Oct. 1 Marks Start of New ‘Safe Patient Limits’ Law for all ICU RNs in Mass. Hospitals
See pages 4 – 7 for complete details
Health Policy Commission Holds Listening Session for Nurses and Others to Assist in Developing an Acuity Tool Under New Law Setting Safe Patient Limits for ICUs

Wednesday, October 29 • 11:30 a.m. – 1 p.m.
Daley Conference Room • Fifth Floor (China Trade Building)
Two Boylston Street • Boston, Massachusetts

Save the Date for October 29 Hearing on ICU Staffing Law

On October 1, the state will implement a new law that will require hospitals to adhere to safe patient limits for registered nurses who work in all the state’s hospital intensive care units, ensuring that no nurse can be assigned more than one patient or in certain circumstances, no more than two patients based on the assessment of the staff nurses (not managers or supervisors) on that unit.

The new law, An Act for Patient Limits in All Hospital Intensive Care Units, applies to ALL types of intensive care units. The law will also establish criteria for an acuity tool to be used by all hospitals to assist staff nurses in determining if their patient is stable enough to allow for a second patient to be added to the nurses’ assignment.

As part of that process, the Health Policy Commission (HPC) will conduct a Listening Session on the implementation of the new law specifically focused on helping the Commission formulate the “acuity tool,” the method of public reporting of staffing compliance, and identifying three to five patient safety quality indicators to be measured and reported by hospitals.

The MNA is currently working with ICU nurses and other nurses across the state to prepare for this hearing, and we encourage ICU nurses to attend this hearing on October 29. For more information about the new law, visit the MNA/NNU web site at www.massnurses.org. If you have questions about the law and would like to speak at the hearing, contact Dorothy McCabe in the MNA/NNU Division of Nursing via email at dmccabe@mnarn.org.

To learn more about the law, join our Telephone Town Meeting on October 15.

You can learn more about the new law, ask questions about what it means for you and your practice, as well as learn how you can participate in the October 29 hearing by joining our Telephone Town Meeting on October 15 at 5 p.m. MNA will call you directly on the primary number we have on file for you shortly before the Town Meeting to connect you to the event. To participate, just pick up the phone when you get the call.
Letter from your MNA president

This edition of the Mass-Nurse e-pub arrives on your newsstand at both a critical and interesting juncture: The MNA’s annual convention is just getting underway, as is the implementation of the state’s new law on safe patient limits in hospital ICUs.

As president of this powerful and prestigious association, I can’t imagine a better scenario! The new ICU law — which is outlined in great depth on the pages of this e-pub — is an historic step in our ongoing campaign for safe patient limits in all units. Having the law go into effect while hundreds of MNA members are gathered together under one roof provides us with the perfect opportunity to talk about 1) how the campaign that led to this historic law unfolded and 2) what we need to do moving forward to ensure that patients and nurses in all hospital units have the same protections.

We have set aside a large portion of the convention’s business meeting to discuss those very topics. I am confident that these conversations will be fruitful and that, as a result, we will be able to go back to members and offer them clear direction of where we most need their support … both today, and moving forward.

Two such occasions where member support will be crucial are just on the horizon:

On October 15 there will be a telephone town meeting, where the entire MNA membership can learn more about the law, as well as ask questions about what it means for you and your practice. Don’t worry about calling us on Oct. 15; we’ll call you at approximately 5 p.m. To participate, simply pick up the phone when you get the call.

On October 29 the state’s Health Policy Commission will hold a listening session that will focus on the implementation of the new ICU staffing law and, specifically:

- Helping the Commission formulate the law’s related “acuity tool”
- Establishing the method of public reporting of staffing compliance
- Identifying three to five patient safety quality indicators to be measured and reported by hospitals

The MNA is currently working with ICU nurses and other nurses from across the state to prepare for this hearing, and we encourage those who are interested to attend. If you have questions about the law or if you would like to speak at the hearing, contact the MNA’s director of nursing, Dorothy McCabe, at dmccabe@mnarn.org.

As always, thank you for your support, your interest, and your dedication. And I look forward to working with you over the coming months as this groundbreaking ICU law unfolds and as we charge ahead with securing the same protections for patients and RNs everywhere.

MNA participates in People’s Climate March in New York City

From California to Massachusetts, NNU member nurses from around the nation were on hand in New York Sunday, to join with environmental, labor, health, and community activists in what was the largest global mobilization for action to stem the worsening climate crisis. The MNA/NNU sent a bus of its members to the March (see photos below). “We are facing a world health emergency,” said NNU Co-President Jean Ross, RN. “Nurses now regularly see patients suffering a variety of ailments, from asthma and other respiratory illnesses to cardiovascular disease that are directly linked to environmental pollution, which is daily exacerbated by the climate crisis.”
This is a historic step in our ongoing campaign for safe limits in all units.

On October 1, 2014 a new law will go into effect that will dramatically improve the care for the state’s most critically ill patients. The new law will require hospitals to adhere to safe patient limits for registered nurses who work in all the state’s hospital intensive care units, ensuring that no nurse can be assigned more than one patient or in certain circumstances, no more than two patients based on the assessment of the staff nurses on that unit.

The baseline standard of one patient per nurse in hospital ICUs is the strictest regulation for ICU care of its kind in the nation, which was the result of concerted negotiations between the Massachusetts Nurses Association/ National Nurses United and Senate Majority Leader Stanley Rosenberg and was passed by a unanimous vote of the entire Massachusetts Legislature. The full text of the law can be found on page seven.

Below are some key highlights about the new law, with answers to commonly asked questions about the law:

- The new law applies to all acute care hospitals in the state both public and private and to all manner of ICUs as defined by the Department of Public health, including NICUs, PICUs, CCUs, SICUs, MICUs, etc.

- The law sets a limit of one patient per nurse. A nurse can only take a second patient based on the assessment of the staff nurses in the unit and a soon to be developed acuity tool. The acuity tool will have standardized criteria to determine the stability of the patient, and all hospitals will be using the same criteria. Further, in no instance and under no circumstances can an ICU nurse be assigned a third patient.

- A powerful aspect of the law is the fact that it is the staff nurses on the unit who assess the acuity/stability of the patient, and it is the staff nurses on the unit who determine if and when a second patient can be assigned to a nurse. A nurse manager has a say on whether or not a second patient is assigned only in those cases where the staff nurses or acuity tool is in disagreement.

- **Who is charged with developing the acuity tool?** The state’s Health Policy Commission will regulate the implementation of the proposed law, including the formulation of the acuity tool, the method of public reporting of staffing compliance in hospital ICUs, and the identification of three to five patient safety quality indicators. ICU nurses will have a chance to influence the development of the acuity tool criteria at a public forum to be held on October 29.

The Health Policy Commission, an independent body established by the legislature to oversee a number of aspects of health care law, is a group we have worked with in the past to establish strong language on what constitutes an emergency situation under our recently passed mandatory overtime law. The HPC will be charged with holding meetings and hearings with stakeholders, including the MNA, to develop the acuity tool criteria that will objectively measure when the patient is stable enough to allow the assignment of a second patient to a nurse’s assignment. Once that acuity tool criteria is established, each hospital will then need to work with the staff nurses to incorporate those criteria into their own hospital-specific acuity tool, and that tool must be certified by the department of public health.

In MNA/NNU bargaining units, the creation of the hospital-specific acuity tool is a subject that must be negotiated with our union nurses.
• What is the timeline for the Health Policy Commission to develop the acuity tool?
The Health Policy Commission has already held a preliminary meeting with MNA leaders to discuss the process for the development of the acuity tool criteria, and it has set a date of October 29 to conduct a public “Listening Session” on the implementation of the new law. The October 29 meeting will be focused on helping the Commission formulate the “acuity tool,” the method of public reporting of staffing compliance, and identifying three to five patient safety quality indicators to be measured and reported by hospitals.

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We expect there may be other meetings scheduled. HPC has indicated it will take a few months to develop the final tool and expects it will complete its work by the end of December or January. Hospitals will then need to develop, in conjunction with the staff nurses, their facility-based acuity tool and the DPH will need to certify the tool for use in ICUs.

• While the acuity tool is being developed, how and who will determine when a nurse can take a second patient?
As stated in the law, the decision as to if and when a nurse can be assigned a second patient will depend on “the stability of the patient as assessed by the acuity tool **and by the staff nurses in the unit.**” Under the law, it is the staff nurses on the unit who will make the assessment of the stability of the patient. Absent the availability of a certified acuity tool, it will be up to the staff nurses themselves to use their professional judgment as to when the assignment of a second patient is appropriate. In addition, managers and supervisors will have no role in making that assessment, unless the staff nurses themselves cannot agree. At that point, and only at that point, can management be involved in the process to resolve a disagreement.

• What happens when nurses are on breaks, on a code team or have to leave the unit for supplies, etc.?
The law is very clear that the standard of care is one nurse to one patient or at the most one nurse to two patients based on the acuity of the patients, with no exceptions. It says nothing about lowering the standard of care for patients based on operational decisions made by the hospital. These staffing levels **must** be in place at all times and it will be up to the hospital to staff these units to accommodate the legal and contractual rights of nurses to take their meal breaks or to be off the unit for other duties.

• What is the MNA doing to assist in the development of the law in general and the acuity tool specifically?
To educate the public, the MNA is launching an ad campaign to notify the public about the existence of the law, what it means for them, and the fact that they should expect and demand this level of care for their loved ones. We are also going to continue our campaign to educate the public and the legislature to extend these limits to all areas of the hospital to ensure all patients are safe.

To educate nurses we will be conducting forums in our bargaining units, MNA regions, and at other venues where nurses can learn about the law, ask questions, and find out how to work with the MNA to ensure that the law is followed by the industry.

To guide the development of an effective acuity tool, the MNA Division of Nursing has been holding meetings with ICU nurses and other members across the state, as well as working with nursing researchers and other experts to develop our position to be presented to the Health Policy Commission.

If you have questions about the new law and this process, we invite you to email or call the MNA/NNU Division of Nursing at dmccabe@mnarn.org; 781-830-5714.

• What factors does the MNA see as being included in an effective acuity tool?
The MNA believes that the decision to assign a second patient to a nurse must be considered in light of factors specific to: 1) the clinical status and acuity of the patient; and 2) specific operational and environmental factors on the unit.
Examples of clinical factors requiring a one-to-one patient assignment for a patient could include:

- Status post code patients requiring frequent monitoring and multiple intravenous vaso pressors with hemodynamic instability.
- Severe septic shock patients requiring frequent monitoring and multiple intravenous vaso pressors with hemodynamic instability
- Unstable cardiac arrhythmias requiring frequent interventions such as defibrillation, transcutaneous pacing, and those requiring multiple anti-arrhythmia agents
- Unstable hyperglycemic/ketoacidotic patients on insulin drip requiring frequent titrations and blood sugar determination
- NIH stroke patients for 24 hours
- Op day open heart surgery patients – during the first 12 hours postoperatively unless patient remains hemodynamically unstable.

*These are just some examples pulled from an acuity tool already in use to dictate one-to-one patient assignments at Steward St. Elizabeth’s Medical Center. We are currently working on developing a more comprehensive list of factors specific to all types of ICUs covered under the law, and will be working with our members in those units to refine those lists for submission to the health policy commission.*

Examples of Operational/ environmental factors requiring a one-to-one patient assignment for the patient could include:

- The skill mix and experience of nurses on the unit, including the use of recent grads, new orientees, floats, per diems or travelers, etc.
- The geography of the unit
- Availability of resources and support staff (MD, secretary, respiratory, pharmacy, ancillary staff, security, etc.)
- Access to technology and equipment (monitors, charting systems, medications, etc.)

**What do we do when the hospital violates the law?**

We expect some hospitals may not be in compliance with the new law and may challenge nurses’ assessment of what constitutes a safe assignment to allow a nurse a two-patient assignment. One of the aspects of the law that will be developed by the Health Policy Commission is a process to monitor the law. Until that is in place, the MNA/NNU will be working with our negotiating committees in local bargaining units to monitor implementation of the law and to challenge management through the labor management process to adhere to the law. We are also creating special reporting forms for ICU nurses to fill out that can be shared with your MNA committee and representatives, and will also have a special form on our web site that nurses can fill out on line to report violations. We can then use that information as we work with the Health Policy Commission, other public officials and even the media to hold the industry accountable for adhering to a law they helped create.

Please keep in mind it is the obligation of licensed nurses to uphold the law that has been created to protect the patients.

**In addition to this law, what is the MNA doing to ensure all nurses on all units will have safe patient limits?**

To be clear, in accepting the compromise that led to the creation of this law, our intent has always been to use this law as only a first step towards the ultimate objective, which is to extend safe patient limits to all other areas of the hospital for all nurses and all hospitals in the state. To that end we have been meeting with members and staff to plan the next phase in our campaign to make safe staffing for all units a reality. This will include the refiling and promotion of legislation to achieve this goal, as well as the consideration of a ballot initiative in 2016 to make this happen should the legislature fail to act on our bill.

We encourage all members and nurses in Massachusetts to stay involved with the MNA and to become active in this ongoing campaign. You can visit the MNA web site at [www.massnurses.org](http://www.massnurses.org), or our campaign web site, [www.patientsafetyact.com](http://www.patientsafetyact.com) or follow us on Facebook to keep abreast of ongoing activities. You can also email Eileen Norton in our Division of Organizing at enorton@mnarn.org to sign up for the campaign going forward.
The Commonwealth of Massachusetts

In the Year Two Thousand Fourteen

An Act relative to patient limits in all hospital intensive care units.

Be it enacted by the Senate and House of Representatives in General Court assembled, and by the authority of the same, as follows:

SECTION 1. Chapter 111 of the General Laws is hereby amended by inserting after section 229 the following 2 sections:-

Section 231. For the purposes of this section, the term “intensive care units” shall have the same meaning as defined in 105 CMR 130.020 and shall include intensive care units within a hospital operated by the commonwealth.

Notwithstanding any general or special law to the contrary, in all intensive care units the patient assignment for the registered nurse shall be 1:1 or 1:2 depending on the stability of the patient as assessed by the acuity tool and by the staff nurses in the unit, including the nurse manager or the nurse manager’s designee when needed to resolve a disagreement.

The acuity tool shall be developed or chosen by each hospital in consultation with the staff nurses and other appropriate medical staff and shall be certified by the department of public health. The health policy commission shall promulgate regulations governing the implementation and operation of this act including: the formulation of an acuity tool; the method of reporting to the public on staffing compliance in hospital intensive care units; and the identification of 3 to 5 related patient safety quality indicators, which shall be measured and reported by hospitals to the public.
MNA RNs working in UMass facilities throughout both the central and Metro West areas of the state have had enough. Enough of layoffs. Enough of dangerous patient assignments. Enough of consultant-driven management plans. And enough of unit closures.

In response, UMass nurses joined forces in recent months and have — in a completely unified voice — boldly taken management on in a David and Goliath-esque battle that has had tremendous support at every turn.

**No Hospital Spared: UMass’ Dangerous Tactics**

- **At the UMass Memorial Medical Center Campuses in Worcester**, MNA members have experienced round after round of staffing cuts; seen drastic cuts to valuable support staff; witnessed the closure of a medical floor; been forced to deal with increases to patient assignments; seen the elimination of one-to-one sits for high risk patients; and were forced to watch as management did away with an invaluable IV Therapy Team. Shockingly, management was brazen enough to implement these changes just a year AFTER the 2,000 nurses on these two campuses were ready to strike in over dangerous patient-care conditions.

- **At Marlborough Hospital**, staffing throughout the facility has long been at unsafe levels, with RNs on the med/surg and telemetry floors forced to care for six, seven and even eight patients at one time. With ratios like those in place, these patients are at a 14 – 31 percent increased risk of injury or death as a result. The situation was exacerbated by a recent decision to cut staffing in the hospital’s emergency department, resulting in longer waits for care and an increase in the boarding of patients. All of these changes were made in the wake of Marlborough Hospital having the second worst record in the state for preventable patient readmissions. When nurses voiced concerns about these changes, your managers told them they needed “to do less with less.”

- **At Health Alliance Burbank Hospital in Fitchburg**, which is owned and operated by the UMass system, managers made a 30 percent cut to RN staff working in the Burbank Urgent Care Center and a 25 percent cut to RN staffing in the Simonds-Sinon Regional Cancer Center. Even more alarming, part of the hospital’s layoff plan called for the replacement of highly skilled RNs with lesser skilled medical assistants who are incapable of providing the assessment, care and treatment that nurses provide. When nurses raised their concerns about these changes, management’s response was “we have become too customer friendly for the business.”

- **And at the Health Alliance Leominster Hospital**, which is also owned and operated by the UMass system, sweeping cuts to nursing and support staff have been announced. These cuts will impact every area of patient care, including a reduction of staff in the emergency department (similar to that carried out at Marlborough Hospital); an increase in patient assignments on the medical surgical floors; and staff reductions in the pediatric and maternity units; and a consolidation of services in the pediatric and maternity units. Each of these changes which will dramatically degrade the quality of care at a hospital that currently has the best outcomes in the system and the lowest rate of preventable readmissions.

Adding insult to injury, is the fact that the UMass system posted profits of more than $80 million in 2013 and more than $300 million over the last five years. Yet CEO Eric Dickson endorsed the aforementioned cost-cutting measures and the reorganization plans based on a supposed “cost savings” manufacturing model borrowed from the auto industry.

**RNs system-wide get active**

As the spring months passed and the summer months approached — and after each bargaining unit tried to no avail to right the ship by addressing their concerns at labor-management meetings, etc. — the RNs at the various UMass hospitals came to two conclusions:

1) It was time for the bargaining units to engage in some organized activities inside of their individual hospitals

2) It was time to join forces and bring these concerns to the media and public directly

**Marlborough Hospital** got things rolling on May 8 when nurses delivered a petition to CEO Steven Roach that called

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**Things Get Hot in Central Massachusetts!**

**RNs in the UMass system unite and fight against management’s widespread, dangerous plans that will harm patients, nurses and communities alike**
on him to address the hospital’s growing patient safety crisis. The petition, which was signed by more than 85 percent of the nurses at the hospital, followed the filing of more than 200 reports of unsafe staffing that RNs document staffing scenarios they believe compromised their ability to deliver appropriate patient care. In addition, the RNs have been wearing buttons on their scrubs that read “Patients Deserve More Not Less” and have been meeting with area legislators to educate them about Marlborough’s poor patient care conditions and how their constituents will be affected.

A month later, RNs at UMass Memorial Medical Center’s University Campus cast an overwhelming vote of “no confidence” in their chief nursing officer, Diane Thompson. By a 60 to 1 margin, nurses endorsed a statement holding Thompson accountable for a “punitive organizational culture that continues to be characterized by oppressive management practices and a disregard for the nurses’ serious concerns over issues impacting their working conditions and their practice of nursing.”

The letter also stated that, “During her relatively short tenure at UMMMC, Thompson has increased nurses’ patient assignments on a number of floors despite the strong objections by the nurses on the floors impacted by the changes … [who have filed] numerous grievances about the hospitals refusal to comply with contractually agreed-upon processes for adjusting staffing and other issues related to the nurses’ work,” as well as pointing that Thompson’s policies exacerbate nurses’ long standing concerns about UMass Memorial administration’s focus on profits over patient care.

Less than a week later, it was the RNs at Leominster Hospital who were at bat. First, they filed an unfair labor practice charge with the NLRB over the fact that hospital management refused to share details from a consultant’s report that ultimately led to their layoff and consolidation plans.

Next, the RNs began gathering signatures as part of a petition campaign. Each petition highlighted the RNs’ beliefs that Leominster’s re-organization efforts were “a deliberate attempt to cut costs by creating a lesser standard of care for patients … [which] will force staff to care for more patients at one time [and will] increase the risk of injury or harm for patients.” The petition also called on management to rescind its misguided proposals.

While circulating the petitions, the RNs began 1) distributing lawn signs to local residents and businesses that read, “Leominster Hospital Nurses Say ‘Staffing Cuts Hurt Us All’” and 2) communicating with both DPH and local legislators about the proposed cuts to staff and services.

RNs Unite at Joint Press Conference

By the end of July, RNs from throughout the UMass system were ready to support each other in a collective activity, and it was decided that they would hold a two-part event on July 31 that included:

- A press conference
- A march to CEO Eric Dickson’s office where they would hand-deliver a letter that outlined both their concerns and opposition

At the press conference, RNs from four UMass facilities — the University campus, the Memorial campus, Marlborough Hospital, and Leominster Hospital — had an opportunity to share their stories and describe, in depth, how their patients are suffering under UMass’ short-sighted, money-matters-more-than-patients business model. Numerous reporters from local media outlets were on hand to cover the event, and within hours of its conclusion related stories were posted on newspaper web sites and on blog sites. The next day yielded several additional story in print newspapers and magazines.

Watch the press conference: http://www.youtube.com/watch?v=xenw5Fft5wk&feature=player_embedded

Following the press conference, a delegation of nurses marched to Dickson’s office to deliver their letter and to demand that he take immediate action to end the system-wide patient safety crisis that has erupted under his leadership. In recognition of Dickson’s history as a physician who practiced alongside many of the nurses, the letter appealed to Dickson in light of his own professional ethics, stating, “As a physician … we are appealing to you personally and professionally to work with us to uphold your own sworn oath to ‘first, do no harm,’ or in this case, to stop the incredible harm your policies are causing our patients, your employees and the communities we serve.”
In an election recently held among the 123 registered nurses at Nashoba Valley Medical Center in Ayer, RNs voted overwhelmingly to join together as part of the Massachusetts Nurses Association/National Nurses United.

Nashoba Valley RNs greeted the election results with cheers and hugs after the vote was tallied on July 24. The election was conducted at the hospital by the National Labor Relations Board.

Nashoba Valley Medical Center is owned by Steward Health Care, and the MNA already represents more than 2,800 nurses and health care professionals at eight other Steward hospitals, including Carney Hospital in Dorchester, Good Samaritan Medical Center in Brockton, Norwood Hospital, St. Elizabeth’s Medical Center in Brighton, Merrimack Valley Hospital in Haverhill, Holy Family Hospital in Methuen, Morton Hospital in Taunton, and Quincy Medical Center.

“This is so big for our patients,” said Sue Fluet, an emergency department RN. “We’re so excited. We finally get to have a say in patient care.”

MNA president Donna Kelly-Williams congratulated the Nashoba nurses for their courageous effort to stand up for their protected right to advocate for their patients and themselves. “When nurses are organized, patients are the biggest beneficiaries,” said Kelly-Williams.

With the election settled, the Nashoba nurses have started forming their local committee(s) and have already begun soliciting proposals from colleagues about what they would like to negotiate into their first contract.

Save the Date...

March 25-26, 2015
DoubleTree Hotel
Millford, MA

Questions can be directed to Dolores Neves at 781-830-5722.
The Report Misses the Mark by Tying the Provision of those Services to Reimbursement Levels and Access to Federal Funding.

Despite finding that the residents served by former NARH have critical health needs and lack the transportation services to access alternative sites, the report would sanction denying necessary services without further federal assistance.

Nurses believe residents of Northern Berkshire County deserve access to needed inpatient services and it is the state’s responsibility to support those services.

NORTH ADAMS, MA -- As Berkshire Medical Center, local and state officials continue to work on re-establishing desperately needed health care services for Northern Berkshire County following the illegal and unexpected closing of North Adams Regional Hospital (NARH), a long-awaited report commissioned by the state to evaluate the health needs of the region has been released today. The report, prepared by Stroudwater Associates, a health care consulting firm, confirms the need for inpatient services for the 37,000 residents of Northern Berkshire County currently without those services. However, the report misses the mark by tying the restoration of services to the financial “viability” of those services and support from the federal government through enhanced reimbursement.

The report clearly shows that the residents of Northern Berkshire County live in a region that is “worse off than the state and national average for a number of health status indicators. Asthma, most cancers and heart disease incidences are higher than the state average, and high percentages of the population are overweight, have a disability, and report poor general health. Combined, these factors create a vulnerable population for healthcare services.” The report also notes that the fastest growing segment of the population is individuals 65 years and older, a population that has the highest utilization of and need for inpatient services. The report also cites broad community concerns about issues with the lack of transportation services to allow access to needed care.

In response to these intense needs, the report does recommend restoring “limited inpatient services,” but states those services, however necessary, be restored “only if the BMC North site (the recently purchased site of NARH where BMC now operates a satellite emergency department) is designated as a Critical Access Hospital.”

Under federal law, if a hospital is designated a “Critical Access Hospital” it is eligible for a higher federal reimbursement for health care services, because that facility serves a rural, isolated population. While the MNA has been leading the fight to secure this designation for BMC North, we firmly believe that residents of Northern Berkshire County should have access to inpatient services in their community and that if the federal government won’t provide Critical Access designation, then it is up to the state and Berkshire Medical Center, along with other stakeholders to find the resources to provide those services.

Most significantly, the report confirms the need for in-patient services in northern Berkshire County. Equally significant, in assessing the purported financial viability of providing those services, the report only looks at historical data from North Adams Regional Hospital as a stand-alone facility, rather than making a new assessment based on improved efficiencies and enhanced reimbursements that will result from now being part of the much larger Berkshire Medical Center health system.

This community has a demonstrated need for a full service hospital. That hospital was taken away from them due to gross mismanagement by previous administrators, and a board of trustees that allowed that mismanagement to continue for years and then broke the law to close the hospital. The health care needs of these residents have not changed. They had a full service hospital and they deserve one now, and our organization along with the hundreds of community members who have been fighting to restore critical services will continue to do whatever is necessary to ensure the residents of Northern Berkshire County have appropriate health care.

In the coming weeks, the MNA will be working with residents, stakeholders and policymakers to ensure the needs of the community are met, including public forums to discuss the report and next steps in the campaign to restore a full service hospital.
MNA Endorsed Candidates for the 2014 General Election*

US Congress

Candidates seeking reelection

Congressman Jim McGovern
2nd Congressional District

Congresswoman Katherine Clark
5th Congressional District

Massachusetts Constitutional Offices

Candidates seeking open seats.

Martha Coakley (D), Governor
Steve Kerrigan (D), Lt. Governor
Maura Healey (D), Attorney General
Deb Goldberg (D), Treasurer

Massachusetts Senate

Candidates seeking open seats

Ann Gobi (D) 5th Worcester
Ashburnham, Ashby, Athol, Barre, Brimfield, Brookfield, Charlton, East Brookfield, Hardwick, Holland, Hubbardston, Monson, New Braintree, North Brookfield, Oakham, Palmer, Paxton, Petersham, Phillipston, Rutland, Spencer, Sturbridge, Templeton, Wales, Ware, Warren, West Brookfield, Winchendon

Eric Lesser (D) 1st Hampden and Hampshire
Belchertown Chicopee, East Longmeadow, Granby, Hampden Longmeadow, Ludlow Springfield, Wilbraham

Barbara L’Italien (D) 2nd Essex and Middlesex.
Andover, Dracut, Lawrence, Tewksbury

Candidates challenging current State Senators

Patrick Leahy (D) 2nd Hampden and Hampshire
Agawam Chicopee, Easthampton Granville Holyoke Montgomer, Russell, Southampton, Southwick, Tolland, Westfield

Candidates seeking re-election

Senator Jamie Eldridge (D) Middlesex and Worcester

Senator Harriette Chandler (D) First Worcester
Boylston, Clinton, Holden, Northborough, Princeton, West Boylston, Worcester

Senator Jennifer Flanagan (D) Worcester and Middlesex
Berlin, Bolton, Clinton, Fitchburg, Gardner, Lancaster, Leominster, Lunenburg, Sterling, Townsend, Westminster

Senator John Keenan (D) Norfolk and Plymouth
Abington, Braintree, Holbrook, Quincy, Rockland

Senator Michael Moore (D) 2nd Worcester
Auburn, Grafton, Leicester, Millbury, Northbridge, Shrewsbury, Upton, Worcester

Senator Marc Pacheco (D) First Plymouth and Bristol
Berkley, Bridgewater, Carver, Dighton, Marion, Middleborough, Raynham, Taunton, Wareham

Senator Dan Wolf (D) Cape and Islands
Aquinnah, Barnstable, Brewster, Chatham, Chilmark, Dennis, Eastham, Edgartown, Gosnold, Harwich, Mashpee, Nantucket, Oak Bluffs, Orleans, Provincetown, Tisbury, Truro, Wellfleet West Tisbury, Yarmouth

Massachusetts House of Representatives

Candidates seeking open seats

Christine Barber (D) 34th Middlesex
Medford, Somerville

Doug Belanger (D) 17th Worcester
Leicester, Worcester

Brendan Crighton (D) 11th Essex
Lynn, Nahant

Mark Dowgiewicz (D) 18th Worcester
Doughlas, Oxford, Sutton, Webster

Candidates seeking re-election

Representative Denise Andrews (D) 2nd Franklin
Athol, Belchertown, Erving, Gill, New Salem, Orange, Petersham, Royalston, Templeton, Warwick, Wendell

Representative Jim Cantwell (D) 4th Plymouth
Marshfield and Scituate

*As of the date of publication
Candidates seeking reelection (cont.)

Representative Nick Collins (D) 4th Suffolk
Boston

Representative Dan Cullinane (D) 12th Suffolk
Boston

Representative Josh Cutler (D) 6th Plymouth
Duxbury, Hanson, Pembroke

Representative Dan Donahue (D) 16th Worcester
Worcester

Representative Marjorie Decker (D) 25th Middlesex
Cambridge

Representative Diana DiZoglio (D) 14th Essex
Haverhill, Lawrence, Methuen, North Andover

Representative Sean Garballey (D) 23rd Middlesex
Arlington, Medford

Representative Denise Garlick (D) 13th Norfolk
Dover, Medfield, Needham

Representative Ken Gordon (D) 21st Middlesex
Bedford, Burlington, Wilmington

Representative Danielle Gregoire (D) 4th Middlesex
Marlborough, Northborough, Westborough

Representative Dan Hunt (D) 13th Suffolk
Boston

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Representative John Velis (D) 4th Hampden
Westfield

Representative Jonathan Zlotnick (D)
Ashburnham, Gardner, Westminster, Winchendon
**Remembering Diane Michael**

It is with deep sadness that the Massachusetts Nurses Association/National Nurses United shares the loss of long-time board member and passionate patient/nurse advocate Diane Michael, who died unexpectedly on July 6.

Diane Michael was a true champion for her profession, a fierce protector of the nurses she led as chair of her MNA/NNU bargaining unit and an unrelenting advocate for the highest standards of care for patients suffering with acute behavioral health conditions.

Born in Springfield, MA, on May 16, 1951, a loving daughter of the late Mark J. Jr., and Patricia (Dowd) Michael, she was raised and educated in East Longmeadow, before becoming a longtime resident of Springfield.

In paying tribute to this great friend and advocate the information below is taken from an application submitted on Diane’s behalf for an award she was nominated for by her longtime colleague Marilyn Hernandez, RN.

Diane received her nursing training at Boston Children’s Hospital graduating in 1974. She began working in Pediatrics at the Providence Hospital in 1974 where the MNA was already representing nurses. She joined the MNA negotiating committee in 1976 and has been an active member continuously since then. In 1996, Providence Hospital closed as an acute care medical facility to reopen as Providence Behavioral Health Hospital where Diane moved to the Adult Psychiatric unit on the 11-7 shift. By this time, Diane had been an MNA co-chair. When her long time co-chair retired, Diane remained as the sole MNA Chair.

Diane’s strong commitment to the Labor Relations Program has been exemplified by her participation within her local unit at Providence, and extending to her many roles on the regional, state and national arenas. As Chairperson at Providence Hospital, she was often the first face of the MNA to new members or to members who needed to file a grievance where she remained with them every step of the way. Diane was a leader at the monthly committee and labor-management meetings, the regular membership meetings, and the contractually negotiated monthly Safe Staffing and Violence Task Force meetings. She had a strong and distinctive voice on her floor and for the nurses in the bargaining unit as a whole.

Diane’s support for the MNA was unwavering. As an 11-7 nurse, she often had to juggle between all her MNA work and sleeping. Traveling to the MNA Canton office at least monthly, she had been an elected member on the MNA Board of Directors since 2004 and was the Chair of the Board of Directors Policy Committee. She was also active in the MNA-PAC and has participated in the legislative briefings that occurred locally in Region 1. Diane was a fixture on the picket and/or strike lines and was a mover and shaker when it came time for MNA to disaffiliate from the ANA years ago, and in the recent fight for the MNA Safe Staffing and MNA Transparency Ballot Initiatives. Nationally, Diane was an NNU Delegate from 2009-2012 where she attended events throughout the country including rallies, meetings and legislative and lobbying events.

She was a selfless, constant advocate for both patient and workplace safety, and for safe staffing in every area of the hospital. She was a colorful person, with a big heart and a great sense of humor. A strong voice for justice and fairness, her dedication reached beyond the nurses and she was instrumental in helping the mental health counselors at Providence organize and ultimately vote to be represented by the UAW. Diane always strove for unity and equality for every person.

Diane was a fearless leader, and her leadership skills were valuable in our facility where there is a constant turnover in hospital management resulting in a lack of institutional memory. The nurses were fortunate to have Diane’s experience, dedication, and long standing strong continuity in her message and actions.

**In Memory of Diane Michael RN**

*A Voice for all RN’s*
Survey of U.S. nurses also underway to evaluate preparedness of nation’s hospitals

The Registered Nurse Response Network (RNRN), a project of National Nurses United (NNU), has initiated a national fundraising campaign to provide desperately needed personal protective equipment for frontline healthcare workers caring for patients stricken by the Ebola virus.

Ebola viruses are transmitted through direct contact with blood or bodily fluids of an infected person, or through exposure to needles that have been contaminated with infected blood or bodily fluids. Healthcare workers must exercise extreme caution and follow Centers for Disease Control (CDC) guidelines to ensure protection from the virus.

Many of the nurses and healthcare providers working in the affected countries who are risking their lives to take care of their patients lack basic protective gear. RNRN, in conjunction with key groups working on the ground, primarily the International Medical Corps, is working for the procurement and training of personal protective equipment.

The cost of a full set of personal protective equipment is approximately $350.

The Ebola outbreak has now killed at least 1,552 people in West Africa and is spiraling out of control, with international healthcare providers saying that they are not able to handle the crisis. The World Health Organization (WHO) has warned that the number of Ebola cases could rise to 20,000. The number of diagnosed cases is widely believed to be under-reported.

Health workers have been hit particularly hard in this outbreak. As of last week, more than 240 health workers have been infected and more than 120 have died. Nurses are on strike to protest the lack of adequate protective equipment at one large hospital in Liberia where, to date, almost 700 people have died.

The CDC has investigated 68 potential cases of Ebola in 29 states, and all but two cases have been ruled out as Ebola. The remaining two cases have results pending.

RNRN sent out a survey to nurses in hospitals throughout the nation last week to evaluate the safety standards in their facilities and to determine next steps to ensure the safest environment for patients, healthcare workers, and the public. Questions include availability of specialized personal protective equipment, adequate numbers of prepared isolation rooms, training and education policies on handling of patients with the virus, and adjusted safe staffing for RNs assigned to isolation patients.

NNU, the sponsor of RNRN, says that the rapid spread of the Ebola virus is a reminder of the need for global action on some of the underlying human factors contributing to the epidemic, including climate crisis-accelerated deforestation, drought, and food shortages, and shortsighted economic policies that have prompted cuts in public health services.

To take the RNRN survey, visit https://www.surveymonkey.com/s/CNANNUEbola.

To make a tax-deductible donations to support those who are on the ground caring for West Africa’s Ebola patients, visit http://www.nationalnursesunited.org/pages/rnrn-disaster-relief-fund.
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