

MASSACHUSETTS NURSE

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THE NEWSLETTER OF THE MASSACHUSETTS NURSES ASSOCIATION ■ www.massnurses.org ■ VOL. 76 No. 7

MNA continues opposing placement of patients in halls

The MNA is continuing its campaign to stop a new policy of the Massachusetts Department of Public Health that allows patients to be boarded and cared for in hallways and corridors of inpatient units as a means of dealing with the problem of emergency department overcrowding. Two meetings have been held with DPH to discuss the issue with a request that the policy be rescinded. The DPH has refused.

"While we are all concerned about the problem of emergency department overcrowding this is not the solution," said Karen Higgins, RN, past president of the MNA and a practicing intensive care unit nurse at Boston Medical Center. "In fact, this policy is a recipe for disaster that would only place patients in greater danger."

As of this printing, there have been no reports of the policy being implemented at any hospital represented by the MNA. However, we have received anecdotal reports of patients being boarded in hallways on inpatient units in non-union hospitals. There is also rumored to be a "gentleman's agreement" among hospital CEOs to avoid ambulance diversion at all costs, thus placing tremendous stress on emergency departments across the state, which threatens to exacerbate the problem.

The policy to allow hallway patients on inpatient units was adopted by DPH last January. The MNA approved a position statement opposing the policy at its April 21 Board of Directors meeting, after it had received reports from its members at some hospitals that the policy might begin to be implemented in May. The MNA opposes the



policy on the grounds that it:

- Endangers patients and results in degrading and substandard care
- Violates patients' rights to dignity and privacy, including numerous HIPAA violations
- Violates fire safety codes
- Violates numerous infection control standards
- Violates the Nurse Practice Act, nursing standards of practice and professional ethics

As a result, the MNA has advised its members against accepting any assignment of patients placed in the hallway of an inpatient unit and believes that the current practice of allowing hallway patients in the emergency department should also be prohibited. The MNA has been working on the bargaining unit level and the state level to resolve ER overflow and diversion issues.

As stated in the MNA's original position statement, "Nurses, both in the emergency department and inpatient units, are already working to their full capacity and, under the current unsafe staffing conditions in hospitals, are caring for far too many patients to provide appropriate care. Now we are asking those nurses to be assigned additional patients who must be cared for in an environment (hallways) that is not conducive to the delivery of any standard of appropriate care. In so doing, they not only jeopardize the safety of the new patients in the hallways, but would now be forced to provide their existing patients with substandard care as well."

"Unless all surrounding hospitals have no staffed beds available to admit patients, it is clearly safer for patients to be stabilized and transported to another facility than it is to place them in an environment that puts

See *Hallway*, Page 9

Workplace violence prevention bill heads to Ways and Means Committee

MNA leads country in efforts to keep RNs safe on the job

After spending only 54 days debating its merits, the Legislature's Public Safety Committee favorably voted out the MNA's proposed legislation regarding workplace violence prevention, S.1329. It will now move on to the Ways and Means Committee for the next vote needed in the approval process.

An Act Requiring Health Care Employers to Develop and Implement Programs to Prevent Workplace Violence, S.1329, aims to make it mandatory for hospitals to provide a comprehensive workplace violence prevention program. It will also mandate that hospitals make counseling programs available to victims of workplace violence. In addition, the bill addresses the risk of violence and the appropriate retirement compensation for those professionals who care for potentially violent patients within public sector settings.

The development and submission of this

bill was entirely spearheaded by the MNA and, specifically, the MNA's Congress on Health and Safety. "This legislation will dramatically improve the working conditions of nurses throughout the commonwealth," said Karen Higgins, RN and MNA past president, "Its progression through the legislative system is both timely and necessary, as it is becoming all too common for nurses to be victims of workplace violence."

The issue of workplace violence in the nursing profession has been regularly covered in both the mainstream media and the MNA's internal publications in recent months, with numerous stories and reports detailing the effects of this unnecessary "job hazard" and its commonality.

In 2004 survey that was commissioned by the MNA's Congress on Health and Safety:

See *Violence*, Page 12

800+ days with no contract



Bill Fyfe, president of Unit 7 employees, was joined by 10 nurses at a State House press conference criticizing Governor Romney for failing to negotiate a contract, causing a staffing crisis in state hospitals and facilities as a result. *Full story*, Page 4.

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Pols delay vote on guaranteed health care

Constitutional amendment for guaranteed health care delayed by Legislature. Details, Page 5.

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

Nurses' guide to single-payer reform

Your relationship to the economy determines your health insurance benefits

By Sandy Eaton, RN

We have a peculiar institution in this country: employment-based health insurance.

Whether you're too young to work; employed or not; work full-time or part-time; are disabled or retired; are a veteran or a veteran's survivor, your *relationship to the economy* determines which insurance plans you may—or may not—be eligible for.

If you feel trapped in a dead-end or unpleasant job, or forced to work more hours per week than you need, just to remain covered by some health insurance plan, you may be thinking, "There must be a better way."

If you're an employer in a culture that has come to expect you to be responsible for providing insurance to those you employ—whether you can afford it or not, whether you want to or not—you're at a disadvantage in the labor market seeking skilled workers if you don't. But, at the same time, you have an advantage in the commodities market

because your lower labor costs will result in lower prices that undercut your competition.

If you do negotiate health insurance plans with a union or on behalf of your employees-at-will or if your workers aren't organized, you may elect to shift more and more of the skyrocketing premium costs onto your workers through demanding they pay a higher percentage of premiums or incur higher deductibles and co-pays.

If an employer operates in several countries, he finds that his costs are lower where health costs are spread across society through broad-based taxation. It's tempting to move more and more work away from the U.S.

With the failure of President Truman's effort to make access to health insurance a right as part of his Fair Deal program after World War II, labor's mainstream settled on keeping access to health insurance a private affair between employers and workers rather

than push for national health insurance.

Because of the entrenched assumptions about the stability and enduring promise of employment-based health insurance, when Canada unfolded a federal-provincial partnership called Medicare with the principle of "everyone in, nobody out," the U.S. adopted its own version of Medicare—a single-payer system for retirees and the disabled, those adults out of the labor market, as well as Medicaid for the very poor. Since then, the percentage of the labor force in unions has plummeted, along with the bargaining power to maintain benefits.

There's been a lot of talk in recent months about the split in organized labor. But there's another split the newspapers *don't* talk about: whether to support single-payer universal health insurance or put more pressure to extract health insurance coverage from employers. In Massachusetts, the MNA, MTA, UE and UAW are among the unions

most prominent in the single-payer fight, while the AFL-CIO is supplying much of the backing of Senator Moore's employer-focused "play-or-pay" Medicaid expansion bill.

Of the four major approaches to health insurance expansion being debated this fall on Beacon Hill, two presuppose the continued role of employers in brokering commercial insurance for their employees, while one—Senator Moore's S.738—actually seeks to further institutionalize this stifling practice. Only the establishment of the Massachusetts Health Care Trust through the passage of S.755 (Tolman/Hynes) will break us out of this dependence on employment and get us away from the sheer waste of having a myriad of competing plans.

This is the time to unite around the fiscally conservative, socially responsible solution: the single-payer universal coverage approach. Such unity will be unstoppable. ■

Testimony from an expert: A selectwoman and RN explains the need for S.755

The following testimony was presented by Katie Murphy, RN, CNRN and chair of the Framingham Board of Selectmen, before the Joint Committee on Health Care Financing at the July 20 hearing regarding S.755.

My name is Katie Murphy and I am a critical care nurse at Brigham & Women's Hospital as well as the chair of the Framingham Board of Selectmen. I see the crisis in health care financing from the following two perspectives: we are not providing the best care we're able, and we are paying far too much for it.

S.755 is the vehicle by which both of these situations can be addressed.

Just yesterday, the Massachusetts Municipal Association and the Massachusetts Taxpayers Foundation released the results of a joint study entitled, "A Mounting Crisis for Local Budgets: The Crippling Effects of Soaring Municipal Health Costs."

This study notes, among many other results, that "since plan benefits have remained essentially the same over the last five years, (the) premium increases reflect the escalating cost of receiving the same health coverage, not an expansion of benefits." More and more of our tax dollars are being spent on the administration of health care, not the health care itself. I am sure you have seen the data showing that all other industrialized nations provide comprehensive medical coverage at a fraction of the money spent in the United States.

My community of 70,000 can serve as an example, because I am certain our experience is not unique. Today in Framingham, one out of every seven municipal dollars is spent on employee health insurance. That is \$25 million out of a \$175 million budget. Our new growth is about \$2.1 million this year, while the health insurance increase alone for Framingham was \$2.2 million.

So much for adding new programs, expanding any services, addressing aging infrastructure or educating more children.

With several years of decreased state aid to municipalities and the realities of Proposition 2½, health insurance is becoming a budget-buster and an enormous challenge to cities and towns.

We pay health benefits for our retirees, so as jobs turn over—especially with teacher retirements occurring at age 57 under the new law—we pay full health insurance for our retirees as well as our new hires.

My community pays about \$25 million for 3,200 employees and retirees that cover about 5,000 people, with over \$5 million going for prescription drugs.

It is vital that citizens of this wealthy nation have health insurance. The vast majority of personal bankruptcies often

follow a health crisis that involves medical bills totaling tens of thousands of dollars. It is far less expensive to prescribe anti-hypertensive medication than to treat a devastating stroke in the emergency department, followed by a prolonged stay in an ICU, rehabilitation and the possibility of leaving the workforce permanently.

The statement that we have "the best health care system in the world" is heard repeatedly. I know firsthand that we have the best practitioners and hospitals in the world, but the system itself is on life-support

Rather than staunch this hemorrhage with a Band-Aid,

we need to move forward with real solutions that provide adequate health coverage for every resident of the commonwealth as well as fiscal relief for strapped cities and towns.

S.755 addresses both the issue of inadequate or absent insurance as well as the skyrocketing costs required by multiple providers, plans and private bureaucracies by creating this single public entity called the Health Care Trust. This Legislation is thoughtful, comprehensive and way overdue.

I urge the General Court of Massachusetts to take the lead in assuring adequate and affordable health insurance for its citizens and providing a model to be used nationwide. ■



"My fortune cookie says Elvis is alive and he's found health insurance for everyone."

Beth Piknick elected president of MNA

Beth Piknick, RN, a staff nurse at Cape Cod Hospital, has been elected president of the Massachusetts Nurses Association. The MNA, with more than 23,000 members, is the largest association of registered nurses and health care professionals and the largest union of registered nurses in the commonwealth.

Piknick, who is the 37th president in the MNA's 102-year history, will serve a two-year term of office. A Hyannis resident, she brings with her more than 34 years experience in nursing and as many years of service to MNA. Piknick holds a diploma in nursing from Faulkner Hospital's School of Nursing and a BS from Lesley College.

"I am honored to have been elected to lead this powerful organization of front-line nurses," Piknick said. "These are turbulent and challenging times for nurses, and for the patients we care for. I am proud to lead an organization that is so committed to protecting the nursing profession and advocating for patients, an organization that is leading the effort to improve the quality and safety of patient care, in whatever setting that care is delivered."

Ultimate goal: RN-to-patient ratios

Piknick is clear that passage of legislation to mandate safe RN-to-patient ratios in our health care facilities is the overriding concern of the MNA membership, as well as the communities we serve. The MNA has filed and is promoting passage of H. 2663, An Act Ensuring Patient Safety.

"When you talk about the problems confronting health care today—be it ER diversions, housing patients in hospital hallways or mandatory overtime—they all come down to one root cause: the hospital industry's failure to provide adequate staffing," said Piknick. "I've learned the true political significance of the MNA while promoting the safe staffing legislation. We are now a strong force against the hospital industry and a strong voice for our allies. We are the experts when it comes to patient care, professional practice and health care for citizens of

the commonwealth. I'm looking forward to being the MNA's spokesperson on this issue, and fighting for the quick passage of this bill.

According to MNA Executive Director Julie Pinkham, "Beth's greatest strength is her experience in the trenches on the front-lines of health care. She has a first-hand understanding of the issues nurses face every day, and has never failed to bring that experience and understanding to her work as a leader and advocate for her profession."

Piknick has spent her entire nursing career as a front-line caregiver and staff nurse, first at Faulkner Hospital and then moving on to Cape Cod Hospital in 1972 where she worked in the ICU. She currently works in CCH's outpatient endoscopy unit.

An active participant in the MNA, Piknick has been and continues to be extremely involved with her local bargaining unit at CCH, working hard with her co-workers to resolve numerous health care issues that impact the nurses and patients. For a number of years, Piknick was the leader of her MNA local, serving as co-chair during an historic nurses' strike in 1981, and she continued to be actively involved in a number of successful contract negotiations. Later she gained prominence as an elected member of the MNA's statewide union leadership body—the Cabinet for Labor Relations.

Piknick also brings a wealth of experience as a leader and spokesperson within the MNA on a variety of issues. She has sat on the organization's Board of Directors for the last four years; she is the president of the MNA's Region 3, which includes the Cape and Islands and many towns in southeastern Massachusetts; she is an MNA representative for the American Association of Registered



Beth Piknick

Nurses; and she is chairperson of the Task Force on Safe Patient Handling. In the past Piknick also sat on the MNA's Congress on Health and Safety.

Ties to safe patient handling

As the chairperson of the Safe Patient Handling Task Force, Piknick is working to prevent back injuries in health care workers, the leading cause of disability for nurses and lost work time for health care employees.

Her connection to this issue is intimate, as she herself once injured her back and was out of work for almost two-and-a-half years as a result.

When she returned to work, she was employed with permanent restrictions in the employee health department of her facility. Piknick was then in a position to request a trial for various lifting devices throughout the facility. The assistant director of the department prepared a detailed account of the cost to the facility and consequently

received approval to proceed with the trial. Based on staff preference of a particular lifting device, five more were purchased.

Piknick was able to bring her experiences to the MNA's Congress on Health & Safety where she received additional feedback from other facilities and, as a result, went on to assist in the publishing of a textbook regarding the affect of back injuries on health care workers.

Currently, she is working with the Task Force on Safe Patient Handling to pass a bill entitled, "An act relating to safe patient handling in certain health facilities." The bill, which would mandate safe-lifting practices, was filed by the MNA last year for consideration during the 2005-2006 legislative session.

"This bill has great importance," explained Piknick. "Its passage will mean that the onus will be on the facility to supply appropriate equipment to prevent injuries, some of which can be life altering or career ending." ■

MNA election results

The MNA Nominations and Elections Committee is proud to announce the names of the MNA members voted to hold office in the 2005 MNA General Election.

President, General

Beth Piknick, RN

Secretary, General

Jim Moura, RN, BSN

Director, Labor

Region 1

Irene Patch, RN

Region 2

Kathlyn M. Logan, RN

Region 3

Barbara "Cookie" Cooke, RN

Region 5

Connie Hunter, RNC

Director At-Large

Tina Russell, RN

Jeannine Williams, RN

Sandy Eaton, RN

Director At-Large

Karen Coughlin, RN, C

Richard Lambos, RN

Barbara Norton, RN

Karen Higgins, RN

Labor Program Member

Beth Gray-Nix OTR/L

Congress on Nursing Practice

Mary Elizabeth (Beth) Amsler, RN

Stephanie V. Holland, RN

Karen Carpenter, APRN, BC, FNP, JD

Ellen Deering, RN, BSN, MPA/H

Congress on Health and Safety

Mary Anne Dillon, RN

Lorraine MacDonald, RN, BS, CLNC

Gail Lenehan, RN, EdD, FAAN

Elizabeth A. O'Connor, RN

Center for Nursing Ethics & Human Rights

Lolita Roland, RN, BSN ■

Weapons of mass destruction: let's not allow them in Boston!

By Mary Crotty

Associate Director Of Nursing

Political opposition to the placement of a dangerous "BSL-4" laboratory next to Boston Medical Center has been growing. The horrendous natural disaster striking New Orleans and its surrounding areas—compounded by the utter failure to rescue or respond—struck fear in the heart of Boston City Council President Michael F. Flaherty recently.

On Sept. 15, less than a week after 200-plus evacuees landed at Otis Air Force base on Cape Cod, Flaherty withdrew his support for Boston University's proposed biological laboratory in the South End. In writing to Anthony S. Fauci, director of the National Institute of Allergy and Infectious Diseases, which would fund the lab, Flaherty called for an immediate halt to the laboratory plan and announced that, "Building [the lab] would be neither a responsible nor safe venture."

Flaherty said he had reconsidered his position after he saw the "total breakdown of government response" after Hurricane Katrina on the Gulf coast. "Due to the fact that Boston, indeed the nation, is not prepared for a major disaster, I must insist that plans for the construction of the lab be halted immediately."

Flaherty's move is a reversal of his previous strong support

for the lab and is politically significant.

The MNA has been working actively to oppose the placement of a BSL-4 laboratory next to the Boston Medical Center campus. MNA organized an extensive inquiry into the controversy surrounding the lab last fall. During an evening hearing, presentations by both lab proponent Boston University and members of the academic health and research communities opposed to the lab's location had opportunities to present their data. Subsequently, the MNA Board of Directors adopted a formal statement of opposition to the placement of the laboratory in downtown Boston.

The MNA has subsequently endorsed legislation that will require regulation of any BSL-4 lab that might end up being located in Massachusetts: H.4249, An Act to Protect the Public Health and Environment from Toxic Biological Agents, is sponsored by state Rep. Gloria Fox (D-Roxbury).

MNA staff and board members have attended and provided testimony in support of Fox's legislation at the following venues:

- The Boston City Council meeting on March 28
- The Supplemental NIH Review at Faneuil Hall on April 25
- The Division of Environmental Health, National Institutes on May 18

- The Joint Committee on Environment, Natural Resources and Agriculture at the State House on June 9
- MNA also recently met with Rep. Fox, Sen. Pam Resor (D-Acton) and Rep. Frank Smizek (D-Brookline) to discuss strategies to secure passage of the bill and amendments to the bill which have led to recent support for the legislation by the Massachusetts Public Health Association
- Actively supported a press conference organized by SafetyNet at Boston City Hall on Sept. 16, followed by a request for a town meeting with Mayor Menino, who has been working with Boston University to get this dangerous lab built. Several members of the City Council joined MNA in voicing their opposition to the BSL-4 lab.

Flaherty's reversal in favor of the MNA's position on the lab came on the heels of another such move by the Massachusetts Public Health Association to oppose the unregulated placement of the lab in Boston.

The Boston mayoral and city council election is set for Nov. 8. Check the Alternatives for the Community and Environment Web site at www.ace-ej.org to verify where Boston politicians stand on this issue and vote accordingly. ■

Nursing on Beacon Hill: Legislative Update

As academic year begins, school nursing takes center stage

By Charles Stefanini
Director, Legislative Affairs

The MNA is working with a broad-based coalition to support school nursing legislation and funding expansion. This was highlighted with an Aug. 29 State House press conference. Speaking at the event, then MNA president Karen Higgins cited a *Boston Globe* editorial on the need for adequately funded school nursing services.

"Time and again, it is school nurses who first identify a health problem, and then make sure the student is referred to a clinic or doctor," Higgins said, quoting from the *Globe* editorial. "Nurses have to be ready to use nebulizers with asthmatics' medication, treat severe allergy reactions with adrenaline shots, and test the blood sugar of students with diabetes. They are a primary source of information for children about the hazards of smoking, drinking, substance abuse and risky sexual activity."

Higgins added, "The 23,000 members of the Massachusetts Nurses Association, the

largest nursing organization in the state, fully support and endorse efforts to enhance school nursing services. As we begin the school year this week we urge the governor to increase funding for school nursing services in order to ensure that all our children have the health services they need." The coalition's goal is to restore \$4 million in prior year's cuts through a supplemental budget and increase funding for the school nurses line-item from \$12 million a year to \$25 million.

Are we prepared?

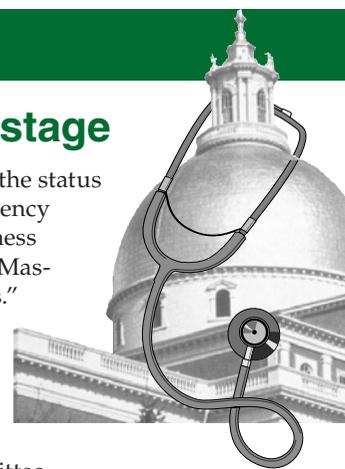
Post 9/11, the MNA testified in front of the Senate Post Audit and Oversight Com-



Charles Stefanini

mittee on the status of "Emergency Preparedness Efforts in Massachusetts." Recently the MNA was invited to join the committee once again to discuss the current status of emergency preparedness in Massachusetts.

The MNA expressed its concern and stated that while people were working hard to reach the appropriate goals, it appears that that state is falling short of where it needs to be—and that there are areas that are well organized and others that are not. In addition, the MNA commented that there needs to be more communication from the state with front-line nurses regarding the plans in the case of an emergency disaster. ■



800+ days without a contract!

Patients threatened by Romney's disrespect of RNs

Wednesday, Sept. 7 marked the 800th day that state-employed registered nurses and health professionals have gone without a contract, a situation that is preventing the recruitment and retention of the professional staff needed to adequately care for the state's most vulnerable residents, including the severely mentally ill, mentally retarded and disabled veterans.

The Romney administration refuses to make public sector nursing and health professional jobs competitive with the private sector despite what their own people are telling them and they continue to drag their feet.

"Governor Romney—while traveling the country to curry favor with voters in his bid for the White House—has abandoned this state's responsibility to care for its most vulnerable residents," said Bill Fyfe, RN and president of the Massachusetts Nurses Association's chapter of state-employed health care professionals, which includes more than 1,800 members. "He has shown a total disrespect for those dedicated professionals who have sacrificed so much to care for them."

State-employed, unionized health professionals (also known as Unit 7) include registered nurses, physicians, pharmacists, psychologists, occupational therapists, physical therapists, dentists, speech and hearing therapists and podiatrists. They work in soldiers' homes for disabled veterans; state hospitals for the mentally ill; residential facilities for mentally retarded adults. They also work at centers for HIV and drug-affected mothers and children; group homes for those cannot live independently; and high-security wards for violent adolescents or suicidal/homicidal residents, mentally ill prisoners, and clients sent for pre-trial evaluations.

"We are the safety net for the state's most troubled and helpless citizens, we're the last stop, and without our care and services, many of these people would end up homeless and many would die," said Fyfe. "The governor's treatment of the state's caregivers represents the shredding of the state's safety net. We will not allow him to continue his campaign for personal gain without waging our own campaign for respect and decency for ourselves and for those truly in need."

Negotiations between the Romney administration and the health professionals began on July 23, 2004. The administration came to the table with more than 100 proposals to cut benefits and no pay increase. The administration has also sought to strip the nurses and professionals of all their rights to have input on staffing conditions at the facilities. According to recent surveys, staffing levels are dangerously low—which severely compromises the quality and safety of care in the state's facilities.

"In order to ensure patient safety, compensation and staffing levels in state facilities must be competitive with the private sector," Fyfe explained. "Working conditions at one state hospital were so bad that the turnover rate was over 80 percent in a five-year period. Patients



are not safe under these conditions, and these conditions also make it extremely difficult to recruit and retain qualified staff."

Poor care due to staffing shortages

The MNA's claims of poor care are supported by hundreds of official reports of unsafe staffing submitted by professionals at a number of the state's facilities in recent years. This includes the results of recent surveys of staff in a number of state facilities for the mentally ill and mentally retarded. Surveys at two of the state's largest mental health hospitals, Taunton State Hospital (TSH) and Worcester State Hospital (WSH) had the following alarming results:

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www.massnurses.org

MNA
MASSACHUSETTS NURSES ASSOCIATION



MNA campaigns to make health care a right via ballot initiative in 2006

As the state Legislature continues to struggle to generate legitimate proposals to address a growing crisis regarding access to quality health care for all in the commonwealth, the MNA is mobilizing the nursing community and working with other interested parties to support a ballot initiative for 2006 that will create a clear mandate for meaningful legislative action.

The MNA is one of a growing number of health care, community and labor organizations to have become active in the Health Care for Massachusetts Campaign, an effort to place and pass a constitutional amendment on the 2006 election ballot that would make health care a basic right of all residents of the commonwealth.

Despite the highest health care spending in the nation, Massachusetts has almost 600,000 residents without insurance who are often unable to get the care they need and who suffer needlessly as a result. The

proposal requires the Legislature to enact a law, subject to voter approval, that "will ensure that no Massachusetts resident lacks comprehensive, affordable, and equitably-financed health insurance coverage for all medically necessary, preventative, acute, and chronic health care needs and mental health care services, prescription drugs and devices."

"The constitutional amendment moves the debate over health care reform and universal insurance coverage away from 'if' we will get this done to 'how' must we get this done," said Julie Pinkham, MNA executive director, who sits on the steering committee for the Health Care for Massachusetts Campaign. "The Legislature would not have the choice or option not to act. It removes all the excuses, stops the stalling and forces the Legislature to act."

The MNA, which continues to propose fundamental health care reform in the form of a

single-payer health care system, has become involved in this campaign because it creates the mandate for action that will move the issue of health care reform forward. It also provides all organizations who want to see the health care system reformed and improved a vehicle that they can all rally around.

"We may not all agree on the specific path to universal coverage and access to quality health care," Pinkham explained. "But we can all agree that there should be a path and that legislators must walk it. That's why this is the most essential and fundamental step towards real reform and it is why the MNA and nurses, who understand the cost we are paying for inaction, are rallying around this initiative."

The proposed constitutional amendment was first advanced in the 2003-2004 legislative session after more than 71,000 voters signed their names to petitions in support. In July 2004, lawmakers approved the amendment

by an overwhelming margin of 153-41.

This legislative session, the proposal will need just 50 votes from legislators at the next constitutional convention, which is where ballot questions such as these are approved to be placed on the 2006 ballot. While it was hoped that the issue would be taken up at the Constitutional Convention of the Legislature on Sept. 14, the debate over a gay marriage amendment prevented the issue from being taken up.

The issue is expected to be taken up at the next Constitutional Convention, which is scheduled for May 14, 2006. If 50 legislators vote in favor of the amendment, it will be placed on the ballot for a vote by the electorate in 2006.

For information on what nurses can do to support this initiative, see the box below. For answers to commonly asked questions regarding this issue, see the related story on this page. ■

Frequently asked questions about the Campaign to Make Health a Right

Why do we need to do this?

- Health care costs are growing 3.5 times faster than wages and faster than corporate income with no end in sight.
- Fewer people get their insurance at work as soaring premiums make insurance unaffordable for employers.
- The state has drastically cut insurance and public health programs.
- More than 600,000 Massachusetts residents are uninsured and often go without needed care and live sicker lives and die sooner as a result.

How can we afford this?

- The money for expanded coverage is already in the system and the amendment is the catalyst for capturing it and reallocating it to expand coverage for all.
- There is more than \$5.8 billion in current spending and potential savings that could be used to expand coverage, cut costs, cut administrative burdens and improve the

quality of care for the insured and uninsured alike.

- Investing in health care stimulates economic growth and competitiveness.
- Economists estimate that every \$1 invested in expanding coverage yields \$1.50 in economic and social benefits.

Will my taxes go up?

- This proposal does not require tax-based funding or that the state be the insurer.
- Doing nothing is the same as a regressive tax hike that disproportionately hurts middle and lower income families forced to drop coverage they now have as it becomes affordable.
- Studies have shown that affordable coverage for all is a bargain as long as the cost is lower than expected premium hikes.

Why a constitutional amendment?

- A purely legislative approach to reform fails because it can not ensure full implementation and funding of the inter-

dependent reforms carefully negotiated by stakeholders.

- A constitutional mandate gives stakeholders and the Legislature the tools they need to sit down and solve the growing problem.
- Language in our state constitution guaranteeing every Massachusetts child a public education ultimately forced major education and financing reform.

Why use the ballot?

- A ballot question gives the voters a voice to tell that they want action now to ensure that everyone can get affordable health insurance.
- There are options on the table that have been carefully studied—expanded public programs, an employer or individual mandate, a mix of tax credits and deductions or a single payer system. Any of these, alone or in combination, could be used to meet the standards set out in the Amendment but still no action. ■

What nurses can do to support the constitutional amendment to make access to quality health care a right

1. Become educated about the initiative, visit the Web site www.HealthCareForMass.org
2. Contact your state senator and representative and tell them you expect their vote in support of this initiative at the Constitutional Convention on May 14, 2006.
3. Educate other nurses and your community about this issue. The MNA has prepared a 10-minute presentation for interested groups. If you want to arrange for a presentation at a meeting of a group or organization to which you belong, contact David Schildmeier, MNA director of public communications, at 781-830-5717 or via email at dschildmeier@mnarn.org. ■

...Disrespect

From Previous Page

- 97 percent of the professional staff at TSH and 96 percent of the staff at WSH reported that their units were dangerously understaffed some or most of the time.
- 95 percent of the staff at TSH and 89 percent of the staff at WSH reported that staffing levels have been chronically inadequate for the past two years.
- 89 percent of the TSH professionals and 77 percent of the WSH staff believe current working conditions force them to provide a level of care below their professional standards.
- 100 percent of the TSH professionals and 81 percent of the WSH professionals reported they lack the sufficient time to prove the level of care their patients require.

Survey results were even more alarming for two residential facilities that specialize in the care of the profoundly mentally retarded—Wrentham Developmental Center and Templeton Developmental Center.

- 100 percent of the registered nurses

and professionals at Templeton and 69 percent of registered nurses and professionals at Wrentham believe their facility is dangerously understaffed some or most of the time.

- 89 percent of the staff at Wrentham and 80 percent of the staff at Templeton reported an increase in medical errors due to understaffing.
- 89 percent of the Wrentham professionals and 75 percent of the Templeton professionals reported that current working conditions force them to provide a level of care below their professional standards.
- And in both surveys, nearly 75 percent of the professionals report they are seriously considering leaving.

"We can no longer allow people with severe mental illness and disability to continue to receive a diminished level of care in an under-funded system," Fyfe concluded. "It is our ethical and professional obligation to advocate for our patients and that is what we intend to do." ■

UAN supports setting minimum nurse staffing levels

The United American Nurses (UAN)—the union arm of the American Nurses Association—expressed its support for H. 2663, a bill that will set minimum RN-to-patient ratios.

In a letter to the Legislature's Public Health Committee, UAN president Cheryl Johnson stated, "As a staff nurse and UAN president, I can tell you that providing enough nurses at the bedside is the most reliable and cost-effective way to ensure high-quality care that protect patients and staff and decrease preventable hospital deaths."

In the letter, the UAN cited several evidence-based statistics in making its case for minimum nurse staffing levels:

- A study reported in the *Journal of the American Medical Association* "found that for each additional patient over four in an RN's workload, the risk of death increased by 7 percent for hospital patients. Patients in hospitals with eight patients per nurse have a 31 percent higher risk of dying than those in hospitals with four patients per nurse."
- A 2002 study by Linda Aiken found that higher emotional exhaustion and greater

"Providing enough nurses at the bedside is the most reliable and cost-effective way to ensure high-quality care which protects patient and staff and decrease preventable hospital deaths."

job dissatisfaction in nurses were strongly associated with higher RN-to-patient ratios. Each additional patient per nurse corresponds to a 23 percent increased risk of burnout, as well as a 15 percent increase in job dissatisfaction. 43 percent of nurses, reporting job burnout and dissatisfaction intend to leave their current position within the next 12 months."

The United American Nurses represents 100,000 RNs nationwide and is a full-fledged affiliate of both the American Nurses Association and the AFL-CIO. ■

Division of Labor Action: Educating Our Members

Workplace benefits: not the result of employers' benevolence or goodwill

By Joe Twarog

You may have seen bumper stickers on vehicles as you drive down the highway that read, "The Labor Movement: The Folks Who Brought You the Weekend."

What exactly does that mean? Well, in a nutshell, it means that many workplace benefits that we all take for granted were issues that were fought for and won by organized labor.

Consistently over the years, it has been labor unions that have waged the battle (and it has *always* been a battle) for improvements for workers—whether in a collective bargaining agreement or through legislation. These include: the non-working weekend; child labor laws; the 40-hour work week; overtime premium pay; contractualized tuition reimbursement; employer-paid health insurance and disability insurance; paid vacation leave; leaves of absence; guaranteed pensions and retirement; health and safety legislation; child care and elder care provisions; paid holidays; due process through a grievance and arbitration procedure; a wage scale with escalator clauses; job security; workplace non-discrimination; and other major intangibles like dignity and respect in the workplace.

Many of these issues have been won over time, with labor working in coalition with other spearhead groups. These also include many of the broader social issues, such as: Social Security; Medicare; civil rights legislation; Fair Labor Standards Act; family and medical leave; and OSHA to name a few.

Which side are you on?

Consistently throughout history, management and employers were on the *wrong* side of these issues. None of these improvements in American workers' lives were given out from the goodness or generosity of the boss. The boss always had an argument why anything that stood to enhance working conditions



Joe Twarog

would cripple their business. This was the case in:

- The late 1800s with the push for the 40-hour work week
- The early 1900s with the drive to eliminate and regulate the use of child labor
- The 1970s and the initiation

of health and safety regulations through OSHA

- 1993 with the passage of the Family and Medical Leave Act
- The current issues of mandating safe needles, bans or limits on mandatory overtime and nurse-to-patient ratios

The arguments of doom and gloom have always repeated themselves. That's why it is important to remind ourselves collectively how the workplace improved. It was Thomas Jefferson (with a sometimes controversial quote, "Every generation needs a new revolution") who realized early in the history of the American republic that the benefits and freedoms enjoyed in this country would be taken for granted by later generations who never experienced first-hand all of the sacrifices made to achieve those gains. Much is the same in labor today.

Collective amnesia

In today's workplace many workers forget—or never had the opportunity to learn—when or where all of these benefits came from. Some workers assume that these benefits are simply a part of the package that employers unilaterally want to offer employees. Others point to non-union workplaces where some or even many of these benefits

are also in place.

It is important to recognize that many non-union facilities are forced to offer some of the benefits that labor has won elsewhere simply to attract and retain employees and to remain competitive in the labor market. These benefits are not offered as a result of the employer's benevolence. Furthermore, in non-union worksites, all benefits that are not protected as a part of legislation are not enforceable because of the lack of a contract. That is, the employer can choose to ignore or to use "management's discretion" in providing or continuing benefits. Such benefits have not become part of the workplace "social contract" as it has in many other countries. Every gain has been fought for—often with blood, sweat and tears—and they are always in danger of being lost.

Employers have fought *all* of these benefits repeatedly using the same old and stale tactics and arguments, such as "the need for management flexibility," or the right to exercise management's prerogative to run the business, or—the most over-used one of all—business cannot afford to operate with such onerous laws that require a minimum wage, or safe working conditions, or bans on child labor, or family leave, etc. Allegedly, these employers won't be able to compete as a result and it will be the end of Western civilization as we know it.

Of course, none of that has happened. What has happened is that because of labor's constant struggle over many of these issues, the workplace is a better and safer place to work. And yes, more rewarding financially as well as personally.

Health care and nurses

For nurses in the workplace, whether in an acute care hospital, mental health facility, school district, visiting nurse/hospice association, or long-term facility, the same lessons hold true.

New nurses coming into the workplace come out of the same popularized culture that tends to hold labor unions in disregard or outright disdain. It is therefore the union's job to educate new members and the general public on what labor has won over the years. This is particularly important in each worksite. The record of improvements in health care work is impressive for the working nurse, as well as for the patient and the overall delivery of health care.

For instance, the hospital industry vigorously fought *against* safe-needle legislation, claiming that prohibitive costs would force them out of business. Yet such federal legislation passed in 2003 and no hospitals have closed over the use of safe needles any more than bottling companies have gone out of business because of the can/bottle deposit law.

Consider the record on:

- Whistle-blower legislation
- Latex sensitivity contract provisions
- Flexible scheduling
- Professional development clauses
- Bans or limits on mandatory overtime
- Living wage ordinances

Where did the health care industry fall in each of these instances? They consistently

fought against them. Labor, along with patient advocacy groups, senior organizations, health care groups, community groups, and health and safety advocates fought long and hard for many of these, and continue to do so.

The fight continues

It is no surprise then that currently in Massachusetts the hospital industry is fighting the MNA's safe staffing legislation in the same manner. They are willing to spend gross amounts of money to mislead and confuse the public and their own employees about such legislation. They have taken out misleading ads and billboards and testified at the State House relating contrived and inaccurate stories about the impact such legislation has had on hospitals in California. Carefully they avoid recognizing the many studies that support and endorse the MNA's position.

None of the workplace victories were easily won. It took sacrifices, and even death, to force changes and improvements—from the Triangle Shirtwaist Factory fire that took 146 lives because of the lack of proper precautions and safety exits, to registered nurses' deaths by AIDS or hepatitis from infected needles and sharps.

Yet there is a constant and ever-increasing onslaught of attacks on these workplace gains from:

- The employer and corporate industry, through mergers, runaway shops, benefit cuts, globalization and outsourcing
- The Legislature and Congress by sacrificing union rights in the Department of Homeland Security and "free trade"
- The executive branch by the loss of public sector collective bargaining rights in Indiana and Missouri by newly elected Republican governors, and anti-union appointments to the courts and the Department of Labor and the suspension of the Davis Bacon Act's prevailing wage provision in the rebuilding of hurricane-ravaged communities
- The media by negatively stereotyping labor and using loaded terminology in news reports such as "special interest group" and "labor bosses"
- And the NLRB with decisions increasingly hostile to workers

Unions remain a progressive force in the United States today, even as its numbers decline in the face of this multi-pronged attack. They are among the most democratic, dynamic and diverse organizations in the country. As organized labor is under attack it has responded by joining coalitions in social justice movements and broadening its own vision. History has shown unmistakably that it is organized labor that has fought for employee rights and against the race to the bottom.

Abraham Lincoln said in his first message to Congress, "Labor is prior to, and independent of, capital. Capital is only the fruit of labor, and could never have existed if labor had not first existed. Labor is the superior of capital, and deserves the much higher compensation." ■

MNA Baseball Caps



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

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

Why we build organizing committees

Successful organizing campaigns begin by having a strong employee organizing committee. A strong organizing committee is the foundation for creating a powerful, democratic and active union.

In an unorganized, or “non-unionized,” workplace:

- Workers have no voice in their working conditions
- Workers are afraid of speaking up to management for fear of being disciplined or worse losing their jobs
- Workers doubt that conditions will ever change for the better
- Workers become apathetic

These conditions lead to a divided workplace where the workers have no power.

When employees decide to organize a union, it is vital that a strong internal organizing committee be formed. Building an active internal organizing committee is not easy. It takes time, but it is necessary if you want to succeed—*campaigns almost never succeed without them*. This model of organizing builds the “union” before the actual election process has occurred.

During a union-organizing campaign, committee members are sought from every area of the workplace and should be representative of the diverse nature of the workers being organized. The committee will receive support, training, and all the needed resources from the MNA. The organizing committee will be the glue that holds

the campaign together as the unionization process moves forward.

Committee members are the contacts for their work areas. They keep their co-workers up to date on union campaign news and

answer any questions that come up during the process. In the workplace, they are up front and strong in their public support for the union. They are ready to answer questions that are almost always generated from

management’s “misinformation”—because management will almost always try to create and peddle “misinformation” about what the organizing committee is doing and how it affects workers.

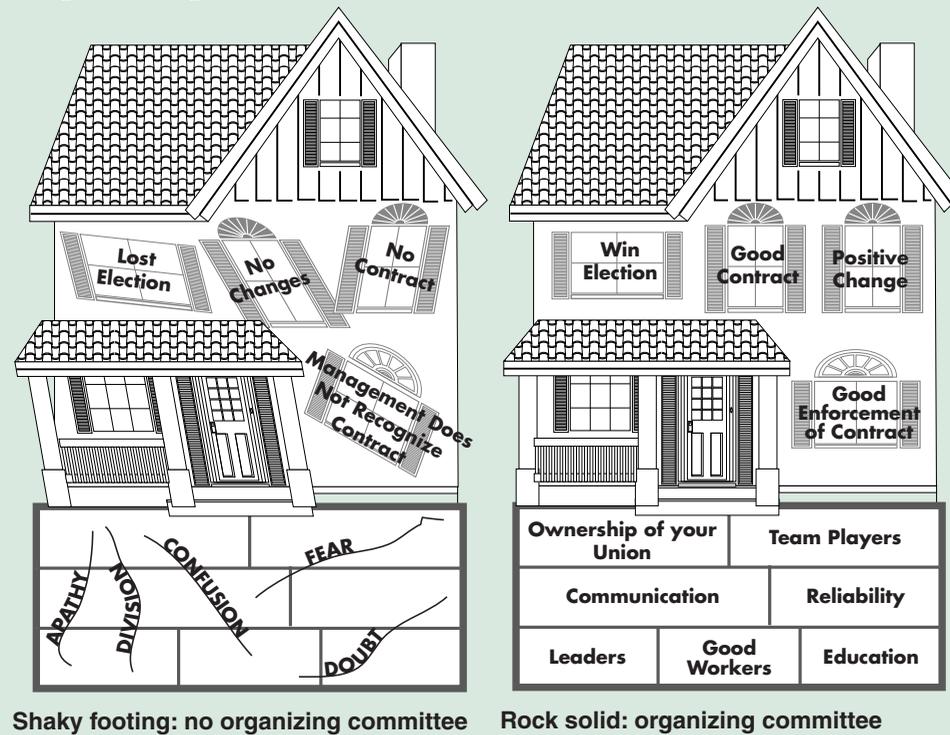
As the organizing campaign moves forward, the committee will help motivate and unify the members. It will interpret misinformation and signals from management and help guide employees to a better understanding of what really is happening in the workplace. The organizing committee is the foundation to a well organized workplace.

Heading into an election with a strong “union foundation” is the key to success. In an organized workplace the workers will finally attain power. They will have a legally protected voice that will enable them to address all their working conditions and their nursing practice issues. They will be active, hopeful and confident. They will be strong and united in their efforts to obtain their first contract with management. They will understand that they, the workers, ARE the union!

It should be noted that all the methods that the MNA employs in conducting a sound organizing drive remain applicable through the whole life of the union that’s been created.

The best contract in the world is just pieces of paper if there is not a strong unified well-led membership to enforce it. The process of building the union needs to be a continuous process that involves all the members. ■

Organizing committee: The foundation of the union



Your rights to organize a union and how to do it

- The National Labor Relations Act (NLRA) protects the rights of employees to form or join a union, and prohibits employers from interfering, restraining or coercing employees in the exercise of their rights to organize.

- The National Labor Relations Board holds the authority to enforce the NLRA. If you want more information on unionizing at your facility please contact Eileen Norton via email at enorton@mnarn.org or call 781-830-5777.

Organizing a union

Short Term Goals: Develop an organizing committee; have 70 to 75 percent of members sign cards
Long Term Goals: Establish a union; achieve first contract

Assessment

Assessment is continuous throughout the organizing campaign at your facility.

- Facility information: The MNA will compile all information on the facility: whether it is a single or merged facility; whether there are satellite units; relevant financial information; information on the Board of Directors, Trustees; information on any pending sales or mergers; and any and all other pertinent information.
- Outstanding issues and patterns of decision making: It is important to know what the issues are, how decisions are made and who is involved in the process.
- Employee and benefit information: The MNA will collect information on the number of units and the number of nurses on each unit, what shifts they work, work status, whether full, part time or per diem, name, address and phone numbers of all potential members, all positions that would be included, policies and procedures, present benefits. Also important to know whether there was a previous union drive, are other employees represented by a union in the facility.

Plan

- Identify and recruit leaders
- Develop organizing committee
- Educate all members, build union
- Have 70–75 percent of members sign cards; if unable to reach this goal, review plan
- Request voluntary recognition from employer
- File a petition for election with the National Labor Relations (NLRB)
- Maintain union strength throughout hearing process at the NLRB
- Educate members to get out the vote

Implementation

- Schedule small group meetings that cover all units, shifts, and groups of employees
- Identify the issues at facility, establish goals
- Assess leadership commitment to building a union
- Build organizing committee with representatives from at least 80–85 percent of the units involved
- Train the organizing committee, continue with group meetings to educate all members
- Assessment by the organizing committee and MNA organizers for readiness to commit to a union campaign; when 70–75 percent ready, have card signing
- Educate all members on what to expect from the “union busters”
- Stay positive and focused on the members issues
- Focus on union building by doing contract surveys, and by working on by-laws that will govern the group after the election
- Test strength of card signers (i.e., have members wear union buttons) to determine their continued commitment

Evaluation

Evaluation is continuous throughout the organizing campaign.

Win or lose:

- Length of time to reach goal of 70–75 percent card signers
- Number of committed leaders
- Number of units/groups represented by leaders
- Number of meetings held during campaign and the average number of attendees
- Number of education sessions with leaders
- Effectiveness of “anti-union” campaign (who, what, when, where)
- Effectiveness of tests used to assess strength of card signers

Walk tall and carry a union card

By Deb Rigiero

It is 10:55 p.m. and my husband and I are at our stations, waiting for our 17½-year-old son Bill to come home. As we are waiting, I am wondering if we've prepared him for the life that lies ahead. I am also thinking about how our home lives mirror our work lives. (Stick with me, I promise you this will all make sense.)

My husband is looking at the clock. "10:59 p.m. Bill's cutting it close. I told him to be home for 11:00."

11:00 on the dot, the front door opens and in comes Bill with a smile on his face. He just made it. So I think that yes, Bill understands the importance of being on time and will be able to get to work on time (when he has a job). Although, I'm sure that Bill is not going to be the type to come in a few minutes early, I am confident that he will be able to meet deadlines and be reliable.

There are glaring differences between family and management. Often, we hear nurses say that work used to feel like being part of a big happy family. Management has changed that and in reality we were never a big, happy family. We were more of a family of obedient children and domineering parents.

Next comes the "management" meeting and the drug screening. Bill knows the routine. First, there are two of us and one of him. This gives the advantage and intimidation factor to Mom and Dad. He gives me his usual hug and my nose immediately does the "sniff-test," which he passes.

Next he hugs Dad, who looks into his eyes and does the pupil check. Then Bill takes the hot seat to tell us what he did for the last few hours. He handles himself well. No slurring or stuttering. He looks my husband straight in the eyes and can answer the questions

rapidly thrown at him. Yes, Bill has the ability to meet with management and handle the intimidation of two against one.

In our house, Bill is a "child-at-will." He has no contract with us and we do not offer to let him have a representative with him during our meeting. There are no Weingarten rights in the Smith household—although, on occasion, we will allow Bill to have a representative with him (his brother or friend).

Next, comes the negotiating phase of our meeting:

Bill: "I'm going to Hampton Beach on Thursday."

Dad: "We haven't decided on that yet. Why do you need to drive?"

Bill: "Ben can't drive and I am the only one legal to drive. Don't worry; they're all chipping in for gas."

Dad: "I don't want you driving fast, no fooling around in the car. 495 is a busy road. I want you to use your head."

Bill: (with a smile on face because he thinks he has won) "Don't worry Dad, I'll be careful."

Yada, yada, yada. The end result of the above negotiations is that Bill can go to Hampton, but only if his summer reading is done. Bill walks away from the negotiations thinking he has won. My husband and I know that we would have allowed him to go anyway—but now we have a few extra chores that Bill negotiated to do and a guarantee that his summer reading will be done or he won't go.

Hopefully, the lesson Bill will take with him from this negotiating session as a "child-at-will" is that he really only got what we were willing to give him. We can take away the privilege at any time if we chose. Even though we allowed him to participate and have input in our discussions, the ultimate authority remains with management (Mom and Dad).

Throughout his short 17½ years, Bill has learned some other important lessons that will prepare him for employment. He has learned that:

- There is no freedom of speech or right to privacy in the workplace (home). He can be disciplined with-

out cause. He needs be considerate of others and to think before he speaks. Also, management (Mom and Dad) reserves the right to go through his room and car because they are our property.

- There are some co-workers who take



pleasure in reporting to management any real or perceived breaking of rules (this would be Bob, "the informer," Bill's younger brother). Although, the "informer" has changed tactics and can now be called the "extortionist" because he has you pay for his silence. Because of this, Bill has learned that honesty is the best policy and on occasion he has even reported himself.

- There is a grievance policy in place at Smith, Inc. Bill is allowed to argue his grievance, occasionally have a supporting witness (Bob) and sometimes this works. However, the final decision concerning the grievance is management's. Our "child-at-will" has no right to call for a neutral third party to arbitrate the grievance—although Bill has attempted to have his grandparents represent him and argue his case.
- Life is not fair. His co-worker, Bob, may get better benefits, more pay or special treatment. He can complain about the unreasonableness and unfairness of this, but that does not make management change its mind. Management can, and often does, show the door to the employee who complains or wants to make changes.

- There is strength in numbers. Bill has a better chance of making changes when he and his co-worker provide a united front. Also, deep down, Bill cares about what happens to his co-worker. He realizes that what impacts his co-worker also impacts him.

What are the lessons Bill can learn from this?

He learns that being an employee-at-will is nothing more than an extension of a child-parent relationship. When you are an employee at-will, you are not treated as an adult. You don't have the authority to make changes. You don't have the right to arbitration. Without a union, you do not have the leverage to negotiate a fair and equitable contract. You do not have a "real" voice.

There are glaring differences between family and management. Often, we hear nurses say that work used to feel like being part of a big happy family. Management has changed that and in reality we were never a big, happy family. We were more of a family of obedient children and domineering parents.

As parents, our goal is to have our children grow up to be independent, productive adults who make a difference in the world. Management wants their employees to tow the company line. Management fights hard and spends lots of money to prevent their employees from unionizing and gaining a seat at the table. The last thing management wants is their employees to have a "real" voice through the power of being a union.

Bill and Bob have been on picket lines, strike lines, protests marches and rallies. They watch the news and the Daily Show and are knowledgeable about current world events. They join in with us when we debate about politics, Wal-Mart, what it means to be American, and what it means to be union member.

As they travel down the road of life, we hope they love, laugh, cry, fight for their beliefs, walk tall—and carry a union card.

Disclaimer: This article is a work of fiction. Names are the products of the author's imagination or are used fictitiously. Any resemblance to actual events or persons is coincidental. ■

Union membership a key to health care coverage

According to a recent study by the non-partisan Employee Benefit Research Institute (EBRI), union members are much more likely to have employment-based health insurance than nonunion workers, but the erosion of union membership is likely to coincide with an overall decline in the percentage of workers with health benefits

The study reported that 86 percent of union members were covered by health benefits through their job, compared with 60 percent of nonunion workers, as of September 2003 (the most recent data available). Union workers in several private-sector fields had very high levels of health insurance coverage, as did union workers in public-sector jobs, the study said. For example:

- 91 percent of union manufacturing workers had health benefits, compared with 74 percent for nonunion workers.
- 88 percent of union workers in agriculture, forestry, fishing, mining, and construction had coverage, compared

with 40 percent for nonunion workers.

- 84 percent of union wholesale and retail trade workers had coverage, compared with 55 percent of nonunion workers.
- The study, "Union Status and Employment-Based Health Benefits," is published in the May EBRI Notes and is available at the institute's Web site, www.ebri.org.
- Some 17.2 million workers were union members, accounting for 15 percent of all wage and salary workers ages 18 through 64, as of September 2003. Union workers were typically concentrated in jobs with high levels of employment-based health coverage. Union members accounted for 36 percent of public-sector workers, but 86 percent of union members had health benefits from their public-sector employers, compared with 68 percent for nonunion workers.

"Hence, unionization appears to increase the probability of having health benefits in the public sector by 26 percent," said Dallas Salisbury, EBRI president.

Union membership also had a major impact on the probability of workers in small firms having health care benefits, the study said. Eighty-two percent of union members in firms with fewer than 25 employees had employment-based health benefits, compared with 36 percent of nonunion workers in firms of the same size.

Overall, only 2.5 percent of union workers were uninsured in September 2003, compared with 15 percent of nonunion workers. "Union workers across the board are more likely to have health benefits than nonunion workers," the study concluded. "All else being equal, if unionization in the United States continues to decline, the percentage of workers with health benefits will continue to decrease and the percentage of workers who are uninsured will continue to increase." ■

...Hallway

From Page 1

them and all other patients on that unit at such great risk."

In fact, this was the expressed policy on how to handle ED overcrowding by the DPH, as outlined in 2001 report. That report also called upon DPH to initiate a number of changes in how they handle patient flow and discharge, which the industry has since failed to implement. "Now, at the industry's urging, instead of fixing the problem, the DPH has joined with hospitals in condoning a policy that degrades the care of patients, as opposed to holding the hospital industry accountable for implementing the system-based changes required," Higgins explained.

Immediately following the release of the position statement, the MNA began educating the leadership of local bargaining units about the problems with the DPH's policy and the MNA's position. The MNA, through the local leadership of its local bargaining units on the hospital level, has informed hospital administrators that we will not tolerate this practice and intend to educate local communities of the dangers of this practice should an attempt be made to implement it.

The MNA has also been reaching out to other interested parties regarding this dan-

gerous policy to seek their support. To date, the Boston and Worcester firefighters associations have sent letters of support for the MNA position opposing the policy to DPH, citing serious fire safety concerns. In addition, the MNA is reaching out to a number of health advocacy organizations to alert them of the inherent dangers of this policy. The Greater Boston Diabetes Association has already endorsed the MNA's position.

The Emergency Nurses Association has informed the MNA that it supports the DPH policy with the rationale that since emergency department nurses are forced to care for patients in hallways, it is acceptable for nurses on inpatient units to do the same.

In a response letter to ENA the MNA suggested a meeting between the two groups to discuss the situation, the MNA reiterated its position by stating, "The MNA is opposed to the placement of patients in hallways of emergency departments as well as for inpatient units. ED overcrowding is a system-wide problem that requires a system-wide solution, however, moving patients from one unsafe environment (an ED hallway) to an equally unsafe environment (inpatient hallway) is not a real solution—it's a travesty and an abrogation of nurses' role as patient advocates." ■

The view from front-line nurses

"As a medical surgical nurse who often finds herself overloaded with very acutely ill and vulnerable patients, I find it hard to believe anyone who cares about the quality and safety of care in a hospital would even suggest boarding patients in the hallways of emergency departments or inpatient units. I can't conceive of how I would be able to manage a normal case load of patients in rooms, and also be assigned a patient in the hallway. How could that patient have any privacy? How can I take a history? How can I maintain any semblance of compliance with HIPAA regulations with that patient out in the middle of the hall? And what happens with their family member? There are so many problems that could arise, including the total lack of infection control, not to mention the management of pumps and other equipment that the patient may need. It's a recipe for disaster. This is not the solution. This is an insult to every patient who is forced to endure such care."

—Marlena Pellegrino, RN, St. Vincent Hospital in Worcester

"Caring for patients in the hallways in and around our ED has become so common that there are now two permanently established beds that are used just for this purpose. These beds are each curtained off and they're outfitted with the basic types of equipment that an RN would need to care for a patient . . . but they're in a hallway! In addition, the hospital will add up to two more beds in the halls if they need to—all while they shuffle patients back and forth between ED rooms, hallway beds and waiting room chairs depending on what a patient's condition and situation are.

"This situation has become the norm in our hospital, and it's one that the patients don't even recognize as dangerous and intrusive. It is also a situation that could potentially put my license in jeopardy. The mandate from hospital management is that we DO NOT transfer patients out, but caring for them in the halls goes against what I was trained to do in nursing school. Under these circumstances, I find that I begin each shift by hoping and praying that there won't be a case that tips the scales—the type of case where I'll have to fight with management over how and where this patient is cared for."

—Diane George, RN, North Adams Hospital

"As an ED nurse for more than 20 years, I understand the frustration of colleagues who struggle every day to provide appropriate care in overcrowded emergency departments, having worked many a shift with stretchers in the halls, waiting for a bed to clear up on the units and floors. But as a patient advocate, I cannot and will not condone a practice that simply transfers the indignity of hallway care from my unit to another unit.

"As an MNA member for my entire career, I know the MNA has never condoned placing patients in hallways anywhere in the hospital. The problem with ED overcrowding isn't about nurses being pitted against nurses, it's a problem with administration.

"I know the reason a bed isn't ready for my patient is because management hasn't staffed or hired enough nurses to open that bed. I know it's because my administrator hasn't taken other steps such as postponing elective surgeries. I know that hospitals that could be going on diversion are choosing not to or are waiting too long to make the decision to go on diversion even though that would be the safe thing to do.

"It's time for DPH and MHA to stop this policy and to work on solutions to deal with this crisis that aren't based on pitting nurses against each other, and most important of all, that put patients' care and well being first and foremost."

—Linda Condon, RN, Quincy Medical Center

The real solution to ED overcrowding

There have been a number of studies and reports conducted on the issue of emergency department overcrowding and ambulance diversion that offer a number of alternative solutions, including one commissioned by the Department of Public Health, and none of them call for the placement of patients in hallways.

There are three root causes of the overcrowding problem in Massachusetts:

1. Understaffing of registered nurses to allow for full utilization of existing hospital capacity to allow for efficient transfer of patients out of emergency departments onto inpatient units.
2. A shortage of beds in the system due to hospital consolidation caused by the industry's reliance on a cut-throat free-market model of health care delivery.
3. A failure of hospital administrators to manage non-emergent, elective surgeries and admissions by physicians to control bed utilization and availability.

The solutions promoted by the MNA that responds to these root causes include:

1. Passage of legislation to regulate RN-to-patient ratios in all acute care hospitals, which includes a ratio for nurses in the emergency department. This law will guarantee full staffing to allow for opening up of bed capacity to ease overcrowding; and it will end the current shortage of nurses who are refusing to work in hospitals because of the current conditions.
2. Creation of a safe, properly-equipped holding area (not a hallway) for patients awaiting a bed on an inpatient unit. This area must be safely staffed with nurses dedicated to caring for those patients. In no instance should an ED nurse be assigned to cover treatment rooms in the ED and still be responsible for patients in a hallway.
3. Staff to full-bed capacity as opposed to the current practice of providing staffing based on an estimated average daily census. Even with the loss of bed capacity in our state's hospitals, in many instances, there are beds available for patients in the hospital; there are just no nurses available on that shift to staff the beds. The

Institute of Medicine, in its groundbreaking report on nurse staffing and patient safety, recommends that hospitals overstaff units to account for and manage variability in patient flow.

4. Mandating that hospitals take appropriate control of elective admissions or regulate suitable hospital discharge procedures to smooth admissions and allow for the capacity to handle spikes in emergency department utilization. The DPH commissioned a study by a team of Boston University researchers who have developed just such a system for hospitals. The program has been adopted by Boston Medical Center and has been working well. But no other hospital in Massachusetts is adopting these policies.
5. Adequately staff ancillary departments to allow for rapid cleaning and turnaround of rooms. In many instances, there is a staffed bed available for a patient, but there is a delay in turning over the room.
6. Ambulance diversion to a well-staffed hospital with the capacity to properly care for a patient is safer than overloading a hospital that is already filled to capacity, thus necessitating care in a hallway.
7. The DPH needs to assess current and future bed capacity, and the state needs to ensure the provision of an appropriate number of beds throughout the state to provide safe, dignified care to the residents of the commonwealth.

The MNA continues to research methods of dealing with ED overcrowding that do not involve corridor care and will educate its members and the nursing community about these alternatives.

It will be conducting a survey of emergency department nurses to determine what hospitals across the state are doing to deal with this crisis and most important of all, it will be pushing for passage this year of legislation to regulate RN-to-patient ratios in hospitals, which is a lynchpin to a true system wide solution.

To review the MNA position statement on this issue, visit the MNA Web site at www.massnurses.org. ■

Boston firefighters say DPH hallway policy undermines fire safety

Boston firefighters are asking the state Department of Public Health to rescind its policy allowing hospital patients to be placed in hallways, saying it undermines fire safety.

In a letter to the state public health commissioner, Edward A. Kelly, president, Boston Firefighters Local 718, said, "We believe this practice presents an unnecessary risk to fire safety for hospitals, as well as a safety risk for patients, patients' families and for hospital staff."

The letter continues: "While a limited number of hospitals may be able to comply with this policy without committing a flagrant violation of fire codes, we believe that any use of this policy would undermine the intent of fire safety laws and ordinances. The addition of patients and their families to hall-

way environments would compromise our ability to appropriately respond to a fire or other emergency requiring rapid and efficient evacuation of a facility, thus placing patients, families and staff at risk.

"As the MNA position statement makes clear, there are a host of patient safety issues raised by the placement of patients in hallways. Solving this problem will require a systems approach, one which the hallway policy clearly does not provide.

"The MNA's position statement outlines a number of steps that can be taken as an alternative to this policy and we strongly urge the DPH to work with all stakeholders to see that these approaches are undertaken. In the meantime, we join the MNA in calling upon the DPH to immediately rescind this policy." ■

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

Worker's comp in Massachusetts: punitive, inadequate and unfair

By Chris Pontus

I met Andrea Goldstein on June 29 at the State House while there to testify in support of two bills that deal with workers compensation. H.3777 addresses changing the process for terminating benefits, medical rates for treatment, lost wage compensation and the employers' role in lump sum agreements. H.3776 considers fair medical rates for treatment.

Andrea was there as a frustrated injured worker who could not believe how punitive and detrimental the existing workers compensation system is. What follows is her testimony.

On June 1, 2004, I was injured in a work-related accident. I am a nurse who was working as a marketing representative for a for-profit hospital corporation. I was stopped at a major intersection when I was hit from behind and pushed into the car in front of me.

It has been nearly 15 months since my accident, and I am no closer to returning to work than I was that day. I have the Massachusetts worker's compensation system to thank. In 1991, in a shameful display of blaming the victim, laws were passed to slash benefits

to injured workers. In the 14 years that have passed, no balance has been restored to the system. The worker's compensation system in Massachusetts is punitive, inadequate, unfair and harmful to the injured worker's health and well-being.

A huge issue affecting injured workers is access to medical care. This should be of major concern to nurses, who care for all. In addition, doctors have become our adversaries as reimbursements from worker's compensation are low, and there are no laws that force a physician to treat a patient on compensation. I was scheduled for back surgery last fall, and when the doctor's office manager found out it was a worker's comp case the surgery was cancelled.

I have been turned away for surgery by nearly two dozen of the best orthopedic and neurosurgeons in Boston because my case remains open. An attempt to settle proved fruitless.

I should not have to compromise my care because I happen to be on compensation. The system is incredibly slow; it will take nearly a year and a half before I have my hearing;

and the judge can take months to render a decision. If the judge does not find in my favor, the process continues. All the while, my physical condition deteriorates.

The money that has been wasted fighting me could have paid for the surgery and medical care I need and I could be back on the job again. I have had to endure numerous insurance-mandated medical exams performed by doctors who are paid to lie, I have been sent for an "impartial" exam, the "exam" part of which lasted less than three minutes. I have been followed by private investigators that have seen me do nothing of note. While this is an issue for any injured worker, it is especially poignant for the injured nurse. After all, we invest all we have in our patients—continually butting up against the system to advocate for their needs, yet when it is our turn, all we hear is silence.

Instead of my days being filled with challenge and purpose, they are filled with pain and despair. I have miserable lower back pain, sciatic pain, nerve pain in my feet and a slowly deteriorating neurological status. I

cannot sit, stand, lie down or walk without pain. I require narcotic pain medications on a daily basis.

Long an advocate for patient issues, I now try to advocate for injured workers. However, here in Massachusetts, injured workers are not organized and the battle is uphill. One bright spot however is a connection I made with an injured worker from California while doing some internet research. She produced a documentary about an injured worker, entitled "Almost Broken." The documentary is outlined and discussed at www.mystatefundstory.com.

This documentary needs and deserves to be shown around the country so that there can be a sea change in the way injured workers are treated. Almost Broken will be aired at the MNA's Canton office in the next couple of weeks, but you can help spread the word now. Call your local cable station and request that they air Almost Broken—because getting this documentary shown throughout the state of Massachusetts will help to bring about a much overdue change in the worker's compensation system. ■

What you need in case of a disaster emergency: a personal checklist

Submitted by the RI Committee on Occupational Safety & Health

If you were without electricity, water, phone and even shelter, what would you do? The devastation of hurricane Katrina should give pause to consider how extreme weather may put any of us in similar dire straits. So if you were to receive an ominous forecast of oncoming extreme and disabling conditions that could mean loss of power and movement (hurricane, severe winter storm, etc.) what can you do?

There are two options: evacuate or ride it out, officially called "shelter in place." In either case, set aside a basic survival kit and a basic plan for survival.

Collect and secure the following (probably enough for three days)

- Bottled water (one to three gallons per person, per day)
- Protective clothing, rainwear and bedding or sleeping bags
- Battery-powered radio, flashlight and extra batteries
- Special items for infants, elderly or disabled family members
- Canned goods and a variety of non-perishables that don't require cooking
- Medications (three-day supply of all daily medications)
- Eating utensils (plastic or disposable)
- First-aid kit (see below)
- Changes of clothing and underwear
- Insect repellent (DEET, Picaridin or P-menthenediol)
- Masking tape, duct tape
- Paper towels, toilet paper and sanitary products
- Pet supplies and carrier (include food, water, leashes and records of shots)

- Plastic sheeting
- A set of disaster posters/labels
- Toiletries (soap, toothpaste and toothbrush, etc.)
- Tools (can opener, knives, pliers; a Swiss army knife, scissors)
- Cash (electronic infrastructure for ATMs may not be working)
- Cell phones (with non-electrical charger). Program an "In Case of Emergency" in your cell phone in case you are incapacitated. Also program emergency numbers of local, state and federal agencies
- Contact information/phone numbers of friends and family
- Important documents (licenses, passport, birth certificate, etc.) in a waterproof container
- Financial inventory (a list of financial accounts, mortgages and loans, including account numbers and location of original documents)
- Medical information (list medications, any chronic conditions and medical history)
- Written instructions on how to turn off electricity, gas and water if authorities advise you to do so.

In case you have to evacuate your home, put these supplies in secure portable containers (a large rolling trash can with a lid, a large rolling cooler or several small coolers). Gauge what you can reasonably carry or store in your car.

If you do not evacuate and have lost power remember that if you use gasoline or diesel-powered generators they pose a deadly invisible hazard—carbon monoxide poisoning. Operate any power equipment outdoors.

If you live in an area such as a coastal plain that has experienced disastrous flooding then you might look at acquiring an inflatable life

raft, sometimes called SOLAS used on commercial fishing vessels. These easily-stored (but not inexpensive) inflatable buoyant apparatuses inflate to a large secure tent and include supplies and first-aid equipment and protective water suits; they are marked and colored to be easily spotted from the air.

Plan ahead

Review the local emergency plan in your area. Some plans are on the internet, but you should also contact a local fire department, a local emergency planning committee or your local health department. Identify emergency evacuation routes and shelters in your community and near your workplace.

- Decide where family members should meet if separated, and add a backup location in case the first location is impossible to reach.
- Identify a point-person who will serve as the central contact to call in case of confusion. Choose an out-of-state friend or relative to serve as a backup contact, in the event that local lines are tied up or out of service.
- Plan for the eventuality of where you pick up kids being at school. Ask for and review the school emergency plan (district-wide plan) so that if the school is evacuated you know where your kids are supposed to be transported.
- Provide every member of the family with a cell phone or prepaid phone card to make sure they can make a call in an emergency.
- Consider special needs while making plans. For example, who will help someone in a wheelchair? Include pets in your planning.
- Time of year will effect your preparation. In the winter you will need heavy clothing.

First-aid kit

Wound care

- One roll of absorbent cotton
- Gauze pads (4 inches square)
- Adhesive tape (1 inch and narrower)
- Adhesive bandages in various sizes
- Butterfly bandages to hold gashed skin edges together
- Wound cleansers (soap, gels or wipes)

Medications

- Analgesic, such as acetaminophen or ibuprofen (in adult and child doses) or aspirin.
- Antihistamine for allergic reactions
- Antiseptic ointment or cream (such as bacitracin or triple antibiotic ointment)
- Calamine lotion or hydrocortisone cream (1 percent) for rashes
- Activated charcoal for inadvertent overdoses
- Saline eye drops
- Antacid for stomach upset
- Antidiarrheal medication
- Oral glucose preparation for low blood sugar

Other supplies

- Ace bandages
- Cold/hot packs
- Cotton swabs
- Flashlight
- Scissors, tweezers and safety pins
- Disposable surgical gloves
- Thermometer

The American Red Cross sells prepackaged first-aid kits and emergency preparedness kits for home use, and a basic disaster-supply kit especially designed for the workplace. For more information, visit www.redcross.org.

Sources: Harvard Medical School. American Red Cross, National Institute for Occupational Safety and Health, Centers for Disease Control ■

*It's not nice to fool mother nature***Environmental pollutants and the immune system**

By David H. Sherr, Ph.D.

*Department of Environmental Health
Boston University School of Public Health*

In evolution, surprisingly little is left to chance. Biologic systems, whether composed of millions of liver cells working in concert to detoxify the blood, or white blood cells attempting to defend against foreign microbe invasion, are "designed" with controls, regulators, checks and balances. The selective value of such biologic oversight is the evolution of systems that, despite their complexity, tend not to fail.

For example, all animal cells are equipped with dozens of proteins that regulate how frequently a cell divides. Should some of the regulatory machinery become defective, cells generally invoke a genetically encoded suicide program.

It actually takes several events to impair both growth regulation and activation of the cell death program, and in that rare instance, a cancer is formed. Even so, most tumors go undetected because they are eliminated quickly by the sentinel immune system.

It's when the balance between growth and death is tipped in the direction of growth, and the immune system is impaired that bad things happen. Our laboratory studies show how several environmental pollutants do exactly that.

Immune system protects health

The immune system is responsible for defending its host against invading bacteria, viruses, fungi, and, as noted above, newly formed cancers. Defense against bacteria and fungi is assumed primarily by a system of interacting white blood cells known as the B lymphocyte arm of the immune system.

B lymphocytes mass produce proteins (antibodies) which bind to and kill microbes. Each B cell is capable of producing antibody of only one given specificity. The development of millions of B lymphocytes expressing millions of specificities insures that the immune system has the potential to respond to millions of different foreign insults.

The B cells must "learn" their specificities early in their development, must grow enough to constitute the host with a significant mass of B cells of every given specificity, and must learn not to respond to self components. B cells that fail to learn the difference between "self" and "foreign" components are forced to activate the suicide program, sparing the host from autoimmune disease. This education occurs continually in the bone marrow, where all eight kinds of blood cells are produced.

The failure of immature B lymphocytes to learn these lessons results either in an inadequate

immune response to foreign microbes, leaving the host susceptible to infection, or to an inappropriate autoimmune reaction to host tissue. Unfortunately, just like babies and young children, bone marrow B cells are more sensitive to environmental pollutants than their more mature counterparts.

Pollutants disrupt immune system

Our laboratory has shown that two classes of common pollutants, aromatic hydrocarbons and phthalates, disrupt B cell education. Hydrocarbons are ubiquitous and are produced every time something organic is burned - from fossil fuels in our cars and coal in our power plants, to charcoal broiled steaks. Phthalates, which leach from hundreds of common products containing plasticizers (e.g. medical tubing, plastic bags, cosmetics), can also be found throughout our environment.

The effects of these chemicals on immature B lymphocytes are dramatic. Hydrocarbons, many of which are carcinogenic, prematurely induce bone marrow B cells to initiate the cell death program. Notably, the doses of hydrocarbons required to suppress B cell development are significantly lower than those required to induce cancers. Consequently, estimates of hydrocarbon exposure risks, which gen-

erally involve cancer as an endpoint, may underestimate the dangers of pollutant exposure.

It has been demonstrated that phthalates similarly induce programmed cell death. Indeed, the strength of the death signal delivered by phthalate-like chemicals is the strongest suicide signal our laboratory has ever seen. At low doses, phthalates spare B cells from the death program but induce them to cease growth.

Research focus

A key goal in our laboratory is to define, on a molecular level, how these chemicals invoke aberrant cellular responses. Both hydrocarbons and phthalates are recognized by distinct cellular protein receptors that transmit signals to cell nuclei wherein reside genetic programs for cell suicide and growth regulation. This begs the question of what these receptors evolved to do in the first place; certainly they haven't evolved to recognize by-products of human industry.

We must conclude then that activation of these receptors by environmental chemicals is an unwise practice, one that clearly was not part of Mother Nature's evolutionary plan.

And we all know that it's not nice to fool Mother Nature. ■

Safe patient handling: it's all been said, now here's what needs to happen

By Chris Pontus

Many nurses wonder what can be said about back injury reduction programs that has not been said already. We understand why many nurses think and feel this way, but nurses also recognize that it is not what we know or what has not been said already, it is what needs to happen.

But it calls for a change in the way we think about nursing, as well as the culture of the organizations we work in before this paradigm shift can occur to make it happen.

Do you remember the term "body mechanics?" Body mechanics was part of the nurses' training and education very early on in most nursing programs. In fact it was one of the first behavioral objectives taught to nursing students before going on into the clinical setting. This approach ensured that the newly acquired skill was practiced throughout all the nursing clinical rotations the nursing student would be exposed to.

Body mechanics was also one of the first concepts and actions a nursing student thought they were practicing in order to take better care of themselves in addition to delivering excellent patient care. Now the new found truth is that body mechanics does not work.

What? How can that be?

That is the general reaction most nurses have when hearing this news. But the rationale is simple: injuries involving work-related musculoskeletal disorders show us that body mechanics does not work. This has become so evident that it has led to some countries in Europe to restrict nurses, doctors and other emergency and medical personnel from manually lifting patients.

Six months ago, Beth Pknic, chairperson of the MNA's Safe Patient Handling Task



Chris Pontus

Force and the newly elected president of the MNA, and I attended a four-day safe patient handling convention. Aside from the fact that we learned much and met many people, we also came back with very specific information to share with our Safe Patient Handling

Task Force.

The task force is made up of MNA members who attend monthly meetings to discuss and develop legislation, educational, training and nursing initiatives to get the word out about safe patient handling methods, ergonomics and lifting devices.

One of the specific points we were able to clarify after coming back from the conference was that "lift teams" were not something we wanted to convey as a panacea. In fact, we found the protocol and concept of the back injury resource nurse (BIRN) much more conducive for a long-term effective approach.

We now understand the value of a safe patient handling and movement program. This program works best as a team. Members of the team are nursing staff (CCNAs, LPNs, RNs), nursing services-safety representatives, peer leaders (BIRN), nursing administrator, risk managers, nurse educators, therapy staff members (OTs, PTs), engineering, employee health representatives, union members, and others who are committed to making this work.

A real benefit to attending the conference was that Beth and I actually meet and spoke to certified BIRN nurses. These frontline staff



Chris Pontus (back right), from the MNA's health and safety program, with Gladeen Jackson (back left), BSN, RN; Christopher Young, an EMT; and Sarah Larry, BSN, RN and a BIRN nurse at the Safe Patient Handling Convention in Florida. Jackson, Young and Larry all practice at the James A. Haley VA Medical Center in Tampa.

nurses from the Florida Veterans Administration were trained and certified in the basic education model. Their current practice with the peer review model of instruction is a testimony to the success of the program when practiced in a supportive environment.

We also met other interested professionals from various backgrounds who are all contributing to what has historically been a nursing issue when it comes to patient care. Clearly the challenge in the nursing profession has been the fact that patients themselves do not come in one size or predictable loads. The requirements for safe patient handling

are often more varied and unpredictable than many manufacturing facilities where the problem can often be engineered out in a more direct and planned approach.

This reality puts the nurse and her profession at a disadvantage in that equipment, time, and nursing personnel are often resources not readily available at most given times while delivering patient care. Therefore, unless there is a program in place in each facility to ensure compliance for objectives of safe patient handling, equipment and personnel can not be properly utilized.

The Massachusetts Nurses Association has submitted to the Legislature a related bill for consideration entitled, An Act Relating to Safe Patient Handling in Certain Health Care Facilities (H.2662). Filed last December, it was referred by the House to the Joint Committee on Public Health in April. The bill is sponsored by Rep. Jennifer Callahan, D-Sutton.

If you are interested in supporting this legislation contact the Safe Patient Handling Task Force at 781-830-5754. ■

Health & Safety Contacts

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

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MNA and GBPSR: working to prevent family exposures to toxins

By Evie Bain

Over the last ten years, the MNA had been involved with the Greater Boston Physicians for Social Responsibility (GBPSR) through activities and committees with MassCOSH, the Massachusetts Department of Public Health, Occupational Safety and Health Program and Health Care Without Harm.

We are pleased to share the following information, as well as the preceding article by David Sherr with the nursing community. It is also expected that the GBPSR will be regularly submitting additional articles of interest to the *Massachusetts Nurse*.

GBPSR goals and activities

Greater Boston Physicians for Social Responsibility (GBPSR) is an affiliate of Physicians for Social Responsibility (PSR)—a national organization of over 30,000 physicians, health care professionals and supporters committed to promoting public policies that protect human health from the threats of nuclear war and other weapons of mass destruction,



Evelyn Bain

global environmental degradation and the epidemic of gun violence.

GBPSR has over 1000 members in eastern Massachusetts who individually and collectively work on a variety of issues relating to health, including quality and access to health care, environmental pollution, militarism and war, community and personal violence, and social justice and human rights.

GBPSR's Human Health and the Environment Project (HHEP) was one of the first in the PSR to focus on the public health consequences of environmental pollution. Since 1992 the HHEP has been active in educating the medical community on the linkages between environmental exposures and health; activating members to work to

protect public health; assisting grassroots groups with technical and scientific issues relating to human health and environment issues; and participating in public policy debates.

Preventing toxic chemical exposures

Most recently GBPSR and its sister Physicians for Social Responsibility chapter in the San Francisco Bay have teamed up on an exciting new project that aims to develop practical tools for pediatric and family care practices to use in preventing exposures to toxic chemicals. The toolkit materials have been piloted at 17 pediatric and family practices in Massachusetts and California. The six-month pilot phase concluded in February 2005, and the findings are currently being presented at medical conferences across the country.

If you are interested in participating in any of the related toolkit training sessions, or if you would like more information on GBPSR, visit www.igc.org/psr. ■

Online audio: workplace latex allergies

Gail Lenehan, national advocate and member of the MNA Congress on Health and Safety, was one of three experts discussing latex allergies on the Legal Talk Network Webcast "Workers Comp Matters."

The show, hosted by attorney Alan S. Pierce, focuses on issues relating to people who have been hurt at work. The aim of the show on the Aug. 23 was to educate listeners on topics relating to how to represent workers with latex allergies that were contracted at the workplace.

Joining Lenehan were Sandra Jutras, a career clinical nurse who developed a serious level one latex allergy, and attorney Jim Brady, of Brady & Monac, P.C. in Walpole, who has a great depth of experience litigating in this arena and who has represented many MNA nurses.

To hear the broadcast via a Web download, visit www.legaltalknetwork.com/, scroll down, and click on the "Workers Comp Matters" image on the right. ■

...Violence

From Page 1

- More than half of those surveyed report that workplace violence has been a serious problem in the last two years.
- Just over 30 percent report being regularly or frequently physically threatened; and between 25 and 30 percent were regularly or frequently pinched, scratched, spit on, or had their hand or wrist twisted.
- Almost 50 percent had been punched at least once; seven respondents report having been strangled in the past two years; eight sexually assaulted and two intentionally stuck with a contaminated needle.
- The majority of violent acts are committed by patients.
- There are a variety of items identified for use as weapons by nurses in the survey, including a third who have seen furniture used as a weapon, just under 30 percent have witnessed pencils or pens and medical equipment used. Less common are scissors (11 percent), knives (9 percent) syringes (5 percent) and guns (2 percent).
- Most nurses continue to work after reporting an incident of violence. Less than 1 percent refused to keep working and less than 2 percent were sent home. Fewer than a quarter were offered relief so that they could stop working if they needed to.
- The majority said that while management was supportive, nothing was done to solve the problem.
- Just over half of those reporting said they later had difficulty concentrating on their job. Others report being easily startled, psychological symptoms such as fear, physical symptoms such as headaches, difficulty working in an environment that reminds them of the past incident, and an actual impact on their ability to work due to injuries sustained.
- Only 20 percent say that they feel their employer is very concerned about their

overall safety at work including workplace violence.

"The statistics that came out of that report were both shocking and eye opening," added Higgins, "but they served as a wake-up call to those concerned with the health and safety of the commonwealth's patients and nurses."

"We're celebrating the passage of this legislation to Ways and Means in large part because of the hard work of the MNA's Health and Safety Committee and because of the blood, sweat and tears that many of our nurses gave to the cause," added Higgins. "Those nurses took extremely traumatic experiences and channeled them in a way that allowed them to become some of the most inspiring advocates that the MNA has ever seen."

The nurse advocates Higgins referred to include Charlene Richardson—an emergency department RN at Beverly Hospital who was assaulted by a man who lunged at her, grabbed her crotch and tore through her hospital scrubs—and Charles Palmer, an RN at Tewksbury Hospital who said during a June 29 hearing on S. 1329 that he "has been punched, kicked, scratched, bitten, even spit on" over the years.

Higgins also recognized the tremendous support that the MNA received from Sen. Jarrett Barrios (D-Cambridge), the bill's lead sponsor, and encouraged MNA members to contact his office and express their appreciation for the work he has done. Sen. Barrios' office can be reached at 617-722-1650 or via email at Jarrett.Barrios@state.ma.us.

Nurses and activists interested in helping S.1329 move through the Legislature are encouraged to contact their local legislators. Contact numbers can be found at www.mass.gov/legis/legis.htm. ■



Sen. Jarrett Barrios, lead sponsor of the Workplace Violence Bill

Health and Safety at Work

Learn about OSHA requirements for health and safety in your hospital

This is an OSHA 10-Hour General Industry Outreach Training with a focus on the health care industry. The program is being offered in two parts in Region 1 of the MNA at Union Station, 125 Pleasant St., Northampton.

Part 1: Tuesday, Nov. 15

Part 2: Tuesday, Dec. 13

8:30 a.m. to 3:30 p.m.

No charge for MNA members

Fee for all others: \$45 for the OSHA Standards textbook

- OSHA Authorized Trainer: Evie Bain, MNA Health and Safety Program Coordinator
- 6.0 contact hours for each part; total 12.0
- OSHA certificate to those who attend parts 1 and 2
- Contact hours provided by the Greater Boston Chapter of the American Association of Occupational Health Nurses
- Lunch provided
- Please bring a two-inch binder for the handouts

MNA members: Register by calling Susan Clish at 781-830-5723

GBAOHN members: Register by calling Terry Donahue at 781-784-5158

Chemical sensitivity: Scents may trigger responses in those with chemical sensitivities. Men and women are asked to avoid wearing scented personal products when attending these trainings.

MNA

OSHA

MNA nurse goes back to Louisiana to help victims of Katrina

By Gail McCarth

Reprinted with permission from
the Gloucester Daily Times

Jeanine Burns' parents live in Biloxi, Miss., a place nearly wiped out by Hurricane Katrina. But they are safe and are with their grandson, Michael, 13, after being moved from Biloxi to another local town.

But after the hurricane, the Burns family was still trying to find Michael's mother, sister and his baby nephew. They were last seen in Pass Christian, Miss., a coastal community.

This is part of the reason Jeanine Burns left her shift as an emergency room nurse at Addison Gilbert Hospital in Gloucester—an MNA bargaining unit—shortly after the hurricane to begin a journey to Louisiana to attend to the medical needs of Hurricane Katrina victims.

Burns took a three-month leave of absence from her job to volunteer for the Louisiana State Nurses Association. She will be based out of Monroe, which has a shelter with more than 2,000 evacuees, many of whom arrived from New Orleans.

Her parents, John and Dolores, were lucky—to a point.

"Their house is still standing, although it was flooded," Burns said. "But they lost five neighbors on the street. They're dead."

Burns is close to her parents, who left Biloxi to stay with other family members near where Burns is working. "I am so fortunate to be based near my family, but we are still searching for others," she said.

Burns said her entire family is in the South. But her daughter, Lani, and husband Justin Heath of Gloucester, just moved to Manchester, and her partner, John Doberman, is a teacher at a Gloucester middle school.

Her father, a retired Navy serviceman, is from Biloxi where her brother, Paul, has been guarding his parent's house.

After the hurricane, Burns tried for six days to reach someone from the nurses association.

"The nurses there were in dire straights," she said. "And the nurse I replaced when I first arrived hadn't been off duty since the hurricane first hit." Burns, who has been residing in a university dorm room, is working 12-hour shifts at the makeshift shelter.

But at some point, she hopes to go work in Biloxi.

Volunteers: be careful about disaster-related hazards

If you are considering volunteering in the Gulf Coast region and you have questions regarding the hazards and worker-safety issues associated with these efforts, call Evie Bain, coordinator of the MNA's health and safety division at 781-830-5776, or visit OSHA's natural disaster recovery page at www.osha.gov. ■

To prepare for her absence, Burns celebrated her daughter's 30th birthday a week early and finalized all arrangements.

"I'm missing my daughter's family and my grandchildren Maya and Lelia," she said.

But her daughter knows her mother's will. Her mother took her feeling of helplessness and turned it into action, Lani Heath said.

"I haven't had many concerns because I know she's strong. I think it's wonderful what's she's doing," said Heath. "My mother is a nurse. She's a giver, and this is something she felt very strongly about. She's always been an activist so I'm not surprised she went." ■



Donated scrubs, t-shirts and toiletries made their way from the MNA's Canton office to the Louisiana State Nurses Association immediately following Hurricane Katrina's terrifying pass through the Gulf Coast.

Debbie Walsh remembered for her passion, professionalism and activism

Debbie Walsh—a life-long nurse and a longtime MNA member—passed away in July after a prolonged battle with cancer.

Debra provided nursing care in Falmouth Hospital's maternity department for more than 30 years, working as a staff nurse, charge nurse, preceptor and as a clinical coordinator. She also served as chair of Falmouth's bargaining unit for most of the past 25 years, and she helped it to grow from a fledgling unit to one that achieved one of the best contracts for nurses in Massachusetts in terms of wages, benefits, education and protection of RNs' rights.



She was also a recipient of the MNA's 2004 Elaine Cooney Labor Relations Award which recognized her significant contributions to the professional, economic and general welfare of nursing.

Debbie's bargaining unit colleagues often said that she enabled "the voice of nursing in how care is delivered" to be heard by many committees throughout the hospital. From her 24-hour-a-day availability to nursing staff during Falmouth's downsizing, to her offering of support and intervention to nurses regarding patient care, Walsh's commitment to the bedside nurse and to patients was inspirational.

In the weeks since her passing, numerous friends and colleagues have contacted the MNA to share their stories and memories

of Debbie—including those below. We hope that these remarks remind all of those who worked with Debbie of the passion, dedica-

tion and love she had for her family, friends and profession. ■

A 'fire in the belly' passion

By Jean Jackson

Debbie was a remarkable woman with a palpable "fire in the belly" passion about the things she cared deeply, especially her professional life as a maternity nurse where she made sure that her moms and babies received the best care, education and birth experience available.

As an MNA chairperson, she cared not just about the nursing staff she represented so ably but also about the very ideals—the art and science of nursing, but particularly the art. Her passion also applied to her personal love of arts and crafts, from decorating and sewing costumes, to making candles and bath salts for gift giving;

But most of all, Debbie was passionate about her beloved daughters. First, last and always she thought about and provided everything she believed was best for her girls.

Debbie possessed honesty, moral integrity and the innate ability to see the big picture. She could be a super-sleuth (you really couldn't get away with anything); an advisor (she held many hands, big and small), and a counselor (whether about a job situation or with a grieving Mom). She had the ability and the wisdom to "know" the right thing to do at the right time—and she always did

it. Her accomplishments in her profession and her years of service in MNA are too numerous to list or possibly know.

She approached her battle over these past few years with the same passion and spirit that were her hallmark. She fought; she felt; and she expressed her passion. She did not fear death—only the physical pain that would accompany her disease. When the time came to abandon her frail, sick body, she surrendered her spirit while sandwiched between her devoted girls, and with them embracing her and with grace, she lifted off to become more fully enveloped in the world that she has always known.

Debbie leaves us her legacy of dedication, her in-your-face honesty, her loyalty, her truthfulness and her passion.

Thank you, Deb, for sharing yourself so openly, willingly and fully with all of us. The world is a much better place because of you.

Deb was loyal, dependable, sincere

By Cheryl Quimby

I knew Deb for 36 years; we went to nursing school together starting September 1969 at Lynn Hospital School of Nursing.

Deb started her leadership skills there when our class staged the first "lay in" for

student rights. As you know, we did not have many.

Deb was awarded the highest honor for maternity nursing at our graduation in 1972 and she continued with her love of that specialty until the day she died.

Deb was the most honest, straight forward person I've known. We worked together in OB for many years and we shared many experiences. Deb always did the "right thing" and she was always professional in every task she undertook.

Deb was loyal, dependable and sincere. She would tell you exactly what she thought and you always knew where she stood. She was fair and would fight for her nurses. Deb never used her position to further her own agenda.

She loved her two girls, Melissa and Marci. She made sure that they were able to reach their goals and dreams, and Deb saw them both grow in to beautiful young women and graduate from college. She was so proud of them.

Deb played a great role in my life and our lives will be forever intertwined as a result.

I will miss her laughter, smile, flaming red hair and all the times we spent together. She will remain in my heart and memories until we meet again. ■

MNA CONTINUING EDUCATION COURSES

Fall 2005 Courses

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. The nursing management of the newly diagnosed diabetic patient, both complicated and not, will be explored. Nursing management of the diabetic patient in the pre/post operative, ambulatory care, home care and school setting will be discussed.

Speaker Ann Miller, MS, RN, CS, CDE,

Date Oct. 27, 2005

Time 8:30 a.m. – 4 p.m. (*lunch will be 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

Interpreting Laboratory Values

Description

This program will enhance the nurse's ability to evaluate and determine the clinical significance of laboratory values. Clinical case studies will be used to illustrate the relationship of laboratory values to patient conditions. Clinical management of abnormal laboratory values will be discussed.

Speaker Carol Mallia, RN, MSN

Date Nov. 1, 2005

Time 5 – 9 p.m. (*light supper provided*)

Place MNA Headquarters, Canton

Fee MNA members \$45; all others \$65

Contact Hours* 4.1

MNA Contact Theresa Yannetty, 781-830-5727 or 800-882-2056, x727

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

Description

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

Speakers Legal Nurse Consultants, Southern New England Chapter of the American Association of Legal Nurse Consultants

Date Nov. 4, 2005

Time 8:30 a.m. – 2 p.m. (*light lunch provided*)

Place MNA Headquarters, Canton

Fee MNA and AALNC members \$75; all others \$99

Contact Hours* 4.8

MNA Contact Liz Chmielinski, 781-830-5719 or 800-882-2056, x719

Oncology for Nurses

Description


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

Speaker Marylou Gregory-Lee, MSN, RNCS, OCN, Adult Nurse Practitioner

Date Nov. 9, 2005

Time 8:30 a.m. – 4 p.m. (*light 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

Cardiac and Pulmonary Pharmacology

Description

This program will provide nurses from all clinical practice settings 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 December 6, 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 800-882-2056, x719

CONTINUING ED COURSE INFORMATION

Registration

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

Payment

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

Refunds

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

**Program
Cancellation**

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

***Contact
Hours**

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

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

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

**Chemical
Sensitivity**

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

**All MNA programs are free of charge
to Region 5 members**

MORE EXCITING GROUP TRIPS TO EUROPE IN 2006!

MNA is pleased to announce we are promoting these trips.

GREECE, WITH A THREE-NIGHT GREEK ISLAND CRUISE

\$1,869* outside cabin or \$1,799* inside cabin
Oct. 24 – Nov. 1, 2006

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



FLORENCE, VENICE AND ROME

\$1,729*
Nov 6-14, 2006

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



Reserve Early  Space is Limited

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

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

MNA membership dues deductibility 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
All Regions	\$16.63	5.0%

The Massachusetts Nurses Association joins MITSS to provide support for nurses as a result of an adverse medical event.

"To Support Healing & Restore Hope"

Program Mission/Philosophy

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

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

MITSS supports clinicians using the following resources:

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

MITSS Toll-Free Number **888-36-MITSS**
MNA MITSS Referral Line **781-821-4625, x.770**
MITSS Web Site <http://mitss.org>

This service is available to any RN in Massachusetts.



MNA

MNA Member Benefits Save You Money

Personal & Financial Services

PORTABLE HEALTH INSURANCE

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.

DISCOUNT TAX PREPARATION SERVICE

TAXMAN INC. 800-7TAXMAN
20% discount on tax preparation services.

HOME MORTGAGE DISCOUNTS

RELIANT MORTGAGE COMPANY 877-662-6623
Save on your next home loan/mortgage with discounts available to MNA members and their families. Receive discounts off mortgage applications for home purchase, refinance and debt consolidation loans. Inquire into no points/no closing costs programs and reduced documentation programs. Receive free mortgage pre-approvals.

TAX REVIEW SERVICE

MERRIAM TAX RECOVERY 508-340-0240
Experts in recovering overpaid taxes.

LIFE & ESTATE PLANNING

LAW OFFICE OF DAGMAR M. POLLEX 781-535-6490
10-20% discount on personalized life & estate planning.

Products & Services

AUTO/HOMEOWNERS INSURANCE

COLONIAL INSURANCE SERVICES, INC. 800-571-7773 OR 508-339-3047
MNA member discount is available for all household members. No service changes when choosing convenient EFT payment plan. Prices competitive with AAA. For a no obligation quote visit www.colonialinsuranceservices.com.

CELLULAR TELEPHONE SERVICE

CINGULAR WIRELESS 781-690-5368
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
Get more of the wireless products and services that keep mobile professionals connected. T-Mobile is offering MNA members and their families a free phone with activation, free nationwide long distance and roaming and free nights and weekends (on specific plans). International rates also available. No activation fee is required for members.

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 617-839-6684
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. Now you can order online with no shipping or account setup fees at www.nextel.com/massnurses/

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.

JEFFY LUBE DISCOUNT

MNA DIVISION OF MEMBERSHIP 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.

OIL BUYING NETWORK DISCOUNT

OIL BUYING NETWORK 800-649-7473
Lower your home heating oil costs by 10-25 cents per gallon or \$150 per year.

WRENTHAM VILLAGE PREMIUM OUTLETS

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

SIGHT CARE VISION SAVINGS PLAN

MNA DIVISION OF MEMBERSHIP 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. Visit www.massnurses.org for a printable coupon to present at time of purchase.

BROOKS BROTHERS DISCOUNT

Enroll online to receive 15% discount at Brooks Brothers, Adrienne Vittadini and Carolee. Visit <http://membership.brooksbrothers.com>. (ID=87400, PIN=97838)

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 DIVISION OF MEMBERSHIP 800-882-2056, x726
Showcase Cinemas/National Amusements, \$7. 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 DIVISION OF MEMBERSHIP 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.

SIX FLAGS NEW ENGLAND

MNA DIVISION OF MEMBERSHIP 800-882-2056, x726
Purchase discount admission tickets for \$24 per person.

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

Wanted! Nurses with professional experience in chemical dependency and/or psychiatric disorders

The Board of Registration in Nursing's Substance Abuse Rehabilitative Program (SARP) is seeking committee members to serve on the evaluation committee. The SARP program is five-year program which exists to assist nurses who have problems with alcohol and/or other drugs to return to practice while protecting the public's health, safety and welfare. The SARP was established as a voluntary alternative to disciplinary action for nurses who have alcohol and drug problems.

Nurses who participate in the program must agree to a five-year contract which requires formal therapy, toxicology screening and attendance at self-help groups. Regular self-assessment of the individual's progress in recovery and stipulations for employment, as well as the use of prescribed and over-the-counter medications, is required of the participants on a quarterly basis and reviewed by the evaluation committee.

The SARP has an oversight committee known as the Substance Abuse Rehabilitative Evaluation Committee (SAREC) which meets monthly in three locations throughout the state to review the status of the nurse participants from the area. The monthly meetings are held in Holyoke, Boston and Plymouth. SAREC committee members are individuals who are knowledgeable in the field of chemical dependence and/or psychiatric disorders and are appointed by the Board of Registration in Nursing. Committee members, with the assistance of the SARP Coordinator, assess, plan, implement and evaluate the treatment plan for nurse licensees participating in the SARP.

There is a critical need for nurses with experience and knowledge in the field of chemical dependence and or psychiatric disorders to serve as SAREC members. It is a voluntary position with a monthly meeting commitment. Volunteer committee members give of their time to share their expertise and serve the needs of such an important and valuable rehabilitative program for nurses in recovery.

Nurses interested in more information regarding the SAREC or the SARP program are encouraged to contact Connie Borden, the SARP coordinator, at the Board of Registration in Nursing at 617-973-0904. ■



MNA

PEER ASSISTANCE PROGRAM

Help for Nurses with Substance Abuse Problems

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

CALL THE MNA PEER ASSISTANCE PROGRAM

ALL INFORMATION IS CONFIDENTIAL

781-821-4625, EXT. 755

OR 800-882-2056 (IN MASS ONLY)

WWW.PEERASSISTANCE.COM

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

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

Boston Metropolitan Area

- Bournwood Hospital, Health Care Professionals Support Group, 300 South St., Brookline. Contact: Donna White, 617-469-0300, x305. Meets: Wednesdays, 7:30–8:30 p.m.
- McLean Hospital, DeMarmeffe Building, Room 116. Contact: LeRoy Kelly, 508-881-3192. Meets: Thursdays, 5:30–6:30 p.m.
- Peer Group Therapy, 1354 Hancock Street, Suite 209, Quincy. Contact: Terri O'Brien, 781-340-0405. 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, for those employed at private health care systems. Contact: John William, 508-834-7036. Meets: Mondays.
- Nurses for Nurses Group, Hartford, Conn. Contacts: Joan, 203-623-3261, Debbie, 203-871-906, Rick, 203-237-1199. Meets: Thursdays, 7–8:30 p.m.
- Nurses Peer Support Group, Ray Conference Center, 345 Blackstone Blvd., Providence, R.I. Contact: Sharon Goldstein, 800-445-1195. Meets: Wednesdays, 6:30–7:30 p.m.
- Nurses Recovery Group, VA Hospital, 5th Floor Lounge, Manchester, N.H. Contacts: Diede M., 603-647-8852, Sandy, 603-666-6482. Meets: Tuesdays, 7–8:30 p.m. ■

Benefits Corner

Life and estate planning services

The law office of Dagmar M. Pollex provides complete personalized life and estate planning solutions. We use innovative and practical strategies to make sure clients achieve their goal of maintaining control over their assets and their lives.

We take the time to learn what's important to our clients so that together we can design a plan that is suitable for their goals. We also provide planning for families who have children with special needs and those who need expert help with long-term care and Medicaid planning.

For more information or to schedule an introductory meeting, call 781-535-6490 or 800-756-7992. ■

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Pain Research, Education and Policy
& Certificate of Advanced Study in Pain Topics

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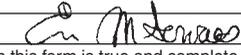
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jeanne.connolly@tufts.edu

CALL:
617-636-3631



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