came out to vote.

Efforts like these are also having an enormous influence on the legislature's continued movement forward to pass the MNA's safe staffing legislation. We have accomplished a great deal on this front already, but your support is still needed.

If you want safe staffing, then you need to get political. Help us ensure that candidates who support the nursing profession are elected.

Contribute today, and please consider making a donation that will allow you to earn a limited edition, 100th anniversary MNA jacket. Doing so is simple and easy—just complete and return the attached form. Thank you for getting political with NursePLAN.

NursePLAN Contribution Form

Name: ____________________

Mailing Address: ____________________

Phone: ____________________ Email: ____________________

Employer*: ____________________ Occupation*: ____________________

*state law requires that contributors of $200 or more per year provide this information

Please circle jacket size (men's sizes) S M L XL XXL XXXL XXXXL

Please check one:

❑ Donation of $100 or more. Please make check payable to NursePLAN. Amountt enclosed__

❑ Donation of $85 and:

❑ I already donate at least $5/month to NursePLAN via Union Direct.

❑ Sign me up to become a monthly NursePLAN donor in addition.

I would like to contribute the additional amount of (PLEASE CIRCLE ONE)

$5/month $10/month $20/month Other $_____/month

Signature ____________________ Date ____________

Some sizes are special order and will take up to 8 weeks to be delivered.

NursePLAN is the voluntary, non-profit, political action committee for the MNA whose mission is to further the political education of all nurses, and to raise funds/make contributions to political candidates who support related issues.

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Just for being a MNA member, you and all household members are entitled to savings on your Automobile Policies. This includes all household members, including Young Drivers!

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12% discount when we write your automobile. 3% renewal credit after 1 year the policy has been in effect.

Introducing The New
MNA Home Mortgage Program
A new MNA family benefit

Reliant Mortgage Company is proud to introduce the **Massachusetts Nurses Association Home Mortgage Program**, a new MNA benefit that provides group discounts on all your home financing needs including:

- **Purchases & Refinances**
- **Home Equity Loans**
- **Debt consolidation**
- **Home Improvement Loans**
- **No points/no closing costs**
- **Single & Multifamily Homes**
- **Second Homes**
- **Condos**
- **No money down**
- **Investment Properties**

Group discounts: As the only MNA-endorsed mortgage lender, we provide qualified members and their families with low rates and group discounts. Take advantage of free mortgage pre-approvals, free credit analysis, and free review of purchase and sale agreements for homes financed through the program.

Expert advice: Whether you're a first-time or experienced homebuyer, choosing the right mortgage is important business. Reliant mortgage consultants are available to MNA members and their families to answer your questions, and walk you through the mortgage process.

We can advise you with options for refinancing your current mortgage to reduce your monthly payments, change the term of your loan, or put the equity in your house to work to consolidate debt or pay for home improvements. And if less than perfect credit (including bankruptcy or foreclosure) is a problem, ask us about practical "make-sense" underwriting. Whatever your needs, we're here to help.
Give us a call at **877-662-6623**. It's toll free.

As an MNA member, you and your family are entitled to receive free mortgage pre-approvals, and credit analysis.

- **$275 Off Closing Costs**
- **1/8 Point Discount off Points Incurred**
- **Free Pre-Approvals**
- **Low Rates & Discounts**
- **No Point/No Closing Cost Programs Available**
- **Also Available to Direct Family Members**

MNA
Massachusetts Nurses Association

Call The MNA Answer line for program rates and details:

1.877.662.6623
1.877.MNA.MNA3

MA Lic. MC1775; NH Lic. # 8503-MBB; CT Lic. 10182; RI Lic. #20011277LB; ME Lic. #SLM5764. Not every applicant will qualify for these programs.

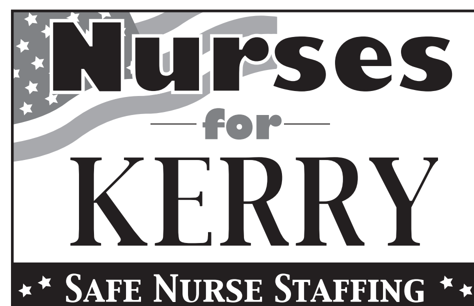
This November 2: Nurses for Kerry

Senator Kerry has been an ally and friend to Massachusetts nurses and has enjoyed a strong working relationship with the Massachusetts Nurses Association. He has worked hard for us, listened to our concerns, advocated for our issues, and has been pro-active in addressing our needs:

Senator Kerry with MNA President Karen Higgins, and MNA Board Members Mary Marengo, Irene Patch and Sandy Ellis

- ☑ He spent more than 15 hours with the staff nurses and worked to convince management to resolve their 102-day Brockton Hospital nurses strike over unsafe staffing levels and mandatory overtime.
- ☑ He sponsored and spearheaded passage of the Nurse Reinvestment Act and secured its funding to provide educational and scholarship incentives for those entering the nursing profession.
- ☑ He co-sponsored legislation with Senator Kennedy regarding minimum nurse staffing levels.
- ☑ He held focus groups with staff nurses from across the state to better understand the concerns and issues facing frontline caregivers.
- ☑ He advocated for the Pembroke Hospital RNs in their effort for union representation with the MNA.
- ☑ He advocated for the St. Vincent Hospital RNs during their strike in 2000.
- ☑ He advocated for the UMass-Memorial/UMass Medical School RNs who were confronted with strong union-busting attempts by their employer.
- ☑ He promotes legislation placing limits on the mandatory overtime hours that a nurse may be required to work.
- ☑ He strongly supports comprehensive whistleblower protections as defined in the Kennedy-Dingell Patient Bill of Rights.
- ☑ He supports card check and neutrality for workers seeking to unionize.

This election is critically important to future of our country and the future of health care services. Under our current administration we have seen dramatic increases in the uninsured; a decreasing commitment to public health; and a lack of respect for those on the frontline of the health care delivery system. President Bush spearheaded the effort to eliminate overtime pay for certain workers which will affect some RNs and health care professionals.



Every day, more and more Americans become frustrated with our health care system.

John Kerry will be a strong ally to registered nurses.
He is committed to quality health care.