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MASSACHUSETTS NURSE

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This is the year!

Momentum builds for Legislature to take up Safe RN Staffing

On Dec. 1, Rep. Christine Canavan, RN (D-Brockton) and Sen. Marc Pacheco (D-Taunton) in conjunction with the MNA and the Coalition to Protect Massachusetts Patients (an alliance of more than 70 of the state's leading health care and consumer advocacy organizations), re-filed the Patient Safety/Safe RN Staffing bill. The bill would set minimum RN-to-patient ratios with an accompanying acuity system to adjust staffing levels as patients needs demand. To date, 104 legislators have signed on as co-sponsors of this important measure.

The legislation was passed favorably by the legislature's Joint Health Care Committee last session and a 10-hospital pilot program was passed in the Senate budget. The House Ways and Means Committee is currently in the process of creating a subcommittee to work on the bill.

The filing of the legislation follows the release of numerous prominent research studies and reports that show understaffing of registered nurses is dangerous—mistakes, serious complications and preventable errors occur when nurses are forced to care for too many patients at once.

"The evidence also makes clear that poor staffing and dangerous working conditions created by the hospital industry have caused and continue to exacerbate a shortage of nurses; these are the nurses who are no longer willing to work in hospitals," said MNA President Karen Higgins, RN. "Passage of this legislation is key to improving care for our patients and to creating conditions that will retain and recruit the nurses we need to provide safe patient care."

During the same week the MNA/Coalition refilled its bill, the Massachusetts Hospital Association held a press conference detailing its plan to file a nurse staffing bill for the 2005-06 legislative session. The foundation of their "feel good" bill is a set of reporting requirements on staffing levels that will have absolutely no impact on the nursing crisis and nearly all of its provisions are required now by various agencies. Nonetheless, it raised the level of debate on this issue. The move signaled a growing sense on Beacon Hill that momentum for a solution to the nurse staffing crisis and its impact on patient safety is building as the 2005-06 session nears.

"The activism of nurses across the state has put this issue on the radar screen. The legislature is poised to tackle this important issue. Keep working hard and keep calling your legislators."
— Rep. Christine Canavan, RN

The importance of the Legislature addressing this patient safety issue is evident in a recent consumer survey which found:

- Almost half the people (45 percent) who have had direct hospital experience believe that their safety or the safety of their immediate family member(s) was — to some extent — compromised by a lack of available nurses.
- More than one third of people with direct hospital experience reported not receiving important elements of care in a timely fashion.
- Forty-one percent of people with direct hospital experience reported not receiving answers to their questions about the illness. One third reported not receiving adequate information about care prior to being released from the hospital.
- More than three quarters (78 percent) of respondents indicated their support for legislative action to ensure an adequate supply of nurses to safely care for hospitalized patients.

For an RNs guide to passing Patient Safety/Safe RN Staffing legislation, please use the convenient 8-page toolkit in the middle of this newsletter. ■

Special 'RN Toolkit for Safe Staffing' inside

Passage of meaningful legislation to establish safe, minimum RN-to-patient ratios will require a concerted effort by the entire nursing community. To help familiarize nurses with this issue, the MNA/Coalition legislation and to outline what each nurse can do to win the bill's passage, a special "RN Toolkit for Safe Staffing," pullout section has been included in this issue of the *Massachusetts Nurse.*

Brigham nurses negotiate retiree health benefit

Brigham & Women's Hospital nurses have recently negotiated a new union contract that will make them the highest paid acute care hospital nurses in Massachusetts, if not all of New England, while also adding a contract provision to provide a retiree health benefit – a first for nurses in Massachusetts.

The contract grants the nurses a 3 percent across the board pay hike for all nurses in each year of the two-year agreement, while granting a 5 percent lump sum payment for those nurses at the top of the pay scale in each year of the contract. By the second year of the agreement the top salary at the Brigham for a staff nurse will be $54.74 per hour or $113,859 per year.

Securing a retiree health benefit was the number one issue for the nurses. While not attaining the level of retiree health benefit they ultimately desired, the nurses were able to get their foot in the door with an agreement to establish a Retiree Medical Savings Account (RMSA). RNs are eligible to participate in the RMSA beginning at age 50 and continuing to age 65 provided they retain a regular full or part-time position. The RMSA will allow regular full and part-time RNs to contribute up to $4,500 per year into the account on a post tax basis with an employer match of 50 percent to a cap of $750 per year and a lifetime cap of $11,250. The RMSA will have a guaranteed minimum interest rate of 5 percent. RN contributions to the RMSA vest immediately, and the hospital contributions vest after five years of service or age 55. Participating RNs will be eligible to continue in a group medical insurance plan maintained by the Hospital at retirement.

"We have established a foothold in our contract for a form of retiree health benefit

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

Nurses' guide to single-payer reform

As policy makers put universal health care on the front burner, single payer approach is the best road to success

The latest annual figures on the number of people in Massachusetts without insurance are dismal. Between 450,000 and 650,000 residents have no insurance at all. And, although politicians boast that every child in our state is covered by "CHIP" (the Children's Health Insurance Plan, which covers only outpatient care), the fact is at least 50,000 kids in Massachusetts have no insurance at all.

The governor and legislative leaders are responding. This is good. Health care is back on the front burner. Unfortunately, the proposals getting all the attention don't address the problems we're facing.

Gov. Romney would cover more working people by allowing insurers to sell low-cost, "bare bones" policies to employers. He'd cut costs in Medicaid by strictly limiting access to care. I've seen those patients when those limits land them in the hospital. We can do better.

Sen. Richard Moore, along with Health Care for All, has introduced a new version of an old idea, requiring every Massachusetts employer to offer insurance to workers and expanding eligibility for Medicaid. They expect opposition from small business owners. We all should be opposed. Forcing employers to purchase insurance products which don't guarantee good, affordable care is bad from both a public policy and economic standpoint.

Well, some would say, these ideas are a step in the right direction. They're not.

All these proposals enshrine the system of multiple insurers, each offering a variety of plans, each variation carrying its own eligibility requirements, approved providers, allowable procedures, co-payments and deductibles. That's why there are more clerical people than clinicians in doctors' offices and hospitals.

As long as that useless administrative complexity persists, we will continue to waste 39 cents, if not more, of every health care dollar in Massachusetts on overhead. And we will pay top dollar for prescriptions, unable to negotiate significant discounts that the Commonwealth could achieve if it was the purchasing agent for 6 million residents.

Over the past decade, the actual value of insurance has plummeted; it costs more and more and delivers less and less. Even those with "good" insurance are scared about gaps in coverage, higher premiums, all the deductibles. Or we fear losing our job and, with it, the health insurance. Labor-management negotiations boil down to workers sacrificing everything else to hold onto health insurance. And even the best insurance in the world isn't much good if you're having chest pains and your local hospital closed down last year. Call an ambulance? Maybe the rescue squad was lost in the last budget debate. OK, so just get to the ER down the highway. Sorry, it's "on divert," no room. Need a nurse? Unfortunately, the money for more of them is fueling the insurance/pharmaceutical monster instead.

We have a choice. Overall annual spending on health care in Massachusetts is about $50 billion. We can either continue to waste nearly $20 billion a year on overhead or we can use that money for actual care. We cannot do both. We can either mandate employers to bear the costs of a terribly inefficient, unjust system or we can, all of us together, equitably share the straight-ahead cost of taking good care of everyone. We can either expand Medicaid to a little higher poverty level income or we can actually provide universal access to compassionate, capable care as needed.

We're long past the stage where expanding insurance to this or that group will work. It's time for common sense, for a universal "single payer" health care system where we all subscribe to one health plan. Blue Cross or anyone else we choose can administer it, if that makes it happen sooner. But it's just one plan, so you're automatically in if you're a resident of Massachusetts. The benefits covered will be those our legislators are currently eligible for in their health plan. Ninety percent of every dollar will go to care. The finances of every hospital and health provider in the Commonwealth will be stable and predictable. And we'll be able to sleep better at night. Oh, did I mention that two independent studies predict the state would also save $1 billion a year in the process? It's not too good to be true. It's just a different way of organizing and using resources.

Learn more about, and do all you can to support, passage of the Massachusetts Health Care Trust. ■

MASSCARE refiles Mass. Health Care Trust bill for single payer health care

Below is the preamble to legislation that would establish a single-payer health care system in Massachusetts, providing access to quality health care for all at a lower cost than the current failing system of health care in Massachusetts.

Section 1: Preamble.

Whereas the health of the people of Massachusetts is the foundation for the welfare of the Commonwealth; and

Whereas it is in the public interest to guarantee every resident timely access to health care, to assure high quality of health services, to assure adequate and stable financing for all providers of health care, and to apportion the costs of care in the most equitable manner possible; and

Whereas, at least half a million Massachusetts residents have no health insurance at all and millions more residents have insurance which is inadequate for their needs; and

Whereas Massachusetts spends significantly more per capita on health care than any other state or nation, putting our state and our businesses at a competitive disadvantage to other states and to all the foreign countries where governments provide universal health care; and

Whereas unstable and unaffordable rate increases for health insurance is causing significant economic hardship for Massachusetts residents and their employers; and

Whereas, the annual double digit increases in the cost of private health insurance are leading more Massachusetts employers to shift costs onto workers or drop insurance of employees and retirees altogether; and

Whereas the escalating cost of insuring public employees is increasing taxpayer burden and preventing municipalities, and the Commonwealth itself, from investing in education, public works, human services, environmental protections, and other projects needed for the public good; and

Whereas the skyrocketing cost of prescription drugs is depriving our people of medications which save lives and prevent costly illness; and

Whereas needed community hospitals, nursing homes, and home health agencies of the state have closed due to inadequate reimbursement of costs; and whereas efforts to control health care costs while maintaining the private health insurance market invariably lead to diminished access and quality in health care; and

Whereas up to 40 percent of every Massachusetts health care dollar goes to inefficient, redundant administrative systems; and

Whereas, independent quantitative analyses have shown that, under a single payer public health insurance system, Massachusetts could afford to cover all residents at no new cost to the state; and

Whereas the same studies have shown that by simplifying administration, achieving bulk purchase discounts on pharmaceuticals and medical supplies, and reducing the use of emergency facilities for primary care, Massachusetts could divert billions of dollars toward providing direct health care and improved quality and access; and

Whereas unacceptable health access disparities exist by region, ethnicity, income, and gender; and

Whereas advances in medical technology are not available to all Massachusetts residents who need them; and

Whereas both health care providers and consumers express significant dissatisfaction with the current health care system; and

Whereas increasing patient volume and a decline in the number of hospitals and emergency departments have made multiple hour waits for emergency care the norm and that ambulance diversion is becoming a common method of dealing with emergency department overcrowding, a problem that poses significant dangers for both insured and uninsured residents of the Commonwealth;

Therefore, the Massachusetts Health Care Trust, a single agency of the Commonwealth, is hereby created with the following purposes:

1. To provide universal and affordable health care coverage for all Massachusetts residents;
2. To provide Massachusetts residents with an extensive benefit package;
3. To control health care costs and the growth of health care spending;
4. To achieve measurable improvement in health care outcomes;
5. To prevent disease and disability and to maintain or improve health and functionality;
6. To increase health care provider, consumer, employee, and employer satisfaction with the health care system;
7. To implement policies to strengthen and improve culturally and linguistically sensitive care; and
8. To develop an integrated population-based health care database to support health care planning. ■

Legislative sponsors of Massachusetts Health Care Trust

Lead Sponsors of re-filed Massachusetts Health Care Trust:

Sen. Steven Tolman (D- Brighton)

Rep. Frank Hynes (D-Marshfield)

Senators who have signed on as cosponsors: (Six as of Jan 1, compared to 16 last session)

Jarrett Barrios (D-Cambridge), Susan Fargo (D-Lincoln), Andrea Nuciforo (D-Pittsfield), Marc Pacheco (D-Taunton), Pamela Resor (D-Acton), Stanley Rosenberg (D-Amherst)

Representatives who have signed on as cosponsors: (22 as of Jan 1, compared to 35 last session)

Ruth B. Balser (D- Newton), Antonio Cabral (D-New Bedford), Mark Carron (D-Southbridge), Edward Connolly (D-Everett), Michael Festa (D-Melrose), Patricia Jehlen (D-Somerville), Peter V. Kocot (D-Northampton), Stephen Kulik (D-Worthington), Jim Marzilli (D-Arlington), Shirley Owens-Hicks (D-Roxbury), Anne Paulsen (D-Belmont), John W. Scibak (D-South Hadley), Carl Sciortino (D-Somerville), Frank I. Smizik (D-Brookline), Joyce A. Spiliotis (D-Peabody), Ellen Story (D- Amherst), David Sullivan (D-Fall River), Timothy Toomey (D-Cambridge), James Vallee (D-Franklin), Anthony Verga (D-Gloucester), Marty Walz (D-Cambridge), Alice Wolf (D-Cambridge).

If the names of both your senator and representative do not appear above, please contact them, tell them you support this bill and hope they will add their names as cosponsors by contacting the office of Senator Tolman or the office of the Senate clerk. If the names of your senator and representative DO appear above, call and thank them. ■

Will the real 'front-line nurses' step forward & claim your right to safe staffing?

By Karen Higgins, RN
MNA President

As many of you know, we came very close last year to winning final passage of desperately needed legislation to establish a safe standard of care through regulation of safe, minimum RN-to-patient ratios in acute care hospitals – a measure supported by 9 in 10 nurses in Massachusetts and 8 in 10 registered voters in the commonwealth, according to independent surveys.

While the bill won unanimous approval from the Health Care Committee, and while an alternative version of the bill passed the state Senate as part of the budget process, a final vote was never taken on the measure. This year we begin the process again, and if all nurses do their part, we can overcome the remaining obstacles and pass this measure in the coming legislative session.

Oddly enough, the biggest obstacle to nurses and patients obtaining the protections and increased level of care provided by this bill are those who dare to call themselves "nursing leaders." Yes, while nine in 10 front-line nurses support the establishment of RN- to- patient ratios as a common sense solution to the current staffing crisis, it is the Mass. Organization of Nurses Executives (MONE), who are leading the charge (along with their hospital CEOs, HMOs and insurers) to kill this bill and to allow you and your patients to suffer under the conditions that have so plagued this profession and our system for more than a decade. At best, nurse executives represent one percent of our profesion, and they are those who have the least contact with patients.

I was appalled to attend a press conference in November where Sen. Richard Moore, on behalf of MONE and the Mass. Hospital Association, introduced a competing piece of legislation that claimed to address the staffing crisis in our hospitals while, in reality, maintaining the dangerous status quo.

Janet Madigan, a MONE member, spoke at the event and made the following statement:

"I am very pleased that this bill allows nurses to set safe staffing levels rather than the government. With all due respect to the legislature, ***caregivers on the front line*** know best how to care for our patients and keep them safe."

First of all, Ms. Madigan is not a front-line nurse, and no member of MONE is or should claim to be. Nor do they have the right to take on the mantle of those of us staff nurses on the front lines to justify their opposition to legislation that staff nurses have created and overwhelmingly support.


Karen Higgins

We staff nurses support legislation regulating ratios specifically because we will not and cannot trust our so-called nursing leaders to continue to make staffing decisions. If we could trust them to make sound judgments about staffing, then why would nurses in 18 states, including ours, be supporting and filing legislation to take that power away from them?

But don't take my word. Let's take an objective look at the record of "nurse executives" as it relates to patient outcomes and the satisfaction of the nurses they manage:

- A study by Linda Aiken at the University of Pennsylvania found that Massachusetts hospitals cut their staffing levels by 27 percent during the 1990's, more than any state in the nation.
- A DPH report found that injuries to patients and complaints by patients related to nursing care in our state have increased by 76 percent in the last seven years. Between 1993 and 1997 the increase in patient complaints and poor care increased by 495 percent -- that's not a misprint, 495 percent.
- It was nurse executives who promoted, defended and implemented workplace redesign and the re-engineering of nursing care during the 90s, resulting in the layoff of thousands of nurses and their replacement by unlicensed personnel – a policy that has been roundly condemned by all the research.
- Nurse executives employed and defended the use of mandatory overtime throughout the late 1990s as a method of staffing hospitals as an alternative to improving ratios.
- Nurse executives continue to employ floating (without orientation or proven competency) as a method of staffing a hospital as an alternative to improving ratios.
- Between 1996 and 2001, nurses at unionized hospitals cast 11 overwhelming strike votes and had to wage two long strikes over the issues of staffing and mandatory overtime.
- A recent study of recently hospitalized patients found that 45 percent believe their care was compromised by poor RN-to-patient ratios, and nearly 80 percent support ratios.
- A national survey of hospital patients by one of the most respected hospital quality research firms found that 195,000 patients die needlessly every year, with the majority of those deaths attributable to "failure to rescue" by nurses (a direct result of understaffing).
- The largest survey of RNs nationally found that hospital staff nurses have the lowest level of job satisfaction of any employee group surveyed by the federal government.
- A survey of Massachusetts nurses found that more than two thirds reported an increase in complications, medication errors, patient injuries and readmissions due to having too many patients to care for.
- More than half the nurses reported that they are considering leaving the profession due to the conditions, and 65 percent believe current working conditions are "brutal" to nurses.
- Another statewide survey of nurses, sponsored by MONE and the MNA in 2002, found that two top reasons nurses are leaving bedside nursing are staffing and workload.

This is nothing less than a record of total failure on all counts. MONE's record is one of patient suffering, injury and yes, unnecessary patient death. For nurses, it is a record that has led to excessive burnout, a massive exodus of caring professionals from the hospital bedside, and an injury rate that ranks nurses on the same level as construction workers.

It is this record that led the prestigious Institute of Medicine (IOM) to conclude in its groundbreaking report on the working conditions of nurses that staff nurses, not nursing administrators, should have the final say on staffing. In that report, the IOM recommends specific ratios for ICUs, and for all other nurses, it recommends that each nurse be granted the power to refuse assignments he or she deems unsafe. It further calls upon patients to have the right to be informed by their nurse when they are being cared for in an environment that the nurse considers unsafe. This report was written by the most influential group ever assembled to study this issue.

In the wake of this record, and in recognition of the fact that under Massachusetts law, each nurse is personally accountable for the safety of his or her patients, we staff nurses must stand firm in our opposition to the status quo. The ratios set forth in the MNA/Coalition to Protect Massachusetts Patients staffing bill provide a standard of care for all patients in all hospitals. These ratios are based on the best scientific research, and more importantly, on the input of real front-line nurses. After developing these ratios, MNA members walked through every floor of more than 30 hospitals in the state and shared them with nurses to see if they made sense. The nurses resoundingly endorsed the minimums proposed.

To provide maximum flexibility and to account for changing acuity, it establishes a standardized acuity scale that calls for patient assignments to be reduced when patient's needs require such a change. It bans the practice of mandatory overtime, mandatory on call, floating without orientation and the substitution of unlicensed personnel for registered nurses. It also specifically prohibits the reduction of LPNs and other ancilary staff. It basically protects all nurses and all patients from the bad decisions of those who would claim to be leaders, and places the power and control of patient safety back where it belongs, in the hands of those delivering care.

The challenge for all of us who take care of patients is to do whatever we can to make sure this bill passes. This issue of the *Massachusetts Nurse* includes a special pull out section that provides a "toolkit" to help you learn about this bill and what you can do to see it is passed. Pick up the tools and help us build a system of staffing that will protect our patients and our profession. ■

Majority of Americans report dissatisfaction with quality of healthcare in U.S.

- One in three people say they or a family member have experienced a medical error; one in five say it was 'serious'
- Nearly 70 percent say there are too few nurses in hospitals to provide safe care
- People with chronic conditions are most likely to report problems

The Kaiser Family Foundation released a national survey showing that five years after the Institute of Medicine's landmark 1999 report "To Err is Human: Building a Safer Health System" on medical errors, Americans do not believe that the nation's quality of care has improved.

The survey was done in collaboration with the Agency for Healthcare Research and Quality (a U.S. Department of Health and Human Services agency) and the Harvard School of Public Health. It assessed Americans' perceptions about the quality of health care, their awareness and reported usage of information in making their health care choices, and their experiences with their health care providers.

Forty percent of survey respondents said the quality of health care has gotten worse in the past five years, while 17 percent say the quality of care has gotten better. The remainder of respondents believed the quality of healthcare had remained the same.

The survey also found that 48 percent of U.S. residents say they are concerned about the safety of the medical care that they and their families receive, and 55 percent are dissatisfied with the quality of health care — up from 44 percent in a similar survey conducted four years ago.

About one-third say they or a family member had experienced a medical error at some point in their lives. The more knowledgeable the consumer, the more concerned they are. People with chronic health conditions are considerably more likely than other consumers to express concerns about their quality of care and report having personal experiences with medical errors.

Consumers were most likely to cite workload, inadequate staffing and poor communication among healthcare providers as causes of medical errors, with 74 percent saying workload, stress or fatigue of health professionals are very important causes. About 70 percent say doctors not having enough time with patients, too few nurses in hospitals and health professionals not working together or not communicating as a team are very important causes of medical errors.

The study is available online at: www.kff.org/kaiserpolls/pomr111704pkg.cfm

Study methodology

The survey is a joint project of the Kaiser Family Foundation, the Agency for Healthcare Research and Quality and the Harvard School of Public Health. The survey was conducted by telephone among a randomly selected nationally representative sample of 2,012 adults 18 years or older. The margin of sampling error is +/-2 percentage points overall. The margin of sampling error will be higher for results based on subsets of respondents. ■

Labor Relations News

Request for union representation increasing at MNA

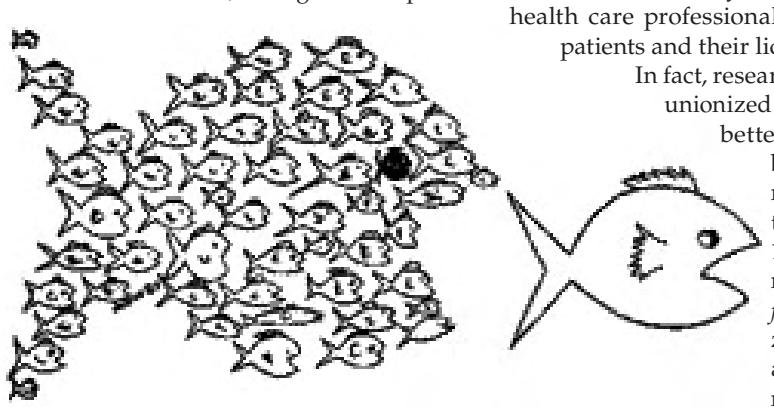
As the health care industry continues to struggle to provide care with a primary emphasis on cost and the bottom line, nurses in a variety of settings are engaged in their own struggle to have a real say about the quality of their work life and nursing practice. More and more nurses seem to be exploring the role a union can play in making their work life better.

According to Eileen Norton, RN, director of the MNA's organizing department, phone calls from nurses to the MNA about union organizing are increasing.

'You need an effective voice'

"We tell these nurses that in today's health care environment it is more important than ever for nurses and health care professionals to have a union at their facility. With the current staffing shortages and speed up in health care you need to have an effective voice. You need to be part of the decision making process so that you have a say in all the decisions that are made that affect you and the work that you do," Norton explained.

Norton adds that as nurses become more vocal about conditions, management responds



with strategies that make them believe they have a voice in what is happening.

"They use nurse councils, task forces, shared governance, quality circles, many and varied committees to redesign the workforce and, of course, the latest ploy, the 'journey to Magnet Status.' All of the above only work as long as management wants the same things that you want. If you sit on any of these committees, try to get something passed that management is opposed to and you will quickly see how they do not work."

Having a legally binding union contract and the ability to sit with management as equal partners at the table where decisions are made is the only way for nurses and health care professionals to protect their patients and their license.

In fact, research has shown that unionized employees are paid better and have better benefits than their non-union counterparts (see Table 1). A survey of nurses by *Advance for Nurses* magazine found that on average, unionized nurses make $2.60 per hour more than non-union nurses and they work 35 percent less mandatory overtime.

Even more important, research shows that patients of nurses in union hospitals have better outcomes than those cared for in a non-union hospital.

The union advantage

	Union	Non-union	Union Advantage
Median weekly earnings	$740	$587	26%
Women's median weekly earnings	$667	$510	31%
African American's median weekly earnings	$615	$477	29%
Latino's median weekly earnings	$623	$408	53%
Guaranteed pension	69%	14%	55%
Receive health benefits	75%	49%	26%
Receive short-term disability	69%	30%	26%
Receive life insurance coverage	82%	51%	31%

Source: (U.S. Bureau of Labor Statistics, 2000; U.S. Department of Labor, 2003)

In fact, a March 2002 study published in *JONA* (*The Journal of Nursing Administration*) found that hospitals with a nurses' union had a "significantly predicted lower risk-adjusted acute myocardial infarction (AMI) mortality." Hospitals with RN unions had 5.7 percent lower mortality rates for AMI after accounting for patient age, gender, type of MI, chronic diseases and several organizational characteristics. This result includes controls for number of beds, AMI-related discharges, cardiac services, staff hours and wages.

The 'voice' function of unions

In discussing how unions impact the quality of patient care, the authors stated, "unions may impact the quality of care by negotiating increased staffing levels…that improve patient outcomes. Alternatively, unions may affect the organization of nursing staff or the way nursing care is delivered in a fashion that facilitates RN-MD communication. This is the 'voice' function of unions…Yet another possible mechanism by which unions can improve care is by raising wages, thereby decreasing turnover, which may improve patient care."

The authors conclude, "perhaps having an RN union promotes stability in staff, autonomy, collaboration with MDs and practice decisions that have been described as having a positive influence on the work environment and on the patient outcomes."

'You need to be involved'

Norton concurs with the researchers' assessment. "The most professional and empowering act that you can make is to form a union at your facility if you do not have one. If you are fortunate enough to have a union you need to be involved in the process. Unions work best when members realize that they are the union and use their collective voices to improve conditions for all," Norton said.

The organizing department at MNA encourages any of you who have questions about organizing a union at your facility to contact us. We also encourage our members to contact us if they know other nurses or health care professionals working at a non-union facility who have expressed an interest in organizing.

Contact us at www.massnurses.org or call 781-821-4625, x 777. ■

Brigham …

From Page 1

that we can build on in the future," said Barbara Norton, RN, chair of the nurses' bargaining unit. "We are pleased to have hopefully laid the groundwork for other bargaining units to also garner this important benefit for our aging nurse workforce."

In fact, nurses at Newton Wellesley Hospital, which is owned by Partners Health Care, which owns the Brigham as well, has a proposal for a retiree health benefit on the table in its current contract negotiation. The MNA has made securing retiree health and improved pension benefits a major focus for the next five years.

According to Norton, "Nurses who have spent their lives safeguarding the health of their patients should have access to quality healthcare when they retire. Nursing is one of the most stressful and strenuous profession, particularly under the conditions we are forced to work and with the high acuity level of our patients. The fact is, many nurses will not be physically able to work until the traditional retirement age. As a result, nurses will be forced to work beyond their physical capacity or to leave the field without health insurance protection."

For MNA, while the Brigham contract opens the door to discussions about retiree health, the ultimate objective is to create what is known as a multi-employer Taft Hartley Trust that would allow a number of MNA local bargaining units to negotiate retiree health and pension benefits that would included in a jointly administered fund controlled by both managers and the union to provide retiree health and pension benefits to nurses across the state.

"Winning this benefit, which is so needed by nurses, will not come easy, but it can and must be done," said Roland Goff, MNA's director of labor relations. "It will take strong resolve by all members and a strong stance at the negotiating table." ■

MASSACHUSETTS NURSE

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Mission Statement: The M*assachusetts 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.

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www.massnurses.org

MNA
Massachusetts Nurses Association

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A primer on the dangers of 'shared governance'

By Roland Golf
Director, MNA Labor Program

As a labor union as well as a professional association, the MNA advocates improved terms and conditions of work, and advocates for improved patient care not only because it is right to do so, but because these issues are inseparable.

As a union, members have a legally protected right to discuss and negotiate any proposed changes in work terms and conditions—either through the negotiation of a new contract or through regularly scheduled labor-management meetings, where the union and administration sit as equal partners. In contract negotiations and in the labor management process, you have the right to say "no," or at least to engage in good faith negotiation to a reasonable agreement.

Shared governance/practice councils and similar bodies are strategies employed by health care administrators as a means of undermining the rights of union members to negotiate over terms and conditions of employment that effect nurses and patients.

Employers create these bodies either as an employer-dominated labor organization or to remove issues from the negotiations or labor/management meetings to a forum in which they dominate the decision making process – an employer-dominated labor organization in disguise. Merely having the opportunity to "have input" or to "make suggestions" or to "share your ideas and opinions" is not real "shared governance." In these settings, if you make a suggestion and management doesn't like it, what recourse do you have? The answer is you have none.

For nurses in unionized settings, it is time that we re-establish our right to have all issues related to working conditions—including improved patient care—brought to the union contract negotiations or labor/management meetings where you have a real voice and, more importantly, the legally protected right to challenge management and to negotiate your position.

At the beginning of the 20th century the biggest threat to employee-led labor unions was the company-dominated labor organization, and it may be re-appearing at the beginning of the 21st century. The Wagner Act granted employees the right to organize into unions that would bargain collectively over terms and conditions of work. The union provided employees the right to organize themselves to bargain collectively with the employer over terms and conditions of employment. Unions empowered employees to address their working conditions and be advocates for better social-welfare programs.

Shared governance/practice councils, in its many forms, claims to enhance accountability, empower nurses and provide for patient advocacy. Merely listing the characteristics of shared governance/practice councils indicates that employers instituting these bodies are seeking to create a mutant unionism that destroys employee-led labor organizations.

An employer engages in an unfair labor practice pursuant to Section 8(a) (2) when it dominates a labor organization of its employees. How do you determine when shared governance/practice councils stop becoming a method to communicate with employees and starts an unfair labor practice? The National Labor Relations Board (NLRB) ruled that an employer dominates when "the impetus behind formation of an organization of employees emanates from the employer and the organization has no effective existence independent of the employer's active involvement, a finding of domination is appropriate if the purpose of the organization is to deal with the employer concerning conditions of employment." (*Electromation, Inc., and the International Brotherhood of Teamsters, Local No. 1049).*

This definition, applying to unionized and non-union facilities, covers many issues addressed in shared governance/practice council bodies (e.g. new technology, scheduling, job descriptions, required duties), and we must review each issue to determine if the shared governance/practice council body is infringing on the legal territory established for the union in federal labor law. Employers retain the right to communicate with their employees and seek their opinion, but it cannot replace negotiations and labor/management meetings with shared governance/practice councils when the issues involve terms and conditions of employment.

Combating employer domination

Depending on your situation, there are several ways to combat attempts of employer domination. If you work in a facility that does not have any type of shared governance/practice councils, then you should block attempts by the employer to create any such body. First, educate your fellow bargaining unit members about the principle that their union is their voice on all matters that affect their work including issues traditionally identified as professional—your ability to care for patients is a condition of employment. Second, inform your employer that you view any attempt to circumvent negotiations or labor/management as an unfair labor practice and assure the employer all the issues may be raised at negotiations or labor/management meetings.

If you work in a facility that has some type of shared governance/practice council, then in addition to educating your fellow bargaining unit members and informing the employer that raising issues about working conditions is illegal, you must monitor the shared governance/practice council discussions. You must infiltrate the committee, voice concerns about issues that you believe must be taken to the union or at least keep (or receive) minutes of the meetings. The recorded minutes and documents creating the body are the essential evidence in establishing an unfair labor practice of creating an employer dominated labor organization. ■

Mandatory, permissive and illegal subjects of bargaining

By Joe Twarog
Educator, MNA Labor Program

Collective bargaining is the process of negotiating a lawfully binding agreement between the union and the employer. This collective bargaining agreement governs the wages, hours and other terms and conditions of employment and is enforceable through the grievance and arbitration procedure. As the exclusive bargaining representative for a defined unit of workers, the union is empowered to negotiate such an agreement.

Questions arise then, what issues can be put on the table for bargaining?

What topics are legitimate and which are not? What does "reasonable times" mean and what is "good faith"? Why does it matter that some issues are mandatory and others are permissive? What does "impasse" mean?

Bargaining basics

The duty to bargain is imposed equally on both the employer and the union. This means that the parties must come to the bargaining table in "good faith" to negotiate. Simply put, this means that the parties bargain with the attempt to reach an agreement. It does not mean nor require that the parties actually reach a final agreement, but rather that they engage in the process of bargaining. This involves meeting at reasonable times and places and with some frequency.

Bad faith bargaining is the flip side of good faith. It is defined not by any single incident, but rather by the whole conduct of bargaining, or, as the National Labor Relations Board refers to as the "totality of conduct." Therefore, if the employer is simply going through the motions of bargaining—showing up at the designated times, but never engaging in the process, exchanging proposals, etc., that is defined as "surface bargaining." Other indicators of bad faith include: long delays in bargaining; canceling or postponing bargaining dates; refusal to meet; unilaterally shortened sessions; failure to exchange proposals.

Finally, "impasse" is the point at which the bargaining process has been exhausted after the parties have engaged in good faith bargaining without reaching an agreement. It is elusive at best to tightly define impasse, but it basically means that further negotiations will not result in any progress towards a final agreement. The problem and danger with reaching impasse is that the employer is then permitted to unilaterally implement its "last, best offer" that it had put on the bargaining table even though no agreement had been reached. The union has the right to strike if impasse and implementation occurs.

Bargaining issues are divided into three basic categories: mandatory, permissive and illegal subjects of bargaining.

Mandatory subjects

Mandatory issues of bargaining are those subjects that directly impact "wages, hours or working conditions." These subjects have also been referred to as those that "vitally affect" employees. This means that any subject that either party proposes to bargain over that impacts any of these three areas, has to be negotiated in good faith. These are subjects over which the parties must bargain if they are requested to do so by the other party. This does not mean however, that the parties have to reach agreement, but rather that they have to engage in the process.

Mandatory subjects for the most part, tend to be reasonably straight forward.

Examples of mandatory subjects include: wages, shift premiums, overtime, premium pay, longevity, pay for training, holidays, sick days, hours of work, work schedules, grievance procedure, workloads, vacancies, promotions, transfers, layoff and recall, discipline and discharge, dues check off, on call pay, severance pay, pensions, health insurance, leaves of absence, tuition reimbursement, job duties, seniority, probationary period, testing of employees, rest and lunch periods, bargaining unit work, subcontracting, no strike clause, nondiscrimination.

Permissive subjects

"Permissive" or non-mandatory issues of bargaining are those which the parties may bargain over, but are not required. If the employer puts a permissive subject on the table, the union may engage in bargaining, but it is not obligated to do so. The union may agree to discuss the matter, engage in full bargaining and reach agreement on the issue, or decline to talk about it at all. That permissive issue then would be a dead issue. Either party may choose to keep it on the table, but they cannot force such an issue to impasse. Also, a strike over a permissive subject would be an unprotected activity, and unilateral implementation by the employer would be illegal.

Examples of permissive issues are: definition of the bargaining unit (found in the recognition clause), retiree benefits, internal union matters (such as how floor representatives are elected, the amount of union dues, union officer structure, etc.), supervisors' conditions of employment, interest arbitration and make-up of the employer's board of trustees or directors

This is an important category to keep in mind as the union bargains. It is not unusual to get bogged down on an issue that the union can simply identify as permissive and decline to continue bargaining over. Let's say the hospital puts a proposal on the bargaining table to remove a classification of nurses from the bargaining unit, like per diem nurses. The union may engage in the process and learn what the hospital's concerns are, but the union can at any time declare the issue to be permissive and refuse to continue bargaining over the item. The union does not have to make any concession or come to any agreement over a permissive issue.

Illegal subjects

The third category is illegal subjects of bargaining. These are items that cannot be bargained over legally by either party. These issues violate a law and cannot be entered into a contract legally even if both parties agree.

Examples of illegal subjects are: discrimination against a legally recognized group of people; hot cargo clauses (a provision allowing workers to refuse to handle material or goods from a struck facility or on an "unfair" list); closed shop clauses (a provision that all employee are union members before being hired-made illegal under the 1947 Taft-Hartley provisions)

It is critically important to understand these issues as well as the types and categories of collective bargaining issues. A clear understanding of these types of issues helps the union to formulate a bargaining strategy and tactics as the process develops. ■

Arbitration awards favor MNA position

The following article summarizes recent arbitration decisions won by the MNA on behalf of its unionized members. One of the most important benefits of a union contract and union representation is the ability to take disputes over specific issues in a union contract to an independent arbitrator as a form of legally binding dispute resolution. Once nurses negotiate a contract, there remains a likelihood that both parties will dispute the meaning and the interpretation of specific provisions of the contract. When those disputes arise and cannot be resolved through negotiation, unions and management have the right to submit the dispute to an arbitrator. Similar to a court proceeding, both parties submit evidence, call and cross examine witnesses. The arbitrator, like a judge, evaluates all the evidence and renders a decision.

In the mater of arbitration between the MNA and Marlborough Hospital:

Issue: Nurses retiring from the hospital with 15 years of service are entitled to cash out 30 percent of accrued sick time; is the nurse who retired from the hospital at age 55 with 24 years of service eligible for the cash out?

Employer position: Only nurses who retire and are eligible for the hospital retirement plan – must be age 60 or older to receive benefits – may receive cash out accrued sick time.

MNA position: An RN who leaves service of the hospital after at least 15 years of service is entitled to the cash out of accrued sick time.

Arbitrator's award for the MNA: RN retired from the hospital to move to Maine, and although the RN is not eligible for retirement benefits yet, she is entitled to cash out 30 percent of for her first 400 hours of accrued sick time.

In the mater of arbitration between the MNA and commonwealth of Massachusetts, Department of Mental Retardation:

Issue: Did the employer have just cause to discipline the grievant by issuing a one-day suspension for failure to conduct a full patient assessment.

Employer position: Grievant failed to perform a thorough assessment of a patient in her care.

MNA position: The assessment by the grievant of the patient's condition was appropriate and adequate.

Arbitrator's award for the MNA: The grievant did not fully assess the patient, but the employer lacked just cause to impose a one day suspension. The appropriate level of progressive discipline was a written reprimand. The one-day suspension is reduced to a written reprimand, and the grievant is made whole for the lost pay.

In the mater of arbitration between the MNA and UMass Memorial Medical Center, Inc.:

Issue: RNs who retire from the UMMMC shall be paid 20 percent of their accrued sick time. Is RN who retired from UMMMC but began working again after she moved to the West coast eligible for this benefit?

Employer position: Retire means that the RN has begun collecting pension benefits.

MNA position: Retire means any resignation from UMMMC except for those employees discharged for cause.

Arbitrator's award for the MNA: Any RN who left service of UMMMC after qualifying (not receiving) for the retirement plan is eligible to receive payment of 20 percent of accrued sick time. Grievant received payment of 20 percent of her accrued sick time. ■

Change in mandated reporting of elder abuse law affecting RNs

The legal responsibility for nurses, as well as a number of other groups of professionals,[1] to report elder abuse was recently expanded by amendment to Massachusetts General Law. The MNA has been asked by the Executive Office of Elder Affairs to alert our members to the increased legal duty for nurses. The amended law now includes self-neglect in the statutory definition of "elder abuse."

"Self neglecting elders" are defined as persons age 60 or older who have unmet essential needs for food, clothing, safe and secure shelter, personal care, supervision and medical care, that will result in serious harm or risk of harm, and the inability of the elder to remain safely in the community.

Mass General Law, Chapter 19A, requires that "any [nurse…] who has reasonable cause to believe that an elderly person is suffering from or has died as a result of abuse, shall immediately make a verbal report of such information or cause a report to be made to the department or its designated agency and shall within forty-eight hours make a written report to the department or its designated agency. Any person so required to make such reports who fails to do so shall be punished by a fine of not more than one thousand dollars." In addition to the new category of self neglect, elder abuse has been defined as an act or omission (of an action) which results in serious physical or emotional injury to an elderly person or financial exploitation.

Nurses are required by law to immediately report elder abuse report to the appropriate Protective Services Agency, with after hours reports called in to the Massachusetts Elder Abuse Hotline at 800-922-2275. Following the verbal report, a written report on a prescribed form available from protective services must be completed. Questions may be directed to the director of protective services, Gregory Giuliano, at 617-222-7464.

Mandated reporters (nurses and others) are immune from criminal or civil liability for making an elder abuse report, unless he/she is the perpetrator of the abuse; and they are subject to a fine of up to $1,000 for failing to make an elder abuse report. ■

[1] Prior law names: " physician, physician assistant, medical intern, dentist, nurse, family counselor, probation officer, social worker, policeman, firefighter, emergency medical technician, licensed psychologist, coroner, registered physical therapist, registered occupational therapist, osteopath, podiatrist, executive director of a licensed home health agency or executive director of a homemaker service agency or manager of an assisted living residence."

For more information, see also:

- **Department of Elder Affairs Web site**: www.mass.gov/portal/index.jsp?pageID=eldershomepage&L=1&L0=Home&sid=Eelders
- **Massachusetts General Law site**: www.mass.gov/legis/laws/mgl/gl-19a-toc.htm

Diversity Corner

Barriers to mental health services for Latinos in Worcester

According to the 2000 U.S. Census data there has been a significant increase in the Hispanic/Latino population in the city of Worcester from 9.6 percent (16,258) of the total population in 1990 to 15.1 percent (26,155) in 2000. However, despite the population growth, non-English speaking Latino individuals and families are grossly underserved in the area of mental health services.

Recognizing that the Latino population is underserved, the Department of Mental Health, Central Massachusetts area, in partnership with Central Massachusetts Area Health Education Center, Inc., Great Brook Valley Health Center, Family Health Center and Clark University, obtained funds from the Blue Cross Blue Shield of Massachusetts Foundation for the purpose of outreaching to the Latino community, conducting a meaningful assessment of mental health needs and collaborating to improve access to culturally competent services and programs. This collaborative expanded to include consumers, community members and representatives of Centro Las Americas and Christian Community Church.

A total of 166 Latino community members participated in face-to-face interviews. The mean age of the participants was 42. The most commonly identified places of birth were Puerto Rico (49 percent), the Dominican Republic (15 percent), mainland United States (10 percent), and various countries in Central America (9 percent). 142 participants have children. The vast majority of the participants felt more comfortable communicating in Spanish than in English (81.33 percent). Participants reported diverse educational backgrounds and employment status. 128 of the respondents reported that they have some type of health insurance. 58.6 percent are Medicaid/MassHealth recipients.

Preliminary analyses indicate that 123 participants reported having experienced some symptoms of a mental health problem at some point in their lives, with 57 percent seeking out some form of help. The three most frequently reported types of symptoms were depression, anxiety, and symptoms of post traumatic stress disorder.

The most common reasons reported for not seeking out treatment included language or cultural barriers, transportation problems, lack of insurance, lack of knowledge about resources and a belief that the problem could be handled without help. Interestingly, less than 2 percent of the participants reported that family disapproval prevented them from seeking out services, in contrast to a commonly-held perception among local providers that many Latino families hold negative perceptions of mental health treatment. Future analyses will investigate the extent to which barriers to help-seeking are influenced by language ability, educational background, and length of stay in the U.S.

One major theme identified through this needs assessment is the importance of having Spanish-speaking capacity at the clinics and hospitals. In the absence of professional staff, trained medical interpreters are essential. Another common theme is the need to include family members and significant others in the treatment approach. Many participants reported that they had heard about mental health services through friends and family contacts and that they rely on the support of friends and family to manage their conditions.

The preliminary findings of this study also highlight the need for more education in the community about mental health issues, treatment approaches and resources. Perhaps with more knowledge about mental health those who said they thought they could handle symptoms by themselves would be more likely to seek services. Additionally, there is clearly a call for educating providers about the health needs of the Latino population and how to meet those needs. Several educational activities will be conducted for providers and community members throughout the year.

For additional information about the Latino Mental Health Project, contact: Sara Trillo Adams, project director, 508-756-6676, x16 ■

Health and Safety at Work: OSHA training

- An OSHA 10-hour general industry outreach training with a focus on the health care industry
- This program is being offered in two parts at MNA Region 4: USI, 12 Gill Street, Suite 5500, Woburn
- Part 1, Thursday, Feb. 17, 8:30 a.m.–3:30 p.m.
- Part 2, Thursday, March 24, 8:30 a.m.–3:30 p.m.
- No charge to MNA members; all others $45 for the OSHA Standards Textbook
- To be run by OSHA authorized trainer, Evie Bain
- Contact hours provided by the Greater Boston Chapter of the American Association of Occupational Health Nurses
- OSHA certificate available to those who attend both classes

MNA members: For information and to register contact Evie Bain at 781-821-4625, x776 or via e-mail at eviebain@mnarn.org. ■

OSHA

How, when and where to report an incident affecting patient safety

By Mary Crotty, RN, MBA, JD
MNA Nurse Researcher

Many nurses have found themselves in situations where patient safety has been jeopardized, where a nurse's voiced concerns have fallen on deaf management ears, or where there is a legal obligation for a nurse to report a patient safety-related incident of which a nurse becomes aware. Hospitals also have legal reporting requirements, but it is often unclear to nurses whether hospitals have met their legal reporting requirements.

The following information is intended to help nurses understand what their legal obligations are and what resources are available to assist them to protect their patients.

The Massachusetts Department of Public Health (DPH) has regulations governing the reporting by hospitals of incidents affecting the health and safety of patients. In addition, nurses themselves may have a duty to report certain behaviors that they observe.

If you are unclear whether your hospital has fulfilled its duty to report, please file again! In fact, the Division of Healthcare Quality has recommended this to MNA.

How to report

1) Contact the Division of Healthcare Quality (DHQ), which is the DPH agency that handles quality concerns. A report form which can be used for this purpose is below; you may modify it as you see fit; or
2) Similarly, you may use this form but report anonymously; or
3) Contact your labor representative at the MNA, who will work with Mary Crotty, RN, JD, associate director of nursing, to file a complaint with DHQ; or
4) Contact Mary Crotty to follow up with your labor representative.

Call, during normal weekday business hours, the DPH intake staff in the Division of Healthcare Quality at (617) 753-8150. After hours emergency callers may contact DHQ at 522-3700.

Mail reports to Department of Public Health, Division of Health Care Quality, Intake Unit, 10 West Street, Fifth Floor, Boston, Massachusetts 02111.

Note: Paul Dreyer is Director of DHQ. Phone (617) 753-8000.

What to report

DPH regulations require that hospitals report fire, suicide, serious criminal acts, pending or actual strike, serious physical injury resulting from accidents or unknown causes, and other incidents that seriously affect the health and safety of patients.

MDPH definitions

- "Serious injury" means injury that is life threatening, results in death, or requires a patient to undergo significant diagnostic or treatment measures.
- "Accidents" include falls, burns, electrocutions, and other misadventures not related to patient treatment.
- "Other serious incidents that seriously affect the health and safety of patients" means incidents that result in serious injury. These include, but are not limited to: poisonings occurring within the facility; reportable infectious disease outbreaks; equipment malfunction or user errors; medication errors; and other incidents resulting in serious injury not anticipated in the normal course of events.

The list below from DPH gives examples as to which incidents are reportable to them.

'Reportable' and 'non-reportable'

- Medication errors including, major I.V. therapy errors such as wrong rate or route, with serious complications (e.g., resulting in death, paralysis, coma, or permanent injury)
- Burns (e.g., hot liquids, equipment, hot packs)
- Slips or falls occurring within the facility that result in serious head injury, coma or permanent injury; or requiring significant additional therapeutic intervention or extended hospitalization.
- Major biomedical device or other equipment failure resulting in serious injury or having potential for serious injury to a patient, visitor, or employee. This would include user errors, as well as those device failures that must be reported to the U.S Food and Drug Administration pursuant to the Safe Medical Device Act.
- Surgical errors involving the wrong patient, the wrong side of the body, the wrong organ or the retention of a foreign object (e.g., sponge or clamp)
- Blood transfusion errors (e.g., wrong type of blood, outdated blood, blood not given when ordered, given to wrong patient, HIV sero-positive transfusion) with potential serious complications (Does not alter requirement for reporting under 105 CMR 135.000)
- Poisonings occurring within the facility
- Infectious disease outbreaks
- Criminal acts or allegations of abuse within the facility that result in serious harm (physical or mental) to a patient
- Fire
- Pending or actual staff strikes
- Supplier strikes that may seriously affect patient services
- Any maternal death within 90 days of delivery or termination of pregnancy
- Death of a patient by suicide
- Discharge of an infant to the wrong family.
- Presentation of an infant to the wrong mother for breast-feeding.
- Serious physical injury resulting from accident or unknown cause

"Non-Reportable Incidents" are adverse outcomes directly related to the natural course of a patient's illness or underlying condition. Other non-reportable incidents include, but are not limited to:

- Medication errors that do not result in serious complications or diminish the therapeutic value of the medication (e.g., medication given early or late, missed dose)
- Minor reaction to medication or blood transfusion where reactions are controlled with minimum amounts of medication or palliative therapy
- Minor bio-medical device failure or damage resulting in no injury to patient, visitor, or employee
- Patient refuses treatment or procedure or leaves against medical advice
- Incorrect, needle, sponge, or instrument count corrected before surgical procedure is terminated
- Dietary problems that do not affect the patient's status (e.g., food allergy)
- Treatment or procedure error with no residual effect (e.g., routine X-ray or lab test performed without order, or results posted late)
- Surgical procedure error with no residual effect, e.g., which does not require a patient to undergo significant additional diagnostic or treatment measures
- Slips or falls resulting in minor injury
- Minor injuries of unknown origin

Nurse's duty to report

A nurse is required to report to the Massachusetts Board of Nursing if he or she directly observes another nurse engaged in any of the following:

(a) abuse of a patient; (b) practice of nursing while impaired by substance abuse; (c) diversion of controlled substances.

Any such report, by law, must be submitted honestly and in good faith.

Other statutory requirements

The Massachusetts Code of Conduct for Nurses also contains a number of other mandatory reporting and other requirements for nurses.

244 CMR 9.03(6) Compliance with Laws and Regulations Related to Nursing.

(a) A nurse who holds a valid license shall comply with M.G.L. c. 112, §§ 74 through 81C, as well as with any other laws and regulations related to licensure and practice. Examples of such laws include, but are not limited to, the following:

- obligation to report elder abuse disabled persons
- report of death to medical examiner
- Controlled Substances Act — requirement for possessing, dispensing, administering and prescribing controlled substances.
- obligation to report abuse of patient or resident
- obligation to report infant with swollen, red, or inflamed eye(s) or with unnatural discharge within two weeks after birth
- obligation to report examination or treatment of child with Reyes syndrome
- obligation to report lead poisoning
- obligation to report child abuse

Feel free to contact Mary Crotty, associate director of nursing at the MNA, for more information about this process:

Mary Crotty, RN, MBA, JD
Associate Director of Nursing
Massachusetts Nurses Association
340 Turnpike Street
Canton, MA 02021
Phone: 781-830-5743
Email: mcrotty@mnarn.org

In addition to hospital requirements to report activities or circumstances dangerous for patients, nurses also may be required by law to report certain activities they observe. Below are some Web sites that spell out these requirements.

www.mass.gov/legis/laws/mgl/gl-112-toc.htmsite

www.mass.gov/dpl/boards/rn/cmr/24409.htm#9.03

For the BORN's "Guideline for Compliance with the Standard of Conduct at 244 CMR 9.03(26) Governing a Nurse's Duty to Report to the Board of Registration in Nursing, visit:

www.mass.gov/dpl/boards/rn/misc/nwrgduty.htm

Sample report form:

Report of Serious Incident Affecting the Health and/or Safety of a Patient

Date: _____

Attention: Vicky Soler, Intake Manager, Complaint Unit, Division of Healthcare Quality
Massachusetts Department of Public Health (617-753-8159)

From *(Report may be sent anonymously)*

Name: _____

Title: _____

Phone: _____

Re: Report of Serious Incident Affecting the Health and Safety of Patient(s)

Name of facility: _____

Patient name (if known): _____

Patient sex and age (if known): _____

Date or approximate date of incident: _____

Describe nature of the incident, providing as much detail as is possible: _____

Fax report to: 617 753-8165

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

New study of Brigham RNs shows lasting effects of poor indoor air quality

A recently completed study of registered nurses at Brigham & Women's Hospital who were negatively impacted by poor indoor air quality at the facility in the late 1980's and early 1990's found that a majority of the nurses report a sustained compromise in their health status 10 years after toxic exposures were identified in their work environment.

The study, conducted by the MNA and UMass Amherst, is the first of its kind to track the long-term health effects of exposure to poor indoor air quality and sheds light on an issue that first made local and national headlines due to the courage and conviction of the nurses of Brigham & Women's to bring the issue to public consciousness (see related story on this page) a decade ago. To review the complete summary of the study results, visit the MNA web site at www.massnurses.org.

According to the report: a significant number of registered nurses at the hospital were exposed to poor indoor air quality as a result of a faulty ventilation system, vapors from sterilizing agents, particulate matter from natural rubber latex gloves, and other potentially toxic products including aerosolized disinfectants utilized in the healthcare environment. According to Howard Hu, M.D., there had been a "general consensus among BWH staff (managers and employees) that some degree of occupational health problems" had existed in the operating rooms for at least 10 years. However, according to Hu, there had been "a marked acceleration for health complaints associated with incident reports" starting in 1993.

Number of symptoms persist

Nurses on various floors experienced a range of symptoms and illnesses over an 11-month period, (around 1993-1994), generating concern over the general working conditions and long-term health of those working in the building. Although the hospital eventually pledged to undergo extensive and costly clean up of dust from natural rubber latex and millions of dollars in revisions to the ventilation system, most of the nurses surveyed found employment elsewhere after long periods of illness and disability.

In 2003, 10 years after these exposures, the MNA surveyed the nurses who had reported the most serious health affects and were known to the Association. The survey was designed to assess the current health conditions of these nurses, as well as health conditions experienced prior to and during the exposure period. This survey, which gathered detailed information on skin, eye, ear, nose and throat (EENT), gastrointestinal (GI), pulmonary, cardiac, neurological, immune system/autoimmune, musculo-skeletal and reproductive conditions provides a statistical summary of the symptoms that these nurses have experienced over this time period. The survey also looked at current work status.

The survey shows that 10 years after the exposure to poor indoor air quality at Brigham and Women's Hospital, many of the nurses surveyed continue to experience symptoms. While the rate of symptoms has declined from a high frequency during and immediately after the exposure, the rate of symptoms has not dropped back to pre-exposure levels. Certain symptoms continue to be present at high levels at the time of this survey.

The most frequently reported neurological symptoms among respondents today are headache 53 percent, memory loss 50 percent, mental cloudiness 47 percent, dizziness 44 percent and paresthesia 42 percent. In addition, several respondents identified other symptoms that were not addressed in the survey, especially other memory-related defects such as word searching or decrease in the ability to focus.

The most frequently reported condition associated with the immune system was multiple chemical sensitivities (MCS). In 1993-1994, 61 percent were diagnosed with MCS. Since that time period, another 29 percent have been worked up for MCS and 53 percent of the total respondents reported being currently diagnosed with MCS.

Four symptoms of pulmonary conditions are still common today; including shortness of breath 64 percent, wheezing 58 percent, cough 50 percent, and chest pressure/tightness 50 percent.

Although most of symptoms of cardiac conditions have declined since the 1993-1994 period, the respondents report cardiac symptoms today between 14 percent and 33 percent, as compared to 0 percent to 8 percent prior to 1993. Symptoms such as palpitation, tachycardia and rate irregularity are persistent among more than 30 percent of respondents.

Symptoms of syncope and hypotension, often associated with allergic reactions, were reported prior to 1993 as hypotension 6 percent, syncope 0 percent; in 1993-94, hypotension 22 percent, syncope 25 percent; and in the present time period, hypotension 17 percent and syncope 14 percent.

Health decline forces many to leave

Participants report that overall their health has declined since the early 1990's. At that time, 78 percent of respondents rated their health condition as excellent, but no respondents did so in 1993-1994. By 1994, those who described themselves as having poor health had increased to 44 percent. Current health conditions among survey participants shows a slight recovery since 1994, but overall health conditions are worse than reported for the early 1990's. Another result is that a large group of the surveyed nurses report their overall health as poor, requiring regular visits to primary care providers, medical specialists and alternative health care practitioners.

A major consequence of the prevalence of the symptoms is that many of these nurses have had to leave the nursing field. The majority of respondents are presently employed and 20 percent are self-employed. A majority of respondents report financial stress due to unemployment or underemployment. They also report being forced into jobs with lower pay scales. Many respondents report tremendous difficulty in maintaining employment due to their health conditions. The surveyed nurses also reported difficulty finding work where employers are willing to accommodate their disabilities.

As a result of their compromised health status, a majority of respondents report that they are financially challenged. Sixty-four percent of respondents report that their earnings are not enough to support themselves and their families; for 42 percent, earnings are not at all sufficient and for 22 percent, earnings are reported as inadequate. Almost 70 percent report that their current earnings are less than they anticipated their salaries would be as registered nurses.

According to the conclusion of the report, "In summary, from the responses reported here for these nurses, the effects of exposure to poor indoor air quality has had a lasting negative impact on their health and well being." ■

Health & Safety **Contacts**

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

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  ebain@mnarn.org
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  Associate Director, Health & Safety
  781-830-5754
  cpontus@mnarn.org

Brigham & Women's RNs use their experience to help others

As a result of the courage, conviction and activism of a small group of unionized nurses at Brigham & Women's Hospital who were harmed by poor indoor air quality in the late 1980's and early 1990's, today thousands of nurses in Massachusetts, and thousands more across the country are safer.

As the story on this page illustrates, during this time, a large number of Brigham & Women's nurses and other hospital workers began to experience a variety of symptoms and illnesses related to their exposure to poor indoor air quality at the hospital. A group affected by the problem began meeting, researching and organizing around the issue in 1993. It started as a support group to provide mutual aide and comfort, but soon grew into a full blown campaign. Among those participating in the original group, initiated by Kathy McGinn-Cutler, were Kathy Sperrazza, then chair of the MNA local bargaining unit at the Brigham, Denise Garlick, Peggy O'Malley and Marie Manion, all of them co-workers on the units hardest hit by the problems.

The group soon began accessing the support of other nurses in the hospital and in the union, and MNA staff, particularly Roz Feldberg, MNA associate director, who worked with the nurses to address the work environment problems at that time. They began collecting data and doing their own research on what was happening. Later they built their case and began presenting their data to hospital management to confront them with the extent and the severity of the issue.

They also presented their data and obtained opinions from the Massachusetts Coalition for Occupational Safety and Health (MassCOSH), U. S. Department of Labor, OSHA, the Massachusetts Department of Public Health, Occupational Safety and Health Program and the Massachusetts Division of Occupational Safety. Eventually the issue reached the federal government, through Senator Kennedy's office and resulted in an onsite survey by a delegation from the National Institute of Occupational Safety and Health (NIOSH) from the Centers for Disease Control in Atlanta. NIOSH prepared an eighty-page report as they addressed these nurses concern and the exposures in their work environment.

They also took the issue and their experience to the local, state and national media, with their story becoming front-page news, ultimately resulting in the award-winning PBS science program, *Nova,* featuring an entire segment on their story and the issue of poor indoor air quality/multiple chemical sensitivity.

At the same time, the nurses began educating the rest of the nursing community, both in Massachusetts and on the national level. Here in Massachusetts, they mobilized an effort to pass a resolution at the MNA Convention which led to the creation of MNA's Occupational Health and Safety Program, This began a program that has become acknowledged as one of the country's most progressive programs to advocate for health and safety issues of importance to nurses.

These nurse activists and advocates have spoken before medical and nursing groups, they have conducted research and counseled other nurses and other union bargaining units on how to identify, confront and address a variety of health and safety issues in the workplace for nurses. They have testified at state and federal legislative hearings on issues related to (poor) indoor air quality and other unsafe working conditions encountered in the healthcare industry.

"These nurses are true heroes and exemplars for all of us," said Karen Higgins, RN, MNA president. "They took what was a devastating personal situation and transformed it into a campaign to help others so that others wouldn't suffer a similar fate. While many of these nurses can no longer practice nursing, through their advocacy and their conviction, they have become nurses to our profession."

Eventually, with the combination of their courageous tenacity and the interventions of regulatory agencies, the hospital began to make changes and improve the work environment for nurses as well as the other hospital employees. ■

‘Safe lifting’ legislation filed by MNA attempts to reduce injuries to health care workers

A bill entitled “An Act Relating to Safe Patient Handling in Certain Health Facilities,” which would mandate safe lifting practices, was filed by the MNA on Dec. 1 at the Massachusetts Statehouse, for consideration during the coming 2005-2006 legislative session.

The nursing bill was developed by MNA’s Safe Patient Handling Task Force and Congress on Health and Safety. It was patterned after a bill which was passed this year by the California legislature but vetoed by Governor Schwarzenegger.

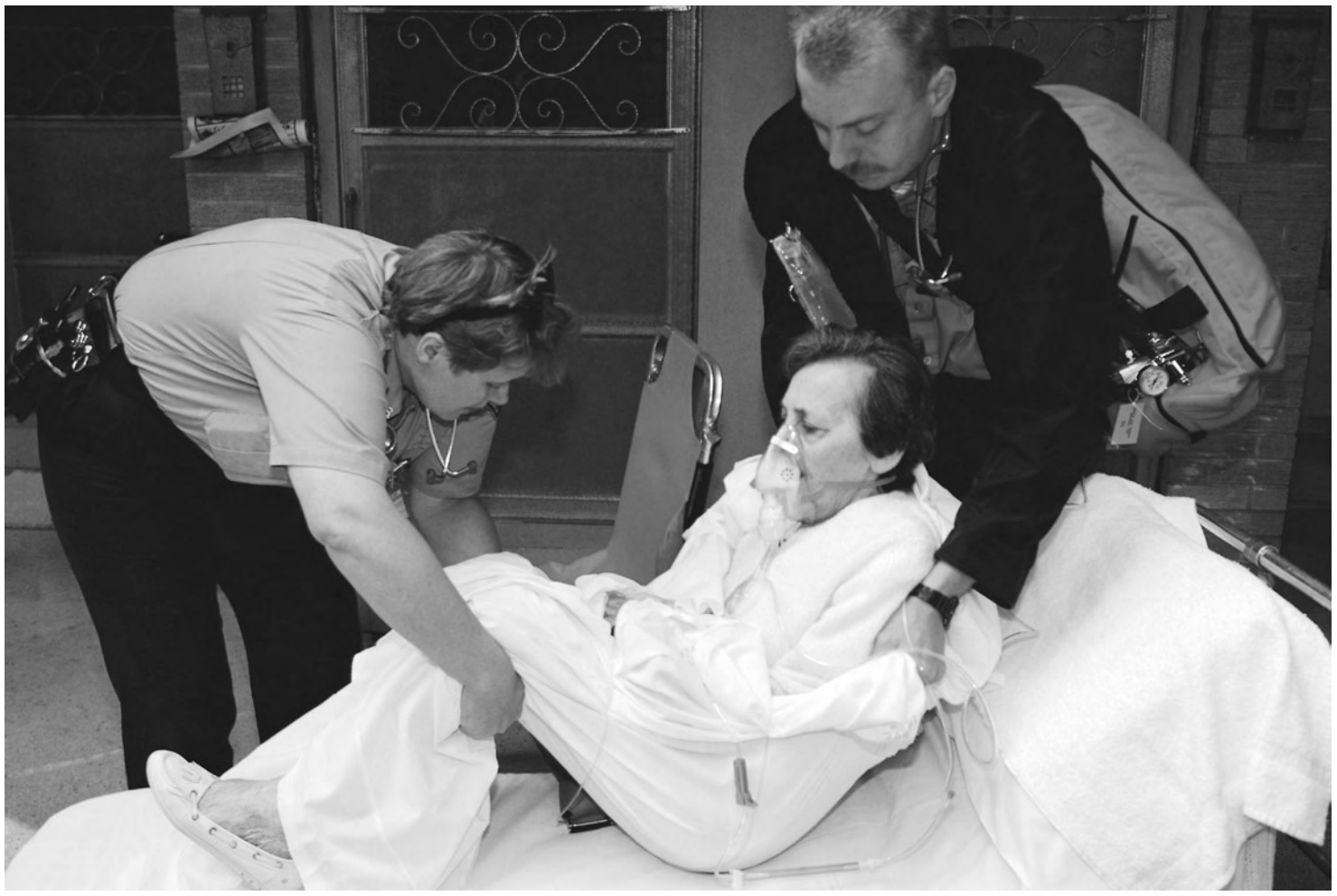
Nurses lead the categories of workers who suffer back injuries, according to statistics kept by the Bureau of Labor Statistics. Estimates of the incidence of back injuries involving lost work days are 181.6 per 10,000 full-time workers in nursing homes and 90.1 per 10,000 full-time workers in hospitals.

The incidence rate of musculo-skeletal disorders was estimated by the Bureau of Labor Statistics in 2002 to be 8.8 per 100 staff in hospital settings and 13.5 per 100 in nursing home settings.

The MNA legislation is written to be broadly inclusive of inpatient, private and public sector acute care hospitals, rehabilitation and psychiatric facilities and nursing homes (long-term care facilities). It would not address outpatient or home care needs at this time.

The act calls for facilities to develop and implement a health care worker back injury prevention plan so that manual lifting of patients is minimized in all cases and eliminated when feasible. Each health care facility will be required to conduct a needs assessment in relation to patient lifts and transfers. As part of the needs assessment, facilities will need to develop a lifting and transferring process that identifies the patients and situations that require the appropriate use of lift teams and or lifting devices and equipment, incorporated into an overall program to recognize occupational health and safety hazards and prevent injuries. The facilities’ “safe patient handling policy” will be required to apply to all shifts, and facilities will be required to provide ongoing training to health care workers on appropriate use of the lifting devices and equipment. The training will need to be provided by qualified personnel and include body mechanics and the use of lifting devices to safely handle patients.

For more information, contact Christine Pontus (x754) or Mary Crotty (x743) at MNA, 781-821-4625. ■



For more information

- The Department of Veterans Affairs Patient Safety Center site: http://patientsafetycenter.com/
- MNA information on using patient handling equipment to reduce injuries: www.massnurses.org/health/articles/osha3.htm

Occupation	Number *(In thousands)*	Median days away from work
Total musculoskeletal disorders	592.5	7
Registered nurses, nursing aides, orderlies, and attendants	**61.5**	**5**
Truck drivers	43.9	10
Laborers, non-construction	36.6	6
Assemblers	19.7	10
Janitors and cleaners	14.0	5
Stock handlers and baggers	11.3	5
Construction laborers	10.8	7
Cashiers	10.0	5
Carpenters	9.3	7

Source: www.spineuniverse.com/displayarticle.php/article1509.html

Number of work-related musculoskeletal disorders involving time away from work and median days away from work by occupation, Bureau of Labor Statistics, 1998.

MNA partners with UMass Lowell in grant to protect home health care practitioners

The National Institute for Occupational Safety and Health (NIOSH) has awarded the University of Massachusetts Lowell a four-year $2 million grant for prevention of needlestick injuries and blood exposures among home health care practitioners. UMass Lowell will form a partnership with industry, the MNA and other labor organizations and with state government to improve the working lives of those practitioners throughout eastern and central Massachusetts.

According to the Centers for Disease Control (CDC), 600,000 to 800,000 injuries occur annually nationwide in all health care settings from needles and other sharp devices, potentially leading to hepatitis and HIV infection. Most prevention efforts have been focused on hospitals, and little attention has been given to the rapidly growing home health care industry, which is predicted to increase 68 percent within the next decade. In 2000, there were 20,655 home health care practitioners employed in Massachusetts and that number is expected to nearly double by 2008, according to First Research.

NIOSH awarded the grant to the newly established School of Health and Environment at UMass Lowell. Under the leadership of Professor Margaret Quinn in the Department of Work Environment, the research will identify working conditions which put home health care practitioners at risk of injuries like needlesticks, work with the partners to set up efficient systems for tracking and analyzing injury patterns, and design ways to help home health care providers work safely while continuing to deliver the best quality care. The new study is named Project SHARRP— Safe Homecare and Risk Reduction for Providers.

"By forming diverse partnerships within our community and by combining scientific research with education, we'll be able to help the growing population of home health care providers lead safer, healthier and more productive lives,” said Dr. Quinn.

Other members of the research team include Dr. Stephanie Chalupka of the department of nursing, Dr. David Kriebel of the department of work environment and Dr. Letitia Davis, director of the occupational health surveillance program at the Massachusetts Department of Public Health.

Project SHARRP is a collaborative effort with five leading home health care agencies and labor unions: VNA Care Network, which operates within 200 communities in the region; the UMass Memorial Home Health and Hospice in Worcester; Winchester Home Care; the MNA and the Service Employees International Union Local 2020.

"This grant perfectly reflects the mission of our new School of Health and Environment," said Dr. David H. Wegman, dean of UML School of Health and Environment. "We'll be able to advance safety and quality of work life in the fast-growing home health care industry, thus helping to reduce the shortage of these professionals."

"At UMass Lowell, we want to help the economy thrive, not just by adding jobs, but by making sure they are jobs people want to have," said Provost John Wooding. "That's what a sustainable economic future is all about," he added. ■

Position descriptions for MNA elected offices

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

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

Board of Directors

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

Meets 10 times per year, usually a full day meeting held on the third Thursday of the month. Board members are expected to attend the annual business meeting held during the MNA Convention in the fall.

Center for Nursing Ethics

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

Congress on Health and Safety

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

Congress on Health Policy and Legislation

The Congress on Health Policy and Legislation develops ideas and policies for the implementation of a program of governmental affairs appropriate to the MNA's involvement in legislative and regulatory matters influencing nursing practice, health and safety, issues, labor issues and health care in the commonwealth. The Congress sponsors educational programs, including two lobby day events at the state house, which are designed to enhance members' political savvy. Participation includes task force involvement, development of educational programs and review of state legislation that is health care related. Meets eight to 10 times per year at MNA or MNA's Region 2 office in West Boylston for two to three hours.

Congress on Nursing Practice

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

Bylaws Committee

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

Nominations & Elections Committee

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

MNA incumbent office holders for 2005

President
Karen Higgins (2003-05)**

Vice President
Patricia Healey (2004-06)*

Secretary
Sandy Eaton (2003-05)**

Treasurer
Nora Watts (2004-06)*

Directors (2 from each Region, Labor seat
Region 1
Diane Michael (2004-06)*
Irene Patch (2003-05)*
Region 2
Mary Marengo (2004-06)
Patricia Mayo (2003-05)*
Region 3
Vacancy
Tina Russell (2003-05)**
Region 4
Vacancy
Vacancy
Region 5
Vacancy
Connie Hunter (2003-05)*

At-Large Directors (Labor seat)
Sandy Ellis (2004-06)*
Denise Garlick (2002-04)
Nancy Gilman (2004-06)*
Elizabeth Sparks (2003-05)*
Barbara Cooke (2003-05)*
Beth Piknick (2003-05)**
Barbara Norton (2003-05)*

At-Large Directors (General seat)
Joanne Hill (2004-06)
Donna Kelly Williams (2004-06)
Richard Lambos (2003-05)**
James Moura (2003-05)**
Sharon McCullum (2004-06)
Rosemary O'Brien (2004-06)
Jeannine Williams (2001-2003-05)**)*

Labor Program Member (Non-RN, health care professional
Beth Gray-Nix (2003-05)**

Nominations & Elections Committee
Stephanie Stevens (2004-06)

Bylaws Committee
Kathryn F. Zalis (1999-2001)
Elizabeth Kennedy (2002-04)
Margaret Sparks (2000-02)
Jane Connelly (2003-05)**
Sandra LeBlanc (2001-05)**

Center for Nursing Ethics & Human Rights
Ellen Farley (2004-06)
Lolita Roland
Anne Schuler
Kelly Shankley (2004-06)

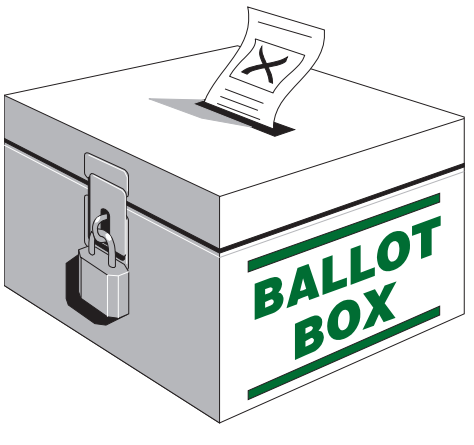
Congress on Health Policy & Legislation
Donna Dudik (2004-06)
Marilyn Crawford (2004-06)**
Sandra Hottin (2002-04)*

Congress on Nursing Practice
Mary Amsler (2001-2004)
Karen Carpenter (2004-2006)
Marianne Chisholm (2004-2006)
Ellen Deering (2004-2006)
Stephanie Holland (2004-2006)
Marion Morgan (2004-2006)
Anne Mullen (2004–2006)
Marian Nudelman (2004-2006)
Paula Whynot (2004-2006)
Margaret Wiley (2002-2004)
Linda Winslow (2004-2006)

Congress on Health & Safety
Terri Arthur (2004-2006)
Mary Bellistri (2003-2005)**
Janet Butler (2004-2006)
Michael D'Intinosanto (2003-2005)*
Mary Ann Dillon (2004-2006)
Sandra LeBlanc (2004-2006)
Gail Lenehan (2003-2005)*
Liz O'Connor (2003-2005)*
Janet Reeves (2003-2005)*
Kathleen Sperrazza (2004-2006)

** Incumbent office holder*
***Unable to run for this office another term*

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



Consent to Serve for the MNA 2005 Election

I am interested in active participation in the Massachusetts Nurses Association

MNA General Election

- ❑ President, General* (1 for 2 years)
- ❑ Secretary, General (1 for 2 years)
- ❑ Director, Labor* (5 for two years) [1 per Region]
- ❑ Director At-Large, General (3 for 2 years)
- ❑ Director At-Large, Labor (4 for 2 years)
- ❑ Labor Program Member* (1 for 2 years)
- ❑ Nominations Committee, (5 for 2 years) [1 per region]
- ❑ Bylaws Committee (5 for 2 years) [1 per region]
- ❑ Congress on Nursing Practice (6 for 2 years)
- ❑ Congress on Health Policy (6 for 2 years)
- ❑ Congress on Health & Safety (6 for 2 years)
- ❑ Center for Nursing Ethics & Human Rights (2 for 2 years)

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

Please type or print — Do not abbreviate

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

Work Title _____ Employer _____

MNA Membership Number _____ MNA Region _____

Address _____

Cfty _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Educational Preparation

School	Degree	Year

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

MNA Offices	Regional Council Offices

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

MNA Offices	Regional Council Offices

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

Signature of Member

Signature of Nominator (leave blank if self-nomination)

Postmarked Deadline: Preliminary Ballot: March 31, 2005
Final Ballot: June 15, 2005

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

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

Summit on health care access

MNA was in the audience at a forum at the JFK Library on providing healthcare for Massachusetts's uninsured. The purpose of the forum, "Roadmap to Coverage: A Summit on Access," was to unveil a report on the cost of caring for the uninsured in Massachusetts, completed recently by a group of researchers at The Urban Institute for the Blue Cross Foundation.

According to the report, Massachusetts healthcare care providers last year spent $1.1 billion to provide medical services to the state's uninsured residents. The research was presented as the first step toward the Blue Cross Foundation's "primary goal," which they report is to develop by spring of 2005 a plan that would provide health coverage to the state's 450,000-500,000 uninsured residents.

The report projects that if covered by health insurance, currently uninsured state residents would use more preventive care services and undergo more medical tests, which would increase medical spending from $2,318 to $3,152 per person, totaling $539 million in additional health care spending for Massachusetts taxpayers. However, that additional spending would increase health care's share of the state economy by less than 1 percentage point. Currently, Massachusetts ranks 47th of the 50 states in taxes and fees paid as a percentage of personal income. Most of all, increasing access for the uninsured would reap three times its cost in social and economic benefits -- up to $1.7 billion, from generating a healthier, more productive population.

Some 300 healthcare and insurance industry representatives attended the presentation, along with legislators including state Senator Therese Murray, chair of the Senate Ways and Means Committee and Senate President Robert Travaglini.

Look for more to come in the next legislative session. Also turn to Page 2 for a discussion of the "single payer" solution to the problem supported by MNA. ■

Support for RNs involved in an adverse medical event

Are you a nurse who has been impacted emotionally by an experience associated with an adverse medical outcome?

The MNA has formed an alliance with Medically Induced Trauma Support Services (MITSS), Inc., a non-profit organization that supports, educates, trains and offers assistance to individuals affected by medically induced trauma.

The MNA/MTTS program is based on the belief that nurses have a professional responsibility to support colleagues who have been affected by unexplained medical outcomes or adverse patient events. MNA/MITSS provides early support to affected nurses to lesson the emotional effects of these traumatic events.

MITSS offers one-on-one interaction via telephone with a therapist, peer led or structured support groups led be a professional facilitator, as well as training to fellow survivors who like to help others.

MNA/MITSS services are available to any RN in Massachusetts. For assistance or more information, call the MNA/MITSS referal line at 800-882-2056, x770; or MITSS directly at 888-36MITSS. You can also visit the web site at www.mitss.org. ■


Peggy O'Malley


Sandy Eaton


A. Eldridge Malone


Julie Pinkham

10,000 nurses for a constitutional right to affordable health care

We're sponsors of the Health Care for Massachusetts Campaign—a citizen-led initiative to create a constitutional right to affordable, comprehensive health and mental health care for every Massachusetts resident. And we're hoping you'll join us in transforming our health care system.

We've endorsed, the MNA has endorsed, 71,385 voters have endorsed, 52 legislators have co-sponsored and 153 legislators voted for the Amendment in the July 14 Constitutional Convention. ***We're half-way to putting this historic amendment on the ballot in 2006.***

We're looking for 10,000 nurses to join us so when we go to the Legislature next session to lobby for the critical second vote we need to put the amendment on the ballot every legislator will know—in no uncertain terms—how important universal health care is to the nurses of Massachusetts.

Join the 10,000 nurse campaign. Endorse yourself and sign up 19 of your co-workers. Then fax it back to the Campaign at 617-868-1363. It just takes a few minutes

Thanks so very, very much.

Name **City/Town**

Senior Nursing Students

The Real Nursing World: Transition from Student to RN

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

March 31, 2005 ♦ 5:30 - 9:30 p.m..
Springfield Marriott, Springfield

April 5, 2005 ♦ 5:30 - 9:30 p.m
Crowne Plaza Hotel, Worcester

April 7, 2005 ♦ 5:30 - 9:30 p.m.
Lombardo's Function Facility, Randolph

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

THE REAL NURSING WORLD – TRANSITION FROM STUDENT TO RN

- ❒ **March 31, 2005 – Springfield Marriott, Springfield**
- ❒ **April 5, 2005 – Crowne Plaza Hotel, Worcester**
- ❒ **April 7, 2005 – Lombardo's Function Facility, Randolph**

Name _____

Permanent Home Address _____

City _____

State _____

Zip _____

Home Telephone: ( ) _____

Email _____

I am a senior nursing student at _____

My graduation date will be: _____

My degree will be: _____

Return completed registration form by March 25 to: Massachusetts Nurses Association, Attn: Nursing Department, 340 Turnpike Street, Canton, MA 02021
To email your registration, include the information requested above and send to: tyannetty@mnarn.org

Save the date!

The **PHASE In Healthcare Project** at UMass Lowell presents its third annual occupational health and safety conference:

Worker Health and Safety in Healthcare:
Learning from the Past, Best Practices for the Future

The conference will be held on **Thursday, April 28, 2005**, from 8:00 AM – 5:30 PM at the BU Corporate Education Center in Tyngsboro, MA.

The conference will feature panels on health and safety programs and on workplace ergonomics. You will hear about study results from the Promoting Healthy And Safe Employment (PHASE) in Healthcare research project, a five year study supported by the National Institute for Occupational Safety and Health. You will also learn about best practices in these areas.

Interactive breakout sessions on violence in the workplace, needle stick injuries, stress, return to work after an injury, OSHA standards for long term care facilities, occupational asthma, and diversity support for employees will round out the day.

Healthcare managers and supervisors, workers, union members, advocates, students, faculty and others interested in healthcare are encouraged to attend. This will be an enlightening event with many opportunities for networking!

UMass Lowell will offer continuing education credits for nurses and other healthcare professionals for attendance at this conference.

For more information call Petra Miesmaa at 978-934-4428, Petra_Miesmaa@uml.edu, or go to **www.uml.edu/phase** and click on "conferences".

We look forward to seeing you there!

This conference is co-sponsored by:
MNA
Massachusetts Nurses Association

Additional sponsors:
Saints Memorial Medical Center • Elizabeth Seton Residence • Life Care Center of Nashoba Valley

This event is supported by a grant from the National Institute for Occupational Safety and Health (NIOSH) Grant #R01-OH07381-05, "Health Disparities Among Healthcare Workers."

MNA Peer Assistance Program

Help for Nurses with Substance Abuse Problems

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

Call the MNA Peer Assistance Program

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

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

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

Boston Metropolitan Area

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

Central Massachusetts

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

Northern Massachusetts

- Baldpate Hospital, Bungalow 1, Baldpate Road, Georgetown. Facilitator: Teri Gouin, 978-352-2131, x15. Meets: Tuesdays, 5–6 p.m.
- Nurses Recovery Group, Center for Addiction Behavior, 27 Salem Street, Salem. Contact: Jacqueline Lyons, 978-697-2733. Meets: Mondays, 6–7 p.m.
- Partnership Recovery Services, 121 Myrtle Street, Melrose. Contact: Jay O'Neil, 781-979-0262. Meets: Sundays 6:30–7:30 p.m.

Western Massachusetts

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

Southern Massachusetts

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

Other Areas

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

MNA Continuing Education Courses

Winter 2004/Spring 2005

Emergency Medical Response to Hazardous Materials and Acts of Terrorism

Description The Massachusetts Emergency Management Agency (MEMA) is sponsoring this program on emergency medical services in response to hazardous materials and acts of terrorism. The program is specifically designed for physicians, nurses, EMTs, and hospital support staff to provide education in the treatment of individuals exposed to chemical and biological agents. The program will include identification of hazardous materials, toxicological and biological effects of chemicals and biological acts of terrorism. The chemical profile of common agents, decontamination procedures and personal protective equipment will be discussed. CDC guidelines for surveillance of exposed nurses and other health care workers and nursing interventions for patient care will be identified. Class size is limited to 25 participants per session. Please reserve your space early.
Speakers Anthony Fucaloro, EMT
Capt. Lawrence P. Ferazani
Christine Pontus, MS, RN, COHN-S
Dates Feb. 15, 2005
Time 9 a.m. – 5 p.m. *(Lunch provided)*
Place MNA Headquarters, Canton
Fee MNA members, $45; all others, $65
Contact hours* 6.9
Special notes Class limited to 25.
MNA contact Susan Clish, 781-830-5723 or 800-882-2056, x723

Oncology for Nurses

Description This program will increase knowledge in oncology nursing. The content of the program will include an overview of cancer management, tumor physiology and staging, relevant laboratory testing and treatment strategies and safe handling of neoplastic agents. Chemotherapy administration, classification of chemotherapeutic agents, management of toxicities and adverse effects of treatments and oncological emergencies will be discussed. The program will conclude with pain and symptom management, palliative care and an overview of hospice care.
Speaker Marylou Gregory-Lee, MSN, RNCS, OCN, Adult Nurse Practitioner
Date March 9, 2005
Time 8:30 a.m. – 4 p.m. *(Lunch provided)*
Place MNA Headquarters, Canton
Fee MNA members, $125; all others, $150
Contact Hours* 7.2
MNA Contact Theresa Yannetty, 781-830-5727 or 800-882-2056, x727

Basic Dysrhythmia Interpretation

Description This course is designed for registered nurses in acute, sub-acute and long-term care settings to learn cardiac monitoring and dysrhythmia interpretation. Implications and clinical management of cardiac dysrhythmias will also be discussed. Course will include a text book and will require study between sessions one and two
Speaker Carol Mallia, RN, MSN
Date March 15 and 22, 2005
Time 5:00 p.m. – 9:00 p.m. *(light supper provided)*
Place MNA Headquarters, Canton
Fee MNA members $90; all others $125
Contact Hours * 9.0
MNA Contact Theresa Yannetty, 781-830-5727 or 800-882-8056, x727

Diabetes 2005: What Nurses Need to Know

Description This program will discuss the pathophysiology and classification of Diabetes Type 1 and 2. Nursing implications of blood glucose monitoring and non-pharmacological interventions such as exercise and meal planning will be addressed. Oral pharmacological agents and a comprehensive update on insulin therapy will be presented. Nursing management of the newly diagnosed diabetic patient, both complicated and not, will be explored. Nursing management of the daibetic patient in the pre/post operative, ambulatory care, home care and school setting will be discussed.
Speaker Ann Miller, MS, RN, CS, CDE
Date April 14, 2005
Time 8:30 a.m. - 4 p.m. *(Lunch provided)*
Place MNA Headquarters, Canton
Fee MNA members $125; all others $150
Contact Hours * 7.2
MNA Contact Liz Chmielinski, 781-830-5719 or 800-882-2056, x719

The Real Nursing World—Transition from Student to RN

Description Don't miss one of these unique programs offering you an opportunity to address questions or concerns to a panel comprised of recent graduates from various schools of nursing and experienced nurses with knowledge in nursing education, nursing administration, labor relations, political action and career counseling. Area hospitals and other health care facilities will be available before and after the program to discuss employment opportunities.
Facilitator Carol Mallia, RN, MSN
Panel TBA
Date March 31, 2005: Marriot, Springfield
April 5, 2005: Crowne Plaza, Worcester
April 7, 2005: Lombardos, Randolph
Time 5:30 p.m. – 9:30 p.m. *(light supper provided)*
Place (see above)
Fee Free to senior nursing students and faculty
MNA Contact Theresa Yannetty, 781-830-5727 or 800-882-8056, x727

Advanced Cardiac Life Support (ACLS)

Description This American Heart Association course will provide information on the clinical management of cardiac and respiratory emergencies through case study approach. Course content includes assessment, arrhythmia recognition, intubation, defibrillation and pharmacological interventions. This is a two-day certification class and a one-day recertification class. Recertification candidates must present a copy of their current ACLS card at the time of registration
Speaker Carol Mallia, RN, MSN
Other instructors for clinical sessions
Date April 26 , 2005 and May 3, 2005
Time 9 a.m. – 5 p.m. *(light lunch provided)*
Place MNA Headquarters, Canton
Fee Certification: MNA members $155; all others $195 others
Recertification: MNA members $125; all others $165
Contact Hours * 16 for certification only
MNA Contact Liz Chmielinski, 781-830-5719 or 800-882-2056, x719

Cardiac and Pulmonary Emergencies

Description This program is designed for registered nurses in acute, sub-acute and long-term care settings to learn the clinical management of cardiac and respiratory emergencies. Clinical management of chest pain, brief EKG interpretation and ABG interpretation will be covered. Clinical management of respiratory distress will also be discussed.
Speaker Carol Mallia, RN, MSN
Date June 7, 2005
Time 5–9 p.m *(light supper provided)*
Place MNA Headquarters, Canton
Fee MNA members $45; all others $65
Contact Hours * 3.6
MNA Contact Theresa Yannetty, 781-830-5727 or 800-882-8056, x727

Cardiac and Pulmonary Pharmacology

Description This program will provide nurses from all clinical practice settings with a better understanding of how cardiac and pulmonary medications work. The actions, indications and nursing considerations will be discussed for the major categories of cardiac and pulmonary medications.
Speaker Carol Mallia, RN, MSN
Date June 21, 2005
Time 5–9 p.m. (light supper provided)
Place MNA Headquarters, Canton
Fee MNA members $45; all others $65
Contact Hours* 3.6
MNA Contact Liz Chmielinski, 781-830-5719 or 800-882-8056, x719

Course Registration Information:

See next page

Continuing Ed Course Information

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

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

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

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

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

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

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

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

MNA membership dues deductibility 2004

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

Region	Amount	Percent
Region 1	$16.63	5.0%
Region 2	$16.63	5.0%
Region 3	$16.63	5.0%
Region 4	$16.63	5.0%
Region 5	$16.63	5.0%

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

More exciting MNA group trips to Italy in 2005!

Reserve Early • Space is Limited

May 5 to 12, 2005: Rome, Italy $1,269*

An eight day, six night city-stay tour to Rome that includes round trip air from Boston; transfers to and from the hotel; and a substantial buffet breakfast daily. You will stay at a four-star hotel in Rome for six nights, with a "welcome dinner" scheduled for the first evening and a full-day panoramic sightseeing tour during your first full day in Rome. For the rest of the week you are free to tour this spectacular city and all it has to offer. Optional excursions can also be arranged. This trip is sure to fill quickly, so reserve soon.

Nov. 12 to 20, 2005: Italian Riviera, $1599 (by credit card) and $1569*

Join this wonderful nine-day, seven-night tour to the beautiful Province of Liguria, which is nestled along the Italian Riviera (north of Florence and south of Milan). You will enjoy a seven-night stay in a first-class hotel overlooking the azure Gulf of Spezia. The tour includes an extensive daily sightseeing program with three meals every day. During this vacation we will visit Portovenere, Genoa, Portofino, Cinque Terre, Carrara, Pisa, Sarzana, Pontremoli, Lerici, San Terenzo and Vernazza. The area's mild climate permits visits to these places all year long and our itinerary features short daily excursions throughout the magnificent countryside and along the beautiful coastal region. Don't miss this grand tour of the picturesque Riveria region.

To receive more information and a flyer on these great vacations, contact Carol Mallia at 781-830-5744 or via e-mail at cmallia@mnarn.org

** Prices listed are per person, double occupancy based on check purchase. Applicable departure taxes are not included in the listed prices above.*

MNA Member Benefits Save You Money

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Ellen Kaplan, Group Health Specialists.....800-604-3303 or 508-875-3288
Managed care & comprehensive indemnity plans through Blue Cross/Blue Shield as well as other carriers.

Professional Liability Insurance
Nurses Service Organization ..... 800-247-1500 (8:00 a.m. to 6:00 p.m.)
Leading provider of professional liability insurance for nursing professionals with over 800,000 health care professionals insured.

Credit Card Program
MBNA America..... 800-847-7378
Exceptional credit card at a competitive rate.

Term Life Insurance
Lead Brokerage Group..... 800-842-0804
Term life insurance offered at special cost discounts.

Long Term Care Insurance
William Clifford.....800-878-9921, x110
Flexible and comprehensive long-term care insurance at discount rates.

Short Term Disability Insurance
ISI New England Insurance Specialist llc .....800-959-9931 or 617-242-0909
Six-month disability protection program for non-occupational illnesses & accidents.

Long Term Disability Insurance
Lead Brokerage Group..... 800-842-0804
Provides income when you are unable to work due to an illness or injury.

Retirement Program
American General Financial Group/VALIC..... 800-448-2542
Specializing in providing retirement programs including 403(b), 401(k), IRA, NQDA, Mutual Funds, etc.

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Discounts on mortgage applications for home purchase, refinance and debt consolidation. Inquire about no points, no closing costs program and reduced documentation programs. Receive free mortgage pre-approvals.

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Marriam Tax Recovery..... 508-340-0240
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Products & Services

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Mansfield: Colonial Insurance Services .....800-571-7773 or 508-339-3047
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Boston: Robert S. Clark Insurance Agency..... 800-660-0168
Lowell: James L. Cooney Insurance Agency 978-459-0505
Woburn: Lennon Insurance Agency 781-937-0050
Falmouth & Pocasset: Murray & MacDonald Insurance Services..... 800-800-8990
Turners Falls: Partridge Zchau Insurance Agency..... 413-863-4331
Save up to 6 percent on Massachusetts auto rates; 12 percent account credit for homeowners when we write your auto policy.

Cellular Telephone Service
Cingular Wireless..... 800-894-5500
Save 10–20 percent on SuperHome rate plans with no activation fee plus 20 percent discount on accessories. Some discount plans include free nights (9 p.m. to 7 a.m.) and weekends.
T-Mobile..... 508-369-2200
MNA members receive free phone with activation, free nationwide long distance & roaming and free nights & weekends (on specific plans). No activation fee for MNA members.
Verizon Wireless..... 617-571-4626
Receive an 8 percent discount on plans priced $34.99 and above! Receive a free Motorola V60s on any new purchase or upgrade.
Nextel Communications, Don Lynch 800-313-2700
Enjoy free incoming call plans and direct connect. Save 10 percent on rates and 30 percent on equipment. Many phones to choose from, including the new 1830 and the new Blackberry 7510.

Discount Dental & Eyewear Program
Creative Solutions Group..... 800-308-0374
Best benefits—a health care savings plan that cuts the cost of health care expenses. Discounts on dental, eyecare and chiropractic expenses.

Jiffy Lube Discount
MNA Membership Department 800-882-2056, x726
Obtain an MNA Discount card to receive 15% discount on automobile products & services.

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

Discount Electronics & Appliances
Home Entertainment Distributors.....800-232-0872 or 781-828-4555
Home electronics & appliances available at discount prices for MNA members.

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Oil Buying Network 800-649-7473
Lower your home heating oil costs by 10 – 15%.

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

Sight Care Vision Savings Plan
MNA Membership Department 800-882-2056, x726
Obtain your Sight Care ID card to receive discounts on eye exams, eyeglasses & contact lenses at Cambridge Eye Doctors or Vision World locations.

Health Care Apparel
Work 'n Gear Discount.....800-WORKNGEAR (for store locations)
Receive 15% discount off all regularly priced merchandise. Simply present your valid MNA membership card at any Massachusetts Work 'n Gear store to pick up your discount card.

Travel & Leisure

Hertz Car Rental Discount
Hertz..... 800-654-2200
MNA members discounts range from 5 – 20% mention MNA discount CDP#1281147.

Discount Movie Passes
MNA Membership Department 800-882-2056, x726
Showcase Cinemas/National Amusements, $6. AMC Theatres, $5.50. Regal Cinemas (not valid first 12 days of new release), $5.50. Call to order by phone with Mastercard or Visa.

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

Central Florida Area Attractions
The Official Ticket Center 877-406-4836
Discount admission to Orlando area attractions.

Anheuser-Busch Adventure Parks Discount
MNA Membership Department 800-882-2056, x726
Obtain Adventure Card to receive discount admission to Busch Gardens, Sea World, Sesame Place, Water Country USA & Adventure Island in Tampa, Fla.

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

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

9th annual golf tournament a big success

The Massachusetts Nurses Foundation—a non-profit organization whose mission is to support scholarship and research in nursing—held its ninth annual golf tournament on June 24 and was successful in raising over $19,600 for its scholarship programs.

More than 100 participants enjoyed the 18-hole Florida scramble style tournament at the Brookmeadow County Club in Canton. The day's events included an exciting $10,000 winner-take-all putting event and a buffet-style awards luncheon where tournament prizes and awards were presented.

The MNF thanks all of its sponsors, players and volunteers for helping to make this year's tournament a success, including MNA Regional Council 2 and 3. A special thank you to Regional Council 5 for generously contributing $10,000 to help the MNF meet its fundraising goal.

Other generous supporters of this year's tournament included Frontier Capital Management, Harbor One Credit Union, McDonald & Associates, N.E. Insurance Specialists, N.E. Regional Council of Carpenters, Plumbers Union Local 12, Renovation Services, Inc. and Colonial Insurance.

From left: Terry Donahue, RN; Evie Bain, RN, MNA associate director occupational health & safety; Kathy Scanlon, RN; and Liz O'Connor, RN

From left, Alan McDonald, Rosemary Smith, director of membership; Warren Smith; Joe Twarog, MNA educator

Betty Sparks, RN, MNA board member and her family

How can you make a difference in the future of nursing? It's easy –

As a member of the MNA, it's easy to make a contribution to the ***Massachusetts Nurses Foundation*** (MNF) & help nurses study clinical issues essential to the improvement of health care. Your help is as easy as –

Write a check

Through your tax-deductible donation, you can make a difference in what the foundation can do! Funds are directed toward nursing scholarships & research. Any donation big or small helps us make a difference!

Are you renewing your MNA membership? You can make a donation at the time of renewal by simply completing the MNF donor form and including your donation with your dues payment to the MNA.

Donate honorariums or travel reimbursements

Have you received an honorarium for a speaking engagement? Consider donating your honorarium to the Foundation. Are you currently serving on an MNA Congress, Committee or Task Force? Consider donating your travel reimbursement – simply check off the MNF box on your MNA travel reimbursement form & the amount of your travel reimbursement will be donated directly to the MNF!

Memorial gifts

A donation can be made in memory of family members, friends & associates or to acknowledge a special event. An acknowledgement will be made to the family of the person being honored.

Planned giving

As you consider your tax planning – we hope you will consider making a tax-deductible donation to the MNF through wills, endowments or legacies.

Participate in MNF fundraising events

Whether it's the MNF Auction, Raffles or Golf Tournament– your participation in MNF fundraising events helps us raise funds to support nursing scholarships & research. Watch for announcements of upcoming fundraising events – your support is always appreciated.

MNF ►Scholarship ►Research ►Education
Massachusetts Nurses Foundation, Inc.

For more information …

Our mission is accomplished only through donations. You can make a difference in the future of nursing – your gift provides the meaningful difference in what the foundation can do! For more information about the MNF or any of our giving programs, please contact us at (781) 830-5745.

Scholarship funding available through the Massachusetts Nurses Foundation

Printable applications are available at www.massnurses.org

Deadline: June 1, 2005

For further information or to request an application, call the MNF voice mail at 781-830-5745 and leave your name (and please spell your name), address and name of the scholarship application you would like mailed to you. ■

Ryan

Driscoll-Ryan

Correction: In last month's issue of *Massachusetts Nurse,* two photos were switched in the story of the annual MNA award and scholarship winners. Paula Ryan, recipient of the Elaine Cooney Labor Relations Award, is shown left, while Denise Driscoll-Ryan, winner of the Regional Council 4 Scholarship, is pictured on the right.

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

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

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Attention Nursing School Faculty Need a Speaker for Your Class?

Call the MNA Speakers Bureau

The Massachusetts Nurses Association has created a speaker's bureau comprised of MNA staff to assist nursing school faculty in their efforts to bring important and topical information on a variety of subjects to their students. Below is a listing of topics and speakers available free of charge to come to your class.

- **Safe Staffing Saves Lives—The Case for RN-to-Patient Ratio Legislation**
  An analysis of the causes and impact of the current staffing crisis in Massachusetts on nurses and patients, review of research to support legislation, detailed explanation of the current safe staffing bill with a discussion of its benefits to the profession and patient care.
  Presented by Charles Stefanini, MNA Director of Legislation and Governmental Affairs
  Contact: cstafanini@mnarn.org; 781-830-5716

- **The Politics of Nursing—The Role of Political Action in Protecting Nursing Practice**
  A review of the impact of politics and government regulation on nursing practice and health care with an emphasis on how nurses can and should use the political process to protect their profession and improve care for their patients
  Presented by Charles Stefanini, MNA Director of Legislation and Governmental Affairs
  Contact: cstafanini@mnarn.org; 781-830-5716

- **No Time for Silence—Using Public Opinion to Protect Nursing Practice**
  A program promoting the need for nurses to be more visible and vocal in the media, in their communities and other forums to help shape public opinion to protect issues important to the profession. Includes a rationale for action, specific communications strategies and case histories.
  Presented by David Schildmeier, MNA Director of Public Communications
  Contact: dschildmeier@mnarn.org; 781-830-5717

- **Medication Errors: Focus on Prevention**
  This program describes the complexity of the medication system in acute care facilities. It utilizes the information from the Mass. Coalition for the Prevention of Medical Errors, the Institute of Medicine Report, "To Err is Human" and the JCAHO Medication Management standards for 2004. It is designed to assess and review medication administration systems to improve their safety.
  Presented by Dorothy McCabe, MNA Director of Nursing
  Contact: dmccabe@mnarn.org; 781-830-5714

- **A Primer on Accepting, Rejecting and Delegating a Patient Assignment**
  This program provides a framework for decision making based on the Nurse Practice Act and other regulatory agencies to safeguard nursing practice and patient care. Case situations are discussed utilizing algorithms of delegation and Accepting/Rejecting an assignment.
  Presented by Dorothy McCabe, MNA Director of Nursing
  Contact: dmccabe@mnarn.org; 781-830-5714

- **Obtaining Your First Position: A Primer**
  A program for senior nursing students to provide practical information on how to secure their first position in the field, including job search, resume preparation and interviewing tips.
  Presented by Dorothy McCabe, MNA Director of Nursing
  Contact: dmccabe@mnarn.org; 781-830-5714

- **Forensic Nursing for Sexual Assault and the Care of the Sexual Assault Patient**
  A discussion on Sexual Assault and the prevalence of assault across the lifespan, options for medical care, forensic medical examinations, prophylaxis, and counseling resources that are available to survivors of sexual assault.
  Presented by Mary Sue Howlett, RN, Training Coordinator, SANE Program
  Contact: mslhsane@comcast.net; 978-687-4262

- **The Role of the Mass. BORN and Its Relationship to Your Practice**
  A program covering the BORN'S regulatory authority in the state, rules and regulations governing the practice of nursing, the BORN disciplinary process, and the need for nurses to maintain professional liability insurance.
  Presented by Mary Crotty, RN, MNA Associate Director/Nursing Research
  Contact: mcrotty@mnarn.org; 781-830-5743

- **The MNA—Who We Are and What We Do**
  A program describing the role, mission, organization and activities of the MNA, with a review of key issues and accomplishments of the organization.
  Presented by David Schildmeier, MNA Director of Public Communications
  Contact: dschildmeier@mnarn.org; 781-830-5717

- **Unions and Nursing—The Power of Collective Bargaining**
  This program covers the history of unionization in nursing, what unions do, the benefits of union representation, as well as information on the process for forming a union.
  Presented by David Schildmeier, MNA Director of Public Communications
  Contact: dschildmeier@mnarn.org; 781-830-5717

- **The History of Nursing in Massachusetts—100 Years of Caring for the Commonwealth**
  This program traces the history of professional nursing and the MNA in the Commonwealth, from its birth in 1903 through establishment of the RN role under law, its growth and development up until today. The program includes the viewing of "The Evolution of the Nursing Revolution," a documentary surveying the past 100 years of the MNA.
  Presented by David Schildmeier, MNA Director of Public Communications
  Contact: dschildmeier@mnarn.org; 781-830-5717

To arrange a presentation, it is best to contact the speaker directly to make arrangements. You can also direct your request to David Schildmeier, Director of Public Communications at dschildmeier@mnarn.org; 781-830-5717.

Massachusetts Nurses Association • www.massnurses.org • 781-821-4625