

the Massachusetts

# nurse



THE NEWSLETTER OF THE MASSACHUSETTS NURSES ASSOCIATION

Vol. 81 No. 8



ADVOCATE

**MNA Unit 7 members making  
a difference in Uganda**



October 2010

**MNA**<sup>SM</sup>

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## North Adams Regional Hospital RNs OK contract

### *Nurses to continue the struggle to protect quality care*

The RNs of North Adams Regional Hospital recently ratified a two-year contract after approving a tentative agreement on Sept. 2, an agreement that averted a strike and ended nearly nine months of contentious negotiations. The new contract maintains important patient care protections in the nurses' contract, while also preserving important rights and benefits the hospital wanted to take away from the nurses.

"Management came to the table with over one hundred concessionary demands and a very negative attitude that was perpetuated by the 'union avoidance' consultant they brought in from Ohio to conduct their negotiations," said bargaining unit and RN Chair Ruth O'Hearn. "Their demands would have left us with little or no protection and would have made it impossible for us to stand up as advocates for our patients. Our members stood very strong and, with the support of the greater community, said these concessions were unacceptable."

In the new contract, the RNS retained the ability to refuse overtime if they are exhausted or too ill to provide safe patient care. The nurses also defended and protected language

in the contract that states the hospital will not admit patients unless they have the staff to provide quality care.

The quality of life issues were very important to the nurses according to unit co-chair Mary McConnell, RN. "We knew that if management prevailed we would have little or no control over our lives. We were able to retain our rights on mandatory overtime and other issues pertaining to scheduling. This was very important to us."

Throughout the long negotiation process, the nurses never lost sight of the hospital's difficult financial position. They neither asked for, nor received, any economic improvements in the contract. The hospital has applied for Critical Access Hospital status and has stated that they are planning to file for bankruptcy protection within the next year. NARH also is in merger/affiliation negotiations with Berkshire Medical Center. "Because of all the issues, we understand that this was just a step in keeping this hospital as the vital community resource it is. We pledge to the community that we will continue to fight for the highest quality of health care for our community and for ourselves," said O'Hearn. ■



**Celebrating victory!** MNA members joined former MNA president and current candidate for state representative Denise Garlick on primary election night to rejoice in Garlick's victory. Pictured above, from left, are MNA President Donna Kelly-Williams, Judy Shindul-Rothschild, Cathy Hogan, Garlick, Peggy O'Malley and Betsy Prescott. The work of MNA members was critical to this primary victory, and the organization is continuing its work to ensure Garlick's victory in the general election. To support Garlick's candidacy, visit [denisegarlick.com](http://denisegarlick.com) or contact Riley Ohlson at 781-830-5740 or via e-mail at [rohlon@mnnarn.org](mailto:rohlon@mnnarn.org).

## the Massachusetts nurse

ISSN 0163-0784: USPS 326-050

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**Mission Statement:** The Massachusetts Nurse will inform, educate and meet member needs by providing timely information on nursing and health care issues facing the nurse in the commonwealth of Massachusetts. Through the editorial voice of the newsletter, MNA seeks to recognize the diversity of its membership and celebrate the contributions that members make to the nursing profession on the state, local and national levels.

Published 10 times annually, in January, February, March, April, May, June, July/August, September, October and November/December by the Massachusetts Nurses Association, 340 Turnpike Street, Canton, MA 02021.

Subscription price: \$25 per year. Foreign: \$30 per year  
Single copy: \$3.00

Periodical postage paid at Canton, MA and additional mailing offices.

**Deadline:** Copy submitted for publication consideration must be received at MNA headquarters by the first day of the month prior to the month of publication. All submissions are subject to editing and none will be returned.

**Postmaster:** Send address corrections to Massachusetts Nurse, Massachusetts Nurses Association, 340 Turnpike Street, Canton, MA 02021.

Contact [MNAinfo@mnnarn.org](mailto:MNAinfo@mnnarn.org) with comments or questions.

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**MNA**<sup>BM</sup>  
MASSACHUSETTS NURSES ASSOCIATION

# Looking back helps prepare us for the year ahead

By Donna Kelly-Williams, RN  
MNA President

The MNA Board of Directors has met 11 times over the past year. These meetings have always been open to the membership to attend, as published in the *Massachusetts Nurse*. Highlights of these meetings are mailed to the bargaining unit chairs and are also available on the MNA Web site in the members-only section. The Board of Directors has been walking through facilities and meeting with nurses nearly every night of the week to support, promote and protect the profession of nursing and our patients.

Immediately following last year's annual meeting, the Board of Directors, as directed by the membership, appointed delegates to represent the nurses of the MNA, with nurses from the California Nurses Association and the United American Nurses, in founding the largest union of registered nurses in the U.S.—the National Nurses United.

Since its inception, the registered nurses of the National Nurses United have been a force to be reckoned with, starting with the organization of an impressive relief effort in Haiti, providing support to this beleaguered nation by sending hundreds of nurses, including many from Massachusetts. True to its principle mis-



Donna Kelly-Williams

sion, the NNU has focused on organizing thousands of nurses, with successful campaigns in Texas, Kansas City, Mo. and Nevada. As unionized nurses have stood up for their rights, the NNU has been there, providing support to nurses on strike at Temple University Hospital in Pennsylvania, as well as to our NNU members in Minnesota, who waged the largest nurses strike in U.S. history. In May more than 1,000 nurses, including a large contingent of MNA members traveled to Washington, D.C. for the first NNU Staff Nurse Assembly, including a march on the Capitol and to meet with legislators to push our national legislation for safe staffing and safe patient handling.

Several members of the Board of Directors have testified, both locally and nationally, at various legislative hearings. On July 2, Gov. Deval Patrick signed the MNA assault bill into law, increasing penalties against individuals who attempt to harm nurses and other health-

care professionals. The bill went into effect immediately.

Nurses across the state are in contentious negotiations with staffing, layoffs, retirement and health care benefits, and restructuring at the center of the debate. The MNA Board of Directors has attended open meetings at numerous bargaining units, participated in informational pickets and met with state and local legislators to ask them to support nurses and health care professionals across the state.

The members of the MNA are grateful to the dedicated staff for their continued support and assistance every day, everywhere across the state and beyond.

On behalf of the Board of Directors, we thank you all for your support and the continued opportunity to represent our members in this leadership role.

On a personal note, I want thank the supportive and dedicated staff nurses at Cambridge Hospital who, over the past year, have respectfully and patiently retrained me to my new specialty as a birth center float nurse after I lost my position as a certified pediatric nurse when my unit was closed during hospital restructuring. ■

*This was the address of Donna Kelly-Williams at the MNA convention earlier this month.*

## the Massachusetts nurse

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## RNs at Quincy Medical Center ratify new contract

### *Pact comes after months of contentious relations with hospital management*

The RNs of Quincy Medical Center ratified a new union contract on Sept. 23, one that they hope will result in safer staffing conditions and that will allow nurses to provide the care their patients deserve. The nurses reached a tentative agreement on the new pact on Sept. 10, a few weeks after placing a full-page ad in local newspapers seeking the public's support in convincing management to adhere to promised staffing levels.

The new contract calls for the hospital to adhere to specific staffing guidelines for each area of the hospital on a daily basis and it also limits the assignments for resource nurses, those nurses whose role it is to manage the flow of care in order to ensure the efficient movement of patients throughout the system.

"We are cautiously optimistic that with this new contract the hospital will honor its previ-

ous commitments regarding nurses' patient assignments," said Paula Ryan, chair of the nurses' local bargaining unit. "However, given the hospital's handling of these negotiations, their treatment of nurses over the last several months, and their past refusal to staff appropriately, we intend to watch this situation closely and will continue to inform the public of our concerns for patient safety."

The nurses agreed to accept the hospital's demand for a 3 percent wage cut, along with a freeze to their pension and other benefit concessions, in exchange for a guarantee that those changes would sunset and wages and benefits would be restored at a specific time. For example, the wage cut will sunset on March 31, 2011 and the pension freeze will be lifted as of Dec. 31, 2010.

"As always, the nurses have agreed to make

sacrifices for the good of the hospital," Ryan said. "All we are looking for is to be treated with respect and to be provided with working conditions that allow us to give quality patient care."

Negotiations for a new contract began on Feb. 18, with only six sessions held, when management abruptly ended negotiations, declared impasse and implemented their last offer on April 4. The nurses immediately filed a charge of unfair labor practice against the hospital and hundreds of nurses picketed the facility on April 1.

When the NLRB failed to uphold the MNA's charge, the union appealed the decision to the NLRB in Washington but agreed to withdraw the appeal following ratification of the contract. The newly ratified agreement expires on Jan. 31, 2011. ■

## UMass Memorial bows to pressure from nurses

### *Cancels gala after RNs' announcement of boycott, demonstration*

Bowing to pressure from outraged MNA nurses in the UMass Memorial Health Care (UMMHC) system, hospital management hastily cancelled a "nursing appreciation gala" scheduled for Sept. 21 after unionized RNs called for a boycott of the event and informed the media of their intent to hold a demonstration outside the gala.

The RNs had raised concerns about the hospital's ongoing disrespect for nurses, poor staffing conditions and management's recent decision to close a much-needed medical surgical floor. That closure, if implemented, will result in the loss of more than 27 nursing positions and several other valuable staff positions.

The announcement of these cuts came just two months after UMMHC issued an internal alert and forced all nurses and support staff to work overtime because there were not enough beds and staff to care for patients safely. Coincidentally, the same day that they announced the cancellation of the gala, the hospital issued

another internal alert that said no beds were available to care for incoming patients—a move that underscored the nurses' opposition to the cuts.

"Even with these 28 beds still in place, we don't have the ability to care for the patients right now. What happens when we don't have these beds, and it's flu season?" asked Lynne Starbard, RN, a nurse on the UMass Memorial campus who co-chairs their local bargaining unit of the MNA. "I'll tell you what will happen, patients will wait longer for care, patients will receive poor care, and many will be harmed."

"The nurses have had it with the complete disrespect for nurses and patients shown by this administration and as demonstrated by the changes taking place," said Kathie Logan, RN, chair of the MNA local bargaining unit on the UMass University campus. "If they want to value nurses, they should provide us with safe conditions."

This occurred after the medical center

posted profits last year of more than \$80 million, and after management hired consultants to implement so-called "lean" production methods—a process that CEO John O'Brien promises will necessitate even deeper cuts in the coming months. These same lean production methods, pioneered by a leading auto manufacturer, led to one of the largest auto recalls in history last year. In a hospital setting, the nurses believe the outcome could mean an increase in patient complications, longer waits for patients and an increase in preventable patient deaths.

The UMass Memorial campus nurses are in the midst of a contentious negotiation for a new contract. An improvement in RN staffing levels is just one of the issues preventing a settlement.

The University campus nurses settled their contract back in February.

UMMHC's campuses include UMass Memorial, Hahnemann, Home Health and Hospice, and the UMass University Medical Center. ■



## Thumbs up to Cooley Dickinson

Thumbs up to management at Cooley Dickinson Hospital for its purchase of nearly \$1 million worth of lifting equipment that will help protect nurses while they are on the job. Each year, thousands of nurses and health care workers across the country are injured from manually lifting patients.

The injuries are the cumulative effect of years of lifting more than the human body can handle and, as a result, 50 percent of health care personnel suffer from chronic pain and at least 12 percent leave their jobs due to permanent/disabling injuries. Management's efforts to curtail this crisis will help to keep the nurses at Cooley Dickinson safe, healthy and providing top-notch quality patient care. ■

# Why are YOU voting **NO** on Question 3?

Question 3, which will be on the ballot on Nov. 2, will, if passed, cut the state sales tax by over 50 percent. This will result in a \$2.5 billion loss of state revenue and the fallout will mean cuts to local services and drastic increases in property taxes.

Here are just some of the reasons why your fellow nurses and health care professionals are voting **NO** on Question 3.



"I am voting **NO** on Question 3 because I do not want my hospital to close. I work at Boston Medical Center, where they have already closed an emergency room that serves the local community. This will have a devastating effect on the vulnerable patients I see. Community hospitals like BMC need investment from the state to survive."

— Lisa Sawtelle, Kingston  
RN, Boston Medical Center



"I am voting **NO** on Question 3 because Western Massachusetts doesn't need any more cuts to local services. Our communities, and particularly our community hospitals, already live on a shoestring in this part of the state. Cutting state revenues by \$2.5 billion would just make that problem worse."

— Donna Stern, Greenfield  
RN, Baystate Franklin Medical Center



"I am voting **NO** on Question 3 because I cannot stand by and watch as services to people with severe mental illness are cut again and again. Our state's safety net has become a thread, and passage of Question 3 will sever even that thread. The patients I see at Taunton State Hospital will have nowhere to go and will end up clogging our already overcrowded emergency rooms."

— Karen Coughlin, Mansfield  
RN, Taunton State Hospital



"I am voting **NO** on Question 3 because I don't want to see school nurse services cut even further. In Taunton, where I work, they have already eliminated two full-time nurses."

We have 786 children in our school system with asthma, 28 with diabetes, and 494 with ADHD/ADD. These children need a quality education, but they won't get one without enough school nurses to manage their health."

— Chris Kimball, Taunton  
RN, Taunton Public Schools



"I am voting **NO** on Question 3 because I am concerned about services in my local community. I have young children and my kids need good schools to go to, vibrant public libraries to use and strong public safety services to protect them. Passage of Question 3 would result in terrible cuts to all of the local services my family depends on."

— Jacqui Fitts, Taunton  
RN, Morton Hospital



"I am voting **NO** on Question 3 because in Worcester they have already cut health services to children in the public schools. I am so concerned about the children in Worcester who have chronic health problems. Who is going to take care of them so they can be in school and learn?"

— Tami Hale, Worcester  
RN, Worcester Public Schools

**VoteNoQuestion3.com**

**On November 2, the Massachusetts Nurses Association urges you to vote NO on Question 3!**

# MNA position statement on conscious sedation

## The challenge: keeping your patient safe while protecting your license in the practice and care of patients receiving mild to moderate sedation

By the MNA's Congress on Nursing Practice with assistance from the

Mass. Board of Registration in Nursing

The administration of conscious sedation is becoming common practice for the registered nurse in the clinical setting. Responsibilities may include the administration and management of mild to moderate sedation. Areas of practice for the nurse in this procedure often include the emergency room, intensive care areas, surgical and outpatient services. The nurse's role in these settings often includes caring for the patient receiving mild to moderate sedation. There are several challenges RNs face when administering conscious sedation in the work setting. For example, consideration must be given to the following criteria:

1. the competency of the prescriber;
2. the policies of the hospital;
3. the effect of the medication ordered;
4. the competence of the nurse experienced in airway management;
5. advanced life support skills to monitor the patient during and after administration.

The American Society of Anesthesiologists (ASA) define the levels of sedation as follows:<sup>1</sup>

"Minimal Sedation is defined as a drug-induced state during which patients respond normally to verbal commands. Although cognitive function and coordination may be impaired, ventilation and cardiovascular functions are unaffected."

"Moderate Sedation /Analgesia is defined as a drug-induced depression of consciousness during which patients respond purposely to verbal commands, either alone or accompanied by light tactile stimulations; patients do not require intervention to maintain a patent airway, maintain adequate spontaneous ventilation, and usually do not require intervention to maintain cardiovascular function."

"Deep Sedation /Analgesia are defined as a drug-induced depression of consciousness during which the patient can be easily aroused, but responds purposely following repeated or painful stimulations. Independent ventilator function may be impaired. The patient may require assistance to maintain a patent airway. Spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained."

As nurses, we must consider multiple factors in caring for patients who receive sedating medications. It is not always possible to predict the potential for rapid or profound changes in sedative or anesthetic depth during sedation. Drugs such as Propofol or Etomidate (short



acting hypnotics used for sedation) require delivery of care consistent with that required for deep sedation. Other considerations when caring for the sedated patient are the competency and availability of the practitioner who is proficient in airway management and advanced life support to correct the adverse physiologic consequences that come with a deeper than intended level of sedation.

The American Association of Nurse Anesthetists has issued the following statement on conscious sedation, "Conscious sedation is extremely safe when administered by qualified providers. Certified Registered Nurse Anesthetists (CRNAs), anesthesiologists, other physicians, dentists, and oral surgeons are qualified providers of conscious sedation. Specifically trained registered nurses may assist in the administration of conscious sedation." The American Association of Nurse Anesthetists (AANA) further states, "That the provider who monitors the patient receiving conscious sedation should have no other responsibilities during the procedure and should remain with the patient at all times during the procedure."<sup>2</sup>

The Joint Commission hospital anesthesia care standards requires that the individuals who are "permitted" to administer sedation are able to rescue patients at whatever level of sedation or anesthesia is achieved. Minimal to moderate sedation is a continuum and patient response can be unpredictable.<sup>3</sup>

Laurie Talarico MS, RN, NP, Nursing Practice Coordinator, Massachusetts Board

of Registration in Nursing, was consulted regarding conscious sedation. Talarico notes that the Board's newly revised "Advisory Ruling Procedural Sedation and/or Mild to Moderate Sedation/Analgesia" formerly titled "Conscious Sedation," guides the practice of the registered nurse (RN) whose clinical responsibilities include the administration and management of medication for minimal to moderate sedation/analgesia.

The Massachusetts Board of Registration in Nursing Advisory revised ruling on June 10, 2009 can be found on the Board's Web site at [www.mass.gov/dph/boards/rn](http://www.mass.gov/dph/boards/rn), scroll to "Nursing Practice," and then scroll to "Advisory Rulings on Nursing Practice."

Advisory Ruling 9101 Procedural Sedation and/or Mild to Moderate Sedation/Analgesia states

- That the registered nurse licensed by the Board will engage in the practice of nursing in accordance with accepted professional standards.

Further, it is the Board's position that these standards, in the context of the care of the patient receiving RN administered minimal to moderate sedation/analgesia, recognize the nurse as responsible and accountable for:

- Verifying the orders are written by a duly authorized prescriber
- Possessing the knowledge, skills, and abilities to perform the activity safely, effectively, and competently
- Ensuring that there are organizational policies for the RN role that include but are not limited to:
  1. Listing the specific medications for mild to moderate sedation
  2. Nursing care responsibilities for care of the patient
  3. Emergency protocols
  4. Protocols for assessing and documenting the education and validation for RN initial and continued competency<sup>4</sup>

The Massachusetts Board of Registration in Nursing continues to receive inquiries about the licensed nurse's role in administration of sedating medications. In April 2010, the issue regarding deep sedation was presented to the Board with unanimous agreement for the following findings:

Find that: Registered Nurses who are duly trained and qualified may receive, accept, and transcribe orders from duly authorized prescribers for medications capable of producing deep sedation.

Find that: the Registered Nurse must ensure that there are organizational policies that include protocols for registered nurses who administer appropriately prescribed medications intended to produce deep sedation in the non-intubated patient. The policies must require that the registered nurse do so in the presence of a provider trained in anesthesia or expert in airway management whose sole responsibility is to manage that patient's airway.

Find that: It is within the scope of practice for a Registered Nurse to administer medications intended for deep sedation when ordered by a duly authorized prescriber for deep sedation in a patient who is already intubated.<sup>5</sup>

The Massachusetts Board of Registration in Nursing also reissued an Advisory Ruling on Verification of Orders on Dec. 9, 2009. This advisory was formerly titled "Verification of Medication Orders." It once again emphasizes the nurse's role in the delivery of safe patient care with accepted standards of care to minimize error.<sup>6</sup>

In reviewing the nurse's role in mild to moderate sedation, the criteria are specific. The workplace will have an infrastructure to ensure the safety of the patient, defining policy, nursing practice and competency.

The MNA reminds nurses that RNs are accountable for ensuring that the orders executed are consistent with current standards of care and should ask themselves the following questions to ensure patient safety and to protect his (her) nursing license:

- Does the workplace have a policy/procedure to ensure the prescriber has the education and training to manage the potential complications of sedation/anesthesia?
- Will the anesthesia provider be present throughout the entire sedation period, be ACLS trained and have the management of the patient's airway as their sole responsibility?
- Does the nurse administering the medication possess the knowledge, skills and abilities to perform the activity safely, effectively and competently?



**If the answer is no to any of the above questions, the nurse should reject the assignment because nurses are accountable for all the care they deliver.**

If a situation is deemed unsafe or you lack knowledge, skills and abilities to care for patients receiving conscious sedation, you should report this to your supervisor and reject

the assignment. As licensed nurses, you have the obligation to practice safely, guided by the policies in your workplace, the Massachusetts Board of Registration in Nursing Nurse Practice Act, the Advisory Ruling on Procedural Sedation and/or Mild to Moderate Sedation /Analgesia and the April 2010 statements on Deep Sedation. ■

## References

<sup>1</sup>American Society of Anesthesiologists. ASA Standards, Guidelines and Statements October 2007.

<sup>2</sup>AANA/ASA Joint Statement Regarding Propofol Administration. Available at [www.aana.com](http://www.aana.com). Sept. 12, 2005.

<sup>3</sup>The Joint Commission. Comprehensive

Accreditation Manual for Hospitals. Refreshed Core, January 2007 Provision of Care, Treatment and Services Standards for Additional Special Procedures pp 41-42.

<sup>4</sup>Mass. Gov. Health and Human Services, "Procedural Sedation and/or mild to mild to Moderate Sedation/Analgesia 2009.

<sup>5</sup>Mass. Board of Registration in Nursing statement May 2010.

<sup>6</sup>Mass. Gov. Health and Human Services, Verification of Orders: Advisory Ruling 9324 Revision: Dec. 15, 2009.

*Approved: BOD Sept. 16, 2010*

## Warning: Nurses experience violence in this emergency department

By Chris Pontus

Associate Director of Health and Safety

It was toward the end of her shift when Brenda Tate's patient in Room 19 rang his call button. She remembers pulling back the patient's curtain. "I could just hear 'Ugh,'" Tate said. Her patient lunged at her and stabbed her three times with a knife. "I'm still having nightmares," said Tate. She was working in the intensive care unit of Sky Ridge Medical Center in February when she was stabbed by



Chris Pontus

a patient who also happened to be a well-known doctor in the Denver area. Grady Michael Holder, 53, was charged with attempted first-degree murder and second-degree assault with a deadly weapon in the attack. He had been admitted to Sky Ridge and transferred to the intensive care unit to be treated for alcohol addiction.

Why were patients allowed to have knives and clubs in the ED? We don't know. We do know that dangerous people have been regularly admitted to our EDs since the first specialized trauma care center in the world was opened in 1911 at the University of Louisville Hospital in Kentucky. Tragically, 99 years later many hospitals have still not recognized the significant value of their nursing staffs and have not proactively implemented procedures that adequately protect them from grave injury.

**Prevent the Violence:** An Act Requiring Health Care Employers to Develop and Implement Programs to Prevent Workplace Violence (S.988) has been filed by Rep. Michael Costello (D-Amesbury) and Sen. James Timilty (D-Walpole). This bill would require health care employers to perform an annual risk assessment and, based on those findings, develop and implement programs to prevent the violence in the first place.

Not providing nurses with a safe and secure ED is unforgivable. After witnessing violent behavior between patients and nurses—and between nursing and medical personnel—in hospitals for close to a century, hospital administrators certainly cannot say that they are unaware that violent situations regularly unfold in their EDs.

The Occupational Safety and Health



Administration suggests that hospitals provide adequate protection against violence in the workplace. OSHA states that, "Workplace violence is an issue in emergency departments because of the crowded and emotional situations that can occur with emergencies. In addition, ED patients could be involved with crimes, weapons and violent behaviors that could put the ED employee at an increased risk of workplace violence."

To manage these risks, OSHA offers guidance in the form of possible solutions, including good work practices such as:

1. Training staff to recognize and diffuse violent situations and patients.
2. Being on the lookout for potential violence and suspicious behavior and reporting it.
3. Providing adequate staffing levels, with experienced clinicians on each shift.
4. Making counseling and treatment programs available to employees who have experienced workplace violence.
5. Using appropriate engineering controls.

The Joint Commission on Accreditation of Hospitals' "Environment of Care Standards" requires health care facilities to address and maintain a written plan describing how an institution provides for the security of patients, staff and visitors. Institutions are also required to conduct risk assessments to determine the potential for violence, provide strategies for preventing instances of violence, and to establish a response plan that is enacted when an incident occurs.

Administrators should be working on the issue of violence in the ED because it represents an opportunity for significant cost savings. With budgets shrinking and management looking for ways to lower business costs, here is a good opportunity to improve workforce morale and foster a less stressful working

### How hospitals can provide a secure work environment

The JCOAH suggests hospitals take the following actions to prevent assault, rape and homicide in the health care setting:

1. Work with the security department to audit your facility's risk of violence.
2. Make improvements to the facility's violence-prevention program.
3. Take extra security precautions in the ED, especially if the facility is in an area with a high crime rate or gang activity.
4. Work with HR to make sure it thoroughly prescreens job applicants and establishes/follows procedures for conducting background checks of prospective employees and staff.
5. Confirm that HR has procedures in place for disciplining and firing employees as a way of avoiding violent reactions.
6. Require key staff to undergo training in responding to patients' family members who are agitated and potentially violent.
7. Encourage employees to report incidents of violent activity.
8. Educate supervisors that all reports of suspicious behavior or threats by another employee must be treated seriously.
9. Ensure that counseling programs for employees who become victims of workplace crime or violence are in place.

*Now is the time for hospital administrators to embrace these essential safety practices, as it takes time to find the human and financial resources required to design and implement improved safety measures in hospitals.*

environment while saving dollars. After all, lowering the frequency of smashed faces and attacks with deadly weapons would be a real win-win situation.

Hospitals are employers that have a legal responsibility to provide employees with a workplace free from hazards that are likely to cause death or serious physical harm<sup>6</sup>. They also have an ethical responsibility to provide a safe, non-violent workplace that fosters a climate of trust and respect.

The continuing lack of strong violence-prevention programs and policies in hospitals must be addressed. In addition, the institutional cultures that refuse to acknowledge the true cost of workplace violence must be changed. ■

*E-mail cpontus@mnarn.org for a list of supporting references.*

## Caring across continents

### Unit 7 members bring smiles to the children of Uganda

By Jennifer Johnson

Associate Director of Media Relations

MNA member Dianne Hinckley and her unionized colleagues at Northeast Residential Services (NRS) in Danvers, have long known the true meaning of caring for those in need. As part of their daily work for the commonwealth's Department of Developmental Services, they help adults with intellectual disabilities live their best lives possible—a charge that could involve anything from providing clients with complicated medical care and occupational therapy, to overseeing their general mental health and quality of life if they are living in a group home setting.

As is the case with so many skilled medical professionals who care for those most in need, Hinckley and her colleagues never seem to “hang up their caring hats” at the end of a work day. Instead, they bring that same level of compassion to others outside of their professional lives, even if that means getting on an airplane and travelling more than 6,000 miles to Uganda.

#### A journey of 6,839 miles

In 2008, two of Hinckley's colleagues, Malé Kamyá and Stephen Kasiryé, arrived at work with photos that were less than typical: not a family vacation or holiday photo in the bunch. Instead, their pictures featured children and teens who had wide smiles despite their often-bleak surroundings.

Kamyá and Kasiryé had just completed a philanthropic project on behalf of the Father Christmas Project—an effort that involved travelling to Uganda to help children in need.

Uganda is a nation that sits in the heart of sub-Saharan Africa and lies astride the equator. “One look at those pictures,” said Hinckley, “and the rest of us decided we needed to support their good work at a whole new level. In a nutshell, we wanted to go on the next trip and help in person.”

In a country where nearly half of the population is younger than 24 years of age and the average life expectancy is just 48 years, the good work that NRS's Unit 7 members wanted to provide would go a long way. “From the terrifying reign of Idi Amin to the devastation that the AIDS crisis brought to the region, Uganda is a country that has weathered storms that U.S. citizens can't even imagine,” said Hinckley. “And, in the midst of all of this, many of the nation's children were often left parentless. We wanted to help those children.”

Thus, inspired by their colleague's first trip, a larger group of Unit 7 MNA members at NRS began working together to support another trip to Uganda.

#### Simple gifts

The NRS group—which included administrator Kathryn LaPlante, RN Vanessa Jerry, OT Brooke Braaten, psychologist Keith Rando and student intern Kathryn Morse—quickly dug in and started planning and raising funds. After collecting nearly five thousand dollars and then purchasing and organizing a limitless array of supplies, Hinckley and her colleagues were ready for the trip of a lifetime.

“Malé and Stephen had established relationships with five orphanages in Uganda, so we had a working list of kids' needs as well as the orphanages' various needs,” Hinckley said. “We had medical supplies, school supplies, clothing, food and a collection of sporting good items packed into 27 oversized travel bags,” Hinckley described.

After 17 hours of air travel, the group stepped off their KLM Royal Dutch Airlines flight and began visiting the orphanages and children for whom they had packed. “These kids, all of them, were sweet, considerate and eager to learn,” Hinckley commented. “And they appreciated



everything that we gave them, even if it was as simple as a pencil.”

Hinckley went on to describe one of the group's most memorable moments. “We visited one orphanage with our bags in tow, but we also had a pair of soccer nets ready for assembly in the back of our vehicle.” She described how the group worked with the children to put the nets together and how, immediately after, a soccer game got underway.

“The kids had a blast, and we had a blast playing with them,” Hinckley said. “But later on, when it was time for us to leave, we noticed that the kids were bringing the nets back to our vehicle. They had not realized that the nets were theirs to keep. What a gift it was to see their excitement when we explained that their soccer game could continue.”

#### Coming home, looking ahead

After returning from their 2009 trip, the National Resistance Movement (NRM)—the political party of Uganda—honored the Father Christmas Project and its Unit 7 supporters at its black-tie gala in Boston. Ugandan officials and dignitaries expressed their gratitude for the group's selfless work and dedication; and the group assured the NRM that their good work would be ongoing. Since then, the group has continued to raise funds, expand its relationships on the ground in Uganda, and to plan for another trip in early 2011. ■

To learn more about the Father Christmas Project, contact Jennifer Johnson via e-mail at [jjohnson@mnarn.org](mailto:jjohnson@mnarn.org).

# Don't whine, organize: Internal organizing and member mobilization

By Joe Twarog

*Associate Director of Labor Education*

Building a social organization of any kind takes constant work. Such organizations are by their very nature fluid and fragile entities. The reasons for that are as legion as the group's members: people move and change interests; family demands emerge; others lose interest and become uninvolved; some feel isolated or out of the loop; many may feel a sense of hopelessness and defeat.

Some of these causes are legitimate and unavoidable (family illness), while others may be due to a failure of the organization itself (such as exclusivity or poor communication).

However, to acknowledge that social organizations are fragile does not mean that they are weak or impotent. Rather it is a constant reminder to "build the group." A labor union shares many of these same qualities, simply because it is made up of working people who have many competing demands on their lives. In general, people will become involved and act for many reasons—including self-interest. Self-interest is not necessarily a bad or selfish thing, but rather a realistic motivator. Nurses negotiate for better working conditions and compensation for themselves and their families as well as for better patient outcomes by limiting mandatory overtime and winning safe-staffing language.

Yet, all too often one hears that the general membership is apathetic. It could be that this is the case, but the cause itself may be internal. This is where internal organizing and member mobilization come in. One cannot adopt a negative or defeatist culture and expect people to flock to become involved with that group.

Many organizations have an active core group that keeps the association together, although when a crisis arises or an important event is scheduled involvement by the larger membership generally soars. I often use the example of church/temple attendance during the year. Most people can typically get a front-row seat in their church or temple, yet one might not even be able to get inside the building on Christmas service or for Yom Kippur.

Similarly, a very small group of officers and activists usually sustain a union throughout the course of a year. However, when contract negotiations are in progress, or layoffs are threatened, the membership will attend meetings and get active ... assuming there is a well-developed plan, structure and opportunity for member participation.

People are social beings. We like to belong. We like to be involved with and connected to something. That is one reason why people join



Joe Twarog

various groups, like community associations, sports groups, book clubs, religious communities, clubs and even on-line groups. Clearly, the current phenomenon of the Tea Party has stirred people into action, albeit for primarily negative and even malicious reasons. Nonetheless, there are lessons to be learned from this.

### Obstacles to organizing

A good starting point may be to look at possible causes for apathy and an uninvolved membership.

**Lack of vision/focus:** The union might not have a well-defined focus on the issues that members care about; or they may be "visionless" on how to change them.

**Poor or one-way communication:** Developing an effective communications network is critical to member involvement. The lack of an open, two-way communications system is deadly.

**Lack of participatory vehicles:** Does the unit have ways for members to get involved, such as regular monthly membership meetings.

**Appears to be a "closed club":** Some members may be alienated because they view the elected leadership as a closed club in which they are not invited to participate.

**Internal politics:** Personality conflicts, creation of personal power bases or fiefdoms, petty disagreements.

**Entrenched leadership:** Elected officers who have become so entrenched that no one would consider running against them. Such officers may in fact have lost their way as true "leaders" and merely hold the title.

**Apathy:** Some synonyms for "apathy" are indifference, lack of interest, lack of concern, lackadaisical attitude. But are workers indifferent about their working conditions and work lives? Or rather, do they feel powerless about how to effect change?

### Tools to overcome the impediments

The MNA has worked hard to overcome many of these impediments, but it is a work in progress that requires on-going efforts. Many of these tools are structural in nature, while others are attitudinal and philosophical.

**Mapping:** The MNA maps (charts) all of its units. This means listing all of the nurses and health care professionals in the units with their

basic information, contact information and social networks. Mapping is really the key to building an effective and powerful union. It is much more than creating a list or phone tree since it involves constant dialogue with the membership and the creation of a structure that is constantly updated. Coordinators from each floor/unit are also an essential part of the mapping process.

**Communications network:** Internal communications are also an important component. These include membership surveys, updated and visible bulletin boards, newsletters and bargaining updates, and regular general membership meetings. Membership meetings are crucial to establish the permanence and presence of the union, regardless of the numbers that attend. All the formal channels are no substitute for the power of one-on-one conversation to communicate with members.

**Union elections:** By federal law local unions must conduct formal elections for their constitutional officers at least every three years. Often, these elections (if held at all) are "loose" to the detriment of the membership, not to mention non-compliance with the law. Open and contested elections clearly neutralize the "closed club" criticism.

**Symbols and group identity:** Symbols have power, much like a nation's flag or anthem. The MNA has jackets, lanyards, caps, buttons, stickers, T-shirts, fleece pullovers, etc. This "branding" exhibits personal pride in the MNA and highlights the organization and its power.

**Challenge to action:** As former House Speaker Tip O'Neill said, "People like to be asked." Union leaders must be conscious that workers should be directly asked to participate. These calls to action are best when they are realistic, simple and defined. Such delegation of authority (to attend a meeting, participate in an action, serve as a contact on the unit) inevitably promotes member ownership of the union.

**Realistic goal setting and accountability:** The practical and measurable assignments and tasks that members have taken responsibility for have to be followed up with recognition and thanks for a job well done.

Robert D. Putnam argues in his book *Bowling Alone: The Collapse and Revival of American Community* that American society has become increasingly disconnected from family, friends and neighbors in the electoral democracy, civic organizations and even in recreation that he terms "social capital decay." Organized labor and the MNA can help to provide the "bonding social network" that Putnam cites as a way to mobilize the membership, build the union and to reverse the decline of the social network. ■



# Flu 2010-2011: what nurses can expect

By Mary Crotty, Joan Johnston and Chris Pontus  
*Associate Directors of Nursing/Health & Safety*

**T**he 2010-2011 influenza vaccine season is expected to get underway early this fall. The vaccine that will be in use was formulated to protect against A/H1N1 influenza, which was the new pandemic threat last year; influenza A/H3N2; and Influenza B.

The MNA encourages its members to avail themselves of influenza vaccine as a means of protecting themselves so they can care for their patients. "It is imperative that the health care workforce be vaccinated against the flu so that they can be on hand to deliver care at a time of intense need," says Julie Pinkham, RN, executive director of MNA. "But that decision must be an informed decision to ensure that those workers who may be medically susceptible to complications from the vaccine do not put themselves at risk." The MNA opposes the mandatory vaccination of workers who, after receiving education about risks and benefits, choose to decline the vaccine. Also, requirements for workers to reveal medical reasons for declination violate individual privacy rights.

## Legal requirements in Massachusetts

All licensed Massachusetts hospitals, clinics and long-term care facilities are now required to offer all personnel (not limited to just employees) influenza vaccine between August and March. Beginning this year, facilities will be required to report doses given by the facility (using number of employees as the metric), doses received by personnel elsewhere (to the best of their ability), and declinations. DPH confirms that facilities are required to report coverage rates, but not name individuals who decline. The new regulations were based on last year's emergency 90-day regulations that called for health care workers to receive education about the vaccine's benefits and risks as well as influenza vaccination unless they fell under an exemption to the requirement. Those regula-

tions were modeled on existing long-term care influenza regulations, which also remain in effect.

## Move toward vaccination mandates

There has been a growing movement to make vaccination mandatory for health care workers. MDPH has expressed disappointment that despite the first-time requirement last year for facilities to offer vaccinations, which was initiated via emergency public health regulations, the results were disappointing, yielding only a 10 percent increase from previous rates. They would like to improve the vaccination rate among health care workers. In a policy statement released in September, the American Academy of Pediatrics, the nation's largest pediatricians' group, strongly endorsed mandatory flu vaccinations for doctors, nurses and other health workers. The Society for Healthcare Epidemiology of America recommends that the annual seasonal flu vaccine be required for initial and continued employment of all health care employees, regardless of whether they have direct patient contact. They refer to the failure or refusal to be vaccinated as "unethical and unprofessional" and have collaborated on a proposal to make flu shots mandatory for those working in the health care field.

In October 2009, the American Nurses Association revealed that it had received two-year funding to promote influenza vaccination among health care workers from CDC (the U.S. Centers for Disease Control). Unfortunately, the conferring of financial rewards to organizations to promote influenza vaccination provides them with a profit motive, muddying the waters regarding the potential for unwarranted bias toward vaccination.

Vaccination remains controversial for various reasons. Some parties question the profit motive of pharmaceutical companies and organizations that receive grant funding to increase vaccination rates. Perhaps the biggest factor is identified by CDC itself. CDC recently released

data showing that the “VE” (vaccine effectiveness) rate for the H1N1 vaccine last year was 62 percent, lending fuel to the concerns of those who question the effectiveness and/or safety of vaccines. Others are concerned that vaccination may be used as an “easy fix” when other worker and patient protections are needed as well.

## Workplace protections

MNA strongly advocates for appropriate workplace protections (see sidebar below) for workers from the threat of influenza to decrease the likelihood that workers will be exposed while caring for patients and then become vectors for disease transmission. Last season, CDC called for N95 respiratory protection for health care workers, but in June 2010 they published updated draft guidance in which they suggest face masks can be used, referring to N95 respirators as an option. The public comment period for this guidance ended on July 22 and CDC stated it “intended to publish final guidance prior to the 2010-2011 influenza season.” However, flu season is here. Vaccine has been delivered to pharmacies. Vaccination of the public has begun—all without any posting of final CDC guidance on respiratory protection. MNA is following the waffling by CDC and will post updated information on the MNA Web site. We have asked CDC whether its previous guidance calling for N95 respirators is still in effect; as we go to print, it has not responded to our inquiry. CDC is undoubtedly under pressure by hospitals to lift the N95 respirator requirement and yet in their own guidance, CDC acknowledges that airborne transmission via small particle aerosols may occur, which would dictate use of N95 respirators to protect against

inhaling airborne particles.

Given that the vaccine is not 100 percent effective and that not all health care personnel will get vaccinated for a variety of medical, religious, personal or other reasons—including potential supply problems, which happened last year—the last line of protection for the nurse and his/her patients is respiratory protection. To compromise patients and staff by providing only simple face masks is unacceptable.

MNA will be posting updates on the 2010-2011 flu season related activity on our Web site. Please contact Mary Crotty or Chris Pontus if

you are asked to sign other than the MDPH and MNA recommended declension form or with other vaccination related questions. Other potentially useful Web sites are listed below.

A statement by MDPH on “Control of Influenza and Pneumococcal Disease in Long Term Care Facilities,” which contains several links to information such as CDC guidelines and the MDPH declination form (which MNA

endorses), is on the MNA Web site.

MDPH has posted “Model Influenza Vaccine Standing Orders” for 2010-2011 on its Web site at [www.mass.gov/flu](http://www.mass.gov/flu) for those nurses involved in administering vaccine.

An acceptable declination form for healthcare workers is on the MNA Web site at <http://www.massnurses.org/files/DPH%20Influenza%20Vaccine%20Declination%20Form.pdf> A link to the form is also on the MDPH Long Term Care statement.

For more information about influenza vaccination, please contact Mary Crotty at [mcrotty@mnarn.org](mailto:mcrotty@mnarn.org) 781-830-5743 or Chris Pontus at [cpontus@mnarn.org](mailto:cpontus@mnarn.org) at 781-830-5754. ■

## DPH regulatory requirements

The Massachusetts Department of Public Health has updated its regulations for vaccination of health care personnel in hospitals, clinics and long-term care facilities.

The complete text of the regulations is on the MNA Web site at [massnurses.org](http://massnurses.org).

The new regulations call for health care workers to receive education about the vaccine’s benefits and risks as well as influenza vaccination unless they fall under a specific exception.

## Influenza protections required by health care workers

OSHA states that health care workers are at “very high exposure risk” and “high exposure risk” from influenza, depending on the jobs they do and the departments they work in...and that they should be provided with or afforded the following protections when exposed to patients known or suspected to have H1N1 influenza.

These are basic CDC infection control guidelines, CDC emergency preparedness guidelines and requirements of OSHA’s respiratory protection standard that hospitals should already have in place.

### Personal protective equipment

- NIOSH-certified respirators that are N95 or higher are recommended by NIOSH and the AMA.
- CDC recommended N95 respirators last year, but changed its recommendation during the pandemic to allow surgical facemasks. As we go to press, CDC is in the process of evaluating this guidance and has issued proposed, but not final, guidance allowing for face masks and asking for public comment on its proposed change.
- CDC states that, “An employer may provide respirators at the request of employees or permit employees to use their own respirators, if the employer determines that such use will not in itself create a hazard.”

*Surgical masks are NOT NIOSH-approved respiratory protection. Before an employee is required to use an N95 respirator, fit testing must be conducted according to the OSHA Respiratory Protection Standard 1910.134. Most hospitals have been fit testing employees for the past few years to meet this OSHA requirement.*

- Gloves and isolation gowns are recommended when caring for these patients.

- Eye and face protection are recommended depending on the likelihood of spray or splatter of infectious materials.

### Engineering controls

- Use specialized negative pressure ventilation rooms for patient care and for aerosol-generating procedures in healthcare settings.

### Work practices

- Provide training and education on all emergency planning and infection control policies and respiratory protection that are relevant to pandemic influenza (H1N1).

### Administrative controls

- Post signs describing CDC Guidelines for Cough Etiquette requesting patients, visitors and others who are in the emergency room or other areas to follow and make surgical masks and tissues readily available for this to occur.
- Provide opportunities for nurses and other hospital employees to receive H1N1 influenza vaccine at no cost to the employee and with the right for refusal.
- Provide employees with paid sick leave and encourage employees who show symptoms of the influenza to stay at home according to Mass. Department of Public Health.



# Day of Caring

**A**s they do each year, members from Region 2 recently worked to make their greater community a better place by partnering with brothers and sisters of other unions on a community service project with the United Way of Central Mass. for its "Day of Caring." This unique community-wide event, which was held on Sept. 15, is made up of volunteer

teams who complete one-day service projects that benefit local non-profit organizations and the clients they serve. This year's team worked on much-needed improvement projects at an area residential facility for developmentally disabled adults. It was a day of hard work made easier by camaraderie and a unified mission to help those in need.



MNA members Lynne Starbard, RN, Deb Holmes, RN, Mary Colby, RN, and Sue Mulcahy, RN, paint the walls and trim of a bedroom. The room was transformed from stark to lovely for the woman who lives there.



2010 Day of Caring Organized Labor Team.



MNA Unit 7 retiree Mary Colby, RN, plants mums.

## Fight for a just health care system ongoing at state, federal levels



A supporter at a rally in Peabody Square.



Ann Eldridge Malone, RN, at a rally in Kenmore Square.



By Sandy Eaton, RN

Shortly after returning from last December's founding convention of the National Nurses United, Karen Higgins, NNU co-president and former MNA president, was being interviewed by a Lowell radio station. Seemingly out of the blue she was asked what the NNU thought about the health care plan unfolding in Washington. Her response? "Why try to reinvent the wheel when we have models in the U.S. that are proven to work, like Medicare and the VA system?"

Despite all of the local and national commotion in recent years regarding health care reform, we still need to transcend the status quo and free ourselves from the clutches of commercial health insurance companies and HMOs. Access, affordability, quality and equality are the four pillars of a just health care system. This system must also include enforceable staffing standards.

The big news locally is the presence of the non-binding "Health Care as a Human Right Question" on the ballot in 14 state representative districts across the commonwealth on Nov. 2 in communities from Becket to Braintree. We have just received word from the secretary of state's office that the question will be listed as Question 4 in all these areas, with the exception of Marlborough, Sunderland and Whately, where it will be Question 5. This initiative was launched by the Massachusetts Campaign for Healthcare Justice, a joint project of Jobs with Justice and the Massachusetts Campaign for Single Payer Health Care (Mass-Care).

Strong movements for fundamental reform are now active in many states, with Vermont and Maine among the most advanced.

For a number of years H.R.676, the Medicare for All bill sponsored by U.S. Rep. John Conyers Jr. (D-Mich.), has been the focal point of work at the national level. H.R.676 won the endorsement of over 500 labor organizations, including 37 state labor federations. Locally, the Massachusetts AFL-CIO, half of the commonwealth's central labor councils, the MNA and many other individual unions endorsed this approach.

The work of the All Unions Committee, which spearheaded the

movement to support H.R.676, was fortified in January 2009 with the founding of the Labor Campaign for Single Payer, bringing together labor leaders and activists from across the country.

Thanks to the hard work of the All Unions Committee and the Labor Campaign, more resolutions supporting the single-payer approach were submitted to the AFL-CIO resolutions committee than resolutions on any other issue in the history of the federation. This led to the unanimous passage at the September 2009 AFL-CIO convention of Resolution 34, The Social Insurance Model for Health Care Reform. Resolution 34 states, "The experience of Medicare (and of nearly every other industrialized country) shows the most cost-effective and equitable way to provide quality health care is through a single-payer system. Our nation should provide a single, high standard of comprehensive care for all." This corresponds to the MNA's ethical imperative to "work for the improvement and availability of health care services for all people."

The Labor Campaign for Single Payer is guided by a 35-member steering committee that includes NNU co-president, Jean Ross; NNU treasurer, Martha Kuhl; and NNU legislative council chair, Sandy Eaton. What happens on Nov. 2 is important for everyone.

Those candidates who support fundamental health care reform, including enforceable staffing standards, need to be elected or re-elected. Please support the candidates endorsed by Mass Nurses PAC, and please support the local coalitions backing the health care ballot question. ■

Contact Mass-Care at 617-723-7001 or at [masscare.org](http://masscare.org) to get involved in this valuable work.

The MNA Labor School has been restructured. It now consists of six separate tracks of classes running for four weeks each (except for Computer Training which will remain at six weeks) in each of the five MNA Regions. The class material is standardized across the regions, so that if someone misses a class in one region, they could pick that up in another region.

At the conclusion of each track, participants will receive a certificate of completion. Any MNA member who completes any two tracks will receive an MNA blue jacket with "MNA Labor School" silk-screened on the jacket.

There are no prerequisites for attending any track. Members are free to attend any track they choose and need not follow them in order. Each track is self-contained with a focus on a specific area of concentration.

Additionally, one does not have to be a union officer or floor representative to participate. All MNA members are welcomed and encouraged to attend.

Pre-registration through the Regional office is necessary. Evening classes run from 5:30–7:30 p.m., with a light meal provided at 5 p.m. **Classes marked in red on the calendar are held in the mornings from 10 a.m. – noon.** Coffee and snacks are provided for morning classes.

All courses are free and open to any MNA member.

Track 1: MNA Overview and Structure					
Region	1	2	3	4	5
<b>Week 1:</b> Overview of the MNA: Divisions and Bylaws, Legislative & Governmental Affairs					
<b>Week 2:</b> Nursing Division and Health & Safety					
<b>Week 3:</b> Public Communications					
<b>Week 4:</b> Organizing and Labor Action Divisions					

Track 2: Role of the Floor Rep., Grievances and Arbitration					
Region	1	2	3	4	5
<b>Week 1:</b> Role of the Floor Rep., Identifying Grievances vs. Complaints, Review of the Grievance Procedure and Timelines	9/15 9/15		9/22* 10/19		9/13
<b>Week 2:</b> Grievance Investigation and the Right to Information, Discipline and Just Cause, Past Practice	9/29 9/29		10/2* 11/1		9/27
<b>Week 3:</b> Writing & Filing Grievances, Preparing the Case, Weingarten Rights, Organizing around Grievances	10/6 10/6		11/10		10/4
<b>Week 4:</b> Presenting the Grievance, Settling Grievances, Arbitration, ULPs	10/20 10/20		11/16		10/18

*\*Special program offers the 4-week track in two full days in Region 3, 10 a.m. – 4 p.m.*

Track 3: The Collective Bargaining Process					
Region	1	2	3	4	5
<b>Week 1:</b> Collective Bargaining and the Legal Foundation, Process Overview, Ground Rules, Bargaining Committees and the Contract Action Team	11/3 11/3	9/16 9/16			11/8
<b>Week 2:</b> Preparing for Bargaining—Surveys, Calendar, Priorities, Defining and Developing a Contract Campaign, The Committee Decision Making Process	11/17 11/17	9/30 9/30			11/22
<b>Week 3:</b> At the Bargaining Table—Tactics and Signals, Roles at the Table, Writing Contract Language, Leverage & Pressure Tactics, Use of the Media	12/1 12/1	10/21 10/21			12/6
<b>Week 4:</b> Contract Costing, Strikes & Job Actions, Mediation, Impasse, Agreement, Committee Recommendation and Ratification	12/15 12/15	11/18 11/18			12/20

Track 4: Computer Training					
Region	1	2	3	4	5
<b>Week 1:</b> Excel 1					
<b>Week 2:</b> Excel 2					
<b>Week 3:</b> Excel 3					
<b>Week 4:</b> Word 1					
<b>Week 5:</b> Word 2					
<b>Week 6:</b> Using the Internet and MNA e-mail					

## Track 5: Building the Unit, Building the Union

	Region	1	2	3	4	5
<b>Week 1:</b> Member Participation, Bargaining Unit Structure and Bylaws, Internal Organizing and Mapping the Workplace						
<b>Week 2:</b> Basic Union Building Tools—Internal Communications, Contract Language, Use of Unit Newsletters & Bulletin Boards, Organizing around Grievances						
<b>Week 3:</b> Running Union Membership Meetings, Leadership Development and Officer Elections, Dealing with Apathy						
<b>Week 4:</b> Strategic Planning, Labor and Community Coalitions, Workplace Actions and Strikes, Work to Rule						

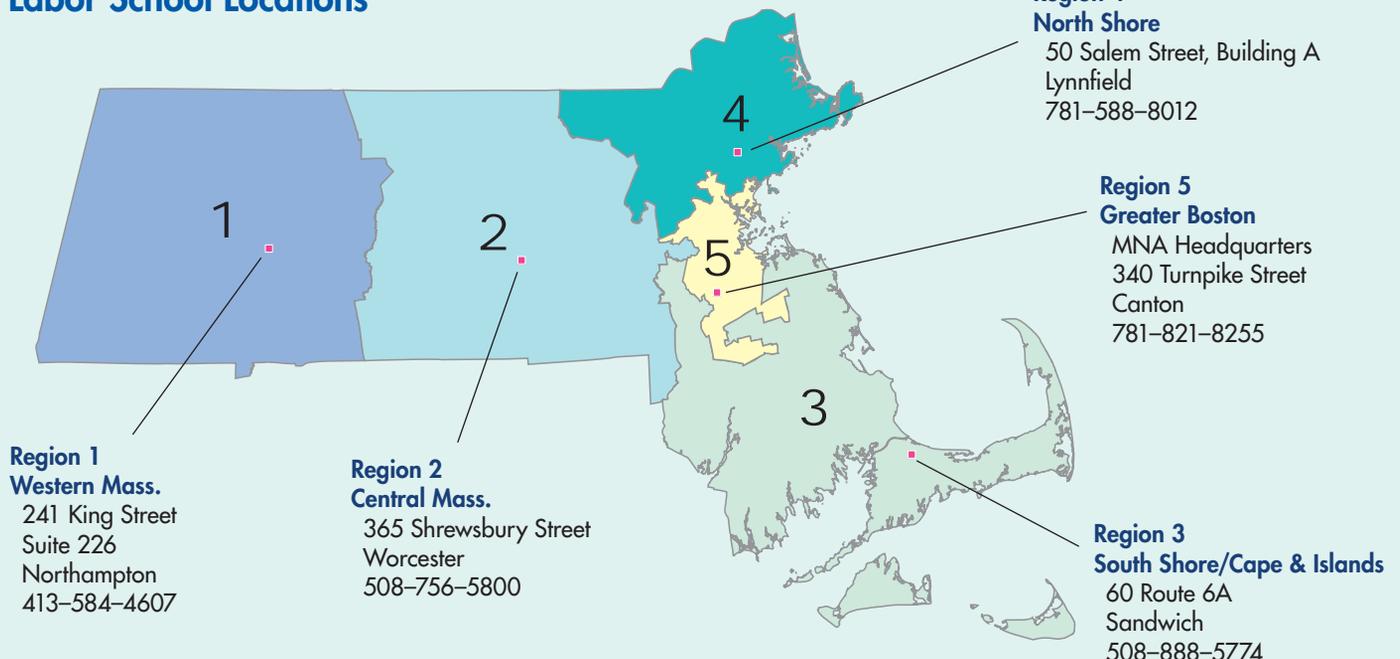


## Track 6: Labor Law and Special Topics

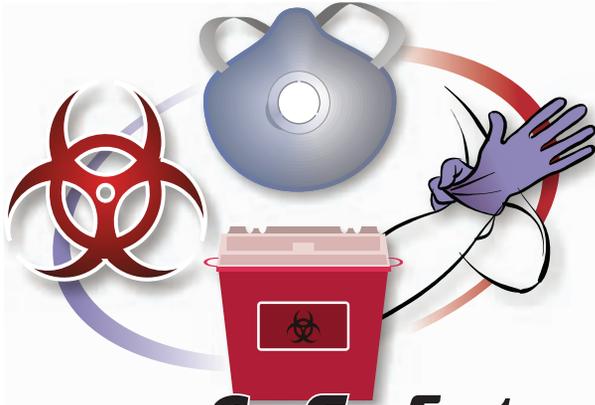
	Region	1	2	3	4	5
<b>Week 1:</b> Family and Medical Leave Act, Massachusetts Small Necessities Leave Act, Worker Adjustment and Retraining Notification Act (WARN)			12/16 12/16			
<b>Week 2:</b> Fair Labor Standards Act, Labor-Management Reporting and Disclosure Act, HIPAA (Health Insurance Portability and Accountability Act)			12/30 12/30			
<b>Week 3:</b> Workers Compensation, Occupational Safety and Health Act, Americans with Disabilities Act, Uniformed Services Employment and Reemployment Act (USERRA)			1/6/11 1/6/11			
<b>Week 4:</b> The Kentucky River/Oakwood Cases and the NLRB and Nurse Supervisory Issues, The National Labor Relations Act and Chapter 150(e)			1/27/11 1/27/11			

**For further details:  
massnurses.org  
781-830-5757**

## Labor School Locations



# Health



## & Safety with the MNA

### CONTINUING EDUCATION ONLINE

[massnurses.org](http://massnurses.org)

Click on **MNA CE ONLINE** on the home page under **Professional Development**

All programs are free of charge to MNA members and others.

#### Program Requirements

To successfully complete a program and receive contact hours, you must read the entire program, take and pass the Post-Test and complete the Program Evaluation. To pass the Post-Test, you must achieve a score of 80 percent or above. Your certificate of completion will be available immediately, from the "My Account Page," upon successful completion of the program.

#### Accreditation

The Massachusetts Nurses Association is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

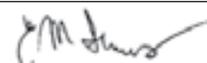
**MNA**<sup>SM</sup>  
MASSACHUSETTS NURSES ASSOCIATION

### United States Postal Service Statement of Ownership, Management and Circulation

1. **Publication Title** Massachusetts Nurse
2. **Publication No.** 326-050
3. **Filing Date** 10/1/10
4. **Issue Frequency** Jan., Feb., March, April, May, June, July/Aug., Sept., Oct., Nov/Dec.
5. **No. of Issues Published Annually** 10
6. **Annual Subscription Price** \$25
7. **Mailing Address of Known Office of Publication:** Mass. Nurses Assn., 340 Turnpike St., Canton, MA 02021  
**Contact Person & Telephone:** Jennifer Johnson, 781-830-5718
8. **Mailing Address of Headquarters or General Business Office of Publisher**  
Mass. Nurses Assn., 340 Turnpike St., Canton, MA 02021
9. **Full Names and Complete Mailing Addresses of Publisher, Editor and Managing Editor**  
**Publisher:** Julie Pinkham, Mass. Nurses Assn., 340 Turnpike St., Canton, MA 02021  
**Editor:** Jennifer Johnson, Mass. Nurses Assn., 340 Turnpike St., Canton, MA 02021  
**Managing Editor:** David Schildmeier, Mass. Nurses Assn., 340 Turnpike St., Canton, MA 02021
10. **Owner:** Mass. Nurses Assn., 340 Turnpike St., Canton, MA 02021
11. **Known Bondholders, Mortgages, and Other Security Holders:**  
None
12. **Tax Status: The purpose, function and nonprofit status of this organization and the exempt status for federal income tax purposes:**  
Has not changed during preceding 12 months.
13. **Publication Title:** Massachusetts Nurse
14. **Issue Date for Circulation Data Below:** September 2010
15. **Extent and nature of circulation**

	Average No. Copies Each Issue During Preceding 12 Months	Actual No. Copies Single Issue Published Nearest to Filing Date
a. Total number of copies (net press run)	21,148	21,019
b. Paid circulation		
(1) Mailed outside-county paid subscriptions	21,148	21,019
(2) Mailed in-county paid subscriptions	0	0
(3) Paid distribution outside the mails	0	0
(4) Paid distribution by other classes of mail through USPS	0	0
c. Total paid and/or requested circulation	21,148	21,019
d. Free distribution	0	0
e. Total free distribution	250	250
f. Total distribution	21,398	21,269
g. Copies not distributed	100	100
h. Total	21,475	21,369
i. Percent paid	98.8%	98.8%

16. **Publication of Statement of Ownership.**  
 Publication required. Will be printed in the October 2010 issue.

17. **Signature and Title.**  
**Date:** 10/12/10  Production Manager

I certify that all the information on this form is true and complete. I understand that anyone who furnishes false or misleading information on this form or who omits material or information on the form may be subject to criminal sanctions (including fines and imprisonment) and/or civil sanctions (including civil penalties.)

# MNA Member Discounts **Save You Money**

**Log onto “myMNA,” the new members-only section of the Web site**

## **Personal & Financial Services**

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### **AMERICAN GENERAL FINANCIAL GROUP/VALIC**

Retirement program.

### **BANK OF AMERICA CREDIT CARD**

Get the Bank of America MNA member Platinum Plus® Visa® credit card.

### **BLUE CROSS BLUE SHIELD**

Call our personal representative for information in regard to the plan.

### **COLONIAL INSURANCE SERVICES, INC.**

Auto/Homeowners Insurance. Discount available for household members.

### **H&R BLOCK**

Receive a discount coupon for your tax preparation.

### **INSURANCE SPECIALISTS, INC.**

Sickness/Accident Disability Insurance

### **JOHN HANCOCK LIFE INSURANCE COMPANY**

Long Term Care Insurance

### **LAW OFFICES OF DAGMAR M. POLLEX, PC**

Estate Planning Services.

### **LEAD BROKERAGE GROUP, INC**

Long Term Disability Insurance and Term Life Insurance.

### **MEMBERSHIP BENEFITS GROUP**

Short Term Disability.

### **NURSES SERVICE ORGANIZATION**

Professional Liability Insurance.

### **RELIANT MORTGAGE COMPANY**

Save on your next home loan/mortgage.

## **Products & Services**

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### **ASSOCIATED EDGE (FORMERLY MEMBERS ADVANTAGE)**

Discount prices on Audio/Video Products, Home Appliances, & more!

### **AT&T**

Save 24% on qualified voice and data plans with AT&T Wireless.

### **BJ's WHOLESALE CLUB**

Get 15 months for \$35 (special offer dates throughout the year).

### **BROOKS BROTHERS DISCOUNT**

Enroll online to receive 15% discount at Brooks Brothers.

### **CAMBRIDGE EYE DOCTORS**

Vision care at rates discounted down from our regular retail pricing.

### **CAPE CLOGS**

MNA Members receive 10% off.

### **DELL COMPUTERS**

7% discount is waiting on you!

### **FINESSE FLORIST**

10% discount to all MNA members.

### **GET SCRUBS MEDICAL APPAREL AND ACCESSORIES**

Show your MNA Membership card and receive 20% discount.

### **HEWLETT-PACKARD**

HP & Compaq consumer products at discounts typically up to 10% off.

### **OIL NETWORK DISCOUNT**

Lower your heating costs by 10-25 cents a gallon.

### **SPRINT NEXTEL COMMUNICATIONS**

Up to 30% off equipment, up to 15% off plans & up to 10% off accessories.

### **T-MOBILE**

10% on qualifying monthly recurring charges for new & existing customers.

### **VALVOLINE**

Instant Oil Change & AAMCO centers 15% discount on total purchase.

### **WORK 'N GEAR**

You'll save 15% off all regularly priced merchandise every day.

### **WRENTHAM VILLAGE PREMIUM OUTLETS DISCOUNT**

Receive a VIP coupon book offering hundreds of dollars in savings.

## **Travel & Leisure**

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### **AVIS CAR RENTAL DISCOUNT**

Low, competitive corporate rates and discounts on promotional rates.

### **BOSTON BRUINS & TD GARDEN**

The Boston Bruins have exclusive online deals.

### **CANOBIE LAKE PARK (SEASONAL)**

Discounted park tickets sold at MNA.

### **CITI PERFORMING ARTS CENTER | SHUBERT THEATER**

MNA members get a savings on tickets to various shows.

### **DCU CENTER WORCESTER**

MNA members get a savings on tickets to various shows.

### **DISNEY WORLD & MORE — TICKETS AT WORK**

Discounts to theme parks & entertainment in Florida and other locations.

### **GO AHEAD TOURS, TNT VACATIONS AND CRUISES ONLY OFFERS**

Save an additional \$150 per person on regular tour package prices.

### **CRUISES ONLY OFFERS THE LOWEST PRICES IN THE INDUSTRY.**

TNT Vacations save an additional 5% on already low prices.

### **HERTZ CAR RENTAL DISCOUNT**

Discounts offered to MNA members range from 5-20%.

### **MOVIE PASSES**

Showcase Cinemas/National Amusements . . . . . \$7.75 each

AMC Theatres . . . . . \$6.00 each

Regal Cinemas . . . . . \$6.50 each

Rave Motion Pictures . . . . . \$7.50 each

### **MR. JOHN'S LIMO**

All members are entitled to minimum 10% discount.

### **SIX FLAGS NEW ENGLAND (SEASONAL)**

Discounted park tickets sold at MNA and online.

### **UNIVERSAL STUDIOS FAN CLUB**

Discounts at Universal Studios and Universal's Island of Adventure.

### **WATER COUNTRY (SEASONAL)**

Discounted park tickets sold at MNA and online.

### **THE WORCESTER SHARKS**

Discounted rates on tickets to select home games at the DCU Center.

### **WORKING ADVANTAGE**

Discounts on skiing, Broadway theaters, online shopping & more.

## MNA members join in 'Nurse Appreciation' festivities in Worcester

Hundreds of MNA members from Region 2 and beyond recently took part in a fun-filled night of free entertainment that was sponsored by Worcester-based radio station 96.1 WSRS. The event, held at the DCU Convention Center and billed as "Nurses Appreciation Night," featured musicians Jim Brickman and Spencer Day; the world's largest game of Operation; dozens of vendors; delicious food from the area's best restaurants; and prize giveaways.



From left, Carolyn Moore, RN, Ellen Smith, RN, MNA President Donna Kelly-Williams, RN, and Margaret McLoughlin, RN, enjoy a moment together.



Kate Jenkins, RN, peruses the goods with a friend.



**'CAUSE LAUGHTER  
IS THE BEST MEDICINE**

**Listen  
Laugh  
Learn**

**The radio show for nurses with RN hosts  
Casey Hobbs, Dan Grady and Maggie McDermott**

**Saturdays 11 a.m. on 1510 TheZoneAM  
Live streaming at [www.1510thezone.com](http://www.1510thezone.com)  
On-demand podcasts at [www.nursetalksite.com](http://www.nursetalksite.com)**

**Sponsored by Massachusetts Nurses Association**

# MNA<sup>SM</sup>

## 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?

Please call us at  
781-821-4625, ext. 755  
or 800-882-2056 (in Mass. only)  
[peerassistance.com](http://peerassistance.com)

All information is confidential

*The MNA Peer Assistance Program is a confidential program provided by the MNA to assist chemically dependent nurses.*

## 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. Donna White, 617-469-0300, x305. Wednesdays, 7:30–8:30 p.m.
- McLean Hospital, DeMarmeffe Building, Room 116. LeRoy Kelly, 508-881-7889. Thursdays, 5:30–6:30 p.m.
- Caritas Good Samaritan Medical Center, Community Conference Room, 235 N. Pearl St., Brockton. Steve Nikolsky, 508-238-8024. Thursdays, 6:30–7:30 p.m.
- Health Care Professional Support Group, Caritas Norwood Hospital, Norwood. Jacqueline Sitte, 781-341-2100. 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. Mondays, 6–7 p.m.

Health Care Support Group, UMass School of Medicine, Outside Room 123, Worcester. Emory, 508-429-9433. Saturdays, 1–2 p.m.

Adcare Hospital of Worcester, 107 Lincoln Street, Worcester. Contacts: Lorraine, 508-410-0225. Mondays, 6–7 p.m.

### Northern Massachusetts

- Baldpate Hospital, Bungalow 1, Baldpate Road, Georgetown. Dana Fogerty, M.A., 978-352-2131, x57. Tuesdays, 5–6 p.m.
- Nurses Recovery Group, Beverly Hospital, 1st Floor. Jacqueline Lyons, 978-697-2733. Mondays, 6–7 p.m.
- Partnership Recovery Services, 121 Myrtle Street, Melrose. Jay O'Neil, 781-979-0262. Sundays 6:30–7:30 p.m.

### Southern Massachusetts

- Peer Group Therapy, 1354 Hancock St., Suite 209, Quincy. Chris Sullivan, 617-838-6111. Tues. 5:15 p.m., Wed., 5:15 p.m. & coed at 6:30 p.m.
- PRN Group, Pembroke Hospital, 199 Oak St., Staff Conference Room, Pembroke. Sharon Day, 508-667-2486. Tuesdays, 6:30–8 p.m.
- Substance Abuse Support Group, AdCare Michelle, 508-965-2479. Mondays, 7–8:30 p.m.

### Western Massachusetts

- Professionals in Recovery, Baystate VNAH/EAP Building, Room 135, 50 Maple St., Springfield. 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. Wednesdays, 7–8 p.m.

### Other Areas

- Maguire Road Group, for those employed at private health care systems. John William, 508-834-7036 Mondays.
- Nurses for Nurses Group, Hartford, Conn. Contacts: Joan, 203-623-3261, Debbie, 203-871-906, Rick, 203-237-1199. Thursdays, 7–8:30 p.m.
- Nurses Peer Support Group, Ray Conference Center, 345 Blackstone Blvd., Providence, R.I. Sharon Goldstein, 800-445-1195. Wednesdays, 6:30–7:30 p.m.
- Nurses Recovery Group, VA Hospital, 6th Floor Lounge, North 650, Manchester, N.H. Contacts: Janet K., 978-975-5711 Sandy, 603-391-1776. Tuesdays, 7:00–8:00 p.m.





## Sorrento Italy

**May 14 – 22, 2011 \$1949\***

Join us on a tour of one of southern Italy's premier vacation resorts. This all-inclusive 9 day/7 night trip includes air, transfers, hotel, and all meals as well as guided tours. The tour will feature Sorrento, Naples, Pompeii, the Isle of Capri, Caserta & Montecassio and the Amalfi Drive. Offered as an all-inclusive trip, this package is a great value. Don't miss the opportunity to visit this spectacularly beautiful part of Italy and some very interesting sites.



## Paris & the French Countryside

**October 8 – 16, 2011, \$1879\***

This trip is back by popular demand. As a wonderful 7-night tour of France that takes in all the highlights of Paris, Normandy, Brittany, the Wine Country, and the Chateau Country. We will enjoy a free day in Paris and conclude the day with a cruise on the river Seine after dinner. This trip includes round trip air from Boston, transfers to and from the hotel. Also includes breakfast and dinner daily as well as full sightseeing tours.

Prices listed above include air, transfers, hotel, all tours and most meals. A fabulous value! Space fills fast, reserve early. For more information on these great vacation and to be placed in a database to receive yearly flyers, contact Carol Mallia at [cmallia@mnarn.org](mailto:cmallia@mnarn.org) with your mailing address.

\* Prices listed are per person, double occupancy based on check purchase. Applicable departure taxes are **NOT** included in the listed prices. Credit card purchase price is \$50 higher than listed price.