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 a hospital if and when 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 supposed to oversee.

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 supposed to oversee.

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.

“One 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 change a serious infection control problem; a California hospital that had no system to ensure sterilization of medical instruments; and a Texas hospital that had 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 a hospital if and when 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 supposed to oversee.

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

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 HMO’s reign—that is, the creation of a multi-tiered health care system guaranteeing 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 (“pay”) 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 coverage. 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 “pay or play” 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 headaches 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 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 purposes:

- Promote and protect 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. 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 important priority. We recognize the need to have a presence in Washington and address national issues. 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 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. I hope we have been increasing our staff to better able to assist our local bargaining units. We are 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. They are also affecting our health care industry by keeping resources and facilities open to those they care for and at the same time 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 achieve.

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 will 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. As we approach 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 are being heard and seen as leaders in health care, and the work that is done in Massachusetts. As your elected leaders we will continue to work on behalf of all of you.
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 TSH 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 that 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 indicated 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 structure 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.

“We have what 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 DHM that the conditions that have led to this exodus cannot continue.”

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**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.
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 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 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 a 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 disconnecting 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 Central 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:

- 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.

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
- Harriette Chandler, 1st Worcester
- Susan Fargo, 3rd Middlesex
- Robert Haven, 4th Middlesex
- Therese Murray, Plymouth & Barnstable
- Robert O’Leary, Cape & Islands
- Angus Mcuilken, Norfolk, Bristol & Middlesex
- Karen Spilka, 2nd Middlesex and Norfolk
- James Timilty, Bristol & Norfolk

Senate open seats/challengers
- Edward Augustus, 2nd Worcester
- Mark Carron, Southbridge 6th Worcester
- Michael Costello, Newburyport 1st Essex
- Joseph Driscoll, Brainfree 5th Norfolk
- James Eldridge, Acton 37th Middlesex
- Barry Finegold, Andover 7th Essex
- David Flynn, Bridgewater 8th Plymouth

House incumbents
- Demetrius Atsalis, Hyannis 2nd Barnstable
- Jennifer Callahan, Sutton 18th Worcester
- Christine Canavan, Brockton 10th Plymouth
- Carol Cooley, North Attleboro 14th Bristol
- Patricia Hadassad, Sommerset 5th Bristol
- David Linsky, Andover 18th Essex
- Barbara L’Italien, Andover 12th Plymouth
- Thomas O’Brien, Wayland 13th Middlesex
- Susan Pope, 9th Middlesex

House open seats/challengers
- Shirley Gomes, Harwich 4th Barnstable
- Mary Grant, Beverly 6th Essex
- Patricia Hadassad, Sommerset 5th Bristol
- David Linsky, Andover 18th Essex
- Barbara L’Italien, Andover 12th Plymouth
- Thomas O’Brien, Wayland 13th Middlesex
- Susan Pope, 9th Middlesex

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 Faione, Saugus
- Michael Festa, Melrose
- John Fresolo, Worcester
- Emile Goguen, Fitchburg

VOTE Nov. 2
**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?

### Safe staffing budget amendment sponsor

<table>
<thead>
<tr>
<th>Safe RN staffing bill co-sponsor</th>
<th>Garrett Bradley</th>
<th>Bradford R. Hill</th>
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<tr>
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<td>Susan Williams Gifford</td>
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<td>Anne M. Gobi</td>
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<td>Emile Goguen</td>
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<td>Shirley Gomes</td>
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<td>Mary E. Grant</td>
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<td>William Greene Jr.</td>
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<td>Patricia Haddad</td>
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<td>Geoffrey Hall</td>
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<td>Lida Harkins</td>
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| Representatives                  | Yes             | No              |
| Cory Atkins                      | No              | No              |
| Demetrius Atraslis                | 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              |

| Senators                         | Yes             | No              |
| Robert Hadwen                    | No              | Yes             |
| Robert Hedlund                   | Yes             | Yes             |
| Brian Joyce                      | Yes             | Yes             |
| Michael Knappik                  | Yes             | Yes             |
| Brian Lees                       | No              | No              |
| Thomas M. McGee                  | No              | No              |
| 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              | No              |
| Marc Pacheco                     | Yes             | Yes             |
| Steven Panagiotakos              | No              | No              |
| Pamela Resor                     | Yes             | Yes             |
| Stanley Rosenberg                | No              | No              |
| Charles Shannon                  | Yes             | No              |
| Jo Ann Sprague                   | Yes             | Yes             |
| Bruce Tarr                       | Yes             | Yes             |
| Richard Tisei                    | Yes             | Yes             |
| Steven Tolman                    | Yes             | Yes             |
| Susan Tucker                     | Yes             | Yes             |
| Marian Walsh                     | Yes             | Yes             |
| Dianne Wilkerson                 | Yes             | No               |

| Senators                         | Yes             | Yes             |
| George Peterson Jr.              | No              | No              |
| Thomas M. Petrolati              | No              | No              |
| Anthony Petruccelli              | No              | No              |
| William Smitty Pignatelli        | No              | No              |
| Elizabeth A. Poirier             | No              | No              |
| Karyn Polito                    | No              | No              |
| Susan Pope                       | Yes             | Yes             |
| John Quinn                       | No              | No              |
| Kathi-Anne Reinstein             | Yes             | Yes             |
| Cheryl A. Rivera                 | No              | No              |
| Michael Rodrigues                | Yes             | Yes             |
| Mary Rogeness                    | No              | No              |
| John Rogers                      | No              | No              |
| Michael F. Rush                  | Yes             | Yes             |
| Byron Rushing                    | Yes             | Yes             |
| Jeffrey Sanchez                  | No              | No              |
| Angelo Scaccia                   | No              | No              |
| John W. Scibak                   | No              | No              |
| Frank Smizik                     | Yes             | Yes             |
| Theodorette Speliotis            | No              | No              |
| Robert Spellane                  | Yes             | Yes             |
| Joyce A. Spilotis                | Yes             | Yes             |
| Karen Spilka*                    | Yes             | Yes             |
| Marie St. Fleur                  | No              | No              |
| Harriet Stanley                  | No              | No              |
| Thomas Stanley                   | Yes             | Yes             |
| Ellen Story                      | Yes             | Yes             |
| 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             | Yes             |
| Eric Turkington                  | No              | No              |
| James Vallee                     | Yes             | Yes             |
| Anthony Verga                    | Yes             | Yes             |
| Joseph Wagner                    | Yes             | Yes             |
| 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
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 smoke from the 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 blazing. 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 artifici 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.shtml, or the CDC’s Web site at www.bt.cdc.gov/disasters/carbonmonoxide.asp.

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, cooking, or cooling. 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.

CDC Fact Sheet/Protect yourself from carbon monoxide poisoning

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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 the process

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 Hunts 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 a mannequin 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 leaders of the bargaining unit 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 participate. 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 commitment that it makes to their input.

In the following example, staffing shortage was identified as a problem. Input from the staff was the information the staff had, but the input was not actively sought or accepted. It was simply dismissed or ignored, while at the same time some in administration focused on the same problem at the same time using other means of problem solving, and the very senior non-nursing hospital administrators demonstrated a willingness to find collaborative ways of problem solving.

The solution also became apparent that what seemed to be a temporal problem began to be discussed in a manner that was not made aware of the union. As a result of this, the union for consideration, the plan was staff created and was not made aware of the union. The union for consideration, the plan was staff created and was not made aware of the union. The union was not made aware of the plan.

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.

The union must be directly involved at all stages of the process that relate to a nurse’s “wages, hours and working conditions” as defined by the National Labor Relations Act. 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, no longer to participate in the decision making.

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

Example of costs of Magnet designation

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

<table>
<thead>
<tr>
<th>Cost Description</th>
<th>Estimated Cost</th>
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<tbody>
<tr>
<td>Appraisal fee (for 500-749 beds)</td>
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<tr>
<td>Appraiser honorariums (3 at $1,000 each)</td>
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<tr>
<td>Site visit fee ($1,500/day, per appraiser; 3 days)</td>
<td>$13,500</td>
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<tr>
<td>Travel, lodging and related fees</td>
<td>$3,000 − $4,000</td>
</tr>
<tr>
<td>Outpatient Magnet designation (if applicable)</td>
<td>$4,500 − $15,000</td>
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<tr>
<td>Additional costs:</td>
<td></td>
</tr>
<tr>
<td>Staff costs to compile policies and procedures, prepare application materials, and pull documentation together. (2,000 hours at $40 per hour)</td>
<td>$3,000 − $4,000</td>
</tr>
<tr>
<td>Total estimated initial costs:</td>
<td>$168,375 − $229,875</td>
</tr>
<tr>
<td>Re-designation fees¹</td>
<td>50 percent of initial fees</td>
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</tbody>
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¹ The average number of beds in a Magnet hospital is 545, from “The Magnet Full: Recognizing Excellence in Nursing Services,” Judith Soulier, PhD, RN, Western Michigan University, Bronson School of Nursing, at www.minursums.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.

By Joe Twang
Associate Director, Labor Education and Training

Magnet status: the cost of the process

A s 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.

The union must be directly involved at all stages of the process that relate to a nurse’s “wages, hours and working conditions” as defined by the National Labor Relations Act. 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, no longer to participate in the decision making.

The “participation” most often is another way to control the workforce. Employees enter the process excited and in good faith—experiencing significant time and effort, only to have their efforts relegated to the level of unenforceable “recommendations.”
the experience of one MNA bargaining unit

Journey to Magnet status: An inside look at the experience of one MNA bargaining unit

Massachusetts Nurse

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

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 heels 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.
use to refer to hospitals which had these characteristics. 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 ANCC, 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 Standards and Guidelines 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.

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.1 Magnet status is awarded for a four-year period, after which the organization must reapply.

The program is marketed by ANCC 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.

ANCC collects a fee from hospitals for its Magnet recognition process. Their fees include an appraisal fee ranging from $9,765 for a hospital with less than 100 beds to $47,250 for a hospital with more than 500 beds. This fee is used to cover the costs associated with the appraisal, including travel, lodging, and other related expenses for the site visit.

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.2 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 ANCC by MGH as evidence illustrating the 95 Magnet and core criteria necessary for MGH to gain its September 2003 Magnet designation.

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.3 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 structured hospital finance. Hospitals began to be compensated for paying (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 healthcare system. Today we see CMS (Centers for Medicare and Medicaid Services, formerly known as HCFA, the Healthcare Financing Administration) beginning to link Medicare payments directly to quality of care, which is viewed as signaling the end to the DRG payment era. CMS is funding pilot projects to tie payments to hospitals to demonstrators of quality.4 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 ANCC and others, publicize the correlation between various indicators of quality such as lower mortality rates and shorter lengths of stay with Magnet hospital status.5 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.6 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 encour-

District 3 offers two-part pulmonary series at new office in Sandwich

Nov. 16, 2004
Managing Pulmonary Emergencies
6:30–8:30 p.m.
Speaker: Carol Mallia RN, MSN
24 contact hours will be provided

Jan. 11, 2005
Pulmonary Pharmacology
6:30–8:30 p.m.
Speaker: Carol Mallia RN, MSN
24 contact hours will be provided

Region 3 office, 449 Route 130, Sandwich

For more information or to register, call 508-888-5774 or 877-888-5774.
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**UNIVERSAL STUDIOS MEMBER EXTRAS**

Log onto the MBNA Web site at www.massnurses.org and click on the Universal Studios Link to obtain special discount prices or e-mail member.extras@universalorlando.com.

**MNA’s premier group benefits programs help you get more out of your membership and your hard-earned money! Take advantage of these special benefits specifically designed for MNA members. For information on our discount programs, contact the representative listed or call Chris Stetkiewicz in the MNA membership department, 800-882-2056, x726.**

All benefits and discounts are subject to change.
## MNA Continuing Education Courses

### Fall/Winter 2004

#### Oncology for Nurses

<table>
<thead>
<tr>
<th>Description</th>
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<tbody>
<tr>
<td>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.</td>
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<table>
<thead>
<tr>
<th>Speaker</th>
<th>Marylou Gregory-Lee, MSN, RNCS, OCN, Adult Nurse Practitioner</th>
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<tbody>
<tr>
<td>Date</td>
<td>Oct. 27, 2004</td>
</tr>
<tr>
<td>Time</td>
<td>8:30 a.m. – 4 p.m. (Lunch provided)</td>
</tr>
<tr>
<td>Place</td>
<td>MNA Headquarters, Canton</td>
</tr>
<tr>
<td>Fee</td>
<td>MNA members, $125; all others, $150</td>
</tr>
<tr>
<td>Contact Hours*</td>
<td>Theresa Yannetty, 781-830-5727 or 800-882-2056, x727</td>
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#### Managing Pulmonary Emergencies

<table>
<thead>
<tr>
<th>Description</th>
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<tbody>
<tr>
<td>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 understanding of how chest tubes and tracheotomies. Program will include ABG interpretation and oxygen delivery system safeguards.</td>
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<table>
<thead>
<tr>
<th>Speaker</th>
<th>Carol Mallia, RN, MSN</th>
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<tbody>
<tr>
<td>Date</td>
<td>Nov. 16, 2004</td>
</tr>
<tr>
<td>Time</td>
<td>6:30 – 8:30 p.m.</td>
</tr>
<tr>
<td>Place</td>
<td>Region 3 office, 449 Route 130, Sandwich</td>
</tr>
<tr>
<td>Fee</td>
<td>MNA members, free; all others, $25</td>
</tr>
<tr>
<td>Contact Hours*</td>
<td>2.4</td>
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</tbody>
</table>

#### 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.

<table>
<thead>
<tr>
<th>Speaker</th>
<th>Ann Miller, MS, RN, CS, CDE</th>
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<tbody>
<tr>
<td>Date</td>
<td>Nov. 18, 2004</td>
</tr>
<tr>
<td>Time</td>
<td>8:30 a.m. – Noon: Diabetes: What Nurses Need to Know 12:45 p.m. – 4 p.m.: Cardiac and Pulmonary Pharmacology</td>
</tr>
<tr>
<td>Place</td>
<td>MNA Headquarters, Canton</td>
</tr>
<tr>
<td>Fee</td>
<td>Per session: MNA members, $65; all others, $95 All day: MNA members, $125; all others, $150</td>
</tr>
<tr>
<td>Contact Hours*</td>
<td>3.6 per session</td>
</tr>
<tr>
<td>Special Note</td>
<td>Lunch provided</td>
</tr>
<tr>
<td>MNA Contact</td>
<td>Liz Chmielinski, 781-830-5719 or 800-882-2056, x719</td>
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</table>

**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.

<table>
<thead>
<tr>
<th>Speaker</th>
<th>Carol Mallia, MSN, RN</th>
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<tbody>
<tr>
<td>Date</td>
<td>Dec. 9, 2004</td>
</tr>
<tr>
<td>Time</td>
<td>8:45 a.m. – 12 p.m.: Cardiac and Pulmonary Emergencies 12:45 p.m. – 4 p.m.: Cardiac and Pulmonary Pharmacology</td>
</tr>
<tr>
<td>Place</td>
<td>Crowne Plaza, Pittsfield, MA</td>
</tr>
<tr>
<td>Fee</td>
<td>Per session: MNA members, $15; all others, $15 All day: MNA members, $20; all others, $20</td>
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<tr>
<td>Contact Hours*</td>
<td>3.6 per session</td>
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<tr>
<td>Special Notes</td>
<td>Lunch provided</td>
</tr>
<tr>
<td>MNA Contact</td>
<td>Liz Chmielinski, 781-830-5719 or 800-882-2056, x719</td>
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#### Advanced Dysrhythmia Interpretation

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<tr>
<th>Description</th>
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<tr>
<td>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.</td>
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<table>
<thead>
<tr>
<th>Speaker</th>
<th>Georgianna Donadio, D.C., M.Sc., Ph.D.</th>
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<tbody>
<tr>
<td>Date</td>
<td>Dec. 1, 2004</td>
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<tr>
<td>Time</td>
<td>5:30 – 9 p.m. (Light supper provided)</td>
</tr>
<tr>
<td>Place</td>
<td>MNA Headquarters, Canton</td>
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<tr>
<td>Fee</td>
<td>MNA members, $65; all others, $95</td>
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<tr>
<td>Contact Hours*</td>
<td>Will be provided</td>
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#### Psychophysiology of Mind / Body Healing: Placebos and Miracles

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<tr>
<th>Description</th>
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<tbody>
<tr>
<td>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.</td>
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<table>
<thead>
<tr>
<th>Speaker</th>
<th>Carol Mallia, MSN, RN</th>
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<tbody>
<tr>
<td>Date</td>
<td>Jan. 11, 2005</td>
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<tr>
<td>Time</td>
<td>5 – 9 p.m.</td>
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<tr>
<td>Place</td>
<td>Region 3 office, 449 Route 130, Sandwich</td>
</tr>
<tr>
<td>Fee</td>
<td>MNA members, free; all others, $25</td>
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<tr>
<td>Contact Hours*</td>
<td>2.4</td>
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</table>

#### Clinical Update 2004

**A.M. Session**

**Cardiac and Pulmonary Emergencies.** This morning program is designed for 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.

<table>
<thead>
<tr>
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<tbody>
<tr>
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<td>Dec. 9, 2004</td>
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<tr>
<td>Time</td>
<td>8:30 a.m. – 4 p.m.: Cardiac and Pulmonary Pharmacology</td>
</tr>
<tr>
<td>Place</td>
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<tr>
<td>Fee</td>
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<tr>
<td>Special Notes</td>
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<tr>
<td>MNA Contact</td>
<td>Liz Chmielinski, 781-830-5719 or 800-882-2056, x719</td>
</tr>
</tbody>
</table>

**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 will be discussed. The actions, indications and nursing considerations will be discussed for the major categories of cardiac and pulmonary medications.

<table>
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<tr>
<th>Speaker</th>
<th>Carol Mallia, MSN, RN</th>
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<tbody>
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<tr>
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<tr>
<td>Fee</td>
<td>Per session: MNA members, $15; all others, $15 All day: MNA members, $20; all others, $20</td>
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<td>MNA Contact</td>
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### Pulmonary Pharmacology

<table>
<thead>
<tr>
<th>Description</th>
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<tbody>
<tr>
<td>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.</td>
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</tbody>
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<table>
<thead>
<tr>
<th>Speaker</th>
<th>Carol Mallia, RN, MSN</th>
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<tr>
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</tr>
<tr>
<td>Fee</td>
<td>MNA members, free; all others, $25</td>
</tr>
<tr>
<td>Contact Hours*</td>
<td>2.4</td>
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Registration information for all C.E. classes is on the next page.
**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.

---

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

**Boston Metropolitan Area**
- Bournemouth 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, DeMammeffe Building, Room 116. Contact: LeRoy Kelly, 608-881-3192. 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.
- Caritas Good Samaritan Medical Center, Community Conference Room, 235 N. Pearl St., Brockton. Contact: Eleanor O’Flaherty, 508-559-8897.
- Nursing 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.

**Central Massachusetts**
- Health Care Support Group, UMass School of Medicine, Room 123, Worcester. Contact: Emory, 508-429-9433. Meets: Saturdays, 11 a.m.–noon.

**Northern Massachusetts**
- Baldwin Park Hospital, Bungalow 1, Baldwin 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.

**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.

**Southern Massachusetts**
- Professionals Support Group, 76 W. Main St., Suite 306, Hyannis. 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., 603-647-8552, Sandy, 603-666-6482. Meets: Tuesdays, 7–8:30 p.m.
Gotta Go Soothe

Stay Two Nights and Save $100
at any of our Northeast Resorts
PLUS receive a $40.00 Dinner Certificate

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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.
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 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.

<table>
<thead>
<tr>
<th>District</th>
<th>Amount</th>
<th>Percent</th>
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<tbody>
<tr>
<td>Region 1</td>
<td>$17.20</td>
<td>4.9%</td>
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<tr>
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<td>$17.20</td>
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<td>Region 4</td>
<td>$17.20</td>
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<td>Region 5</td>
<td>$17.20</td>
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<tr>
<td>State Chapter</td>
<td>$19.34</td>
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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 tdadfd@comcast.net

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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 combined 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.
• NursePLAN ranked as one of the state’s top 20 PACs in 2002.

Feel 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. Amount 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 contributions 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.
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.

- $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

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

Call The MNA Answer Line For Program Rates And Details:

1.877.662.6623
1.877.MNA.MNA3
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 proactive in addressing our needs:

- 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."