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THE NEWSLETTER OF THE MASSACHUSETTS NURSES ASSOCIATION ■ www.massnurses.org ■ VOL. 77 No. 1

Reconciling medications: whose responsibility is it?

The reconciliation of medications is a new safety standard of the Joint Commission on the Accreditation of Hospital Organizations, but the licenses of nurses are being compromised in the implementation of this

new practice by their employers. The reconciliation process is the responsibility of the prescriber.

The nurse caring for the patient in the reconciliation process is not the prescriber. The prescriber or provider is the physician or an advanced practitioner who has prescription authority. The prescriber is the responsible party for the reconciliation of the patient's medication list throughout the patient's continuum of care, which includes admission and transitions in care (transfers

and discharge).

In some hospitals, nurses are being requested to obtain a list of patient medications upon their admission and inappropriately asked to verify this list with the patient's pharmacy for accuracy. At fault with this practice is the reality that patients often use more than one pharmacy for their prescriptive needs and this may be unknown in the reconciliation process. Upon receipt of the information from the pharmacy, the nurse can be required to reconcile the list from the patient and the pharmacy with new medications ordered by the physician upon admission. This is a process that must be completed by the physician/prescriber. **Signing medication orders is not within the scope**

See *Meds*, Page 5



Momentum grows on nurse staffing bill

Things have shifted into high gear on the safe RN staffing legislation. There is heightened discussion within the Legislature on what a compromise bill would look like, in particular taking the best of both bills (H.2663 and S.1260) as recommended in a recent editorial in the *Sentinel & Enterprise*. The MNA believes the main tenets of this potential compromise should include:

- The creation of programs to increase nurse faculty
In the current climate, prospective nursing students are being turned away from schools because of faculty shortages.
- The availability of scholarship/educational incentives for nursing students
In order to ensure that the pipeline of nurses continues to meet the challenges of an aging population, scholarship and educational incentives must be provided to young people considering the nursing profession.
- A limit on the number of patients an RN is assigned at one time
When nurses are forced to care for too many patients at once, patients suffer the consequences in the form of preventable errors, avoidable complications, increased lengths of stay and readmissions. By limiting the number of patients a nurse must care for, all patients will receive better care.

"It's time to focus on a solution," said MNA President Beth Piknick. "The debate has gone on too long and patient care continues to suffer."

See *Staffing*, Page 6

With the MNA, your Continuing Education credits are free

The MNA is proud to announce the availability of two new innovative and convenient opportunities that will let members earn CE credits at no cost: an all-day clinical conference, scheduled for May 19, and a Web-based curriculum that allows members to take advantage of timely courses from the comfort of their own homes.

"The MNA is dedicated to providing its members with quality education that is relevant to their clinical practice," said Dorothy McCabe, RN and director of the MNA's divisions of nursing and health and safety. "We're also committed to bringing in experts who can educate RNs and health care professionals about the many components that make up today's diverse health care environment. Both the new clinical and Web-based CE programs

meet these goals."

The development and implementation of both opportunities is based on a need that the MNA anticipated and that members communicated.

"In this day and age, it's important to provide people not only with pertinent programs, but also flexibility in terms of when, where and how they can participate in those programs," explained McCabe. "An all-day clinical conference, combined with our Web-based programs, will offer members the best of both worlds."

Clinical Nursing Conference

The MNA's "1st Annual Clinical Nursing Conference" will be held on May 19 at the Doubletree Hotel (formerly the Wyndham

900+ days with no contract: Unit 7's fight continues

On Dec. 16, Unit 7 members went to the State House to celebrate the holiday season with Governor Romney. While he was not able to go outside and address the crowd, Romney did send out the "Romney Grinch" to deliver a holiday gift they said that Unit 7 members deserved: coal.

The members responded by singing mock Christmas carols adapted to reflect their ongoing contract struggle. Afterwards, in the name of all Unit 7 employees atnd their patients, several union leaders each deposited a symbolic piece of coal into a large stocking which was then delivered to the governor's office. For more on Unit's 7 ongoing fight for a fair contract, visit www.savestateservices.com. ■



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MNA Clinical Nursing Conference

Free to MNA Members!
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For the latest
developments
impacting nurses,
visit the
MNA Web site, www.massnurses.org

Hotel) in Westborough, Mass. from 8 a.m. to 4 p.m. Program topics will include:

Keynote Address: 25 Stupid Things Nurses Do to Self Destruct

Concurrent Sessions:

- Diabetes Pharmacotherapy
- Neurological Assessment
- Public Health Emergencies
- Renal Failure and Electrolytes
- New Advances in Cancer Therapy
- Understanding Today's Street Drugs

Closing Address: Crucial Conversations: Survival Skills for the Future

Presenters will include nationally recognized speakers in nursing, as well as local and MNA-affiliated health care experts.

There is no registration cost for MNA members. See *Free CE*, Page 3

Executive Director's column

The hospital industry's Web scam: a public relations ploy by any other name

By Julie Pinkham, RN
Executive director of the MNA

The latest twist in the hospital industry's efforts to obstruct the passage of our RN-to-patient ratios bill is a public relations scam involving the introduction of "Patients First."

Kind of makes you wonder where hospitals placed patients before if not "first," doesn't it? "Patients First" is a Web-based program that the MHA claims will "disclose hospital staffing plans online to consumers." But what it really reveals is the industry's ongoing plan to under staff our hospitals. The site shows that hospitals have wild variations in staffing.

Yes . . . according to the MHA, you or your loved one can now—assuming you have Web access—look up what a particular hospital's staffing plan is. But the site doesn't list every unit in the hospital. It cherry picks only a selection of units and, even if you find the staffing plan, it is presented in a way that is totally incomprehensible to most patients.

As you delve a little deeper into the Web site you'll also find that the listing for RNs includes not only those directly assigned to patients but other RNs as well. At some hospitals, it lists RNs and LPNs as interchangeable, equal professionals. Given that it's hypothetical (it's based on an average daily census) the fact that your unit is full—or may have even taken care of more patients than the total number of beds with discharges and admissions—is obscured to say the least. There is no way to determine the actual RN-to-patient ratio on the site, which is the only realistic measure of a nurse's patient assignment.

So when you look up this information and then look around the very units sited to see if rhetoric meets reality, don't be surprised

if it doesn't. Even the inadequate plan isn't met by these institutions (there's a shock).

And what do the patients glean from this? Well, there's some indication of an institution's commitment to deliver safe nursing care, but what do they really get? Nothing other than rhetoric.

Actually, what they get is something worse: they get misled.

So with hospitals reaching nearly a billion dollars in profits last year we can certainly see their commitment to patient care in the form of a slick PR campaign designed to obfuscate the crisis that is the lack of nurses willing to stay at or return to the bedside due to overburdened, unsafe workloads. There is now abundant research to clearly prove the following:

- That RNs make the difference in patient outcomes
- That safe staffing not only saves lives, but it saves money as well
- That retention and recruitment issues are resolvable with the implementation of safe RN-to-patient ratios
- That safe RN-to-patient ratios are as appropriate and necessary to patients as are clinical treatments such as anti-coagulant therapy for heart attack and strokes and preventative cancer screenings

Even with all of this research, the industry's position on RN-to-patient ratios remains the same: no way, no how, not now, not ever.



Julie Pinkham

Fortunately for us, the public, 106 advocacy organizations and the overwhelming majority of our elected leaders agree with the MNA and not the hospital industry. So with our continued push—meaning that we keep the emails, post cards and calls to our legislators going—leadership at the State House is positioning to move this issue to a vote and passage this session.

If you need some extra motivation, just click on the MHA's Web site to see what their "plan" is. Then send an email message to your legislators dispelling the hospital industry's "Web myth," and share a dose of nurse/patient reality. Here are some things you might point out:

- Let them know what the staffing plan is for your unit and, if you don't have the staff promised in the plan, tell them how many patients you are really assigned.
- If you're assigned more patients than the MNA's safe staffing bill recommends, tell them that for every patient you're assigned above that number, multiply it by 7 percent to determine the morbidity and mortality rate for all your patients.

If you don't know your legislator's email address, visit the MNA Web site at www.massnurses.org and click on the "Write Your Legislator" link. ■

...Free CE

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bers (the cost is \$195 for non-members), but registration is required for both members and non-members (see Page 20). Please note that registration is on a space available basis and will end once seating capacity is reached (600 person max). For more information, contact MNA's Division of Nursing at 781-830-5727, 781-830-5723 or 781-830-5719.

Online CE

The MNA is now also offering members access to free CE programs via the Web. Initial program topics will include:

- Fragrance Free! Creating a Safe Healthcare Environment
- Workplace Violence

All online CE courses are available at www.courseserver.com/mna/. Participating RNs and health care professionals have the option to either complete their studies in "one sitting" or over several days and/or visits—whatever is most convenient.

The new online CE programs will be free of charge to both MNA members and non-members.

To register go to www.courseserver.com/mna/ and click on "REGISTER." The subscription code for members is mna001, non-Members is mna002, and students is mna003. Fill out all of the fields in the form and press submit. This information will also be listed on our Web site at www.massnurses.org. For more information, contact the Division of Health and Safety at 781-830-5723.

Contact hours will be 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. To successfully complete a program and receive contact hours, you must: 1) sign in, 2) be present for the entire time period of the session and 3) complete and submit the evaluation. ■

MNA HOODED SWEATSHIRTS NOW ON SALE

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ITEM	SIZE	PRICE	QTY	TOTAL
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Sweatshirt	Large	\$35.50		
Sweatshirt	X-Large	\$35.50		
Sweatshirt	XX-Large	\$38.50		
Sweatshirt	XXX-Large	\$41.50		
Shipping & Handling (\$5.50 per item)				
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Signature as shown on credit card

Return this form with payment to MNA, 340 Turnpike Street, Canton, MA 02021

New MNA hooded sweatshirts are now available.

Gray, hooded sweatshirts of cotton/poly blend are excellent quality and feature the MNA logo on the chest and across the back.



- Small
- Medium }\$35.50
- Large
- X-Large
- XX-Large.....\$38.50
- XXX-Large\$41.50

Nursing on Beacon Hill: Legislative Update

House and Senate pass differing versions of health care reform

Before recessing for the holiday break the Massachusetts House and Senate passed differing versions of a health care reform bill designed to provide health care access to the uninsured and increase reimbursement levels to providers. The differences in the bills are now being worked out in a "conference committee." Action on a final bill is expected soon.

The following charts outline the specific details of both plans:

	House Bill (H.4479)	Senate Bill (S.2265)
Medicaid Eligibility	Expands income eligibility of children from 200% to 300% FPL; Expands income eligibility of parents from 133% to 200% FPL; Restores coverage to all lawfully present adult immigrants. Increases MassHealth Essential enrollment cap from 44,000 to 60,000; Increases CommonHealth cap from 14,000 to 15,600; Increases MassHealth HIV cap from 1,050 to 1,300.	Expands income eligibility of children from 200% to 300% FPL; Expands income eligibility of parents from 133% to 200% FPL; covers all childless adults under 65 up to 100% FPL; Increases MassHealth Essential enrollment cap from 44,000 to 60,000; Increases CommonHealth cap from 14,000 to 15,600; Increases MassHealth HIV cap from 1,050 to 1,300.
Medicaid Benefits	Restores adult dental benefits; Creates a pilot smoking cessation program and wellness program	Restores adult dental benefits, eyeglasses and other benefits cut after Jan. 2002; Creates pilot program for smoking cessation.
Medicaid Rates	In FY 07, adds \$80M for hospital & physician rate increases and \$10M for health centers. Rate increases tied to quality and performance benchmarks; DHCFP to prepare annual report on adequacy of rates.	Creates \$90M annual fund for two years to pay for transition to Medicare fee schedule for hospitals and health centers, and \$16 million for physicians; Creates health care industry payment advisory board DHCFP to prepare annual report on adequacy of rates.
Other Medicaid Items	Prohibits more restrictive disability standard than SSI; Codifies FY 06 budget items: providing MH Essential for elderly & disabled legal immigrants with no sponsor deeming; raising HIV income ceiling to 200% FPL; requiring a public hearing before rule changes restricting eligibility or benefits; Requires report to Joint Mental Health Committee prior to change in behavioral health contracts.	Prohibits more restrictive disability standard than SSI; Codifies FY 06 budget items: raising HIV income ceiling to 200% FPL; requiring a public hearing before rule changes restricting eligibility or benefits. Requires report to Joint Mental Health Committee prior to change in behavioral health contracts.
Insurance Partnership	Repeals program, effective 7/1/2007	Renames program Health Care Plus and moves to Labor & Workforce Development; Raises family income eligibility from 200% to 300% FPL and raises size of qualifying small employer from 50 or fewer employees to 75; Raises annual employer subsidy from \$400 to \$600 for an individual; \$800 to \$1200 for a couple, and \$1000 to \$1500 for a family.

Beacon Hill Briefs

Emergency contraception law

Legislation endorsed by the MNA that requires hospitals to offer emergency contraception (EC) finally went into effect on Dec. 14, 2005—90 days after it was passed over Governor Romney's veto. The Mass EC Network has expressed appreciation to the MNA for its support of this important legislation protecting women's rights.

EC refers to FDA-approved contraception for use after sexual intercourse when contraceptives have failed or when no contraceptives were used, such as with a sexual assault.

EC is 75 to 89 percent effective in preventing pregnancy if taken within 72 hours after unprotected sex. It can also be effective when taken up to five days after unprotected sex.

"Plan B" is the brand name for EC in the US. It contains the same hormones found in birth control pills. The first pill is taken as soon as possible after unprotected sex and the second pill 12 hours later. The more quickly the medication is taken, the more effective it is in preventing an unwanted pregnancy.

On Dec. 12, the Massachusetts Department of Public Health sent a letter to all acute care hospitals in the commonwealth outlining provider requirements for providing EC to rape survivors, effective Dec. 14. The Board of Registration in Pharmacy has also posted guidelines on its Web site for pharmacist

dispensing of EC. Once pharmacists have completed an accredited training, signed an agreement with a physician, and met the other prerequisites in the guidelines, they will be able to begin offering EC to women who come in without a doctor's prescription.

For more information, visit:

- www.masseccnetwork.org/
- www.mass.gov/dph/dhcq/emergency_contraception.htm ■

Rep. Walsh leads effort on behalf of RNs

State Rep. Steven Walsh (D-Lynn) recently sponsored an amendment to the House Health Care Reform legislation to include a representative of the MNA on the Public Health Council.

The Massachusetts Public Health Council serves as a public entity to the Department of Public Health. It has an important voting and decision-making role, including the "determination of need" process for hospitals and nursing homes; promulgation of new public health regulations; and hospital sales, transfers and licensing.

The MNA believes Walsh's work on this amendment is an important initiative—and one that would provide the council with an additional voice from the front-line of health care delivery in the commonwealth.

Nurses—the single largest occupation of health care professionals providing care on a 24/7 basis in all aspects of health care delivery—are on the front-line of health care delivery. Nursing is a critical component of providing quality health care. A front-line RN on the Public Health Council can provide important insights and an articulate viewpoint from a health care professional's perspective regarding their responsibility as a patient advocate. ■

Sen. Barrios leads effort on workplace violence

State Sen. Jarrett Barrios (D-Cambridge) led efforts in the Senate Health Care Reform debate to address workplace violence issues in health care facilities.

Barrios, who has been an active and outspoken advocate on this issue, serves as the chairman of the Public Safety Committee. He has sponsored legislation this session to create, develop and implement a workplace violence prevention program in health care settings. This bill, S.1329, was reported favorably from Barrios' committee. He then filed an amendment to the health care reform bill to include the workplace violence program. While the amendment was unsuccessful Barrios' efforts were critical in continuing to move the legislation forward. ■

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MNA

MASSACHUSETTS NURSES ASSOCIATION



...Meds

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of the RN who is not a prescriber.

This example occurred recently at a local hospital. The admitting physician who was responsible for the admission reconciliation did not reconcile all the medications with his signature before the medications were ordered from the pharmacy. The nurse tried to contact the physician. He was not available and a covering physician approved the reconciliation via telephone. The nurse signed the reconciliation form which was then transmitted to the pharmacy. The attending physician, in reviewing the patient's orders the next day, questioned the appropriateness of the ordered medications for this patient.

1. What was the nurse's liability in this situation?
2. Why is this issue so important to the safety of your practice and license?

Once again, it is important to remember that a registered nurse is not authorized or approved to sign orders that must be reconciled with patient preadmission medication or orders written before transfer or discharge.



There are many variations to this new practice and nurses need to be aware of what the medication reconciliation process is and what it isn't according to the regulatory requirements of their practice. Taking a medication history on admission has always been part of the nursing assessment, but the nurse is practicing beyond her scope if she reconciles these medications without the prescriber's signature either in the computer or in the chart before sending these orders to the pharmacy or administering the medications.

The Massachusetts Board of Nursing is definitive in its definition of the registered nurse:

Registered Nurse is the designation given to an individual who is licensed to practice professional nursing, holds ultimate responsibility for direct and indirect nursing care, is a graduate of an approved school for professional nursing, and is currently licensed as a Registered Nurse pursuant to M.G.L. c. 112. Included in such responsibility is providing nursing care, health maintenance, teaching, counseling, planning and restoration for optimal function-

ing and comfort of those they serve. (244CMR Board of Registration in Nursing Section 3:01)

There is no mention in the definition that the registered nurse can approve prescriptive orders or reconcile these orders with medications that the patient is receiving before admission, transfer and/or discharge. This is the role of the physician, a physician assistant or a nurse in the expanded role. 244CMR 4.05 defines the authority of a nurse in an expanded role:

A nurse engaged in prescriptive practice is a nurse with:

- (a) Authorization to practice in the expanded role
- (b) A minimum of 24 contact hours in pharmacotherapeutics which are beyond those acquired through a generic nursing education
- (c) Valid registration(s) to issue written or oral prescriptions or medication orders for controlled substances from the Massachusetts Department of Public Health in accordance with M.G.L. c. 94C #7(g) and, where required, by the U.S. Drug Enforcement Administration

In reviewing the reconciliation process in Massachusetts hospitals, many are attempting to comply with the following regulations published in 2006 by the JCAHO:

JCAHO Requirement 8A requires organizations to: "Implement a process for obtaining and documenting a complete list of the patient's current medications upon the patient's admission to the organization and with the involvement of the patient. This process includes a comparison of the medications the organization provides to those on the patient's list." (JCAHO Comprehensive Accreditation Manual for Hospitals 2006, Page 11.)

JCAHO Requirement 8B states: "A complete list of the patient's medications is communicated to the next provider of service when a patient is referred or transferred to another setting, service, practitioner, or level of care within or outside the organization." (Ibid, Page 11.)

"In the context of Goal 8B, we consider the provider to be another health care organization or an independent practitioner (LIP)," explained Rick Croteau, MD and executive director for patient safety initiatives at the JCIC for Patient Safety. "In general, the 'provider' would not be a nurse although it could be an advanced practice nurse. APRs can function as independent practitioners within a defined scope of practice in most states. Whether an organization, physician, APR, or other LIP, the information could be received by an "agent" of the organization or practitioner, who could be a nurse."

The rationale for this measurement by JCAHO is stated as follows: "Patients are most at risk during transitions in care (handoffs) across settings, services, providers or levels of care. The development, reconciliation and communication of an accurate medication list throughout the continuum of care are essential in the reduction of transition-related adverse drug events." (Ibid, Page 11.)

As hospitals attempt to develop systems that meet the JCAHO criteria, nurses are being asked to take on additional responsibilities for clarifying the medications the

Medication reconciliation

Role of authorized prescriber	What is not acceptable practice for the RN
Medication History	
The medication history can be an order sheet if each medication and dose listed is designated to be continued on admission and signed by the patient's authorized provider (prescriptive authority). This process can be done via computer or paper record. Computerization can require the prescriber to complete the process before logging off.	The medication history is not an order sheet unless each medication is reviewed and signed by the authorized provider. The registered nurse who is not an authorized prescriber should not authorize the order sheet.
Patient transfers and discharges	
Patient transfers and discharges are the responsibility of the authorized provider who reviews each medication the patient is currently receiving in the hospital, and verifies whether the medication should be continued or discontinued before the patient is transferred to another area or is discharged to another facility or home. Once again, a computerized system will require completion of the process before logging off.	The transfer and discharge medication reconciliation process is reviewed and signed by the authorized provider not the nurse assigned to the patient. Once this reconciliation process has been completed, the nurse fulfills her role in the administration of medication and or the discharge teaching required for the patient.

patient took before admission or treatment at a hospital, and reconcile these medications upon transfer and or discharge. Many Massachusetts hospitals are in various stages of compliance with the above standards. Some are beginning the reconciliation process, while others are in the testing phase.



The nurse needs to be aware of her/his responsibilities in relation to the nurse practice act and have an awareness of the following:

1. The medication history assessment can be an order sheet if each medication listed is verified and signed by the prescriber.
2. The medication history assessment, if computerized, must be reconciled by the prescriber before logging off before medication orders can be processed.
3. Obtaining patient information from a

pharmacy can be incomplete; it is not recommended to participate in this step of the process.

4. The prescriber must reconcile all orders before transferring the patient within the institution.
5. The prescriber must reconcile all orders before discharge or transfer to another institution.

Many hospitals are struggling to comply with these new criteria. What may be a simple process to many can become complex as each hospital orients staff to its new systems. Hospitals with computerized patient systems will need to program these systems with checks to ensure that the prescribing provider completes the reconciliation process before exiting the system.

Hospitals with paper patient-record systems may need to have several forms for reconciling (i.e. admission, transfer and discharge to reduce error that could occur with an overlapping form).

Nurses must be aware that their availability at the bedside 24 hours a day can target them for requests to practice beyond their scope (i.e., authoring the admission patient history medication list as a medication order sheet for the pharmacy). This same process could be replicated on transfer and discharge.

During 2006, every RN will have a role in medication reconciliation. It is imperative that in your role you follow the regulations of the nurse practice act to protect your patients and yourself. ■

Medicare's new prescription drug program

Helping your patients navigate the morass

The Medicare Modernization Act of 2003 made significant changes to the way the government pays health care expenses for people who are 65 or older, as well as people with disabilities. As part of this process, Medicare began to offer recipients access to prescription drug plans on Jan. 1.

The goal of the plan was—and still is—to offer eligible Medicare recipients the opportunity to save on their prescription drug costs. But, as we all know by now, the actual process of getting to that point has been less than smooth. In fact, any number of recent newspaper headlines proves this point:

- "States Intervene After Drug Plan Hits Snags" (*New York Times*, 1/8/06)
- "Lawmakers Detail Drug-plan Complaints" (*Boston Globe*, 1/6/06)
- "A Dose of Confusion With New Drug Plan" (*Los Angeles Times*, 12/31/05)
- "Seniors Find Medicare Drug Plan Options Bewildering" (*Washington Post*, 11/19/05)

Current failures and successes aside, the new Medicare prescription drug plan is still a "sticky wicket" that most seniors—including many of your patients—will need to grapple with and reach a decision on by May 15, 2006.

Outlined here is a brief history of Medicare Part D, as well as a short list of hints, tips and resources that may provide you and your patients with additional guidance in selecting the prescription drug benefit plan that is most appropriate.

Medicare Part D in a nutshell

Medicare Part D, or the Medicare prescription drug benefit, is a federal health insurance program that offers prescription drug coverage to people with Medicare Part A or Part B. It is a voluntary, subsidized, guaranteed enrollment, prescription drug insurance plan administered by private health insurance companies. Many companies bid for the right to work with Medicare as Part D administrators. As with other insurance plans, the Medicare recipient will pay a monthly premium and a share of the cost of the prescription drugs (www2.epocrates.com).

Medicare Part D is administered in two ways:

1. A stand-alone Prescription Drug Plan (PDP).
2. Integrated with medical coverage as a Medicare Advantage Prescription

Drug plan (MA-PD). Patients can add a PDP policy to traditional Medicare Part A and/or B, or any medical-only insurance supplemental policy. MA-PDs replace both supplemental medical and prescription drug coverage. All PDPs and MA-PDs must adhere to standards set forth by Medicare to ensure reasonable drug coverage.

Individual Part D plans will vary significantly by insurer (from what drugs are covered to what pharmacies are included), but all health plans must offer a benefit that is financially equivalent to the "standard plan."

In a "standard plan," enrolled participants will pay a variable percent of their prescription drug costs—depending on how much they actually spend on prescription drugs. Patients who do not qualify for additional assistance pay a monthly premium (national average is \$32 per month or \$385 annually) to participate in the prescription drug coverage program. After a \$250 deductible, patients pay 25 percent of the next \$2,000 in drug costs (or up to \$500 in expenditures).

If patients spend more than \$2,250 in total drug costs, there is no insurance coverage for the next \$2,850 in drug costs. This is often called the "donut-hole" or "coverage gap" in the prescription drug program. Patients are expected to pay this amount out-of-pocket.

After the additional \$2,850 in out-of-pocket costs, coverage resumes at a rate of 95 percent, with patients paying 5 percent of remaining drug costs, unlimited until the end of the calendar year.

So what's the problem?

So what's the problem here? Well the "donut-hole" scenario for one thing, as it forces the vast majority of every day, average citizens to pay out-of-pocket for some pretty hefty drug expenses. In the donut-hole scenario, only the healthiest people and the most seriously ill benefit substantially.

And then there is the basic issue of information overload—resulting in good, old-fashioned confusion. Many participants live in areas that offer upwards of 40 plans, and each plan then includes a wide range of drugs, at widely varying prices, from widely varying pharmacies.

As Jane Bryant Quinn wrote in the Oct. 24, 2005 edition of *Newsweek*, "Who are we kid-

ding? Even if you're a sharp and healthy 65, or a younger person helping a parent, your eyes will cross."

Timing is everything

Many experts, pharmacists and policy promoters have been steadfast in telling people to enroll in a Medicare Part D plan sooner rather than later, saying that waiting too long means that recipients run the risk of incurring "penalty fees."

To some extent this is true, because those who enroll after May 15 and who do not have creditable coverage (as determined by

Helpful Web resources

- www.familydoctor.org/848.xml
- www.medicare.gov/medicarerreform/drugbenefit.asp
- www.kaiseredu.org
- www.altrue.net/site/msac

Medicare) will face a late enrollment penalty fee (i.e., premiums will increase by 1 percent a month for every month that they wait to join).

But others, including health policy advocates with the MNA, recommend doing otherwise.

"Waiting as long as possible to select a plan is the best piece of advice I've heard," said Mary Crotty, RN and an associate director in the MNA's division of nursing. "Immediately after the Jan. 1 launch date passed, it became apparent that this whole program was almost too complicated to be effective. By now, there's talk that changes to the program could be imminent and that it could even be evolving *while* people are in the midst of selecting a plan. If people can wait, they should wait. Let the dust settle first."

Individuals who receive both Medicaid and Medicare benefits were enrolled in a Part D plan automatically and were notified of this automatic enrollment via mail. According to an article by Donna Kruck, a contributing writer at cpes.com—a Web-based community advocacy group—the automatic enrollment process was random, but not written in stone. "People who receive both Medicaid and Medicare benefits can change their plan the following month if it is not a plan they want."

To move ahead with a plan change, individuals should call 1-800-MEDICARE or visit www.medicare.gov.

Keep it simple when starting

Utilizing the aforementioned 1-800 number might be time consuming, but it doesn't have to be merely an exercise in futility either—especially when you're just beginning the process of selecting a plan.

So how do you best manage your initial call? Easy: keep it simple.

"If someone currently has a Medicare plan they like," writes Kruck, "have them call to see if they can keep it under Medicare Part D. They should ask about any premium changes and if their medications are still on the new formulary." This approach provides individuals with a clear starting point with some initial comparative shopping built right in.

Don't rush, but consider the future

Someone who has health insurance other than Medicare or who is not currently using any prescription medicines is probably wondering whether to enroll in a new Medicare Part D plan. Kruck's column at cpes.com offers some guidance:

"Medicare Part D is an insurance plan, just like house, car or life insurance," writes Kruck. "The longer you wait to buy it the more it will cost for the premium. Similarly, when you buy life insurance the older you get the more expensive it is. And flood and car insurance costs more if you wait until after the flood or car wreck! So ask yourself now: do I want insurance for prescription drug costs that I might have in the future?"

Clarifying 'creditable coverage'

Anyone with other health insurance should have received a letter telling them whether or not it is "creditable coverage" (equal to) for the Medicare Part D plan.

If it is creditable coverage, then enrollment in Medicare Part D by May 15 is not required. In addition, when an individual with creditable coverage (or with prior creditable coverage) does decide to enroll in Medicare Part D they will not be charged any penalty on the premium for doing so.

Kruck offers important advice in her column in the topic of creditable coverage: "Keep that letter in case you need it to enroll in Part D later on!" ■

...Staffing

From Page 1

Piknick's remarks came on the heels of a recent meeting of the Legislature's Special Committee on Nursing Ratios at which the MNA outlined a three-point compromise to the competing legislation—increasing nurse faculty, increasing recruitment and scholarship programs, and placing limits on a nurse's patient load.

Buoying the nurses' efforts to have a safe limit on their patient loads is mounting evidence that links safe nurse-staffing levels to cost savings for hospitals and the overall health care system.

For more information on the safe RN staffing bill, see Pages 7 to 9. ■

Join the 'team' – STAT!

MNA forms rapid response 'STAT TEAM'

You are invited to join!

The mission of this mobilization group is to have a network of nurses and health care professionals who can be called upon to respond quickly to MNA visibility events and other urgent actions.

Being a member of this mobilization task force does not require attendance at regular meetings, but instead offers opportunities for activists to participate in events throughout the year that require a strong MNA presence. These actions may include bargaining unit pickets, legislative actions, leafleting and other visibility events.

We hope you will join with other MNA activists in this exciting new venture. For more information, call Eileen Norton at 800-882-2056, x777 or via email at ENorton@mnarn.org.



Minimum nurse staffing levels prove cost-effective

Mounting evidence-based research finds a clear cost benefit of minimum nurse staffing levels savings resulting from better patient care by reducing complications, errors, length of stay and readmissions.

Most recently the August 2005 issue of *Journal Medical Care* found minimum nurse staffing levels are cost effective, with 50 percent of costs being recouped.

"We wanted to test our hypothesis that improved patient outcomes from lower ratios would cost less than many other commonly accepted safety measures. Our study bore

that out," said Michael B. Rothberg, MD, MPH, assistant professor of medicine at Tufts University and physician with the Division of General Medicine and Geriatrics at Baystate Medical Center, Springfield.

In fact, the cost of minimum nurse staffing levels is less than other common preventative life-saving measures that are currently common in hospitals, including the cost of conducting PAP tests for cervical cancer and clot-busting medications to treat heart attacks.

"Considered as a patient safety inter-

vention, improved nurse staffing has a cost-effectiveness that falls comfortably within the range of other widely accepted interventions," Rothberg said.

An initial report released last summer in Boston at the AcademyHealth Annual Research Meeting found an overall cost savings to hospitals. The AcademyHealth is the professional home for health services researchers, policy analysts, and practitioners. It is also a leading, non-partisan resource for the best in health research and policy. ■

You can help pass a real solution to stop understaffing

In order to succeed in passing a bill that will improve the nursing care provided to patients, we MUST maintain as much constant grassroots contact with legislators as possible. The message is simple:

There needs to be a limit on the number of patients a nurse is assigned at one time.

It is imperative that legislators know that front-line nurses want safe staffing. The Massachusetts Hospital Association is telling legislators that their bill, which just maintains the status quo, is enough. Don't let hospital administrators speak for you. Safe RN staffing, H.2663, is the only bill that would protect

patients and the nursing profession.

An easy way for you to participate in this effort is to visit <http://capwiz.com/massnurses/> and email your legislators with one click of your mouse. Also, please take a minute to call your state senator and state representative at 617-722-2000. ■

Industry still refuses to set limit on a nurses' patient load

Hospital profits in Massachusetts near \$1 billion

Massachusetts hospitals have posted astounding profits totaling nearly \$1 billion for the past fiscal year. According to information provided by the Massachusetts Department of Healthcare Finance and Policy, total hospital profits surpassed \$823 million for fiscal year 2005, which represents a 58 percent increase over figures for 2004.

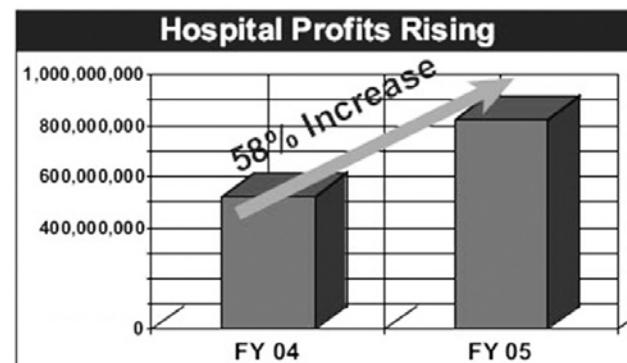
The nearly \$1 billion profit margin comes at a time when health reform proposals being debated on Beacon Hill could land the industry another \$300 million.

"These figures shatter the hospital industry's claims that they cannot provide a safe standard of RN staffing, as called for in pending legislation to establish safe minimum staffing levels in our hospitals," said Beth Piknick, RN and president of the Massachusetts Nurses Association, one of more than 100 organizations supporting H. 2663. "This year's profits

could pay for the staffing needed to protect patients many times over. The time has come for the hospital industry to put patients ahead of profits."

Accountants refer to these dollars as a hospital's "surplus," rather than its "profit"—because almost all hospitals in the state are "non-profit, charitable" institutions. Moreover, the dollars reflected in these figures represent only the hospitals' surpluses. The total additional dollar profit generated by health care systems, such as mammoth Partners Healthcare System, is not reflected in these whopping numbers.

For example, UMass Memorial Healthcare System separately reported a huge figure of just under \$80 million dollars in hospital surplus, and an additional \$14 million-plus in system surplus, for a total of \$94.3 million for the year ending Sept. 30, 2005. That profit comes on top of a \$129 million



expansion and renovation underway of the UMass University emergency department and trauma center. ■

Coalition to Protect Massachusetts Patients is now 100 members strong

The Coalition to Protect Massachusetts Patients—a broad-based consumer and advocacy organization created to support H. 2663, the Safe RN Staffing bill—is now 100 members strong. The coalition includes:

Ad Hoc Committee to Defend Health Care
AIDS Action Committee of Massachusetts
AIDS Care Project
Alzheimer's Association, Mass. Chapter
American Diabetes Association of Greater Boston
American Heart Association
American Lung Association of Greater Norfolk County
American Lung Association of Massachusetts
American Medical Student Association
American Psychiatric Nurses Association - New England Chapter
Amyotrophic Lateral Sclerosis Association
Arise for Social Justice
Boilermakers Local Union 29
Boston AIDS Consortium
Boston Carmen's Union Local 589, ATU
Boston ElderINFO
Boston Health Care for the Homeless Program
Boston Police Patrolman's Association
Boston Women's Commission
Cambridge Women's Commission
Cape Organization for Rights of the Disabled
Maureen Carney, Northampton Ward 1 City

Councilor elect
Central Massachusetts AFL-CIO
Coalition Against Poverty
Coalition for Social Justice
Committee of Interns & Residents of Massachusetts
CWA Local 1365
Community Church of Boston
Family Economic Initiative
Favorite Nurses Favorite Temps
Fenway Community Health Center
Gay and Lesbian Advocates and Defenders
Governor's Councillor Peter Vickery (8th District)
Greater Boston Diabetes Society
Hampshire Franklin Central Labor Council
Health Care for All
IBEW Local 2222
Independent Living Center of North Shore and Cape Ann, Inc.
Institute for Health and Recovery
Ironworkers Local 57
Jobs with Justice
Jon Weissman (President, NALC 46)
Jonathan M. Cole Mental Health Consumer Resource Center
Judy Norsigian (Co-author of "Our Bodies, Ourselves")
Laborers International Union Local 429
Latin American Health Institute
League of Women Voters of Massachusetts
Lynn Health Task Force
Mass. Asian AIDS Prevention Project

Mass. Association of Councils on Aging
Mass. Association of Nurse Anesthetists
Mass. Association of Older Americans
Mass. Association of Public Health Nurses
Mass. Brain Injury Association
Mass. Breast Cancer Coalition
Mass. Coalition of Nurse Practitioners
Mass. Federation of Teachers
Mass. Human Services Coalition
Mass. Immigrant and Refugee Advocacy Coalition
Massachusetts Nurses Association
Mass. School Nurse Organization
Mass. Senior Action Council
Mass. Society of Eye Physicians and Surgeons
Sister Rosellen Gallogly of Market Ministries, Inc.
Mass NOW (National Organization for Women)
Massachusetts Spina Bifida Association
MASSPIRG
Mass. State UAW CAP Council
Merrimack Valley Central Labor Council
Mental Health Association, Inc.
MetroWest AIDS Program
MetroWest Latin American Center
National Alliance for the Mentally Ill of North Central Massachusetts
National Association of Social Workers - Massachusetts Chapter
National Association of Socially Responsible Organizations

National Kidney Foundation of MA, RI, NH, Vermont, Inc.
Neighbor-to-Neighbor
New England Coalition for Cancer Survivorship
New England Nurses Association
New England Patients Rights Group, Inc.
Pile Drivers Local Union #56
Pioneer Valley AFL-CIO
Retired State, County and Municipal Employees Assoc. of Massachusetts
Search For A Cure
SEIU Local 263
Sprinkler Fitters Local Union 669
The Abortion Access Project
The Association of periOperative Registered Nurses
The Brighton/Allston Improvement Association
The Carroll Center for the Blind, Inc.
The Consortium for Psychotherapy
The Episcopal Diocese of Western Mass.
The Massachusetts Coalition of Families and Advocates for the Retarded
UAW Local 2322
United American Nurses
United Food & Commercial Workers Local 1459
United Steel Workers of America
Victory Programs, Boston
Vineyard Health Care Access Program
Women's Health Institute

Nurse-to-patient ratios working in California

Legislated minimum nurse staffing levels have been in effect for more than two years in California—and they are working just fine according state health officials and other observers:

"... there seems to be no negative impact on the health care system... Our data shows that hospitals have been able to meet the lower ratios... hospitals had to follow the new rules and discovered they were not as burdensome as they had feared."

— Sabrina Demayo Lockhart
California Health & Human Services Agency
Los Angeles Times (11/12/05)

HOUSE BILL 2663

AN ACT ENSURING PATIENT SAFETY

There is a debate right now in the State Legislature over nurse staffing levels in acute care hospitals in Massachusetts. House Bill 2663 is the ONLY bill that will protect patients and the nursing profession. House Bill 2663, the nurses' bill, will set a limit on the number of patients a nurse is forced to care for at one time.

Officials from the Massachusetts Hospital Association are telling legislators that their bill, which just maintains the status quo, is enough. Don't let your hospital administrators speak for you - Safe RN Staffing, House Bill 2663, is the bill written by nurses and for patients!

It is imperative that legislators know that frontline nurses like you want safe staffing.

Myth**Fact**

You will have to take more patients if your hospitals ratios are better than what is passed in the law.

- ✓ The ratios are a limit, by unit, on how many patients a nurse can be assigned at one time. There is specific language (section c) in the bill that states that nothing should preclude a hospital from staffing in addition to these minimums.

Your hospitals will close.

- ✓ No hospital has or will close because it had a safe and appropriate nurse staffing level. Deregulated competition has forced the market place to close hospitals, not nurse staffing.

It costs too much.

- ✓ The cost implementation of H. 2663 is 1% of hospital revenue. 50% of those costs will be recouped from resulting better care.

Other hospital personnel will lose their jobs.

- ✓ The bill contains specific language (section l) to ensure this does not happen.

We need flexibility

- ✓ This is simply a limit on the number of patients a nurse must care for at one time. Flexibility for hospitals is built into the bill with an accompanying acuity based system.

What you can do to help pass H.2663

- ✓ Call your Representative and Senator.
 - Don't let your hospital administrators speak for you! Call and email your elected officials and tell them why safe staffing is important for your patients' safety and what type of care you can provide when staffed appropriately.
 - **Go to:** <http://capwiz.com/massnurses/>, **enter your zip code and scroll down to find your elected officials and their contact information.**
- ✓ Email your Representative and Senator.
 - You can email your elected officials directly from the website listed below. There is a preformatted letter on the site. Please take a few minutes to personalize the letter with information such as where you work, how long you have been an RN, and any other relevant facts.
 - **To email your legislators, goto:** <http://capwiz.com/massnurses/>



Safe RN Staffing Saves Lives

<h2 style="text-align: center;">Nurses Care About Patients</h2>	<h2 style="text-align: center;">Hospitals Care About Profits</h2>
<p>The Nurses' Bill (H. 2663):</p>	<p>The Hospitals' Bill:</p>
<p>Common-sense approach Nurses are at patients' bedsides and say they can't take adequate care of those patients. The bill would limit the number of patients a nurse is assigned to care for at one time.</p>	<p>Protects their profits It's a cynical measure that does nothing to address the real needs of patients. The bill calls for no improvements in staffing and no required standard of care. The hospitals are serving up the status quo to protect their profits.</p>
<p>By bedside nurses Minimum RN staffing levels created by real bedside nurses for patients.</p>	<p>By hospital administrators The hospitals' plan was created by hospital administrators for hospital administrators.</p>
<p>Simple It's the only bill that will actually protect patients. It is a simple plan that will limit the number of patients a nurse can care for, in the interest of giving patients better, safer care.</p>	<p>Bureaucratic boondoggle It calls for more studies, another "task force," replication of existing standards, duplication of federal loan programs, and involves nearly a dozen state agencies.</p>
<p>It's time It's time to listen to frontline RNs. Only with safe RN staffing can patients be assured that they will suffer fewer complications, medical errors and readmissions.</p>	<p>They've had enough time The hospitals have had a dozen years to deal with nurse understaffing and created the current situation we have.</p>
<p>Concrete Based on medical research and nurses' judgment, it limits how many patients a nurse can be assigned to care for at one time.</p>	<p>Toothless The bill proposes to address patient safety without ever defining what "safe" means. That's like proposing to establish highway safety with voluntary speed limits.</p>
<p>A real solution Burned out with high patient loads, RNs are leaving the bedside. Research shows 65 percent of RNs will return to the bedside once there is a limit on the number of patients they can be forced to care for.</p>	<p>More of the same Takes the exact same steps that led to current bedside RN woes. There is <u>no</u> shortage of RNs in Massachusetts. It is simply that RNs are unwilling to stay in hospitals under current working conditions. For the last decade RNs have left the hospitals faster than they could be replaced.</p>
<p>Reduces costs Minimum nurse-staffing levels will reduce costs for hospitals and insurers. Studies show that because patients will suffer fewer complications, medical errors and be readmitted less frequently, hospitals will actually save money.</p>	<p>Taxpayers' subsidize inefficiency RN turnover adds as much as 5 percent to a hospital's operating budget. Nursing turnover doubles when patient-to-nurse ratios are 7:1 as opposed to the 4:1. Recruiting and training RNs is costing hospitals millions. In contrast, every dollar spent on establishing patient-to-RN ratios returns \$1.20 in savings from decreased turnover and nursing agency costs.</p>
<p>Public supports the nurses' bill Patients experience inadequate care every day in Massachusetts' hospitals. They know that the hospitals cannot be relied on to change that situation. That's why 76 percent of the public wants legislators to pass the nurses' bill, H. 2663 An Act Ensuring Patient Safety.</p>	<p>Structured for hospital administrators The bill has no standard of care for patients and no accountability for hospitals. In the absence of government regulation, hospitals will continue to put profits before patients and unsafe RN staffing will continue.</p>



Division of Labor Action: Education & Training

Leaders in American labor history: a two-part series

The following are profiles of some of the most prominent labor leaders in American history. They have varied backgrounds and represent diverse workers, industries and workplaces. But they all shared a burning desire and life-long commitment to activism, equality, and social and economic justice—as well as a belief in the dignity of all workers.

Often they were controversial figures, but they all dedicated their lives to helping working men and women, usually at great personal sacrifice and expense, up to and including their own lives.

They are great examples and inspirations for those who struggle for equality, justice and economic well-being today. Too little is taught in our schools about the rich history and figures of labor history, and the topic is almost never highlighted in the media or celebrated in popular culture. What follows is a meager attempt to address that vacuum.

Mother Jones

Born Mary Harris Jones (Aug. 1, 1837 - Nov. 30, 1930) better known as Mother Jones, was a prominent labor and community organizer. She has become known as “The Grandmother of All Agitators.” Mother Jones rose to prominence as a fiery orator and fearless organizer for the mine workers during the first two decades of the 20th century. Her voice had great carrying power. She felt so strongly about the labor movement that she once said, “The labor movement was not originated by man. The labor movement, my friends, was a command from God Almighty.”



Mother Jones

Her energy and passion inspired men half her age into action and compelled their wives and daughters to join in the struggle. She welcomed African American workers and involved women and children in strikes. She organized miners' wives into teams armed with mops and brooms to guard the mines against scabs. She staged parades with children carrying signs that read, “We want to go to school and not to the mines.”

In her 80s, Mother Jones settled down near Washington, D.C., but she continued to travel across the country. In 1924, although unable to hold a pen between her fingers, she made her last strike appearance in Chicago in support of striking dressmakers—hundreds of whom were arrested and black-listed during their ill fated, four-month struggle. She died at the age of 94 in Silver Spring, Md., and was buried in the Union Miners Cemetery in Mount Olive, Ill. Her most memorable and celebrated quote? “Pray for the dead and fight like hell for the living!”

John Sweeney

President of the AFL-CIO since 1995, Sweeney was also a past president of the Service Employees International Union (SEIU). Born in the Bronx in 1934 to Irish immigrant parents, he attended union meetings with his father from an early age. He worked as a grave-digger and building porter (when he first joined a union) to pay his tuition at

Iona College where he earned a degree in economics.

Sweeney initially worked at IBM but took a huge pay cut to take a position as a researcher with the International Ladies Garment Workers Union. He eventually took a position with SEIU and became president of the large New York City SEIU Local 32B where he aggressively led the union to win contracts with significant wage and benefit increases for maintenance workers. As SEIU president, the union grew to a one million members in 1993—the first union to do so in over 20 years.



Sweeney

He is also recognized for working on behalf of the poorest and least powerful segments of the work force. He pushed for rapid expansion into new sectors and base areas, including office and health care workers. Under Sweeney, the union began pushing for stronger federal laws in the area of health and safety, sexual harassment, and civil and immigrant rights. It also advocated for legally-mandated paid family leave, health care reform and a raise in the minimum wage.

Internally, Sweeney devoted nearly a third of the union's budget to organizing new members and pushed for stronger diversity in the union's ranks. In 1995 he led a “New Voice” slate of candidates—with aggressive agendas—to win elections as heads of the AFL-CIO. He challenged labor to major reforms, including: a major expansion of the federation's role in organizing; hiring and training thousands of new organizers; union “summer programs” that employed college students; creating a Center for Strategic Campaigns to coordinate all national contract campaigns; creating a Strike Support Team of organizers that could be deployed to help support strikes; called for a modification of labor's political tactics and withdrawal of support for Democrats who did not support labor's agenda; and an expansion of the political activities of the state federations and central labor councils.

Sweeney also called for internal changes in the federation to insure more women and minority representation. His tenure as head of the AFL-CIO has accomplished much, but there has been continued decline in the percentage of organized workers in the US. In 2005 a group of unions disaffiliated from the AFL-CIO to create The Change to Win Coalition—a new labor federation aimed at organizing aggressively to reverse this trend of declining numbers.

Sweeney, the author of “America Needs A Raise: Fighting for Economic Security and Social Justice,” recently said, “We believe hard work nourishes the soul and should nourish the body and support the family as well. We believe every one of us has an equal claim to the prosperity of America. And that it's our job to ensure a better life for the generations that come after us.”

A. Philip Randolph

April 15, 1889 - May 16, 1979. Born in Crescent City, Fla., A. Philip Randolph was the son of an ordained minister and a skilled seamstress. He excelled in school and traveled to New York City to seek employment.

While there, Randolph took classes in economics and philosophy at City College. As a writer and editor of the black magazine *The Messenger* (later, *The Black Worker*), which he helped to found, Randolph became interested in the labor movement. He unsuccessfully ran for political office in New York, but in 1917 he organized a small union of elevator operators in New York City.

He was involved in organizing black workers in laundries, clothes factories and cinemas and eventually became president of the Brotherhood of Sleeping Car Porters (BSCP). Over the next few years he built it into the first successful black trade union despite the Pullman Company's bitter and vicious opposition. At that time, the Pullman Company was the one of the most powerful business organizations in the country. After years of bitter struggle, it finally began to negotiate with the Brotherhood in 1935, and agreed to a contract with them in 1937.

Randolph eventually won recognition for the Brotherhood of Sleeping Car Porters, with pay increases and shorter hours. He understood that, “Nothing counts but pressure, pressure, more pressure, and still more pressure through broad organized aggressive mass action.” An untiring fighter for civil rights, he organized the 1941 March on Washington Movement in protest against job discrimination and racial discrimination in the armed forces. This movement, although it did not culminate in a march, is credited with hastening the establishment of the Fair Employment Act of 1941 during World War II. It was the first federal law to prohibit employment discrimination in the United States.

Randolph was also one of the most prominent leaders in the fight against segregation in the armed forces. Throughout his long career, he consistently kept the interests of black workers at the forefront of the racial agenda. According to Randolph, “A community is democratic only when the humblest and weakest person can enjoy the highest civil, economic and social rights that the biggest and most powerful possess.”

Walter Reuther

Reuther was born in Wheeling, W.Va. in 1907. He attended Wayne State University in Detroit. At the age of 29, he was elected president of his Local 174 of the United Automobile Workers (UAW) and rose to become one of the most influential labor leaders of the century as a reform-minded, liberal and responsible trade unionist.

He is considered the leading labor intellectual of his age, and a champion of industrial democracy and civil rights who used the collective bargaining process and labor's political influence to advance the cause of social justice for all Americans. Reuther had a passion and personal commitment to civil

rights, social and economic justice.

He also firmly believed that the impact of unions must reach beyond their own membership bases. This belief led him to become an advisor to presidents and instrumental in the passage of civil rights legislation and in developing programs for President Johnson's “War on Poverty.” He helped get passed through Congress increases in social security payments, which benefited millions of people who were not union members.

Reuther also helped finance through the UAW the Freedom Marches in Detroit and Washington, including the 1963 march where Dr. Martin Luther King delivered his famous “I Have a Dream” speech. As leader of the UAW he led strikes and organized workers to win the members unprecedented gains in their working lives, including financial benefits, pensions, vacations, increased job security and supplemental unemployment benefits. He prided himself in the fact that he was the lowest paid union president in the country.

During World War II, Reuther had the foresight to propose that auto plants be converted to produce aircraft for the war effort with a goal of producing 500 aircraft daily. He was the target of kidnappers and assassins on a number of occasions, suffering permanent arm damage from a shotgun blast in 1948. He pioneered organizing internationally to deal with multi-national corporations decades in advance of the hyper-globalization that is occurring today. And finally, Reuther was an ardent advocate of worker education and to that end established an education center in Black Lake, Mich.

He and his wife were tragically killed in an airplane accident while flying to the education center in 1970, but Reuther's philosophy on labor and activism has endured: “There is no greater calling than to serve your fellow men. There is no greater contribution than to help the weak. And there is no greater satisfaction than to have done it well.”

Elizabeth Gurley Flynn

Flynn, known as “Rebel Girl,” was a union organizer for the Industrial Workers of the World (the IWW). She was born in 1890 and raised in poverty in New Hampshire and the South Bronx. At an early age she became



Flynn

interested in the U.S. Constitution and Bill of Rights; attended political meetings; and became active in the IWW.

Later Flynn organized immigrant workers and helped to lead major strikes in the mills of Lawrence, Mass. and with silk workers in Paterson and Passaic, N.J. She was a

See *Free CE*, Page 11

Division of Labor Action: Bargaining Unit Updates

Region 1

Berkshire Medical Center

The MNA bargaining unit at Berkshire Medical Center continued with the arbitration over medical insurance costs on Jan. 26.

Mercy Hospital

Mercy Hospital has reopened the contract and has begun negotiations. The MNA also had an arbitration award upheld in the first circuit court reinstating a nurse who was terminated without just cause. At this time, management has not further appealed the decision.

Clinton Hospital

Clinton Hospital and the MNA recently settled a two-year contract that included language improvements on equitable distribution of extra shifts. Increases to shift and call differentials were also established, with salary increases of 13 to 16 percent over the two years. A program entitled, "Accepting, Rejecting and Delegating a Work Assignment" will be presented to the bargaining unit on Jan. 18.

Cooley Dickinson Hospital

Began contract negotiations on Dec. 12.

Noble Hospital

Local elections were held on Oct. 20 and the following local representatives were elected:

co-chairpersons: Sharon Cygan and Paul Dubin, secretary, Marie Kaleta; treasurer, Sherry Labay; at-large, Norma Hartman-Besette and Maura Donahue

West Springfield School Nurses

The West Springfield School Nurses are currently negotiating their first MNA contract. The biggest issues for them center on obtaining pay parity with teachers in the school district and addressing professional issues in their contract. The members, in conjunction with their labor director and the MNA's public communications department, are preparing a PowerPoint presentation to assist in making their argument. The bargaining unit meets almost every week and the nurses are cohesive and energetic.

Region 2

Leicester School Nurses

Continuing to negotiate.

Leominster Hospital

The bargaining unit at Leominster Hospital ratified a three-year agreement on Oct. 14.

UMass Medical Center

The bargaining unit at UMass Medical Center, University Campus continues to negotiate over the Lakeside expansion process and it expects these talks to continue

over the next two years. Contract negotiations began on December 21.

Wachusett School Nurses

The Wachusett School Nurses have filed for mediation after coming to an impasse with the school committee over wages.

Region 3

Methuen School Nurses

The Methuen School Nurses conducted an informational picket outside a school committee meeting on Oct. 11. Nurses are meeting with school committee members and mayoral candidates. Patty Comeau recently spoke with reporters from the *Boston Globe* and *Eagle Tribune*.

Region 4

Jordan Hospital

Currently in negotiations; after each negotiation session the bargaining committee is posting reports about what transpired in that session.

Region 5

Brigham and Women's Hospital

At its November Advisory (labor/management) meeting, the MNA committee presented concerns for nurses' safety on the floors and in the ICUs related to the lack of guidelines for the visitor policy and the

ongoing staffing, patient safety and forced overtime issues in the OR.

Caritas Christi Norwood

Currently in negotiations; after each negotiation session the bargaining committee is posting reports about what transpired.

MetroWest Medical Center, Leonard Morse Hospital

Currently in negotiations; after each negotiation session the bargaining committee is posting reports about what transpired.

New England Medical Center

Numerous staffing concerns have been brought to the MNA committee and they are being addressed in monthly labor/management meetings. Nurses are urged to contact committee members with any issues or concerns they would like addressed. Members of the MNA staff were invited to our bargaining committee meeting and presented information on the Magnet Recognition program. The committee is discussing how this issue will be addressed by the bargaining unit. The MNA was informed that the hospital has changed law firms and will be using a different attorney for the next round of negotiations. The bargaining committee has expressed concern about how this will affect the negotiations—it is hoped that this change will not prolong the process. ■

...Labor History

From Previous Page

founding member of the American Civil Liberties Union and was active in the campaign against the conviction of Nicola Sacco and Bartolomeo Vanzetti.

Flynn was also fiercely committed to the struggle for women's rights and criticized the unions' leadership for being male dominated and not responsive to women's issues. Later in life she was convicted and spent time in a federal penitentiary for her political beliefs. She died in 1964.

Flynn's personal philosophy is summarized with the following quote: "What is a labor victory? I maintain that it is a twofold thing. Workers must gain economic advantage, but they must also gain revolutionary spirit, in order to achieve a complete victory. For workers to gain a few cents more a day, a few minutes less a day, and go back to work with the same psychology, the same attitude toward society is to achieve a temporary gain and not a lasting victory."

Lucy Parsons

Lucy Parsons was an African, Native and Mexican-American revolutionary anarchist and labor activist during late 19th and 20th century America. Emerging out of the Chicago Haymarket affair of 1886, in which eight anarchists were imprisoned or hung for their

beliefs, Lucy Parsons led tens of thousands of workers into the streets in mass protests across the country.



Parsons

Defying both racial and gender discrimination, she was at the forefront of movements for social justice her entire life. She sparked rebellion and discontent among poor and exploited workers wherever she spoke and her fiery, powerful orations invoked fear in authority nationwide. The Chicago Police Department termed her "more dangerous than a thousand rioters."

After almost 50 years of continuous activism, Parsons died in a fire in her Chicago home in 1942. Viewed as a threat to the political order in death as well as life, her personal papers and books were seized by the police from the gutted house. More than 60 years after her death, one of her most recognized quotes still rings true: "Never be deceived that the rich will permit you to vote away their wealth." ■

Record contract at Henry Heywood Hospital

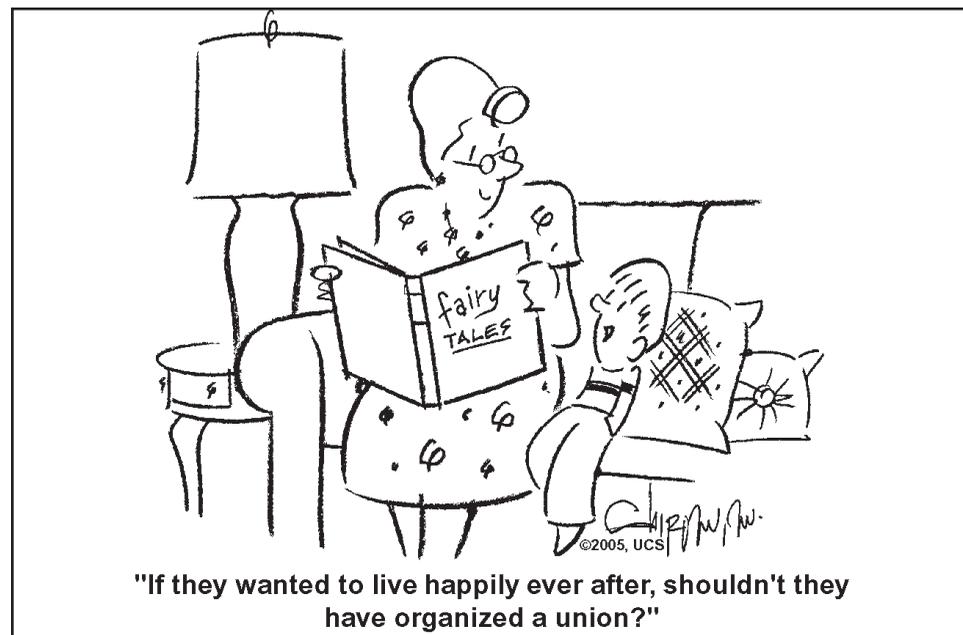
The RNs at Henry Heywood Hospital in Gardner recently approved a contract that brings over \$100,000 a year in base salary to senior nurses. This is the first time in the northern Worcester county area that a nursing pay scale has broken the century mark.

According to RN Bob King, co-chair of the hospital's MNA bargaining unit, the settlement came at the end of a process that was much easier than the last time around. "For our last contract we settled for a one-year deal with a modest increase, and didn't get it done until the year was almost over," explained King. "We decided that we would concentrate on this year's negotiations."

Going into this year's negotiations the union proposed a multiple-year deal with a large pay increase. The goal was to make Heywood competitive with other hospitals in the area. "On the first day of negotiations it was clear that management had come to the table ready to deal. We were able to complete the process in just six meetings. We feel that our contract is not only competitive but sets the standard in the area," said King.

The deal, which runs through the end of 2007, raises the top salary to \$48.42 an hour. Management also agreed to add four new steps at the top of the scale, making the contract very beneficial to senior nurses who are committed to staying at Heywood.

In addition to the 26.5 percent increase for the senior nurses, the new contract also calls for increases in shift differentials and on-call payments, and also establishes an earned time system that allows nurses to buy back a week of surplus time each year. ■



Scholarships available through Mass. Nurses Foundation

Printable applications with instructions and eligibility requirements are available at www.massnurses.org or by calling the MNF at 781-830-5745.

The deadline for returning applications is June 1, 2006. ■



MNA, colleagues mourn passing of Liz Joubert

Liz Joubert—a longtime friend of the MNA and a dedicated nursing advocate—passed away on Nov. 20, 2005, after a courageous battle against breast cancer that lasted for nearly 18 years.

She was 62 and had lived in Weymouth and Pittsfield before settling in Rockland.

Joubert's distinguished nursing career spanned more than 38 years and included work in surgical nursing, intensive care, coronary care, post anesthesia care, and as a leukemia research nurse and clinical supervisor.

Recognized by her colleagues as a role model of excellence in nursing care, she was continually sought out for her extensive knowledge and was ultimately awarded the MNA's "Image of the Professional Nurse Award" in 2004. A colleague once stated

that, "Liz was ever vigilant; nothing pertaining to the patient would go unnoticed. She saw the whole patient and was a patient advocate, even if it meant upsetting the status quo."

As a member, chair and co-chair of her MNA bargaining unit at Dorchester's Carney Hospital her leadership inspired her fellow nurses to work for quality patient care, as well as professional and economic advancement.

Joubert was able to accomplish all of this despite, as one colleague put it, "facing a lion at the door" as she met the challenge in 1987 of breast cancer and a continuing journey of treatment, remissions and recurrences. She continued to treat and advise patients and to teach and support nurses. She also established a Breast Cancer Support Group

at Carney to extend help to other women in the community. In addition, Joubert also enhanced the image of the nursing profession within the community as a member of the Massachusetts Breast Cancer Coalition where she helped to raise support in fighting for a cure breast cancer.

Although she retired from bedside nursing in 2001, Joubert continued to participate in her profession as a member of the MNA's Board of Directors and as member of its finance committee.

Joubert's friends and colleagues at the MNA and at Carney Hospital will remember her for all that she was—a dedicated nurse; an inspiring union activist; a caring soul; a loving friend, and a devoted wife, mother, sister and grandmother. And her life will be celebrated. ■



Liz 'Jane' Joubert: my friend

By Eileen Norton, RN

Director of the MNA's Division of Organizing

To her many colleagues at Carney Hospital and the MNA she was Liz. To her family and others she was Jane. But whatever name you used, she was an extraordinary person who left an impression on all she met.

It is hard to find the words to express the essence of Liz, she was many things to many people—but to me she was a true friend, a confidant, a sister. Liz was an inspiration to all of us, she taught all who knew her how to live life to the fullest and how to appreciate every day.

Liz and I were co-chairs of the bargaining unit at Carney Hospital and we shared many great times plotting union activities along with the committee and Julie Pinkham, who was our associate director at the time. Liz and I were also delegates to the ANA and, along with others, we celebrated when our hard work earned us the right to disaffiliate.

Liz and I worked closely together at Carney not only on union activities but as nurse colleagues. I worked in the OR and Liz in the

PACU so we saw each other every working day. I eventually went to work for the MNA and Liz went to work for her brother's company, Siena Construction, where she was the safety officer. She quickly adapted to this new environment and was excellent at her job.

Thankfully, Liz remained active at the MNA, serving on the Board of Directors. She also served as treasurer of the finance committee and was on the board of the Massachusetts Nurses Foundation.

Throughout the past two years as Liz was dealing with her reoccurrence of breast cancer, she remained active in many MNA activities. She was on the scholarship selection committee; attended lobby day on July 13, 2005; participated in a training video for the bargaining units; and attended the MNA's annual convention in September 2005. She never complained even when you knew she was struggling and she always greeted everyone with a smile.

Over the last two years I was fortunate enough to be Liz's neighbor. I will forever treasure the time we were able to spend together. Our trips to the Villa in Jamaica; our



Happy times and memories. Liz Joubert (left) and Eileen Norton.

many visits to Cape Breton; our excursions to Foxwoods; the Sunday football games with Liz's family; her garden tomatoes and cucumbers that were the best; and stopping in every night on the way home from work to share

each others' day.

Liz, you taught us all how to be brave and how to enjoy life. I, along with many others, will miss you always but will forever treasure all the memories. ■

California hospital shows 'Magnet' designation a sham

The ANA, through its ANCC Magnet Credentialing and Promotion arm, refers to Magnet as the "Gold Standard." ANA promotes Magnet as a way to acknowledge hospitals that act as a "Magnet" for excellence by creating a work environment that recognizes, rewards and promotes professional nursing. Magnet hospitals in turn tout that they are superior to other institutions that haven't been able to achieve this "status."

Let's hear it directly from ANCC:

Where can you find the best patient care? Just remember:

Magnet Means Excellence!

When you, your family or friends need medical care, you want the best.

Try telling that to California patients, regulators and malpractice attorneys. Or to the federal government, which just stripped a major California Magnet facility of its certification for a liver transplant program, saying it was "endangering patients." The University of California Irvine Medical

Center—Magnet-certified in July 2003—has paid millions of dollars to settle legal claims stemming from recent health care scandals. Yet it received Magnet certification over a year and a half ago.

The most recent scandal at this Magnet hospital is the deaths of more than 30 patients who were waiting for liver transplants while the hospital turned down organs because it was medically understaffed. The *Los Angeles Times* reported that UCI received 122 liver offers between August 2005 and July 2005 but only transplanted 12. Attorneys for plaintiffs are busy showing that "defective" organs worked miraculously well when redirected to other hospitals—maybe even some non-Magnet ones.

One patient recently sued the Magnet hospital because she found out that they had turned down 95 organs—38 livers and 57 kidneys—that could have been appropriate for her. After four years on UCI's transplant list, her kidney specialist finally suggested she transfer elsewhere, and she

received kidney and liver transplants in two months. She was initially told by UCI she would receive donor organs within a week to six months.

The *L.A. Times* report pointed out a number of violations by UCI of various federal requirements, yet none of these violations apparently have affected its Magnet eligibility:

1. Federal standards require that a surgeon be constantly available according to the *Times*, though UCI said there will be no full time transplant surgeon at the hospital until early 2006.
2. Federal certification of the program requires a 77 percent survival rate and UCI has a 69 percent one-year survival rate.
3. Federal requirements call for a minimum of 12 annual transplants and UCI performed only eight a year between 2002 and 2004.

UCI has had other major transgressions.

In the 1990s it paid nearly \$20 million to settle claims from a fertility clinic scandal in which its doctors stole patients' eggs and implanted them in infertile women. Since 1999 they have also paid large sums to resolve claims stemming from allegations that the director of their donated cadaver program sold cadaver spines outside the facility.

To add frosting to this sorry cake, the new head of the University of California Regents' committee on Health Services, Sherry Lansing, said she visited the Magnet UCI hospital two weeks ago and "was not told of any of these problems."

Yet, this is a Magnet facility.

So much for ethics, professionalism, patient safety, quality, transparency and the "right to practice in a safe environment that fulfills the nurse's obligations to society and to those receiving nursing care," as promised by ANA in their Bill of Rights for Registered Nurses.

Magnet credentialing wasn't enough to attract those rights for its UCI nurses. ■

Benefits Corner

Save 20 percent on tax preparation at Tax Man

Take 20 percent off the cost of professional tax preparation services provided by Tax Man Inc. at any of their 24 offices statewide. Call 800-7-TAXMAN or visit their Web site www.taxman.com for a complete list of office locations & telephone numbers.

Tax preparation fees are based on the complexity of your tax return and the forms needed to accurately file your taxes, so you'll never pay more than what your unique tax situation calls for. Tax Man also offers 100 percent satisfaction guarantee on all tax services.

To receive your 20 percent discount, present a valid MNA membership card at the time of service and enjoy stress-free tax preparation this year. ■

Update: Health Care for Massachusetts Campaign

More than 1,000 days ago the Health Care for Massachusetts Campaign began with a dream: affordable, comprehensive coverage for every Massachusetts resident. In 300 days we can make that dream come true.

Your hard work has helped us get this far. The dream became a very real Citizens Initiative Amendment signed by over 71,000 voters from every legislative district in the state in the fall of 2003. An effort started by a few people grew into a campaign supported by over 50 organizations representing a quarter of a million people—and it's still growing. An amendment that many people dismissed in the beginning got its first ConCon approval by an overwhelming 153-41 vote.

We're now in the home stretch, with two steps left to go:

- A second approval (50 votes) at the May 10 Constitutional Convention
- A resounding victory at the polls on Nov. 7

There are only 120 days left until the May 10 ConCon. We need to remind the Legis-

lature that the Health Care Constitutional Amendment is still out there; that it builds a foundation for the reforms being debated now; and, most important, that it has the wide support of people like you.

We're now launching our "50,000 by 5/1 Postcard Campaign" and we're asking for your help once again. The goal? 50,000 postcards by May 1 that we will deliver to the Legislature reminding them that you support the Health Care Constitutional Amendment and that you want their commitment on May 10. Impossible? Not by a long shot.

Please take a minute to do two things to make 2006 a truly historic year!

1. Visit <http://healthcareformass.org/postcard/> to download your postcard.
2. Get 10 friends, neighbors and co-workers to sign one. Forward this e-mail to them or request postcards from our Campaign Manager,
3. Postcards are also available by calling Michael Carr at 617-868-1280

Thank you for your continued support. ■

MNA members: Access the HED company store and save!

Amazing discounts on electronics, jewelry, digital cameras and appliances



The MembersAdvantage™
Custom Rewards Program

1. Visit: www.hedcompanystore.com
2. Simply click the "Register" button
3. Enter your first and last Name
4. In the "company code" field, enter **HED2006** (Note: this *is* case sensitive)
5. Then enter your email address, a password and password confirmation
6. Click "Continue Shopping" continue and, after a few moments of processing, you will be ready to shop.

Once registered, you will automatically see the discount pricing that is available exclusively to MNA members. Happy shopping!

Rediscover what led you to nursing to begin with



Team members needed for short-term medical missions trip to Honduras

The MNA's diversity committee is sponsoring a week-long medical missions trip to Honduras from April 19 – 26—and it needs a few good men, women, nurses and/or caring souls to join in.

If you are interested in learning more, contact Carol Mallia at 781-830-5744 or via email at cmallia@mnarn.org . . . and rediscover what led you to nursing to begin with.



SAVE THE DATE

MassPRO and the Massachusetts Adult Immunization Coalition present
The 11th Annual Adult Immunization Conference

Protecting Adults: Old and New Threats

Tuesday,
April 11, 2006
8:00 a.m. to 3:00 p.m.
DCU Center, Worcester, MA

Keynote Address:

William L. Atkinson, MD, MPH

Medical Epidemiologist
National Immunization Program
Centers for Disease Control and Prevention

CEUs will be offered for nurses and nursing home administrators.

More information will be online at www.masspro.org.



This material was prepared by MassPRO, the Medicare Quality Improvement Organization for Massachusetts, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. 8sow-ma-immun-05-07 std-dec-5k

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

MNA position statement on safe patient handling

Nursing is the highest risk occupation in the United States with respect to lifting and handling-related injuries. It is the profession most associated with work-related musculoskeletal disorders and back injuries. Injury data show that nearly 12 out of 100 nurses in hospitals and 17.3 out of 100 nurses working in nursing homes report work-related musculoskeletal injuries, including back injuries, which is about double the rate for all other industries combined.

According to a United States Bureau of Labor Statistics 2000 report, six of the top 10 professions at greatest risk for back injury are: registered nurses, nurses' aides, licensed practical nurses, radiology technicians and physical therapists. The rate of injury among workers in nursing care facilities is higher than in the trucking, logging or construction industries.

In 2000, the Veterans Health Administration (VHA) found that nurses were injured six times more frequently than any other single occupational group; back injuries represented 19.1 percent of all injuries; and another 25.5 percent, upper extremity injuries. Back injuries resulted in the most lost workdays.

Greater than one-third of back injuries among nurses are attributed to the handling of patients and the frequency with which nurses are required to manually move patients. From a worldwide perspective, back injuries to nurses have point prevalence of approximately 17 percent, an annual prevalence of 40-50 percent and a lifetime prevalence of 35-80 percent. (See *A Business Case for Patient Care Ergonomic Interventions*, 2005).

Nurses lift, move and turn patients who may easily weigh 250 pounds or more on an hourly basis, and most would consider a 100-pound patient to be "light." However, many U.S. industries and the U.S. Postal Service follow lifting regulations to the letter by supplying lifting and handling equipment for

any loads over 50 pounds or above shoulder height. The National Institute of Occupational Safety and Health (NIOSH) guideline for the maximum lifting load that anyone should routinely lift is 51 pounds. That 51-pound federal guideline applies to lifting of a stable object with handles. Moreover, nurses must frequently lift or move patients while also cautiously handling their patients' intravenous (IV) or other tubing, casts, wound dressings, injured limbs, etc., which limits nurses' flexibility in their lifting movements and which places them at risk. Patients don't come equipped with "handles." Patient lifting and handling is significantly more difficult and more demanding than moving boxes around.

Some of the factors exacerbating the risk of work-related injuries for caregivers include those listed below. These factors are multiplicative: the more of these occurring at a given time, the greater the risk of injury.

- Heavy physical work
- Lifting and forceful movements
- Bending and twisting (awkward postures)
- Whole-body vibration
- Static work postures

Additional risk for nurses comes from the increasing levels of obesity among the general population; the marketing by hospitals of weight loss treatments, resulting in previously relatively unseen numbers of bariatric surgery patients (who receive surgical treatment for morbid obesity; gender (high numbers of female workers); the aging nurse workforce (more vulnerable to injury or repeat injury); staffing shortages with fewer staff to share in the lifting and turning of heavy patients; cumulative trauma—both long term and short term, related to nurses working long hours; stress due to organizational change (nurses working as temporary workers or "floating" to units where they may be exposed to unfamiliar or completely unrec-

ognized manual handling risks, unfamiliar patients or unfamiliar lifting equipment).

Finally, nursing education has historically emphasized patient safety but has been lacking in emphasis on self-protection in contrast to the physical therapy discipline, which underscores both self-protection and patient safety during all patient handling and movement tasks. The physical therapy culture also emphasizes promotion of the patient's functional status and independence, which can mean limits on use of handling aids. These professional cultural differences have led to discrepancies in strategies and techniques for patient handling among nurses as well as between disciplines. It is time to promote an interdisciplinary approach to patient handling that will optimize caregiver and patient safety as well as patient rehabilitation.

A plan of action

The MNA calls for an approach that would require all health care facilities in the state to develop and implement a health care worker back injury prevention plan to protect nurses and other caregivers, as well as patients, from injury. The plan would mandate the following:

- **A systematic process in each facility for addressing ergonomics, recognizing occupational health and safety hazards and preventing injuries specific in each health care facility.** Each facility will have a written organization-wide safe lifting and handling plan containing: policy and procedures describing their safe patient handling and lifting philosophy and approach; procedures; equipment type, numbers and location; mechanism for addressing nurses' refusal to perform unsafe lifting and handling; and education and training programs conducted or utilized at their facility by qualified personnel.

Each facility will implement safe handling

and lifting methods that are appropriate for their patient populations, size and scheduling needs.

- **Needs assessment by facilities of patients' lift and transfer requirements and resulting handling, lift and equipment needs.**

Each facility will develop needs assessments appropriate to the lifting and handling requirements of their patients, with the policy describing how the institution will manage the enforcement of policies and procedures.

- **Specialized training of health care workers and lift team members by qualified personnel, with demonstration of proficiency in handling techniques and use of handling equipment.**

Each facility will use qualified personnel, i.e., personnel with recognized certification such as Back Injury Resource Nurse (BIRN) Trained Faculty, as resource nurses and educators in their patient lifting and handling education and training programs.

- **Protection of workers against disciplinary action for refusal to lift or handle patients due to concerns about patient and worker safety.**

When there is insufficient or unsafe lifting or handling measures and/or equipment available and/or the lack of trained personnel, health care workers shall not be subject to disciplinary action by the hospital or any of its managers or employees. Each facility must have a policy and procedure in place describing a non-punitive process for resolution of such situations.

MNA has filed legislation for passage in the commonwealth's 2005-2006 legislative session: HB 2662, "An Act Relating to Safe Patient Handling in Certain Health Facilities." This bill prescribes the measures required to produce safer working conditions for nurses and as a result, for patients as well. ■

Ergonomics in health care: key Web resources

Compiled by **Jamie Tessler, MPH**
Occupational Ergonomics Consultant

1. Patient care ergonomics resource guide: safe patient handling and movement

www.patientsafetycenter.com

By the Patient Safety Center of Inquiry of the Veteran's Health Administration and the Department of Defense, Ergonomics Technical Advisory Group. This guide may be the most comprehensive resource to date for health care facilities on workplace assessment; equipment evaluation; patient assessment; no-lift policies; administrative strategies; and establishing competency programs.

2. Nursing home initiative: getting to zero

www.lni.wa.gov/insurance/HIP/default.htm

The Safety and Health Assessment and Research for Prevention (SHARP) program within the Washington State Department of Labor and Industries launched an initiative to implement and evaluate ergonomic interventions in the nursing home industry.

3. OHSAH: The Occupational Health & Safety Agency for Healthcare in British Columbia

www.ohsah.bc.ca

This non-profit agency is dedicated exclusively to the health and safety of health care workers. Its Web site includes excellent materials on patient handling issues and ergonomics.

4. OSHA

www.osha-slc.gov/SLTC/ergonomics/index.html

The Web site for the Occupational Safety and Health Administration contains materials related to nursing home hazards and ergonomics in health care.

5. NIOSH

www.cdc.gov/niosh/topics/ergonomics/

The National Institute for Occupational Safety and Health (NIOSH) has produced dozens of excellent reports, health hazard evaluations, research digests and fact sheets about ergonomics.

6. New York State Public Employees Federation

www.pef.org/healthandsafety/files/patienthandlingsolutions.pdf

The New York State Public Employees Federation publishes an equipment directory of patient handling equipment as a resource guide to facility-based ergonomics committees. This comprehensive directory contains toll-free numbers and brief descriptions of state-of-the-art lifting devices, lateral transfer equipment and other useful tools.

7. Center for Occupational and Environmental Medicine

www.ErgonomicsInHealthcare.org

This Web page is dedicated entirely to ergonomics in health care.

8. WING-USA: Work Injured Nurses Group

www.wingusa.org

This site includes links to legislative and other news about preventing ergonomic injuries among nursing personnel.

MNA advocate testifies at hearing on safe patient handling bill

Jamie Tessler, an occupational ergonomics consultant and an MNA advocate, recently provided key testimony to the Massachusetts Legislature on behalf of the MNA in support of H. 2662, "An Act Relating to Safe Patient Handling in Certain Health care Facilities."

My name is Jamie Tessler. I am an occupational health professional and I have a long history of working with health care workers to prevent work-related musculoskeletal disorders. I am also a doctoral candidate in occupational ergonomics at the University of Massachusetts. My goal today is to draw a few key points from the large body of peer-reviewed scientific literature that identifies an epidemic of back injuries among nursing personal and to highlight the burden this epidemic is placing on Massachusetts' nurses and other health care workers.

The evidence is overwhelming: An epidemic of occupational back injuries has been occurring, worldwide, and is associated with patient lifting and patient repositioning in acute and long-term care settings. As early as 1988 we knew that nurses who handled patients had 3.7 times the prevalence of low back pain as nurses who didn't handle patients. Now we know that nurses are leaving the profession due to the physical working conditions, among other safety and quality-of-life-factors.

Biomechanical research—using key principles of physics and engineering applied to the human body—has provided us with the science to quantify the limits of human lifting capacity. We have useful tools to measure or predict the physical demands of manually moving patients in health care settings. Dozens of scientific studies focusing exclusively on the hazards of patient handling/patient transferring have been published in peer-reviewed journals. In one

meta-analysis of 10 studies of low back compression from patient handling, all of the studies reported common everyday lifting tasks that exceeded the "safe" lifting guidelines established by the National Institute of Occupational Safety and Health.

Several studies documented that certain one-person lifts exceeded NIOSH's "Maximum Acceptable Weight Limit" (MAWL). Six of the 10 studies documented that two-person lifts—intended to reduce the hazard of lifting — resulted in exertions that exceeded spinal tolerance levels in both employees.

The conclusion? Two decades of biomechanics research applied to health care workers has demonstrated that everyday ordinary patient care tasks require health care workers to use their bodies in ways that exceed human physiologic limits.

I will introduce, therefore, the radical idea that there are two types of patient handling tasks in health care facilities: 1) those that can be performed by human beings, using proper technique, and 2) those that should not be performed by people without lifting equipment because the task exceeds human physiologic limitations.

National and Massachusetts injury statistics support the foundation for this act: the toll of preventable and life-altering musculoskeletal injuries associated with manual handling of patients in multiple health care environments is devastating.

Among employees in the Massachusetts "services" industry, RNs had the second highest number of reported injuries/illnesses of all occupations with 1265 injuries among RNs reported in 2002. Only nursing aides/orderlies/attendants, with a grand total of 3155 injuries, was higher within this sector.

Throughout the state in 2001, 10,400 cases of nonfatal occupational injuries/illnesses were reported among hospital employees alone. Another 7,600 cases can be found among nursing home and personal care facilities. A closer analysis shows that well over half of all lost work time injuries in this sector are associated with sprains, strains and cumulative trauma to the back and other body regions.

Despite our advanced medical infrastructure in Massachusetts and our state-of-the-art treatment centers, Massachusetts incidence rates (2001) are no lower than the national averages. The vast medical knowledge embodied in health care facilities is not reflected in the programs to prevent occupational injury to nurses.

But we can turn the tide.

Examining national statistics, hospitals came in as the third most hazardous work environment in the United States when compared to all other industries. Nursing homes came in first, with the known-to-be-hazardous trucking industry scoring second.

The incidence of reported non-fatal occupational injuries/illnesses in the nursing home sector in 2001 was 14.8 per 100 full time employees (FTEs), 9.0 per 100 FTEs in hospitals, showing an increase for hospitals and nursing homes over 2000 data (BLS, 2000 & 2001).

Behind each statistic is the real person, often a nurse. Costs to Massachusetts's health care workers in terms of personal suffering, the impact on families and communities is difficult to measure. Sourcing direct and indirect costs from employee injuries, lost work time, overtime for replacements, training and recruitment and other indirect expenses take its toll. A comprehensive safer lifting program addresses both employee health and the

quality of patient care and patient safety.

Sadly, these numbers are the tip of the iceberg. Underreporting is rampant among health care workers, and RNs are the first to admit it.

Researchers have concluded that 33 percent to 69 percent of all injuries are overlooked by the Bureau of Labor Statistics. I addressed hundreds of operating room nurses last April; collectively they estimated that 75 to 95 percent of all injuries among their nursing colleagues go unreported.

In neighboring Connecticut, only 10.6 percent of all work related musculoskeletal cases filed a comp claim, with 70.9 percent using their own insurance for medical care. In one study, 50 percent of employees had persistent pain and symptoms, but only 5 percent filed injury reports, and only 7 percent of work related musculoskeletal disorders were listed on OSHA logs. Therefore we must assume that these devastating statistics are a gross underestimation of the epidemic.

The good news is that there is a long-term solution at our fingertips. While traditional "lifting techniques" training programs are proven to not work, "safer lifting" programs do work. Hazards are eliminated at their source. Patient handling technology on the market is better than even. The most hazardous lifts can be eliminated, and the risk of lifting tasks can be lowered to below the NIOSH action limit.

H. 2662 can help to transport the large body of evidence from the academy into the front door of the facility. We now have road maps in place of successful programs. Cash can be saved by facilities. The time is now to support this timely "act." This type of program also bolsters other facility initiatives. It increases patient safety, nurse retention, job satisfaction and employee morale and loyalty. ■

Vinyl medical gloves: what are the concerns?

Question: I'm working at a hospital that is searching for an alternative to latex gloves. Vendors are pointing us in the direction of polyvinyl chloride gloves. Is this really an improvement? Any suggestions?

Answer: Vinyl, also referred to as polyvinyl chloride or PVC, is one of the materials commonly used to make examination gloves. Concerns about vinyl exam gloves can reflect three areas of the glove's life: manufacturing, use and disposal.

Concerns about manufacturing vinyl products include 1) that PVC is produced from vinyl chloride monomer, a very toxic substance that is a known human carcinogen and 2) that dioxin, another likely human carcinogen and a persistent bioaccumulative toxic substance (PBT), can be emitted as an unintended byproduct of PVC production.

While using vinyl gloves, two things to consider include the following:

- A number of studies suggest that PVC medical gloves are not as robust a barrier to bloodborne pathogens as other gloves. Since the primary reason for wearing medical gloves is for barrier protection, one must carefully consider the barrier performance in selecting gloves.
- Although there is little evidence of a specific health hazard to the wearer of vinyl gloves, the literature suggests that in rare instances there may be allergic contact dermatitis reactions to certain additives in the PVC plastic.

When gloves are disposed, many end up in waste incinerators. At this stage a concern is that under certain typical incinerator conditions, incineration of PVC can result in the formation of dioxins (the same family of chemicals described

above). It is possible to imagine that if vinyl gloves were land-filled, plasticizers could leach out under some conditions, although the Sustainable Hospitals Program (SHP) staff has never seen any studies documenting this.

The SHP has two online fact sheets on Selecting Medical Gloves that outline steps for making an informed choice of gloves. Basically, a facility should define who the glove is protecting, what is being protected against (e.g. blood and body fluids, chemicals, chemotherapy drugs, et cetera), and how long the glove is worn. Once this baseline is defined, the hospital can work with manufacturers or vendors to obtain gloves that have been tested and demonstrated as effective barriers for the specific hazards. You can see the SHP fact sheets on glove selection at the following links:

- *Glove Selection fact sheet:* www.sustainablehospitals.org/HTMLSrc/IP_Latex_GloveFacts.html
- *Gloves for Chemotherapy fact sheet:* www.sustainablehospitals.org/PDF/ChemotherapyGloves.pdf

More information, including references, is also available on the SHP Web site at www.sustainablehospitals.org. ■



Studying up: MNA members and others study intently during a recent program about OSHA training related to safety in the health care industry. The program was held Dec. 13 in Northampton.

Health & Safety Contacts

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

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cpontus@mnarn.org

Did we learn anything about avian flu from SARS?

By Thomas P. Fuller PhD, CIH

Recent history indicates that nurses and other health care workers should be provided with the highest level of respiratory and other personal protection in the event of any unknown or highly contagious virus.

The Severe Acute Respiratory Syndrome (SARS) outbreak in 2002 resulted in 8,450 cases. It involved 33 countries on five continents. The death rate conclusively reported by the World Health Organization (WHO) was 9.6 percent. In the infirm and elderly death rates were reported as high as 40 percent.

The WHO reported that 21 percent of all SARS cases were health care workers. But other sources reported 62 percent in Hong Kong and 43 percent in Toronto. Significantly more nurses died than doctors with a relative ratio of 10:3 in Hong Kong.

The lessons learned by the SARS incident highlighted the following weaknesses in our health care systems:

- The inability to identify and contain infectious agents
- Inadequate patient and worker surveillance and contact tracing
- Misunderstanding of methods to prevent transmission (particularly in the hospital setting)
- Unavailability of rapid diagnostics and integration of information
- A shortage of isolation equipment
- Inadequate tracking, monitoring and evaluation of patient cases

The inadequate understanding of the value, failure to use or unavailability of personnel protective equipment (PPE) was likely another significant source of agent transmission to health care workers. It is probable that the differences in worker infection rates and fatalities in different countries were closely related to the effective use of PPE in countries with lower rates.

Unfortunately, when there is an outbreak like this local and federal governments are often unprepared to offer advice on protection and control of the latest agent or its mutation. The numerous factors that must be included in determinations of protective practices include:

- Communicability
- Lethality/medical outcomes
- Treatments
- Preventions
- Diagnostics
- Susceptible populations

Other factors that are important to consider are the:

- Environmental viability of the agent
- Dose needed for infection (number of particles)
- Routes of exposure
- Environmental monitoring
- Availability of protective controls

As the SARS outbreak unfolded a broad variety of conflicting and confusing information was disseminated. It became clear only much later that the information about the modes of transmission, the virulence, and the methods to protect health care workers was grossly inadequate.

It was originally thought that the agent was similar to influenza. Droplet precautions were advised. It is assumed that many workers used surgical masks as their PPE during

these early phases. Later more was learned and it was realized that the virus could also follow an airborne exposure route through aerosolization of small particles and that the agent could remain viable in the air for several hours. It is not clear when this became known to the entire international health care community and when respirators began to be used universally.

After the outbreak it was also learned that many worker and patient illnesses were hospital acquired. The virus can be transmitted by patient contamination of surfaces and materials with the SARS virus that can then infect other workers and patients by contact with mucosal tissue in eyes, mouth, and open cuts. The virus was found as far from the patients' bedsides as nursing stations and break areas. It can be assumed that at least some health care workers exposures and deaths could be attributed to inadequate use of gloves, gowns, and hand-washing in addition to inadequate respiratory protection.

Moving forward the international health care community is trying to contain the latest outbreaks of avian viruses and understand how the agents are changing and moving through the environment and species. The avian virus H5N1 has been shown to be particularly infective and lethal with a death rate of about 50 percent (WHO HHS). The virus has also been confirmed to be transmissible from birds to humans with several workers in Asia becoming infected via close proximity to infected birds or poultry products.

At this time the WHO has issued a Pandemic Alert Phase 3, defined as "Human infections with a new subtype but no human-to-human spread or at most rare instances of spread to a close contact." If this virus mutates in such a way that the disease can be transmissible from human to human like SARS did a serious pandemic could become a reality. If transmission can also become transmissible via aerosolized particles and fomites like the SARS virus did, and it still has a 50 percent death rate, the consequences could be devastating to nurses and other health care workers, their families and the public.

In May 2005 the CDC issued "Interim Guidance on Infection Control Precautions for Patients with SARS and Close Contacts in Households." These guidelines recommended the protection factors of a NIOSH-certified N95 respirator at a minimum.

On Nov. 16, 2005, protective measures suggested by the CDC, Infection Control Guidance for the Prevention and Control of Influenza in Acute-Care Facilities now called for only "the use of gloves and surgical masks." This guidance is based upon the continued assumption that current flu strains are only transmissible person to person via large virus-laden droplets that are generated when persons cough or sneeze in close proximity (within three feet). In an earlier contradictory paper published by Steven Lenhart at the CDC National Institute for Occupational Safety and Health he states that "risks of exposure to infectious particles are likely to be predominately to aerosols consisting of evaporating droplets and droplet nuclei that remain suspended in room air for prolonged periods and not from large particle droplets. He also states that "defining a specific distance as the boundary of a health

care worker's exposure to particles exhaled by a patient with a contagious respiratory infection may be inappropriate."

This Nov. 16 recommendation by the CDC is a non-conservative approach to worker health and safety and assumes that when and if the virus changes and can be transmitted as an aerosol, then the information would be made known immediately and additional precautions could be upgraded appropriately. If aerosolization of the virus is possible and it is viable in the air for even just a few hours, then the surgical masks recommended by the CDC on November 16, 2006 for worker protection are grossly inadequate and N95 masks, recommended earlier in May of 2005 for SARS, should be used at a minimum when in the proximity of the influenza patient.

It is not known when the virus could mutate to a strain that could be transmitted by the air. Neither is it clear when the CDC would become aware of that change, or how long it would take to send a notice to upgrade precautions out to the public. In the case of SARS the upgraded precautions appeared to come too late for many nurses and other health care workers. It is not certain that the health care system weaknesses listed above have all been fully addressed at this time.

Other factors go into the selection of respiratory PPE. The cost of N95s versus surgical masks, availability, the requirement to perform medical clearances and qualitative fit-tests, and the tasks to be performed by the worker. On the other hand when doubts exist about the severity of an occupational hazard, prudent precautionary action must

be considered immediately and taken as appropriate (International Commission on Occupational Health, (2002) International code of ethics for occupational health professionals. Retrieved Jan. 1, 2004 from www.icoh.org.sg/eng/core/code_ethics_eng.pdf.

As the industrial hygiene manager at a large hospital in an urban area it is my job to anticipate, recognize, evaluate, and control hazards in the workplace. I try to work very closely with the infection control committee and hospital epidemiologists to provide insight and recommendations regarding PPE, ventilation systems and other controls to reduce employee exposures and risks.

With the threat of an influenza outbreak that can mutate and be more transmissible and virulent it seems that a more protective approach to worker and patient protection may be warranted. Unlike hazardous chemicals or even radiation, it is difficult to measure the germ load in a work environment and relate that to a "safe" worker dose. In addition, the infectivity of infectious agents is often unknown and the "safe" exposure level of workers is difficult to predict. Therefore, more conservative approaches to worker protection are warranted and even necessary.

There are numerous sources of information on infectious diseases including the WHO and other government and professional organizations. Healthcare facilities should be encouraged to seek information from all sources and set policies and programs according to the needs and capabilities of their facilities. A more protective approach may be advisable. ■

MNA Baseball Caps



Adjustable baseball caps featuring the MNA logo are \$4.99 each, plus \$3.95 shipping and handling if mailed

To order, contact the MNA's Division of Membership, 781-830-5726, or send checks to: MNA Division of Membership, Attn: MNA baseball hats, 340 Turnpike Street, Canton, MA 02021.

Consent to Serve for the MNA Regional Council

I am interested in active participation in MNA Regional Council

At-Large Position in Regional Council

I am a member of Regional Council

__ Region 1 __ Region 2 __ Region 3 __ Region 4 __ Region 5



General members, labor members and labor program members are eligible to run. General means an MNA member in good standing & does not have to be a member of the labor program. Labor means an MNA member in good standing who is also a labor program member. Labor Program Member means a non-RN Healthcare Professional who is a member in good standing of the labor program.

Please type or print — Do not abbreviate

Name & credentials _____
(as you wish them to appear in candidate biography)

Work Title _____ Employer _____

MNA Membership Number _____ MNA Region _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Educational Preparation

School	Degree	Year

Present Offices/Association Activities (Cabinet, Council, Committee, Congress, Unit, etc.)

MNA Offices	Regional Council Offices

Past Offices/Association Activities (Cabinet, Council, Committee, Congress, Unit, etc.) Past 5 years only.

MNA Offices	Regional Council Offices

Candidates may submit a typed statement not to exceed 250 words. Briefly state your personal views on nursing, health care, and current issues, including, if elected, what your major contribution(s) would be to the MNA and in particular to the position which you seek. This statement will be used in the candidate biography and published in the *Massachusetts Nurse*. Statements, if used, must be submitted with this consent-to-serve form.

Signature of Member

Signature of Nominator (leave blank if self-nomination)

Postmarked Deadline: Preliminary Ballot: March 31, 2006
Final Ballot: June 15, 2006

Return completed forms to the Chairperson of your specific Regional Council:
 Region 1: Patricia Healey, MNA Region 1, 241 King Street, Suite 215, Northampton, MA 01060
 Region 2: Jeannine Williams, MNA Region 2, 193 Boylston Street, Suite E, West Boylston, MA 01583
 Region 3: Peggy Kilroy, MNA Region 3, 449 Route 130, Sandwich, MA 02563
 Region 4: Catherine Evlog, MNA Region 4, 10 First Avenue, Suite 20, Peabody, MA 01960
 Region 5: James Moura, MNA Region 5, 340 Turnpike Street, Canton, MA 02021

Regional Council election

Pursuant to the MNA Bylaws: Article III, Regional Councils, Section 5: Governance
 The governing body within each region will consist of:

- a. (1) A Chairperson, or designee, for each MNA bargaining unit.
 (2) One Unit 7 representative on each regional council, to be designated by the Unit 7 President.
 (3) Seven at-large elected positions. General members, labor members, and labor program members are eligible to run for these at-large positions. At-large members serve a two year term or until their successors are elected.
- b. At-large members shall be elected by the Regional Council's membership in MNA's general election. Four at-large members shall be elected in the even years for a two year term and three at large members shall be elected in the odd years for a two year term.

Proviso: This election commences in 2006

Please note the consent to serve form for the Regional Council at-large positions is on this page. Four members will be elected this year to serve a two-year term. ■

R.A.D. MNA to hold Rape Aggression Defense System classes

The Rape Aggression Defense System (R.A.D.) is a women-only program of realistic and comprehensive self-defense tactics. It teaches the importance of awareness, prevention, risk reduction and risk avoidance, while progressing on to the basics of hands-on defense training. R.A.D. is not a martial arts program.

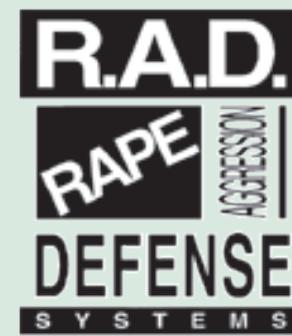
The MNA will be offering a three-part R.A.D. program to its members beginning in March 2006:

- Monday, March 27
5:30 - 9:30 p.m.
- Monday, April 3
5:30 - 9:30 p.m.
- Monday, April 10
5:30 - 9:30 p.m.

All classes will be held at MNA headquarters in Canton, and all classes will be taught by nationally certified R.A.D. instructors. A workbook/reference manual will be provided.

There is a no charge for MNA members. Non-MNA members will be charged \$45 for the three-part program, but are not eligible for reimbursement.

For more information or to register, contact Susan Clish at 781-830-5728.



Position descriptions for MNA elected offices

Running and winning election to MNA offices is one of the most important ways for you to have an impact on your profession.

An orientation is given each elected member prior to assuming positions. An MNA staff person is assigned to each group to assist members in their work. Travel reimbursement to the MNA headquarters for elected members is provided. As stated in the MNA bylaws, absence, except when excused in advance by the chairperson, from more than two meetings within each period of 12 months from the date of assuming an elected or appointed position of the Board of Directors or a structural unit of the MNA shall result in forfeiture of the right to continue to serve and shall create a vacancy to be filled.

Board of Directors

The specific responsibilities and functions of the Board of Directors are to: (1) Conduct the business of the association between meetings; (2) Establish major administrative policies governing the affairs of the MNA and devise and promote the measures for its progress; (3) Employ and evaluate the executive director; (4) The Board of Directors shall have full authority and responsibility for the Labor Program; (5) Adopt and monitor the association's operating budget, financial development plan, and monthly financial statements; (6) Assess the needs of the membership; (7) Develop financial strategies for achieving goals; (8) Monitor and evaluate the achievement of goals and objectives of the total association; (9) Meet its legal responsibilities; (10) Protect the assets of the association; (11) Form appropriate linkages with other organizations; and (12) Interpret the association to nurses and to the public.

Meets 10 times per year, usually a full day meeting held on the third Thursday of

the month. Board members are expected to attend the annual business meeting held during the MNA Convention in the fall.

Center for Nursing Ethics

The Center for Ethics and Human Rights focuses on developing the moral competence of MNA membership through assessment, education and evaluation. It monitors ethical issues in practice; reviews policy proposals and makes recommendations to the Board of Directors; serves as a resource in ethics to MNA members, regions and the larger nursing community; works with MNA groups to prepare position papers, policies and documents as needed; and establishes a communication structure for nurses within Massachusetts and with other state and national organizations. Meets eight to 10 times per year at MNA for two to three hours.

Congress on Health and Safety

The Congress on Health and Safety identifies issues and develops strategies to effectively deal with the health and safety issues of the nurses and health care workers. Meets eight to 10 times per year at MNA for two to three hours.

Congress on Health Policy and Legislation

The Congress on Health Policy and Legislation develops ideas and policies for the implementation of a program of governmental affairs appropriate to the MNA's involvement in legislative and regulatory matters influencing nursing practice, health and safety, issues, labor issues and health care in the commonwealth. The Congress sponsors educational programs, including two lobby day events at the state house, which are designed to enhance members' political savvy. Participation includes task force involvement, development of educational programs and review of state legislation that is health care related. Meets

eight to 10 times per year at MNA or MNA's Region 2 office in West Boylston for two to three hours.

Congress on Nursing Practice

The Congress on Nursing Practice identifies practice and health and safety issues impacting the nursing community which need to be addressed through education, policy, legislation or position statements. Meets eight to 10 times per year at MNA for two to three hours.

Bylaws Committee

The Bylaws Committee receives or initiates proposed amendments to the Bylaws and reports its recommendations to the Board of Directors and the Voting Body at the annual business meeting; reviews all new, revised, or amended Bylaws of constituent regions for approval of conformity; reviews all MNA policies for congruency with existing Bylaws; interprets these Bylaws. Meets eight to 10 times per year at MNA for two to three hours.

Nominations & Elections Committee

The Nominations and Elections Committee establishes and publicizes the deadline for submission of nominations and consent-to-serve form; actively solicits and receives nominations from all constituent regions, congresses, networks, standing committees and individual members; prepares a slate that shall be geographically representative of the state with one or more candidates for each office; implements policies and procedure for elections established by the Board of Directors. The committee meets for one to two -3 hours twice or three 4 times during the year at MNA headquarters. Limited conference call options are available. All updates and correspondence from the committee are conducted by email whenever possible. ■

MNA incumbent office holders for 2006

President

Beth Piknick, RN (2005-2007)

Vice President

Donna Kelly-Williams (2004-2006)*

Secretary

Jim Moura, RN, BSN (2005-2007)

Treasurer

Nora Watts (2004-2006)*

Directors (2 from each Region, Labor Seat)

Region 1

Diane Michael (2004-2006)*

Irene Patch (2005-2007)

Region 2

Mary Marengo (2004-2006)*

Kathlyn M. Logan, RN (2005-2007)

Region 3

Vacancy

Vacancy

Region 4

Vacancy

Fran O'Connell (2005-2007)

Region 5

Elizabeth J. Sparks (2003-2006)*

Connie Hunter, RNC (2005-2007)

At-Large Director (Labor Seat)

Karen Coughlin, RN, C (2005-2007)

Richard Lambos, RN (2005-2007)

Barbara Norton, RN (2005-2007)

Karen Higgins, RN (2005-2007)

Sandy Ellis (2004-2006)**

Nancy Gilman (2004-2006)*

Judy Smith-Goguen (2005-2007)

At-Large Director (General Seat)

Tina Russell, RN (2005-2007)

Jeannine Williams, RN (2005-2007)

Sandy Eaton, RN (2005-2007)

Joanne Hill (2004-2006)*

Sharon McCullum (2004-2006)*

Rosemary O'Brien (2004-2006)*

Labor Program Member

(Non-RN, Health Care Professional)

Beth Gray-Nix, OTR/L (2005-2007)

Nominations & Elections Committee

Stephanie Stevens (2004-2006)

Bylaws Committee

Kathryn F. Zalis (1999-2001)

Elizabeth Kennedy (2002-2004)

Margaret Sparks (2000-2002)

Jane Connelly (2003-2005)**

Sandra LeBlanc (2001-2005)**

Center for Nursing Ethics & Human Rights

Ellen Farley (2004-2006)

Lolita Roland

Anne Schuler

Kelly Shanley (2004-2006)

Congress on Health Policy & Legislation

Donna Dudik (2004-2006)

Marilyn Crawford (2004-2006)**

Sandra Hottin (2002-2004)*

Congress on Nursing Practice

Mary Amsler (2005-2007)

Karen A. Carpenter (2005-2007)

Marianne Chisholm (2004-2006)*

Ellen Deering (2005-2007)

Stephanie V. Holland (2005-2007)

Marian Nudelman (2004-2006)*

Christine A. O'Brien (2004-2006)

Margaret M. Webster (2004-2006)

Linda A. Winslow (2004-2006)*

Congress on Health & Safety

Terri J. Arthur (2004-2006)*

Janet Butler (2004-2006)*

Mary Ann Dillon (2005-2007)

Sandra E. LeBlanc (2004-2006)*

Kathleen Sperrazza (2004-2006)*

Lorraine MadDonald (2005-2007)

Gail Lenahan (2005-2007)

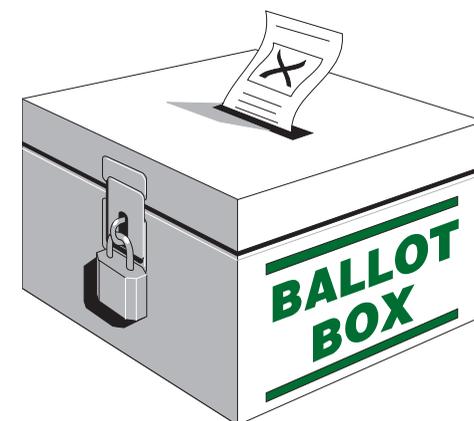
Elizabeth O'Connor (2005-2007)

Mary V. Bellistri (2005-2007)*

Michael A. D'Intinosanto (2004-2006)*

Janet K. Reeves (2004-2006)*

See next page for
Consent to Serve form
and further information
about seeking elected
office with the MNA.



Consent to Serve for the MNA 2006 Election

I am interested in active participation in the Massachusetts Nurses Association

MNA General Election

- | | |
|--|---|
| <input type="checkbox"/> Vice President, Labor*, 1 for 2 years | <input type="checkbox"/> Nominations Committee, (5 for 2 years) [1 per region] |
| <input type="checkbox"/> Treasurer, Labor*, 1 for 2 years | <input type="checkbox"/> Bylaws Committee (5 for 2 years) [1 per region] |
| <input type="checkbox"/> Director, Labor* (5 for two years) [1 per Region] | <input type="checkbox"/> Congress on Nursing Practice (6 for 2 years) |
| <input type="checkbox"/> Director At-Large, General (4 for 2 years) | <input type="checkbox"/> Congress on Health Policy (6 for 2 years) |
| <input type="checkbox"/> Director At-Large, Labor (3 for 2 years) | <input type="checkbox"/> Congress on Health & Safety (6 for 2 years) |
| | <input type="checkbox"/> Center for Nursing Ethics & Human Rights (2 for 2 years) |

**General means an MNA member in good standing and does not have to be a member of the labor program. Labor means an MNA member in good standing who is also a labor program member. Labor Program Member means a non-RN health care professional who is a member in good standing of the labor program.*

Please type or print — Do not abbreviate

Name & credentials _____
(as you wish them to appear in candidate biography)

Work Title _____ Employer _____

MNA Membership Number _____ MNA Region _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Educational Preparation

School	Degree	Year

Present Offices/Association Activities (Committee, Congress, Regional Council, Unit, etc.)

MNA Offices	Regional Council Offices

Past Offices/Association Activities (Committee, Congress, Regional Council, Unit, etc.) Past 5 years only.

MNA Offices	Regional Council Offices

Candidates may submit a typed statement not to exceed 250 words. Briefly state your personal views on nursing, health care, and current issues, including, if elected, what your major contribution(s) would be to the MNA and in particular to the position which you seek. This statement will be used in the candidate biography and published in the *Massachusetts Nurse*. Statements, if used, must be submitted with this consent-to-serve form.

Signature of Member

Signature of Nominator (leave blank if self-nomination)

Postmarked Deadline: Preliminary Ballot: March 31, 2006
 Final Ballot: June 15, 2006

Return To: Nominations and Elections Committee
 Massachusetts Nurses Association
 340 Turnpike Street, Canton, MA 02021

- Hand delivery of material must be to the MNA staff person for Nominations and Elections Committee only.
- Expect a letter of acknowledgment (call by June 1 if none is received)
- Retain a copy of this form for your records.
- Form also available on MNA Web site: www.massnurses.org

Mass. BORN makes changes to its Web site

The Massachusetts Board of Registration in Nursing has started an electronic newsletter on its Web site www.mass.gov/dph/boards/rn.

The BORN has also announced that it will begin posting disciplinary actions against nurses during the month of February. ■

Scholarship funding available through the Massachusetts Nurses Foundation

Printable applications with instructions and eligibility requirements are available at www.massnurses.org. You may also obtain an application by calling the Massachusetts Nurses Foundation at 781-830-5745.

The deadline for returning applications is June 1, 2006. ■

Donations Needed for MNF Annual Auction!

We Need Your Help: The Massachusetts Nurses Foundation is preparing for the annual golf tournament that is scheduled for June 2006, as well as its annual silent and voice auction to be held during the MNA's 2006 convention.

Donations are needed to make these fundraising events a big success. Your tax-deductible donation helps the Foundation raise funds to support nursing scholarships and research.

Your support is appreciated

Jeannine Williams
MNF President

Patricia Healey
MNF Secretary

- ✓ Valuable Personal Items
- ✓ Gift Certificates
- ✓ Works of Art
- ✓ Craft Items
- ✓ Memorabilia & Collectibles
- ✓ Vacation Packages
- ✓ Gift Baskets

Contact the MNF at 781-830-5745 to obtain an auction donor form or simply mail or deliver your donation to:

MNF
 340 Turnpike Street
 Canton, MA 02021





1st Annual MNA Clinical Nursing Conference

May 19, 2006 • Doubletree Hotel (formerly Wyndham Hotel) • Westborough

Free to MNA Members!

Limited to 600 participants

Featured Speakers



Keynote Address:
25 Stupid Things Nurses Do to Self Destruct

A dynamic and entertaining speaker, **Laura Gasparis Vonfrolio, RN, PhD**, has helped thousands of nurses over the last 16 years to prepare for the CCRN and the CEN examinations and has worked as staff nurse,

staff development instructor and professor of nursing. Author of numerous books and articles, Dr. Vonfrolio is the proprietor of Education Enterprises and the former publisher of *Revolution: The Journal of Nurse Empowerment*.



Closing Address: *Crucial Conversations: Survival Skills for the Future*

Terry Johnson, ARNP, RNC, MN, is a neonatal nurse practitioner who consults to systems and individuals in the areas of communication, work style and conflict negotiations.

Important Information

Hotel Information

The Doubletree Hotel in Westborough is offering a special room rate of \$92/night for single or double occupancy. For reservations call 508-616-7406.

Refund Policy

Refunds for educational programs will be issued up to two weeks before the program date minus 25 percent processing fee. Requests for refunds *will not* be honored within the 14-day period of the program date. On-site registration is contingent upon space.

Chemical Sensitivity

Attendees are requested to avoid wearing scented personal products when attending the conference.

Contact Hours

Continuing nursing education contact hours will be 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.

To successfully complete a program and receive contact hours you must: 1) sign in, 2) be present for the entire time period of the sessions, and 3) complete and submit the evaluation.

Questions

Call MNA's Department of Nursing at: 800-882-2056, x727, x719 or x723.

Conference Schedule

- 8:00-8:30 a.m. Registration and Breakfast
- 8:30-10:00 a.m. **Keynote Address:** *25 Stupid Things Nurses Do to Self Destruct*
Laura Gasparis Vonfrolio RN, PhD
- 10:00-10:15 a.m. Break
- 10:15-11:45 a.m. **Concurrent Sessions 1-3:**
 - 1. *Diabetes Pharmacotherapy: Insulin and Insulin Pumps*, Ann Miller, MS, RN, CS, CDE
This presentation will review commonly used insulins and the new antidiabetic injectable medications, Byetta and Smylin. Other topics include insulin regimens from conventional to intensive management and an update on insulin delivery systems.
 - 2. *Neurological Assessment Made EZ*, Laura Gasparis Vonfrolio, RN, PhD
How to perform a quick neurological assessment. Understanding what the clinical findings indicate in terms of your patient's prognosis. Nursing interventions for decreasing your patient's intracranial pressure, what to do and not do.
 - 3. *Public Health Emergencies: Pandemics; Disasters—Natural and Man-made*
Jonathan Burstein, MD, FACEP
This program will speak to potential large-scale acute threats both natural and human, and the effects to our public health. The program will also address the types of needed response and explain the roles that nurses may play.
- 11:45-12:45 p.m. Lunch
- 12:45-2:15 p.m. **Concurrent Sessions 4-6:**
 - 4. *Acute Renal Failure and Attractions in Electrolytes*, Laura Gasparis Vonfrolio, RN, PhD. Laura will discuss the clinical management of acute renal failure as well as related electrolyte imbalances.
 - 5. *New Advances in Cancer Therapy*, Sharon Lane, RN, MS
Defining characteristics of the types and stages of breast cancer, lung cancer and colon cancer will be presented. Current treatment strategies, new therapies and nursing implications will be addressed. Future trends will be explored.
 - 6. *Understanding Today's Street Drugs*, Donna White, RN, PhD
This workshop will focus on current drugs of abuse—both prescriptive and street-oriented. Topics covered will be the latest developments in patterns of use; drug-related language and terms; populations at risk; and an overview of drug paraphernalia.
- 2:15-2:30 p.m. Break
- 2:30-4:00 p.m. **Closing Address:** *Crucial Conversations: Survival Skills for the Future*
Terry Johnson, ARNP, RNC, MN
Six key critical issues facing nurses and the nursing profession today will be addressed. Utilizing key concepts of Susan Scott's "Fierce Conversations," participants will learn how to interrogate reality; provide learning, tackle challenges, enrich relations and apply these components of "fierce conversations" to nursing's critical issues.

REGISTRATION FORM: 1ST ANNUAL MNA CLINICAL NURSING CONFERENCE • MAY 19, 2006

Name _____
 _____ RN _____ LPN _____ APN _____ Other (specify) _____
 (MNA membership only) MNA Region _____
 Address _____
 City _____ State _____ Zip _____
 Telephone: Daytime _____ Evening _____
 Place of employment _____

OFFICE USE ONLY	
CHG CODE: _____	AMT. _____
V/MC _____	
CK# _____	CK. DATE _____
INIT. _____	DATE: _____

Fees: Members: free All Others \$195

Please choose **one** of the following morning concurrent sessions:

- Diabetes Neurological Assessment Public Health Emergencies

Please choose **one** of the following afternoon concurrent sessions:

- Renal Failure Cancer Therapy Today's Street Drugs

Please make checks payable to **MNA**, 340 Turnpike Street, Canton, MA 02021. To register with a credit card please call **the MNA Nursing Department** at 781-821-4625 or 800-882-2056, x727, x719 or x723. Registration is on a space available basis. Registration closes once seating capacity is reached.

MORE EXCITING GROUP TRIPS TO EUROPE IN 2006!

MNA is pleased to announce we are promoting these trips.

GREECE, WITH A THREE-NIGHT GREEK ISLAND CRUISE

\$1,869* outside cabin or \$1,799* inside cabin

Oct. 25 – Nov. 2, 2006

We are offering this spectacular nine-day/seven-night tour to Greece and the Greek Isles at a beautiful time of year for the area. While in Greece, we will be staying in Athens and touring the local sites of the ancient capital. We will also tour key sites outside of Athens in Delphi and Corinth. This trip will include a three-night cruise aboard the Louis Cruises' *Perla*. While onboard we'll visit the following Greek Islands: Mykonos, Rhodes and Patmos as well as the Turkish Island of Kusadasi. This trip includes round trip air from Boston and transfers to and from the hotel. Almost all meals are included (three lunches are on your own) as well as daily tours. This trip is sure to fill quickly, so reserve soon.



FLORENCE, VENICE AND ROME

\$1,729*

Nov 9-17, 2006

Join this wonderful nine-day/seven-night tour featuring Florence, Venice and Rome with tours included in each city as well as the beautiful Tuscan cities of Siena, San Gimignano and Assisi. The tour will include four nights in the beautiful Spa town of Montecatini (just outside of Florence). From there you will have day trips to Florence, Venice, Siena and San Gimignano. On the day we travel south to Rome, we will visit the picturesque city of Assisi. The remaining three nights will be in Rome where we will have a full-day tour of the Colosseum, the Parthenon, the Spanish Steps, the Trevi Fountain and much more. The other day in Rome will include a tour of Vatican City. This trip includes round trip air from Boston and transfers to and from the hotel. Breakfast and dinner daily is included as well as one lunch. Don't miss this grand tour of Italy's key cities.



Reserve Early  Space is Limited

To receive more information and a flyer on these great vacations, contact Carol Mallia, RN, MSN at 781-830-5744. Leave your mailing address on the message or email requests to cmallia@mnarn.org.

*Prices listed are per person, double occupancy based on credit card purchase. Applicable departure taxes are not included. Check purchase price is \$30 lower than the price listed.

MNA membership dues deductibility 2005

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.

Region	Amount	Percent
All Regions	\$28.50	5.0%

The Massachusetts Nurses Association joins MITSS in providing support to nurses involved with an adverse medical event.

"To Support Healing & Restore Hope"

Program Mission/Philosophy

- We believe that nurses have a professional responsibility to support colleagues who have been affected by unexplained medical outcomes or adverse patient events.
- We believe that early support can lessen the emotional effects on the nurse clinician provider.
- **Are you a nurse who has been impacted emotionally by an experience associated with an adverse medical outcome?**
- **Would you like to talk confidentially to a MITSS therapist?**
- **Would you like to join in a peer-led support group?**
- **Would you like to join or participate in a structured support group led by an experienced psychologist?**

Medically Induced Trauma Support Services (MITSS), Inc. is a non-profit organization that supports, educates, trains, and offers assistance to individuals affected by medically induced trauma.

MITSS supports clinicians using the following resources:

- One-on-one interaction via phone
- Group sessions led by a professional facilitator
- Training for fellow survivors who would like to help others

MITSS Toll-Free Number
MNA MITSS Referral Line
MITSS Web Site

888-36-MITSS
781-821-4625, x.770
<http://mitss.org>

This service is available to any RN in Massachusetts.



MNA

MNA CONTINUING EDUCATION COURSES

Winter/Spring 2006 Courses

Diabetes 2006: What Nurses Need to Know

Description This program will discuss the pathophysiology and classification of diabetes Type 1 and 2. Nursing implications of blood glucose monitoring and non-pharmacological interventions such as exercise and meal planning will be addressed. Oral pharmacological agents and a comprehensive update on insulin therapy will be presented. Nursing management of the newly diagnosed diabetic patient, both complicated and not, will be explored. Nursing management of the diabetic patient in the pre/post operative, ambulatory care, home care and school settings will be discussed.

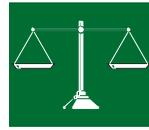


Speaker Ann Miller, MS, RN, CS, CDE
Date February 23
 March 2 – Snow Date
Time 8:30 a.m. – 4 p.m. (light lunch provided)
Place MNA headquarters, Canton
Fee MNA members free; others \$150
Contact Hours* 7.2
MNA Contact Liz Chmielinski, 781-830-5719 or 800-t-2056, x719

Time 5:30 – 9:30 p.m. (light supper provided)
Place (see above)
Fee Free to senior nursing students and faculty
MNA Contact Theresa Yannetty, 781-830-5727 or 800-882-2056, x727

Nurse Protect Thyself...Tools to Minimize Your Legal Exposure

Description This program will provide nurses with a tool kit of information to minimize liability in nursing practice situations. The elements of negligence and how nurses are accountable through regulations, scope of practice and standards of care will be addressed. Documentation and its uses in litigation will be discussed and strategies provided to protect your nursing practice.



Speakers Legal Nurse Consultants, Southern New England Chapter of the American Association of Legal Nurse Consultants
Date April 7
Time 8:30 a.m. – 4 p.m. (light lunch provided)
Place MNA headquarters, Canton
Fee MNA and AALNC members \$75; others \$99
Contact Hours Will be provided
MNA Contact Liz Chmielinski, 781-830-5719 or 800-882-2056, x719.

Oncology for Nurses

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



Speaker Marylou Gregory-Lee, MSN, RN, NP
Date March 8
Time 8:30 a.m. – 4 p.m. (light lunch provided)
Place MNA headquarters, Canton
Fee MNA members free; others \$150
Special Note Limited to 25 participants.
Contact Hours* 7.2
MNA Contact Theresa Yannetty, 781-830-5727 or 800-882-2056, x727

Advanced Cardiac Life Support: Certification & Recertification

Description This American Heart Association course will provide information on the clinical management of cardiac and respiratory emergencies through case study approach. Course content includes assessment, arrhythmia recognition, intubation, defibrillation and pharmacological interventions. This is a two-day certification and a one-day recertification course. Recertification candidates must present a copy of their current ACLS card at the time of registration.



Speaker Carol Mallia, RN, MSN and other instructors for the clinical sessions
Date April 11 and April 18 (Certification)
 April 18 (Recertification)
Time 9 a.m. – 5 p.m. (light lunch provided)
Place MNA headquarters, Canton
Fee Certification: MNA members free; others \$195
 Recertification: MNA members free; others \$165
Contact Hours* 16 contact hours for certification only
MNA Contact Liz Chmielinski, 781-830-5719 or 800-882-2056, x719

Managing Conflict: The Verbal Solution

Description This program will provide nurses with an understanding of the management of conflict in the workplace and skills necessary to its effective management.

Speaker Joe-Ann Fergus, BSN, RN
Date March 22
Time 5:30 – 9 p.m. (light supper provided)
Place MNA headquarters, Canton
Fee MNA members free; others \$65
Contact Hours* 3.0
MNA Contact Liz Chmielinski, 781-830-5719 or 800-882-2056, x719

Cardiac and Pulmonary Pharmacology

Description This program will provide nurses, from all clinical practice settings, with a better understanding of how cardiac and pulmonary medications work. The actions, indications, and nursing considerations will be discussed for the major categories of cardiac and pulmonary medications.



Speaker Carol Mallia, RN, MSN
Date May 16
Time 5 – 9 p.m. (light supper provided)
Place MNA headquarters, Canton
Fee MNA members free; others \$65
Contact Hours* 4.5
MNA Contact Liz Chmielinski, 781-830-5719 or 800-882-2056, x719

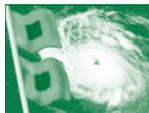
Workplace Violence: Health Care is Not Immune

Description This course is designed for registered nurses and others in the health care industry who are affected by workplace violence and/or are developing workplace violence prevention programs.

Speaker Evelyn Bain, MEd, RN, COHN-S
Date March 29
Time 8:30 a.m. – 1 p.m.
Place The Lantana, Randolph
Fee MNA members free; others free
Contact Hours* TBA
MNA Contact Susan Clish, 781-830-5723 or 800-882-2056, x723

Disaster Preparedness: An All-Hazards Approach for Nurses

Description This three-part program provides an overview of the "All-Hazards Approach" to disaster management geared to the special role of nurses. The development of approaches and capacity to deal with common natural and technological disasters (hurricanes, floods, forest fires, earthquakes, flu outbreaks, power outages, natural gas explosions) as well as with chemical, biological, radiological and nuclear threats and the role nurses can play in responding to disasters will be discussed. Part 1) All hazards approach overview; Part 2) Community, family, self: disaster planning, nurse involvement; Part 3) Psychosocial affects of disaster, nursing management. Participants may elect to attend any or all parts.



Speakers Part 1: Anthony Fulcalaro, EMT; Capt. Lawrence P. Ferazani
 Part 2: Cynthia R. Butters, RN, MS, Ed.D.; Mary Conant, RN, BSN
 Part 3: Lisa Gurland, RN, Psy.D; Karen Carpenter, APRN, BC, FNP, JD
Date June 1 – Part 1
 June 14 – Part 2
 June 21 – Part 3
Time 5 – 9 p.m. (light supper provided)
Place MNA headquarters, Canton
Fee MNA members free; others \$45
Contact Hours* Will be provided
MNA Contact Susan Clish, 781-830-5723 or 800-882-2056, x723

The Real Nursing World: Transition from Student to RN

Description Don't miss one of these unique programs offering you an opportunity to address questions or concerns to a panel comprised of recent graduates from various schools of nursing and experienced nurses with knowledge in nursing education, nursing administration, labor relations and political action, and career counseling. Representatives from area hospitals and other health care facilities will be available before and after the program to discuss employment opportunities.



Facilitator Carol Mallia, RN, MSN
Panel TBA
Date March 28 – Springfield Marriott, Springfield
 March 29 – Worcester Crowne Plaza, Worcester
 April 4 – Lombardo's, Randolph

Cardiac and Pulmonary Emergencies

Description This program is designed for registered nurses in acute, sub-acute and long-term care settings to learn the clinical management of cardiac and respiratory emergencies. Clinical management of chest pain, brief EKG interpretation and ABG interpretation, as well as clinical management of respiratory distress, will be addressed.



Speaker Carol Mallia, RN, MSN
Date June 20
Time 5 – 9 p.m. (light supper provided)
Place MNA headquarters, Canton
Fee MNA members free; others \$65
Contact Hours* 3.9
MNA Contact Theresa Yannetty, 781-830-5727 or 800-882-2056, x727

Emerging Infectious Diseases

Description This program is designed to educate registered nurses and others about the most current information regarding emerging infectious diseases such as avian flu, Marburg virus, and other diseases. The morning portion of the course will address specific diseases and their associated processes, treatments and preventions. The afternoon portion of the course will address protecting nurses and others from disease exposures through the use of environmental and work-practice controls, as well as personal protective equipment.



Speaker Evelyn Bain, MEd., RN, COHN-S
Date June 27
Time 8:30 a.m. – 4:30 p.m. (light lunch provided)
Place TBA
Fee TBA
Contact Hours* Will be provided.
MNA Contact Susan Clish, 781-830-5723 or 800-882-2056, x723

CONTINUING ED 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, Visa or Amex 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 due to extenuating circumstances. **In case of inclement weather**, please call the MNA at 781-821-4625 or 800-882-2056 to determine whether a program will run as originally scheduled. Registration fees will be reimbursed for all cancelled programs.

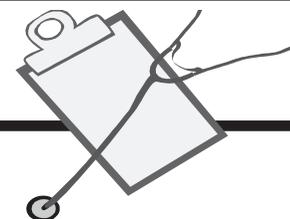
***Contact Hours** Continuing education contact hours for all programs except "Advanced Cardiac Life Support" are provided by the Massachusetts Nurses Association, which is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation. Contact hours for "Advanced Cardiac Life Support" 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
- 3) Complete and submit the evaluation

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

Senior Nursing Students



The Real Nursing World: Transition from Student to RN

These unique programs provide senior nursing students with the opportunity to hear, first-hand, what it is like to transition from the school environment to the world of professional nursing. A distinguished panel of guests that includes recent graduates and experienced nurses will share their experiences and present strategies for transitioning successfully. Topics will include:

- How to best manage a job search in today's nursing environment
- The importance of securing a complete new-graduate orientation program and preceptorship
- Successful interview strategies for finding the right job

Representatives from area hospitals and other health care facilities will be available before the program to discuss employment opportunities. Attendees are encouraged to bring copies of their resumes. A light supper will be served.

March 28 ♦ 5:30 - 9:30 p.m..
Springfield Marriott, Springfield

March 29 ♦ 5:30 - 9:30 p.m
Crowne Plaza Hotel, Worcester

April 4 ♦ 5:30 - 9:30 p.m.
Lombardo's Function Facility, Randolph

These programs are free to all senior nursing students and nursing faculty. Space will fill quickly! You must pre-register for the program by contacting Theresa Yannetty at the MNA, 800-882-2056, x727, or by email at tyannetty@mnarn.org, with all the information listed.

THE REAL NURSING WORLD – TRANSITION FROM STUDENT TO RN

- March 28 – Springfield Marriott, Springfield**
- March 29 – Crowne Plaza Hotel, Worcester**
- April 4 – Lombardo's Function Facility, Randolph**

Name _____

Permanent Home Address _____

City _____

State _____

Zip _____

Home Telephone: () _____

Email _____

I am a senior nursing student at _____

My graduation date will be: _____

My degree will be: _____

*Return completed registration form by March 24 to: Massachusetts Nurses Association, Attn: Nursing Department, 340 Turnpike Street, Canton, MA 02021
 To email your registration, include the information requested above and send to: tyannetty@mnarn.org*

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Get more of the wireless products and services that keep mobile professionals connected. T-Mobile is offering MNA members and their families a free phone with activation, free nationwide long distance and roaming and free nights and weekends (on specific plans). International rates also available. No activation fee is required for members.

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MNA DIVISION OF MEMBERSHIP800-882-2056, x726
Obtain an MNA Discount card to receive 15% discount on automobile products & services.

CONSUMER REFERRAL SERVICE

MASS BUYING POWER..... 866-271-2196
Mass Buying Power is a no-cost, no-obligation benefit offered to MNA members. Before you make your next purchase visit www.massbuy.com for any new products and services. Log in as a group member (sign-in name: MBP, password, MBP)

DISCOUNT ELECTRONICS & APPLIANCES

HOME ENTERTAINMENT DISTRIBUTORS800-232-0872 OR 781-828-4555
Home electronics & appliances available at discount prices for MNA members.

OIL BUYING NETWORK DISCOUNT

OIL BUYING NETWORK 800-660-4328
Lower your home heating oil costs by 10–25 cents per gallon or \$150 per year.

WRENTHAM VILLAGE PREMIUM OUTLETS

Present your valid MNA membership card at the information desk at the Wrentham Village Premium Outlets to receive a VIP coupon book offering hundreds of dollars in savings.

SIGHT CARE VISION SAVINGS PLAN

MNA DIVISION OF MEMBERSHIP800-882-2056, x726
Obtain your Sight Care ID card to receive discounts on eye exams, eyeglasses & contact lenses at Cambridge Eye Doctors or Vision World locations.

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CHOICE HOTELS INTERNATIONAL (SOS PROGRAM)..... 800-258-2847
20% discount on participating Comfort, Quality, Clarion, Sleep, Econo Lodge, Rodeway & MainStay Suites, Inns & Hotels. Advanced reservations required mention SOS Program #00801502. Membership in Guest Privileges Frequent Traveler Program.

CENTRAL FLORIDA AREA ATTRACTIONS

THE OFFICIAL TICKET CENTER 877-406-4836
Discount admission to Orlando area attractions.

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MNA DIVISION OF MEMBERSHIP800-882-2056, x726
Obtain Adventure Card to receive discount admission to Busch Gardens, Sea World, Sesame Place, Water Country USA & Adventure Island in Tampa, Fla.

UNIVERSAL STUDIOS MEMBER EXTRAS

Log onto the MNA 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.

WORKING ADVANTAGE (NEW)

Members now have access to discounts for movie theatres, movie rentals, theme parks, ski tickets, Broadway shows, and much more. Register today at www.workingadvantage.com (member ID number located in the MNA's "Money Saving Discounts" flyer).

SIX FLAGS NEW ENGLAND

MNA DIVISION OF MEMBERSHIP800-882-2056, x726
Purchase discount admission tickets for \$30 per person (seasonal).

**Take advantage of these special discounts specifically designed for MNA members.
For more information, contact the representative listed or call member discounts at the MNA, 800-882-2056, x726.
All discounts are subject to change.**

Medical Mission: Honduras, April 2006

The MNA Diversity Committee is seeking donations of medicines and other items that will make a difference in the lives of Honduran citizens. These items will be delivered to Honduras in April during a medical missions trip.

Below is a list of items that are needed. All donations will be appreciated.

Donation Wish List

- Infant and pediatric Tylenol, liquid and tabs
- Pediatric Motrin
- Infant and pediatric decongestant
- Adult Motrin, Naprosyn and Tylenol
- Adult cold and cough remedies
- Adult vitamins
- School supplies
- Shoes and socks
- Toothbrushes
- Bar soaps; hotel soaps are great
- Reading glasses—invaluable!
- Spanish-language children's books
- Popsicle sticks and yarn
- Cash donations—to help people in need of medical treatments/interventions.
- *Please, no candy or balloons*

Please make sure all expiration dates are at least one year out.

Send donations to MNA, Attn: Medical Missions,
340 Turnpike St., Canton, MA 02021.

For information—including how to join the medical missions team—contact
Carol Mallia at 781-830-5744 or via email at cmallia@mnarn.org.



The MNA
Diversity Committee



MNA

PEER ASSISTANCE PROGRAM

Help for Nurses with Substance Abuse Problems



Are you a nurse who is self-prescribing medications for pain, stress or anxiety?



Are you a nurse who is using alcohol or other drugs to cope with everyday stress?



Would you appreciate the aid of a nurse who understands recovery and wants to help?

CALL THE MNA PEER ASSISTANCE PROGRAM

ALL INFORMATION IS CONFIDENTIAL

781-821-4625, EXT. 755

OR 800-882-2056 (IN MASS ONLY)

WWW.PEERASSISTANCE.COM

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

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

Boston Metropolitan Area

- Bournwood Hospital, Health Care Professionals Support Group, 300 South St., Brookline. Contact: Donna White, 617-469-0300, x305. Meets: Wednesdays, 7:30–8:30 p.m.
- McLean Hospital, DeMarmeffe Building, Room 116. Contact: LeRoy Kelly, 508-881-3192. Meets: Thursdays, 5:30–6:30 p.m.
- Peer Group Therapy, 1354 Hancock Street, Suite 209, Quincy. Contact: Terri O'Brien, 781-964-9546. Meets: Wednesdays, 5:15 p.m. & coed at 6:30 p.m.
- Caritas Good Samaritan Medical Center, Community Conference Room, 235 N. Pearl St., Brockton. Contact: Eleanor O'Flaherty, 508-559-8897.

- Meets: Fridays, 6:30-7:30 p.m.
- Health Care Professional Support Group, Caritas Norwood Hospital, Norwood. Contact: Jacqueline Sitte, 781-341-2100. Meets: Thursdays, 7–8:30 p.m.

Central Massachusetts

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

Northern Massachusetts

- Baldpate Hospital, Bungalow 1, Baldpate Road, Georgetown. Facilitator: Teri Gouin, 978-352-2131, x15. Meets: Tuesdays, 5–6 p.m.
- Nurses Recovery Group, Center for Addiction Behavior, 27 Salem Street, Salem. Contact: Jacqueline Lyons, 978-697-2733. Meets: Mondays, 6–7 p.m.

- Partnership Recovery Services, 121 Myrtle Street, Melrose. Contact: Jay O'Neil, 781-979-0262. Meets: Sundays 6:30–7:30 p.m.

Western Massachusetts

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

Southern Massachusetts

- Professionals Support Group, 76 W. Main St., Suite 306, Hyannis. Contact: Kathy Hoyt, 508-790-1944. Meets: Mondays, 5–6 p.m.
- PRN Group, Pembroke Hospital, 199 Oak Street, Staff Dining Room, Pembroke. Contact: Sharon Day, 508-375-6227. Meets: Tuesdays, 6:30–8 p.m.

- Substance Abuse Support Group, St. Luke's Hospital, New Bedford, 88 Faunce Corner Road. Contact: Michelle, 508-947-5351. Meets: Thursdays, 7–8:30 p.m.

Other Areas

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

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A new MNA family benefit



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

MNA
MASSACHUSETTS NURSES ASSOCIATION

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
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- Low Rates & Discounts
- No Point/No Closing Cost Programs Available
- Also Available to Direct Family Members

CALL THE MNA ANSWER LINE FOR PROGRAM RATES AND DETAILS:

1.877.662.6623
1.877.MNA.MNA3



NEED A SPEAKER FOR YOUR CLASS?



Call the

MNA

Speakers Bureau

The MNA Speaker's Bureau provides experts to assist nursing school faculty in their efforts to bring important and topical information to students. Below is a listing of topics and speakers available free of charge to speak to your class.

- **Safe Staffing Saves Lives—The Case for RN-to-Patient Ratio Legislation**
An analysis of the causes and impact of the current staffing crisis in Massachusetts on nurses and patients, review of research to support legislation, detailed explanation of the current safe staffing bill with a discussion of its benefits to the profession and patient care.
Presented by Charles Stefanini, MNA Director of Legislation and Governmental Affairs
Contact: cstafanini@mnarn.org; 781-830-5716
- **The Role of Political Action in Protecting Nursing Practice**
A review of the impact of politics and government regulation on nursing practice and health care with an emphasis on how nurses can and should use the political process to protect their profession and improve care for their patients
Contact: cstafanini@mnarn.org; 781-830-5716
- **No Time for Silence—Using Public Opinion to Protect Nursing Practice**
A program promoting the need for nurses to be more visible and vocal in the media, in their communities and other forums to help shape public opinion to protect issues important to the profession. Includes a rationale for action, specific communications strategies and case histories.
Presented by David Schildmeier, MNA Director of Public Communications
Contact: dschildmeier@mnarn.org; 781-830-5717
- **Medication Errors: Focus on Prevention**
This program describes the complexity of the medication system in acute care facilities. It is designed to assess and review medication administration systems to improve their safety.
Presented by Dorothy McCabe, MNA Director of Nursing
Contact: dmccabe@mnarn.org; 781-830-5714
- **A Primer on Accepting, Rejecting and Delegating a Patient Assignment**
This program provides a framework for decision making based on the Nurse Practice Act and other regulatory agencies to safeguard nursing practice and patient care.
Contact: dmccabe@mnarn.org; 781-830-5714
- **Obtaining Your First Position: A Primer**
A program for senior nursing students to provide practical information on how to secure their first position in the field, including job search, resume preparation and interviewing tips.
Contact: dmccabe@mnarn.org; 781-830-5714
- **Forensic Nursing and Care of the Sexual Assault Patient**
A discussion on sexual assault and the prevalence of assault across the lifespan, options for medical care, forensic medical examinations, prophylaxis and counseling resources.
Presented by Mary Sue Howlett, RN, Training Coordinator, SANE Program
Contact: mslshane@comcast.net; 978-687-4262
- **The Role of the Mass. BORN and Its Relationship to Your Practice**
A program covering the BORN'S regulatory authority in the state, rules and regulations governing the practice of nursing, the BORN disciplinary process, and the need for nurses to maintain professional liability insurance.
Presented by Mary Crotty, RN, MNA Associate Director/Nursing Research
Contact: mcrotty@mnarn.org; 781-830-5743
- **The MNA—Who We Are and What We Do**
A program describing the role, mission, organization and activities of the MNA, with a review of key issues and accomplishments of the organization.
Contact: dschildmeier@mnarn.org; 781-830-5717
- **Unions and Nursing—The Power of Collective Bargaining**
This program covers the history of unionization in nursing, what unions do, the benefits of union representation, as well as information on the process for forming a union.
Contact: dschildmeier@mnarn.org; 781-830-5717
- **History of Nursing in Mass.—100 Years of Caring for the Commonwealth**
This program traces the history of professional nursing and the MNA in the commonwealth, from its birth in 1903 through establishment of the RN role under law, its growth and development up until today.
Contact: dschildmeier@mnarn.org; 781-830-5717
- **Managing Conflict: The Verbal Solution**
This program is designed to provide the nurse with the basic skills for managing conflict in the workplace environment. Conflict resolution strategies, including situational analysis and effective listening and communication skills will be addressed. The program will conclude with an interactive discussion of case scenarios related to conflict management.
Contact: jfergus@mnarn.org; 781-830-5714
- **Recognizing and Supporting Colleagues with Substance Abuse Problems**
The disease of addictions, affects 10-15 percent of the nursing profession. This program will discuss the risk factors for nurses as well as the occupational signs and symptoms.
Contact: cmallia@mnarn.org; 781-830-5755
- **Menu of Occupational Health and Safety Programs**
 - **Bloodborne Pathogens—Your Legal Rights:** Addresses OSHA regulations related to the Bloodborne Pathogens Standards.
 - **Ergonomics—No More Aching Backs:** Addresses the myths around musculo-skeletal injuries, the regulatory guidelines to reduce such injuries and an overview of the types of patient lifting and moving equipment that are available in the marketplace today.
 - * **Fragrance-Free—Creating a Safe Health Care Environment:** Addresses the scientific evidence of the toxicity of chemical components of fragrances and the adverse health effects these products are known to cause in patients and workers.
 - * **How Safe is Your Hospital? Recognizing Hazards in Your Work Environment:** Provides an introduction to the types of hazards that are present in hospitals and other health care settings and methods to reduce and eliminate those hazards.
 - **Latex Allergy:** Addresses the extent of the problem, the signs and symptoms of latex allergy and methods to eliminate exposure to natural rubber latex in health care settings.
 - **Smallpox - A Brief Introduction:** Utilizes materials from the CDC and Massachusetts Department of Public Health to provide nurses with tools to recognize the signs and symptoms of smallpox and to become familiar with the plan to be implemented in the event of an outbreak.
 - **The Adverse Health Effects of Environmental Cleaning Chemicals:** Addresses the scientific evidence of the toxicity of chemical components of many environmental cleaning chemicals and the adverse health effects these products cause in patients and workers.
 - **Workplace Violence - Recognition, Intervention and Prevention:** Addresses the frequency and risk factors associated with workplace violence in health care settings. The program also identifies strategies to reduce risk factors and provide effective interventions for nurses and other health care workers physically injured and psychologically affected by violence at work. There is an emphasis on the importance of reporting such violence and reporting tools are supplied to participants. .
Contact Evie Bain, EvieBain@mnarn.org; 781-830-5776 or Chris Pontus, cpontus@mnarn.org