

the Massachusetts **nurse** Advocate

THE NEWSLETTER OF THE MASSACHUSETTS NURSES ASSOCIATION ■ VOL. 79 NO. 4



April 2008

YOU'RE INVITED

National Nurses Day Celebration & Rally May 6, 2008

Featuring Speeches By
**Patti LaBelle &
Suzanne Gordon**

see
Page 3

Origins of Mass-Care	2
Rep. Walsh, Sen. Galluccio: our allies, our friends	4
Help save your Social Security	5
Q & A with health care journalist Suzanne Gordon	6
Organizing around grievances	8
Bargaining unit updates	9
Medication Reconciliation in EDs	11
MNA position statement on exposure to chemicals	12
Election season is here	14
Spring CE courses	19
MNF scholarships	21

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A brief history of Mass-Care

By Sandy Eaton, RN
Mass-Care Vice-chair

Readers of *The Massachusetts Nurse Advocate* have seen frequent references to Mass-Care. MNA has been involved with this statewide coalition for fundamental healthcare reform since its inception in 1995. Here are some highlights of this exciting 13-year history.

The Massachusetts Campaign for Single Payer Health Care grew out of a statewide battery of local non-binding ballot questions in November 1994. These questions urged legislators to support bills to create a publicly-funded, universal, portable, comprehensive healthcare system for the commonwealth. A solid majority of voters in eight communities spread across the state affirmed the need for real change. Even though there had been such ballot initiatives in the past—and indeed single-payer bills filed—this time an organizational structure was in place to keep the momentum going.

Jobs with Justice is a national labor-community coalition working for workers' rights and economic justice. The Massachusetts chapter had a functioning healthcare action committee, which had been engaged for several years in lobbying for progressive legislation on the state and national levels, as well as in rallying the troops for such demonstrative action as encircling the John Hancock tower in Boston with red tape, symbolizing the wasteful overhead of commercial health insurance. Meeting in the South Boston offices of UE Local 262, Jobs with Justice resolved to pull together the local and statewide organizations that had been working on the ballot questions in order to form a broad and powerful movement for healthcare justice. The JwJ committee then disbanded.

Since MNA had resolved at its 1994 business meeting to endorse the single-payer ballot initiative, it became involved in Mass-Care right from the beginning. Several years ago, Jobs with Justice reconstituted its healthcare action committee in order to draw more of organized labor into the healthcare fray. Coming full circle, this JwJ committee now meets monthly in the Chinatown office of Mass-Care and is considered its Boston chapter.

Mass-Care constituted itself as a coalition of organizations which support the single-payer solution to the access-affordability-quality crisis in health care. It established a coordinating committee, made up of representatives of each of its participating organizations, meeting monthly in a central location, usually Worcester, to decide on direction and policy. An advisory board, recently enlarged and

enlivened, brings the weight of expertise and political savvy to Mass-Care. The Universal Health Care Education Fund was incorporated as a 501(c)(3) to stimulate education and research.

Since 1996, Mass-Care has filed legislation to create the Massachusetts Health Care Trust each biennial session. With each refiling, the language has been sharpened. Sen. Bob Travaglini and Rep. John Stefanini had been lead sponsors of Mass-Care's bill in earlier years. Sen. Steve Tolman and Rep. Frank Hynes have led the way in recent sessions. Although the bill has yet to come out of committee, single-payer activists have had the opportunity to press forward on educational work and research.

Two independent studies commissioned by the Massachusetts Medical Society and funded by the Senate Ways & Means Committee in 1999—one by Solutions for Progress, the other by the Lewin Group—have shown that a single-payer system in Massachusetts would cover everyone and save money. Parallel initiatives around Question 5 on the 2000 Massachusetts ballot and the subsequent constitutional amendment campaign have produced studies that reached the same conclusion.

For 10 years now we've held an annual celebration of the contributions of one of our early champions, the late psychiatrist Benjamin Gill. This affords us the opportunity to honor living champions, to come together to explore burning issues, and to solidify our movement.

What do we now have to show for all this work? Currently, more than 100 organizations have come forward to endorse the bill and the campaign, from such large membership organizations as the Massachusetts Teachers Association to town committees. The League of Women Voters, the Massachusetts Senior Action Council and, of course, the Massachusetts Nurses Association, are among the most active. A score of municipalities have resolved to support single payer, including the city councils of Northampton and Boston. Organized chapters of Mass-Care exist from the Berkshires to Cape Cod.

Nothing beats solid grassroots organizing, and nothing of consequence will succeed without it. As the inadequacies of the market-based approach to health care reveal themselves in more and more medical bankruptcies, premature deaths and denial of care, the single-payer approach, with healthcare seen as a right and not a commodity, will come to the fore as the only rational and humane step forward.

To contact Mass-Care, call 617-723-7001 or go to its Web site, www.masscare.org. ■

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www.massnurses.org

MNA^{BM}
MASSACHUSETTS NURSES ASSOCIATION



MNA initiatives on safe staffing, safe patient handling move forward

As the spring season arrives and with it the hopes for all things new, so too can nurses take hope that new improvements in their practice – both to protect their patients and their own safety – may be on the horizon.

In recent months, we have seen positive movement by the Legislature on two key bills filed by the MNA. The Public Health Committee has given favorable reports to the MNA's safe patient handling bill, and most exciting of all, to our safe RN staffing legislation, H.2059.

The safe patient handling bill would require health care facilities to provide safe patient handling systems and technology to prevent muscular-skeletal injuries. The safe RN staffing bill would set a safe limit on nurses patient assignments, require hospitals to adjust staffing based on acuity, ban mandatory overtime

and floating without orientations, while providing numerous initiatives to increase the recruitment and retention of nurses. Action on the safe staffing bill could take place at any moment, so please visit the MNA Web site at www.massnurses.org for regular updates on this vital measure that could dramatically improve nurse practice for every acute care nurse in the Commonwealth.

National Nurses Day celebration and rally—see you on May 6

With spring also comes National Nurses Week, May 6–12. The MNA has planned an exciting event for all nurses on National Nurses Day, May 6. This celebration in honor of nurses and their contributions to quality patient care will run from 10 a.m. to noon at the Hynes Convention Center, featuring a keynote address

from Grammy-award winning singer Patti LaBelle in addition to a presentation from Suzanne Gordon, an award-winning journalist and author of seven books on nursing.

A rally for safe patient limits on the steps of the Statehouse will culminate the May 6 MNA National Nurses Day celebration. Open to all nurses, nursing students and supporters of nurses, the 1–2 p.m. rally will be in support of legislative action on H.2059, the Patient Safety Act. ■



Beth Pickett

Patti LaBelle keynote speaker during MNA National Nurses Day celebration May 6

Patti LaBelle, multiple Grammy-award winning singer, actress, and best selling author will deliver the keynote address on May 6 during the MNA National Nurses Day celebration.

The special event in honor of nurses and their contributions to quality patient care is free to all nurses and nursing students and will run from 10 a.m. to noon at the Hynes Convention Center, followed by a 1 to 2 p.m. rally on the steps of the Massachusetts Statehouse.

Recognized for her support of social causes, LaBelle has for many years worked tirelessly to raise awareness about AIDS, Alzheimer's disease, diabetes, cancer and foster care. Her May 6 keynote speech at the Hynes Convention Center, titled "Singing Their Praises: One Woman's View on the Difference Nurses Make" is a subject LaBelle has intimate knowledge of. As chronicled in her book "Don't Block the Blessings" LaBelle is all too familiar with the impact of safe patient ratios on the nursing industry. The best-seller was authored by LaBelle following a series of traumatic personal medical events, including the loss of her mother, three sisters and best friend to diabetes and cancer.

A diabetic herself, LaBelle has been proactive in the fight against the disease that claimed her mother's life. She serves as a spokeswoman for the National Medical Association, the National Minority AIDS Council's "Live Long, Sugar" campaign and the American Diabetes Association. Her inspirational speeches convey a powerful message of hope

— YOU'RE INVITED —

National Nurses Day

May 6, 2008 

MNA™

National Nurses Day Celebration & Rally
Featuring Speeches By Patti LaBelle & Suzanne Gordon

- ▶ Hynes Convention Center 10 a.m. – noon
- ▶ Rally For Safe Patient Limits State House Steps 1 – 2 p.m.

FREE to all Nurses and Students ♦ Bus Transportation Provided

To register for the event and to reserve a seat on a bus, call the MNA at 888-662-0411

for nurses and patients who must work in partnership to fight disease and achieve healing.

Suzanne Gordon, an award-winning journalist and author of seven books on nursing, including "Life Support: Nursing Against the Odds" will also be a featured speaker during the 10 a.m. to noon event. Her book, "Safety in Numbers: Nurse-to-Patient Ratios and the Future of Health Care" is slated for publication by Cornell University Press this month. "Safety in Numbers" is the first book to examine the arguments for and against ratios. During the May 6 MNA National Nurses Day celebration, Gordon will discuss her findings and provide insight into the measures nurses

in Massachusetts can take to win their fight for safe patient limits.

A rally for safe patient limits on the steps of the Statehouse will culminate the MNA National Nurses Day celebration. Open to all nurses, nursing students and supporters of nurses, the 1 to 2 p.m. rally will be in support of legislative action on H.2059, the Patient Safety Act.

The MNA will provide bus transportation to this special event from stops throughout the state; however bus seating is limited. To register for the event or to reserve a bus seat, call 888-662-0411 without delay or visit www.massnurses.org for more information. ■

Standing tall with nurses on Beacon Hill

Representative Walsh, Senator Galluccio are strong allies

When workers call, he always answers

Rep. Martin J. Walsh, a Democrat representing the 13th Suffolk District of Boston, has been a member of the Massachusetts House of Representatives since 1997. A lifelong resident of Dorchester, Walsh quickly embraced public service as his calling in life. An advocate for children's issues, substance abuse treatment, and high quality public services, he has served his constituents in Dorchester well. But it is as an advocate for organized labor in Massachusetts that Walsh has



Martin Walsh

really distinguished himself. After completing high school, and long before Walsh entered politics, he followed in his father's footsteps and worked as a laborer in Laborers Local 223. He wasn't just a union member, he was a union activist and leader, and from day one in the legislature Marty has continued to be a tireless advocate for labor unions and a vehement opponent of legislation and policy threatening the rights of workers in Massachusetts.

Again this year, as the commonwealth faces yet another difficult budget cycle, state employee health insurance benefits are on the chopping block. And again this year Walsh has readily agreed to lead the fight to protect those important benefits. The MNA represents about 1,800 RNs and health care professionals who work for the state. Those workers face a 67 percent increase in the cost of their health insurance premiums under the schemes presently proposed. Win or lose, we can count on Walsh to fiercely resist this proposal.

"This proposed increase is just unacceptable," Walsh said. "State employees pay more

for their health insurance every year. Between rising premiums and exorbitant co-pays and deductibles, state employees are paying more out of pocket than ever."

We also count Walsh as one of the strongest supporters of H.2059, The Patient Safety Act, which would set a safe limit on the number of patients that a hospital nurse has to care for at once. "It is time for action on this issue," said Walsh. "Study after study has demonstrated the connection between nurses forced to care for too many patients at once and poor patient outcomes. Still, the hospital industry resists this commonsense reform. It is time for the legislature to pass H.2059."

No matter the issue on organized labor's agenda, we can count on Walsh to take the lead on fighting for workers.

New senator, long track record

State Sen. Anthony Galluccio (D-Cambridge) is one of the newest members of the Massachusetts State Senate. He won a special election to fill the seat previously held by Jarrett Barrios in October of last year, so he has been serving in the Senate for just a few months. But despite his short tenure in the state legislature, Galluccio has a long track record of supporting MNA members. It was this track record that led the Mass Nurses PAC to endorse him in his race for the Senate last year, and it is this same track record that gives our members such a high degree of confidence in his willingness to fight hard for them.



Anthony Galluccio

Prior to his election to the Senate, Galluccio

was a member of the Cambridge City Council for 14 years and was first elected in 1994. He was in that role when Cambridge Hospital changed from a city-based facility to a public health commission. He fought hard throughout that process to protect community-based, quality health care services, and led the effort to create the Cambridge Health Alliance (Cambridge Hospital, Somerville Hospital, Whidden Hospital and related neighborhood health clinics) so as to preserve those services. But Galluccio wasn't just interested in protecting services – he was also passionately committed to protecting employees. He insisted that the employees of Cambridge Hospital maintain their hard-won wages and benefits.

"Anthony Galluccio fought to protect the pensions and health insurance benefits of the nurses at Cambridge Hospital," said Donna Kelly-Williams, chair of the Cambridge bargaining unit and Vice President of the MNA. "We turned to him again and again for help, and he was always there for us."

Now that he's in the Senate, the battle looming for RNs is the fight over H.2059, The Patient Safety Act, which would set a safe limit on the number of patients that a hospital nurse has to care for at once. In that fight, we know that Galluccio will be one of our strongest supporters. In fact, Galluccio, a member of the legislature's Public Health Committee, pledged his public support for the bill at a public hearing on Oct.24 as one of his first acts as a Senator.

"Quality health care was one of the key issues during my campaign," said Galluccio. "H.2059 is critically important to quality health care, along with the many professional development enhancements within the bill."

Our members look forward to continuing to work with their old friend and ally, now-Senator Galluccio. ■



Washington Lobbying: A spirited group of MNA members traveled to Washington in February to lobby members of the Massachusetts Congressional delegation — including Senator Kennedy — on a range of important issues.

The Patient Safety Act: Next steps

Your state representative needs to hear from you!

Thanks to you, H.2059, the Patient Safety Act, has been reported favorably out of the Public Health Committee.

Now is the time for you to contact your state representative and ask him/her to urge the speaker to move H.2059 to the House floor. To find out who your state representative is, go to www.capwiz.com/massnurses

We need your help! Please call your representative and urge him/her to make getting the Patient Safety Act bill on the floor of the House a priority. These calls really make a difference! It's important to make that call today. Patients are suffering and dying. It's time to act.

Are you a public sector employee? If so, help save your Social Security!

Social Security Fairness Act of 2007:

Your U.S. congressperson and senators need to hear from you!

S. 206/H.R. 82
In January 2007, The Social Security Fairness Act of 2007 was referred to the Senate Committee on Finance and the House Subcommittee on Social Security, and it has not moved since.
Now what?

Call your U.S. congressperson and senators and ask that S. 206/H.R. 82 be moved out of committee now! To find out who your U.S. elected official is go to www.capwiz.com/massnurses

Decades ago Congress enacted the windfall elimination provision and the government pension offset, both of which reduce social security benefits for public employees in Massachusetts who have paid into social security.

When talking to your U.S. senator/congressperson let them know:

- You appreciate them being a co-sponsor on this legislation.
- With the Democrats in control of Congress, they are in a position to actually move this legislation, which languished for years while the Republicans were in control.
- Ask them to use their position in the majority party to correct this problem
- Public sector workers should not be unfairly penalized for their years of public service.

Leominster seniors make calls for patient safety

Leominster Senior Center members and guests, frustrated that a House vote has yet to be taken on H.2059, recently flooded the Statehouse with calls urging passage on The Patient Safety Act. Their state Rep. Jennifer Flanagan (D-Leominster) has been and remains one of the strongest supporters of the bill.

While Leominster seniors have consistently expressed gratitude for the hard work and advocacy of Flanagan, they hoped to stress the urgency of the bill's passage with their phone calls to her. The seniors delivered the message loud and clear that they make up the largest patient population and suffer the most catastrophic illnesses in our hospitals and want assurances that they receive the safest care possible when they or their loved ones become patients.

Under the leadership and guidance of Leominster Senior Center Director, Joan Fitzgerald, roughly 50 calls were made to Flanagan's office. ■



Leominster seniors congregated at their town Senior Center recently to make phone calls to the Statehouse urging passage of the Patient Safety Act.

Safety in numbers: nurse-to-patient ratios and the future of health care

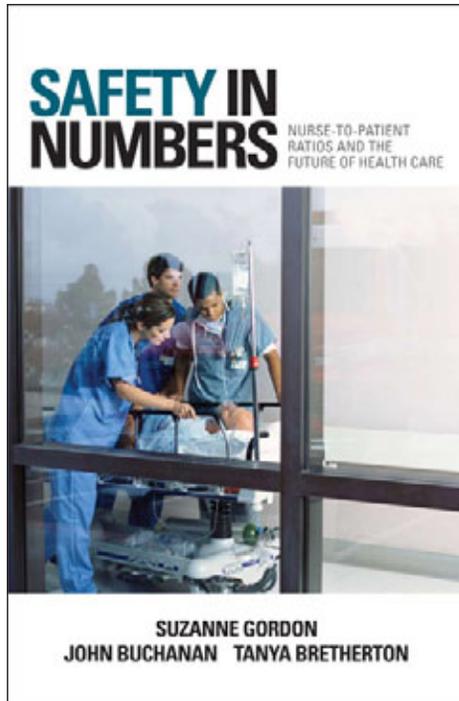
MNA goes one-on-one with award-winning health care journalist Suzanne Gordon

Author Suzanne Gordon raises a series of compelling issues in her soon-to-be released book *"Safety in Numbers: Nurse-to-Patient Ratios and the Future of Health Care."* Utilizing survey data, interviews and additional original research, Gordon and healthcare workforce researchers John Buchanan and Tanya Bretherton weigh the cost, benefits and effectiveness of ratios in California and the state of Victoria in Australia, the two areas where RN staffing levels have been mandated for the longest length of time. Gordon, also the author of *"Nursing Against the Odds: How Health Care Cost Cutting, Media Stereotypes, and Medical Hubris Undermine Nurses and Patient Care"* and *"Life Support: Three Nurses on the Front Lines"* recently sat down with the editorial board at MNA to discuss her latest book.

Q For someone who has spent the better part of two decades writing about nursing and nursing issues, what has led you to focus an entire book on the issue of safe staffing legislation?

A The answer is both personal and professional experience. I wrote my first book about nursing, *"Life Support: Three Nurses on the Front Lines"* which profiled three nurses at the Beth Israel hospital in Boston in the early 1990s. I spent almost three years at the BI and was constantly impressed with the quality of the nursing care. There was no talk about staffing ratios then – things looked really good for nurses and patient care in the late 80s and early 90s as hospitals were trying to resolve the last nursing shortage. I never asked about ratios and no one mentioned them. Why? Because they were excellent. On med/surg the ratio was probably 1 to 4 and remember this was a time when nurses were working eight hour days, were younger and patient acuity was much lower. The care was superb.

Enter managed care – or as I call it mangled care – and hospital restructuring. And I could see with my own eyes and hear with my own ears how bad things were getting and continued to become. I watched nurses scrambling. I heard their stories. I saw the despair and weariness etched on their faces. And I saw and heard what happened to patients. My mother, mother-in-law and father-in-law were some of those patients. Nurses were rushed and brusque; some seemed downright callous and uncaring. They got the basics done – sometimes – but when it came to emotional connection,



education, advocacy, forget it; they simply did not have time.

What is more, before restructuring, when I'd done interviews with patients and family members about nursing care, or when I appeared on call-in shows about nursing on the radio, all I heard were great stories about nurses. "Oh the nurses were so terrific...oh, they made such a difference." Those were the comments I would hear. Then I began to hear something entirely different. "We barely saw the nurse." "Where were the nurses?" "Oh they were so rushed; I didn't want to bother them. Poor things." So you had patients trying to nurse the nurses. Or you had patients actually blaming the nurses for system problems – like understaffing and work intensification because after all, most patients and families aren't sophisticated enough to tell the difference between the nurse who's required to enact bad policies and the people who make those policies – people with whom the patient never comes in contact.

So it was becoming clear that there was something drastically wrong. And then of course, as I was reporting on what was wrong, we started hearing about efforts to implement staffing ratios. I spent a great deal of time in California and several months, on and off, in the state of Victoria in Australia. I wrote about staffing ratios in *"Nursing Against the Odds"*

but I could only deal with the subject in brief. It seemed impossible not to explore this issue more thoroughly.

I decided I wanted to write a book about the issue for the series of books on *The Culture and Politics of Health Care Work* that I co-edit with Sioban Nelson, who is now the dean of the University of Toronto School of Nursing and who was, until several years ago, the dean at the University of Melbourne School of Nursing. I knew that I could not possibly research the situation in Victoria – the other major spot where ratios have been enacted – from this distance. Fortunately, I was able to hook up with two wonderful health care workforce researchers – John Buchanan and Tanya Bretherton at the University of Sydney. They had documented and analyzed work intensification or overload in nursing and other areas of work. They had conducted a number of excellent studies on nurses' problems in Victoria for the Victorian Branch of the Australian Nursing Federation. I was so thrilled that they agreed to partner with me and look at the history, struggle for, and outcomes of ratios in Victoria.

Q Having spent years studying this policy initiative in California and Australia, the most important question nurses and policymakers would want to have you and your colleagues answer is simply this...are the ratios working?

A First, let me say that John, Tanya and I are not cheerleaders for ratios. We support ratios but we do not think they are a panacea for the many ills besetting nursing. But we are convinced that other solutions will simply not work without the control of the nursing workload. If nurses come to work not knowing whether they will take care of four patients or 14 patients, then they will simply burn out and either quit or detach from their work.

The dirty secret of work overload is that if you overburden nurses with too many patients who are as sick as they are in hospitals today, patients will become a problem, an undesirable, and not a challenge to them...and the challenge is the reason why they became nurses in the first place. Nurses will want to flee their patients and their workplaces, not embrace patient care and their work. And that's exactly what we are seeing. We are seeing nurses facing unacceptable levels of stress. We are seeing patients

suffer, and we are seeing new recruits fleeing the hospital because they just can't take the work overload.

We have seen all this occur in California and in Victoria, which is why the ratios solution seemed to these nurses the only way to begin solving a whole host of problems. And yes, also as a solution to work overload; to unbearable levels of job stress; and to burn out...the ratio solution is clearly working. In Victoria, more than 7,000 inactive nurses were brought back into the systems. Nurses we have interviewed have said they cannot imagine how they managed without ratios and have fought – in two sets of subsequent contractual negotiations – to fight to retain and improve ratios that were implemented in 2000.

In California, nurses fought for over a decade to win ratios and all the nurses I have interviewed say things are better because of those nurses. Linda Aiken and Sean Clarke at the University of Pennsylvania have done research on the ratios there and have concluded that they are indeed improving recruitment, retention, job satisfaction and reducing burn out.

Are they solving every problem? No. Can they solve every problem? No. But when it comes to patient care we have to be very careful not to let the perfect become the enemy of the good.

Q Did you detect key differences in approach between California and Victoria that other states like Massachusetts can learn from?

A Yes, I think it makes a lot of difference when you have a tax supported universal health care system – as they do in Victoria – and a largely for-profit private system as we do in the US. For example, because they actually do health care planning in Victoria, ratios are a funded mandate.

It also makes a difference when you have a union that represents 65 to 70 percent of nurses in the system, a union that additionally represents nurse unit managers and even CNOs. What is really interesting about the situation in Victoria is that so many nurse managers understood what, tragically, nurse managers fail to understand here. Ratios make it easier to manage care. Ratios protect the nursing budget. With ratios, doctors and medicine and administration cannot keep poaching from the nursing budget. Also the Victorian ratios are not 1 to 4 on med/surg but 5 to 20, an interesting twist which merits exploration.

Q You focus an entire chapter in your book on the research that has been done concerning this issue. In summary, what did your review of this research tell you about the efficacy about regulating staffing levels?

A The research is unequivocal. Staffing – particularly understaffing – makes a significant difference in patient mortality and morbidity. That's unarguable. We don't know what the perfect number is... is it 1:3, 1:4, 1:5? We just don't know. But we sure know what it isn't. And it isn't 1:7, 1:8 or 1:15. What these studies also suggest is that if people want to hone in on a more precise number above which it is unsafe to staff, then do the research and figure it out. It's tough but it ain't rocket science. Plus, we need to look not only at patient outcomes but to also consider the impact of work overload on nurses' health. It's time we stopped considering nurses as some sort of disposable medical equipment. You use it, you break it, you throw it out and well, we know nurses are self-sacrificing angels of mercy, so they won't be bothered when their health suffers. That kind of thinking must stop.

Q You also featured an entire chapter in your book on the arguments the hospital industry and others have used against this type of legislation. You even used arguments taken directly from Mass. Hospital Association ads against the MNA bill. How do the industry's arguments stand up against the experience with ratios you studied in California and Victoria?

A The issues made by many opponents to ratios are serious ones. It is because we take them so seriously that we have dedicated an entire chapter to them. We believe, however, that any debate about ratios should be based on a realistic view of how nursing care is provided in an unregulated environment in which considerations of cost tend to predominate. Much of the anti-ratio propaganda is, unfortunately, based on a fantasy of how care is currently delivered and a fictional view of how much power nurse executives have in the current environment.



Suzanne Gordon

Q In studying how these laws were achieved in other places, what advice would you give our readers about what is needed to make this law pass here in Massachusetts?

A It's absolutely critical to mobilize the public, nurses, and patients and families around these issues. I have long been a proponent of ratios because of my professional observations and because I have observed the care close friends and relatives receive. I have become even more concerned about staffing arguments since my own unfortunate experience with hospital care a year and a half ago.

I had an emergency appendectomy in Vermont. It was Columbus Day weekend, not the best time for such an event. The unit was clearly understaffed. Things were particularly hectic at night. I realized then, what a myth it is that patients aren't as sick at night and therefore you don't need as many nurses on the unit. I was operated on at around 8 p.m. on Sunday night and got back to the unit near midnight. It was nighttime and I was sick.

When I was alert enough to observe things, what I realized was that new graduates and even people still in nursing school were my primary caregivers. Some of them had four year degrees in other subjects. They were very smart, but they had no experience in nursing and clearly no mentoring. They had way too many patients. I could see them fall apart in front of my eyes as things got more hectic. One of them thrust a basin and washcloth in my hands and told me, "Here, wash yourself." I was on pain meds and hadn't pooped for three days. No one even mentioned a bowel regimen. I ended up with two serious complications, one which still bothers me. And I almost ended up with an impacted bowel and am thankful I didn't get an infection because one of the nurses didn't wash her hands. When I describe my experience to people, they say, "I can't believe that happened to you." Well, let me tell you, I wasn't shy, I politely told them I was a journalist and that I wrote about nursing. And it mattered not a jot. If you're taking care of seven patients – some of who were a lot worse off than I was – you just can't deliver good care. When I lay in that hospital bed, in pain, frightened, and far from home, all I could think about was, "how can anyone (pardon my French) screw around with nurse staffing. What are they thinking? ■

Organizing around grievances

By Joe Twarog

The grievance and arbitration procedure is the key enforcement mechanism in a labor contract. When violations of the contract occur, the grievance procedure is the primary procedural way to challenge the violation and have it remedied. However, the procedure is a tool and not necessarily a solution. Successful resolution of disputes may and can occur without the grievance process.

Furthermore, many workplace issues are settled either informally or at the first step of the process, especially where there is a mature bargaining relationship and the employer recognizes the union as a fact of life at the workplace

Most MNA contracts have a grievance article that includes 3 progressive steps followed by arbitration. Timelines are usually indicated throughout the process: for filing at each step; for a hearing; and, for a response from the employer. However, often these timelines are waived for any number of reasons.

Time delays, however, can expand a normally long process into often an interminably lengthy, tedious and drawn out affair that frustrates and angers the grievant and delivers justice so slowly that it seems lost.

In some instances delays cannot be helped due to either the nature of the grievance or the availability of the parties for a meeting. But in many other cases, it is intentional and by design. That is, the employer is more than happy to have the grievance experience be a protracted and painful one in order to send the union and the grievant a message. The grievance process can be manipulated by the employer into a “paper war” that focuses on frustration rather than on resolution.

The grievance process itself is often isolating for the grievant and removed from the daily workings of the unit or floor. Very few people are involved even though a significant amount of time and effort is spent fighting the grievance. However, the union can help shine a light on the grievance and publicize it so that the issue becomes one that the union as a whole fights for and not just the grievant alone. Many grievances involve matters that impact far more than only one individual.

Take the case of a union activist who is targeted by the employer because the employer feels threatened by the union and that person in particular. The activist may be disciplined or even terminated for an alleged “clinical practice” issue. That action has a chilling effect on union activism throughout the bargaining unit, until the case is resolved. Unfortunately, that result could be two years away. In the mean-



Joe Twarog

time, management has effectively curtailed the union through intimidation even if the grievance is lost in arbitration many months hence. It is an old tactic that many employers still use. It is considered the price of “doing business” – lose the grievance and pay the penalty, but weaken the union in the process.

The union can challenge this in many ways, while still proceeding with the formal grievance process. Here are some ways. None of these are mutually exclusive and may be pursued at the same time.

1. Information requests. The union is entitled to information to investigate and process the grievance. It should be the norm to file a written information request for all relevant material, data and witnesses associated with the case. Bob Schwartz, (a Boston-based attorney who has written extensively on union rights in the workplace) has stated that employers often feel much more pressure from the information request than from the grievance itself. This act in itself may go a long way towards a resolution of the matter.

2. Group grievances. There is always safety in numbers and for those workers who are a little reluctant to “rock the boat” on their own, they can find safety and comfort with a group grievance. Such a grievance obviously involves more people and makes it harder for the employer to minimize the contract violation. Simply put; more people are invested in the issue and the outcome.

3. Visible and public response. The union can effectively add pressure on management to deal with the grievance by displaying some visible and public message targeting the issue. This outward sign of unity and support can take any number of forms, including: a sticker, ribbon, petition, unity break, or whatever way the members feel comfortable doing. The visibility in itself has multiple positive effects as it: reassures the grievant(s); challenges management to stop any delays and resolve the matter; builds the strength and unity among the membership; etc. Finally, the resolution of the grievance should be included in the unit’s newsletter so that all the members are aware of the matter.

4. Action. The members may decide to further increase the pressure by engaging in some form of activity. These also have a wide range- from a “unity break” to an informational picket. These actions serve the purpose again of: exposing the

violation and problem; uniting the members; and, of taking control of the process.

5. Creativity and confrontation. The activities should be creative, inventive compelling and even fun. They also should engage the members and make the unmistakable point of challenging and confronting management’s contract violation. Organizing around grievances in such a manner empowers the membership, speeds up the process, builds the union, and is one that management has no control over at all. Finally, confrontation can hold **individuals** responsible for their actions, rather than a faceless institution.

Management may attempt to delay the grievance process procedurally and frustrate all involved, but the union can respond with such a creative campaign. For those employers that choose to undercut and abuse the process, the union must respond forcefully and publicly. Organizing around grievances has innumerable benefits, but most of all it removes the grievance from management’s control and comfort zone where delays and manipulation is often their goal. The union is only as strong as its membership, and involving the membership in the fight to enforce the contract makes the contract all the stronger. ■



MNA Region One Legislative Breakfast

Saturday, May 31
The Delaney House
Holyoke, MA

The Topic will be
suicide prevention and
CEU’s will be provided.

**Look for details in the next
Region One newsletter.**

Bargaining unit updates

Worcester School Nurses

Worcester School Nurses continue in mediation. A grievance was won on behalf of a nurse who was denied her appropriate step raise. An additional grievance was settled involving overpayment to a nurse.

West Springfield School Nurses

West Springfield School Nurses have met to begin the process of gathering proposals for upcoming negotiations. Additionally, an election for new officers is underway.

Mercy Medical Center

Mercy Medical Center nurses have been in negotiations since October and have filed for Federal Mediation. The nurses are particularly concerned about the many takeaways and attacks to nurses' professional practice at a time when so many unsafe staffing forms are being filed. The economics proposals are also a problem.

Jordan Hospital

The Jordan Hospital MNA staff nurses have formed a Peer Support Team. Members of the team have training in conflict management and communication. The mission of the team is to provide a non-biased, confidential environment for conflict resolution within the workplace. All meetings are strictly on a voluntary basis. The goal of the Peer Support Team is to foster a positive work environment by helping to facilitate constructive, collaborative interaction among peers. It is hoped that nurses will feel free to voice their concerns in a confidential, non-judgmental and non-punitive environment.

In addition, the nurses at Jordan Hospital are preparing for elections. The consent to serve forms are in the mail.

MetroWest Medical Center/Leonard Morse

The nurses at MetroWest Medical Center/Leonard Morse are in negotiations. The key issues on the table include proposals by the

nurses to set safer staffing levels, to limit mandatory overtime, to establish a float pool and for a competitive salary scale with other hospitals in the region. They now have their own Web site and are posting up-dates to the site.

Caritas Norwood Hospital

RNs at Caritas Norwood Hospital are in negotiations. The committee has surveyed the bargaining unit and held open meetings on Jan. 31 to define the priority issues, which include retiree health insurance and language to protect nurses' union rights in the light of the 'Kentucky River' decision from the National Labor Relations Board.

VNA of Cape Cod

It was a stunning blow when Cape Cod Healthcare offered early retirement packages last fall and five of our 65 RNs offered to accept the offer. New employees, however, are coming in, some successfully, others not so. With the union leadership present, we are challenging VNA to come up with a better, more structured precepting program to ensure the success of those hard to come by new employees. This has been an ongoing topic at labor-management meetings and we will not stop pushing for the best precepting program until it is where it should be. We have had a few grievances, including a step-3 grievance for a wrongful termination. The word from the staff, once again, is that management is coming down on overtime and productivity. Members should not let management intimidate them into doing a less than adequate or rushed job, because they are worried about overtime and finances. Bottom line to members—if you didn't write it down, then you didn't do it. So type away and make your notes as thorough, yet concise as they need to be. We will be having elections this spring for the chair and secretary positions and for site reps for Hospice, Hyannis, Evenings and Dennis. Also, we need new grievance reps and staff to sit on the transient election and bylaws committee. ■

Basic Spanish for Health Care Professionals

May 7, 14, 21, June 4 & 11, 2008
MNA Headquarters, Canton

5:30-8:45 p.m. Light supper served at 5 p.m.

This 15 hour training program offers RN's an opportunity to learn conversational Spanish which will assist them in communicating with patients and their families. Topics covered in this 15 hour presentation include: greetings and goodbyes, etiquette, introductions and self-identifications, numbers, days/months/dates, communication strategies, patient body commands, calming phrases, intake and vitals, blood draw, administering medicine and injections, family member identification and parts of the body. No prior knowledge of Spanish is necessary. This program is NOT for individuals who already possess Spanish language ability.

Please note:

- Participants are expected to attend all sessions. Placeholder fee is refunded to MNA members who attend all five sessions.
- Enrollment is limited to 20 participants. Registration is on a space available basis.
- This program does not award continuing nursing education contact hours.

Fee for MNA Members: A deposit of \$145 is required, which includes a placeholder fee of \$95 and \$50 for course materials. The placeholder fee will be refunded upon completion of the program. These fees should be submitted in separate checks, payable to MNA.

Fee for Non-MNA Members: A deposit of \$275 is required, which includes a registration fee of \$225 and \$50 for course materials. Make checks payable to MNA.

Course materials: The cost of course materials, which include a Spanish booklet and CD is \$50 and is included in the registration fee. Materials will be provided on the first day of the program. The fee for course materials is non-refundable.

Program cancellation: MNA reserves the right to change speakers or cancel programs for extenuating circumstances. Registration and fees will be reimbursed for all cancelled programs.

Chemical sensitivity: Scents may trigger responses in those with chemical sensitivity. Men and women are requested to avoid wearing scented personal products when attending this program.

To Register: Call Phyllis Kleingardner in the MNA Division of Nursing at 781-830-5794 or 1-800-882-2056 x794. Enrollment is limited to 20 participants. Registration is on a space-available basis.



The MNA Labor School educates members—soup to nuts—on a variety of union issues. The courses are organized into “tracks” with a specific overall focus. Five or six classes make up each track, and each class is two to three hours long. A certificate of completion is awarded to members at the end of each track. In addition, members who complete any two tracks will be given an MNA Labor School jacket. Members may select any track and may attend at any location. There is no commitment to attend all tracks. Classes run from 5–7:30 p.m.

For more information, contact your local Regional office or the MNA division of labor education at 781-830-5757.

Track 1 & 2 sessions are completed. New sessions for all Regions will be announced soon.

Track 3: Building the Union & Computer Skills Training*

	1	2	3	4	5
Week 1 Member Participation Structure of the MNA and typical bargaining unit Organizing and mapping the workplace Contract Action Teams – Mobilization/Activists Structure	1/29 Tues.	12/12 Wed.	3/19 Wed.	C O M P L E T E D	3/10 Mon.
Week 2 The Community and the Media Media Training and Working with the Press	2/12 Tues.	1/9 Wed.	4/1 Tues.		3/24 Mon.
Week 3 Computer Training to Build the Union Hands-on Training in Use of Spreadsheets (Excel) Useful for Mapping Facilities, Costing Contracts, Tracking Member Participation	2/27 Wed.	1/23 Wed.	4/15 Tues.		4/7 Mon.
Week 4 Strategies of Action and Work Place Actions Running Effective Union Meetings Escalating Pressure Tactics Strikes and Work Stoppages	3/11 Thurs.	2/13 Wed.	4/29 Tues.		4/21 Mon.
Week 5 Excel Spreadsheet Training Continued	TBA	3/5 Wed.	5/13 Tues.		5/5 Mon.

Track 4: Labor Laws & Special Topics

	1	2	3	4	5
Week 1 Family Medical Leave Act Massachusetts Small Necessities Leave Act	3/25 Tues.	3/18 Tues.	9/9 Tues.	1/10 Thurs.	5/19 Mon.
Week 2 Fair Labor Standards Act Overtime Rules Labor-Management Reporting & Disclosure Act (LMRDA) Union Officer Elections	4/1 Tues.	4/2 Wed.	9/23 Tues.	1/24 Thurs.	6/2 Mon.
Week 3 Workers Compensation OSHA American with Disabilities Act	4/16 Wed.	4/23 Wed.	10/7 Tues.	2/14 Thurs.	6/16 Mon.
Week 4 Employment Discrimination and Title VII/Federal Civil Rights Act Age Discrimination in Employment Act (ADEA) The Worker Adjustment and Retraining Notification Act	5/6 Tues.	5/7 Wed.	10/21 Tues.	2/28 Thurs.	6/30 Mon.
Week 5 The NLRB and Kentucky River/Oakwood Cases Nurse Supervisor Issues, HIPAA	5/27 Tues.	5/28 Wed.	11/5 Tues.	3/19 Wed.	7/14 Mon.

Labor School Locations

Region 1, Western Mass.

241 King Street
Northampton
413.584.4607

Region 2, Central Mass.

365 Shrewsbury St.
Worcester
508.756.5800

Region 3, South Shore/Cape & Islands

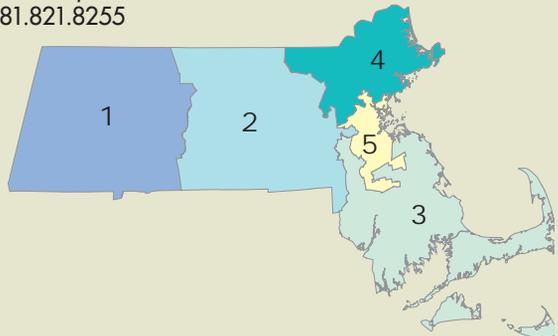
60 Route 6A
Sandwich
508.888.5774

Region 4, North Shore

10 First Avenue, Suite 20
Peabody
978.977.9200

Region 5, Greater Boston

MNA Headquarters
340 Turnpike Street, Canton
781.821.8255



For further details:

www.massnurses.org
781-830-5757

* Due to the availability of instructors for the Track 3 segments, each week’s material may vary by Region (i.e. the subject matter for Week 2 in one region may differ from that of Week 2 in another region). Participants are urged to check with their respective regions for training content in each week of Track 3.

Medication reconciliation in the emergency department setting

By Richard A Lambos RN

Interim ER/ICU Clinical Coordinator,
Martha's Vineyard Hospital

The Joint Commission's 2008 National Patient Safety Goals for hospitals once again has medication reconciliation as one of its goals.

The section dedicated to this topic is Goal 8, which reads: "Accurately and completely reconcile medications across the continuum of care." This year's Goal 8 is no different from The Joint Commission's 2007 National Patient Safety Goal 8.

The publication of The Joint Commission's 2007 National Patient Safety Goals concerns about the impact on efficient operation and implementation of medication reconciliation in emergency departments prompted three groups with direct knowledge of ED procedures — Emergency Nurses Association (ENA), American College of Emergency Physicians (ACEP) and the American Association of Emergency Medicine—to get involved. Below are excerpts from a May 30, 2006 letter sent jointly by Nancy Bonalumi, RN, MS, CEN, president of ENA, Frederick C. Blum, MD, FACEP, FAAP, president of ACEP, and Tom Scaletta, MD, FAAEM, president of AAEM to Dennis S. O'Leary, MD, president, Joint Commission on Accreditation of Health Care Organizations:

"This correspondence is to express our grave concern regarding JCAHO's medication reconciliation standard (MM 4.10) and National Patient Safety Goal 8 that will seriously impact the ability of already overtaxed emergency departments (EDs) to effectively care for our patients while, at the same time, will not improve the quality of patient care or patient safety for the over 110 million patients we see annually."

The correspondence further states:

"Regarding the compilation of a drug list for essentially each ED patient and the dissemination of that list to either the admitting physician or the primary care physician if the patient is discharged, it is contended that:

1. EDs would be disproportionately burdened with this task because of the large number of patients seen in the ED compared to other areas of the hospital
2. For the vast majority of patients, the compilation of a comprehensive medication list will not be germane to the patient's visit in the ED
3. The majority of medications administered in the ED are given on a one or two time basis and, as such, drug interactions with prior medications are highly unlikely
4. ED medications are fundamentally not danger-prone drugs (mostly pain medica-

tions, antibiotics and GI medications) and those that are (thrombolytics, blood, etc) are administered using tight protocols

5. Primary care physicians are the appropriate physicians to determine all of the drugs that their patients are taking and they are in the best position to modify medications based on their knowledge of the patient

When we posed a question to the JCAHO about the medication list for ED patients we were told that any patient receiving a drug in the ED must have a medication list made for them and if the patient is not be able to provide the list of medications, it is the ED staff's responsibility to contact the patient's pharmacy, physician(s) or family members.

Historically, these two requirements mandated by the JCAHO are unprecedented in their impact on the day-to-day operation of hospitals and, in particular, their EDs. Just the fact that the JCAHO gave hospitals a year to prepare for the implementation of these mandates reflects the magnitude of the required changes and their unprecedented nature.

It is our position, based on the available data and the views of our constituencies that the following should occur:

Reconciliation of medication lists should be limited to patients admitted to the hospital and conducted by in-patient personnel."

(JCAHO changed its name last year and is now known as The Joint Commission.)

This correspondence and a follow-up letter in Nov. 9, 2006 from the same three organizations, with specific recommendations about Goal 8 to The Joint Commission's executive director for patient safety initiatives prompted The Joint Commission to release a clarification of Goal 8 in a 17-page FAQ document released in January 2007 that embodied the ENA, ACEP, and AAEM recommendations.

To my knowledge, however, there has been no updated interpretation of Goal 8 since the release of The Joint Commission's clarification. Seeing that there have been no changes in the text of Goal 8 in this year's Safety Goals, I look at the following two questions and answers taken from that 17-page document as definition of the core requirements for medication reconciliation in the ED:

[8A] What is the current expectation for medication reconciliation in the Emergency Department (ED)? Can we use different levels of medication reconciliation depending on the severity of the patient's condition?

A consensus recommendation of the American Association of Emergency Medicine (AAEM), the American College of Emergency Physicians (ACEP), and the Emergency Nurses Association (ENA) provides for three levels

of intensity of the medication reconciliation process in the ED, as follows:

- a. "Screening reconciliation" for all ED patients should include routinely obtaining from each patient at each ED visit a list of the patient's current medications (usually done by the triage nurse)
- b. "Focused reconciliation," as directed by the emergency physician, based on medical relevance, should include seeking additional information about the patient's medications (exact drug list, dosage/route, etc.) from the patient's pharmacy, primary care physician, family, etc.
- c. "Full reconciliation," for admitted patients should be completed by the receiving inpatient unit and pharmacist

This consensus recommendation from the AAEM, ACEP and ENA is in full compliance with NPSG requirement 8A since each level includes obtaining a list of the patient's current medications to be used when ordering or prescribing medications in the ED. Therefore, this approach is acceptable to The Joint Commission in meeting requirement 8A. [New, 1/07]

8A&B] Will The Joint Commission be expecting to see a specific form or document in the clinical record?

No. On admission/entry to a care setting, the expectation is that the patient's current medication list is documented in some identifiable fashion as part of the patient/client/resident's record. The organization should specifically define the expected time frame for that to occur. A surveyor may during the course of a patient tracer review a patient/client/resident's record to see if the medications on admission/entry were noted. If this information is only available electronically, the surveyor may ask the organization to describe or demonstrate how information about medications upon admission/entry is obtained and made available to appropriate staff. [2/06]

It is my belief that the Joint Commission's agreement with ENA, ACEP and AAEM recommendations will assist EDs across the nation in functioning more efficiently. Their recognition that the expectations of medication reconciliation in EDs prior to the January 2007 clarification document would greatly impede the delivery of quality care in the already overburdened ED system is outstanding and the elimination of the need for additional paperwork to accomplish compliance with Goal 8 will maximize efficiency in the delivery of nursing care in the emergency department setting.

I would be interested in receiving feedback from RNs around the state as to how their EDs are dealing with this issue. Please email me at rickbos2001@yahoo.com. ■

MNA Position Statement: Exposure to environmental cleaning chemicals in healthcare settings

For many years the MNA Congress on Health and Safety and the Division of Health and Safety have addressed the concerns of hazards associated with many environmental cleaning agents used in healthcare settings. Exposure to these products may result in adverse health effects ranging from dermatitis, eye, nose and throat irritation, minor sensitization reactions such as itching, tearing, sneezing and coughing to serious skin and eye damage, asthmatic reactions and anaphylaxis; headaches, nausea and dizziness may also occur. Patients and visitors alike are at risk, as are staff members. Safer products exist and are currently in use in many facilities, resulting in better air quality for everyone

This position statement describes toxicity issues, the planning process

Statement of the problem

In recent years, research projects, booklets and articles have focused on the health effects of chemical exposures to nurses and other workers in the healthcare industry. These chemicals include pesticides, antimicrobial and

environmental cleaning agents such as disinfectants and floor wax strippers. While the majority of the research projects focus on information related to asthma and reactive airway disease syndrome (RAADS), neurological symptoms such as headache, dizziness and nausea, skin disorders such as rashes,

blisters and burns and allergic sensitization may also result from exposure to these chemicals.

According to Health Care Without Harm, since 1980 asthma caused or significantly exacerbated by work exposures, has emerged as the most commonly reported occupational lung condition. The overall prevalence of adult asthma related to the work environment is unknown but recent studies estimate that occupational asthma accounts for 5 to 37 percent of all asthma. In the U.S. studies have estimated

that 10 to 23 percent of new adult onset asthma is due to occupational exposures. Asthma ranks within the top ten conditions causing limitation of activity and costs our nation 16.1 billion dollars annually in healthcare, loss of work productivity and premature deaths.

While the symptoms and disability are realized by the affected employees, the expense for treating asthma is shared with the employer through health insurance and Workers' Compensation expenses. Employees require and seek treatment for asthma and other breathing difficulties, whether they associate it with work related exposures or not. Additionally, the employer incurs expenses for sick time and for overtime for workers who remain on the job or replacement workers to fill in for those who become ill or disabled.

It is important to recognize the connection between work exposures and asthma as quickly as possible as delays in diagnosis result in poorer prognosis for the affected employee. Information to identify those exposures and symptoms is often close at hand in a document known as a Material Safety Data Sheet (MSDS). The MSDS is required by the OSHA Hazard Communication Standard 1910.1200.

Manufacturers are required to identify the adverse health effects of the chemicals in their product on the MSDS. The MSDS for an industrial strength floor stripper commonly used in hospitals and identified by affected employee's states:

Effects of Acute Exposure:

Eyes: Corrosive. May cause permanent damage including blindness.

Skin: Corrosive. May cause permanent damage.

Inhalation: May cause irritation and corrosive effects to the nose, throat and respiratory tract.

Ingestion: Corrosive. May cause burns to mouth, throat, and stomach.

Medical conditions aggravated by overexposure: Individuals with chronic respiratory disorders such as asthma, chronic bronchitis, emphysema, etc. may be more susceptible to irritating effects.

for changing to safer products and identifies useful resources.

Nurses and others who are affected by asthma as a result of exposure to environmental cleaning chemicals used in their workplace should report this matter to their managers, supervisors, occupational health department and safety officers in their hospitals as well as to the Massachusetts Department of Public Health, Occupational Health Surveillance Program (OHSP). A confidential reporting form for the Massachusetts DPH can be obtained by calling OHSP at 617-624-5632.

A copy of the position statement can be obtained on the MNA website, www.massnurses.org. Click on search and enter Position Statements.

—**Evie Bain, Health & Safety Coordinator**

Workers, patients and visitors at risk

Nurses and other healthcare workers may be exposed to environmental cleaning chemicals on a daily basis as floors are stripped; finishes are applied and then buffed to maintain the "shine." These repeated exposures have the potential for workers to develop chronic inflammation or become sensitized to the product. Patients are also exposed at a time when their health and often their respiratory systems are already compromised. There is the potential for visitors to be exposed to these irritating and sensitizing products as well.

Another consideration when addressing exposure to toxic chemicals is individual susceptibility. This health concept refers to the fact that one person may have factors such as age, weight and gender or existing health conditions that would make them more susceptible to the chemicals when exposed. Unfortunately, many employers focus on individual susceptibility and fire sensitive people or decide that the problem is the employee and not the exposure.

From the stories of many nurses who have been made ill from exposure to environmental cleaning products, there seems to be little value in scheduling cleaning operations that utilize toxic products to weekends or night shifts or when known sensitized individuals are not on duty. Moving these toxic processes to the night and weekend shifts puts all those who routinely work these shifts at greater risk of developing symptoms and/or sensitization through repeated exposures. Often employees requiring accommodations are present when the cleaning process takes place and suffer the adverse consequences of exposure that result in emergency medical treatment and lost work time.

Products commonly used in healthcare

Pesticides: It is no longer acceptable to follow a program that states "we spray every Friday." Pesticides by their very nature are meant to kill. Some do it by attacking the nervous system, while others attack the reproductive system or



respiratory system of the pests they are meant to destroy. Some pesticides may be classified as carcinogens, teratogens or mutagens. Pesticide exposure has been associated with several neurological diseases in humans. Workers who apply pesticides are at highest risk. ^(1.)

Antimicrobial Cleaning Products: Disinfectants and sterilizing chemicals composed of chloramine, hexachlorophene, glutaraldehyde, ethylene oxide, quaternary ammonium compounds (quats) and formaldehyde are commonly used in healthcare settings today. According to MSDS's and other sources, exposure can occur by inhalation and to a lesser extent by absorption of the chemicals through the skin. These chemicals are associated with asthma and neurological symptoms (headache, nausea and dizziness). ^(3.)

Environmental cleaning agents: Floor strippers, floor polishing chemicals, toilet and glass cleaners are comprised of multiple chemicals and may include chlorine bleach, ethanalamines, glycol ethers (e.g. 2 butoxyethanol and sodium hydroxide). These chemicals are associated with respiratory and neurological symptom and a splash to the eyes and/or skin could result in tissue irritation and burns. The MSDS for one of these products used in healthcare settings warns of corrosion that could result in blindness if a splash to the eyes should occur. ^(4.)

VOC's – Many of these products contain a classification of chemicals known as volatile organic compounds (VOC's). VOC's, which are derived from petroleum products, vaporize quickly at room temperature. VOC's are inhaled in varying concentrations from different products. Ventilation (frequency of air exchanges) in place at the location of use, as well as the manner in which the product was prepared, mixed or diluted (or not) and applied will influence the amount of chemical in the air and the exposure to staff and bystanders. VOC's that are inhaled into the respiratory tract are absorbed by the bloodstream and move quickly to the brain. ^(1.)

Fragrances: Fragrances in healthcare settings exist from a variety of sources. These range from personal hygiene products used by staff and patients to those fragrances added to environmental cleaning and disinfecting products. Many hand sanitizers contain fragrances and are an additional source of VOC's. The health effects from fragrances are similar to those described above for other products including contributing to or exacerbating asthma, respiratory irritation and/or neurological symptoms. ^(1.)

Alternatives exist

As a concern and interest in preventing occupational and environmental exposure

to chemical toxins becomes widespread, the manufacturers and distribution companies for environmental cleaning products are offering broad ranges of products for their customers. Changing to safer products may simply involve an open discussion and trial of new products with the current chemical supply company, rather than locating a new chemical supplier and changing to a new product line. The need to change to new supply companies has often blocked this type of quality improvement process in the past.

Alternatives to Pesticides: – A process known as Integrated Pest Management (IPM) begins with steps that should be taken to remove the attractions for pests and pathways for pests before chemicals are used. Such steps include: improved sanitation practices, (empty refuse containers more frequently), structural repairs (holes in the wall) to block the pathways for entrance and the use of non chemical pesticide devices, such as vacuuming crumbs and utilizing traps. Chemical pesticides have a place in this process but only as the last resort. Pesticides should only be applied in hospitals by those who have been specifically trained to do so. ^(5.)

Alternatives to Antimicrobial Cleaning Products: All antimicrobials have a measure of hazard associated with them. This is evident by reviewing the MSDS that accompany the products. By their nature disinfectants and sterilants are developed to destroy living organisms. While few safer alternatives exist, educating and training workers in the safest application and handling, utilizing proper dilution as well as appropriate personal protective equipment when working with these chemicals can reduce exposure and adverse health effects. In many cases, cleaning is needed but antimicrobial products are not and the total amount of antimicrobials used can be reduced.

Alternatives to Environmental Cleaning Agents: Safer cleaning chemicals exist and are in use today in many environmentally conscious healthcare facilities. These products have chemical properties that do not cause or aggravate asthma or other respiratory conditions; they do not cause blindness if splashed into the eyes; they do not pollute the waterways when they are discharged in wastewater. ^(1.) Micro fiber mops and cleaning cloths are recognized by the U. S. Environmental Protection Agency (EPA) as a meaningful alternative to conventional floor cleaning with wet mops and buckets. This process eliminates the ergonomic hazard of lifting heavy water buckets and the EPA emphasizes that it dramatically reduces the amount of water and chemical products required for routine cleaning of hospital rooms. Microfibre mopping processes have been associated with a reduction in frequency of slips,

trips and falls because of the reduction in the amount of water that remains on the floor. ^(6.)

Fragrance - Free Environments: Fragrances can cause symptoms in those individuals with asthma and chemical sensitivity. ^(1.) Prominent signage stating a "fragrance - free facility" and the availability of supportive information promotes the concept of voluntary compliance with a fragrance-free environment. Even voluntary compliance is associated with a marked decrease in the amount of fragrance use among individuals. Most vendors of environmental cleaning products provide a line of fragrance-free products and personal hygiene products for patient care are available without fragrance. Several hospitals and other facilities in Massachusetts have taken the step toward becoming a fragrance free environment. Their signage simply states "Men and women are asked to refrain from using personal fragrances when working or visiting in this building."

Association Position

MNA believes that health care facilities should:

- evaluate the environmental cleaning and antimicrobial products they currently use by reviewing the adverse health and environmental effects noted on the MSDS. They should begin to use alternative products with less potential for adverse health effects and environmental pollution. This is the most important strategy for protecting the health of nurses, other healthcare workers and patients, as well as the environment.
- include a person with expertise in occupational health and safety on any committee or group that selects environmental cleaning products, antimicrobials and/or pesticides.
- provide hazard communication training that meets the following requirements of the OSHA Hazard Communication Standard 1910.1200 (h) (3) Training and Education - (must) contain at least (ii) the physical and health hazards of the chemicals in the work area and (iii) the measures for workers to use to protect themselves from these hazards and follow the requirements of the Standard 1910.1200 (g)(8) MSDS to be readily available. The process to access MSDS should be posted and available at all times. ^(7.)
- develop and communicate methods for reporting any symptoms that workers and patients experience when environmental cleaning products are in use. Medical evaluation and treatment should be pro-

See **Position Statement**, Page 20

Consent to Serve for the MNA 2008 Election

I am interested in active participation in Massachusetts Nurses Association.

MNA General Election

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

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

Please type or print — Do not abbreviate

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

Work Title _____ Employer _____

MNA Membership Number _____ MNA Region _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Educational Preparation

School	Degree	Year

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

MNA Offices	Regional Council Offices

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

 Signature of Member

 Signature of Nominator (leave blank if self-nomination)

Postmarked Deadline: Preliminary Ballot: March 31, 2008
 Final Ballot: June 16, 2008

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

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

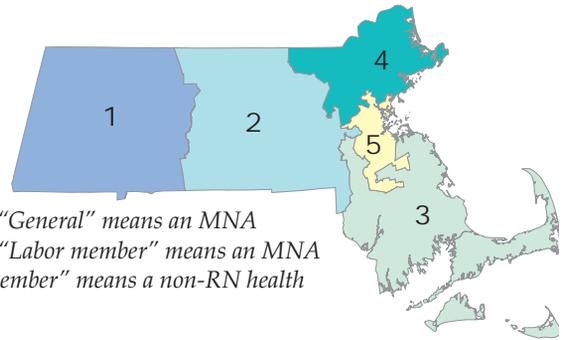
2008 Consent to Serve for the MNA Regional Council

I am interested in active participation in MNA Regional Council

At-Large Position in Regional Council (2-year term; 2 per Region)

I am a member of Regional Council

Region 1 Region 2 Region 3 Region 4 Region 5



General members, labor members and labor program members are eligible to run. "General" means an MNA member in good standing and does not have to be a member of the labor program. "Labor member" means an MNA member in good standing who is also a labor program member. "Labor program member" means a non-RN health care professional who is a member in good standing of the labor program.

Please type or print — Do not abbreviate

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

Work Title _____ Employer _____

MNA Membership Number _____ MNA Region _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Educational Preparation

School	Degree	Year

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

MNA Offices	Regional Council Offices

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

 Signature of Member

 Signature of Nominator (leave blank if self-nomination)

Postmarked Deadline: Preliminary Ballot: March 31, 2008
 Final Ballot: June 16, 2008

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

MNA nominations & election policies & procedures

1. Nomination process & notification of nominees

Revised policy

- A. All candidates for office, submitting papers to the Nominations & Elections Committee, shall be notified in writing upon receipt of materials by the MNA staff person assigned to the Nominations & Elections committee. The letter of acknowledgement will identify the office sought. All notifications will be sent by MNA no later than June 15 of each year. If no acknowledgment has been received within 7 days of sending the consent to serve form, it is the nominees' responsibility to contact MNA regarding the status of their nomination.
- B. All candidates must be an MNA member or a Labor Program member in good standing at the time of nomination and election.
- C. A statement from each candidate, if provided, will be printed in the Massachusetts Nurse. Such statements should be limited to no more than 250 words.

2. Publication of ballot

- A. Preliminary Ballot: All candidates who are members in good standing shall have their names printed on the ballot provided the nomination papers have been received by the Nominations & Elections Committee or designee by the deadline date established by the committee and communicated in the Massachusetts Nurse. The order names are listed on the ballot is determined by random selection.
- B. Final Ballot: All candidates who are members in good standing, shall have their names printed on the ballot provided the nomination papers have been received by the Nominations & Elections Committee by the deadline date established by the committee and communicated in the Massachusetts Nurse. The order names are listed on the ballot is determined by random selection by the Nominations & Elections Committee or their designee.

All candidates will receive a draft copy of the Final Ballot prior to the Election Mailing for verification purposes. Confirmation/request for corrections to the ballot should be made in writing to the Nominations and Elections Committee or their designee postmarked within seven days of receipt of the draft ballot.

For uncontested positions the Nominations & Elections Committee may solicit candidates, accept late applications, and add to the ballot after the final ballot deadline with approval of the majority of members of the Nominations & Elections Committee present and voting.

- C. Ballot Information: All inquiries related to deadlines, status, policies, eligibility to vote and receipt of ballots are to be addressed to the staff person to the Nominations & Elections Committee or a designee.

3. Publication of policies/procedures/campaign practice

All policies, procedures and campaign practices related to the MNA elections shall be distributed to candidates upon receipt of their nomination papers. Notice to all members of availability shall be published in the Massachusetts Nurse annually.

4. Campaign practices

- A) All candidates shall have access to the following: membership lists/labels; structural unit rosters; bargaining unit rosters; and MNA on-site mailboxes. Candidates may also have access to campaign space in the Massachusetts Nurse and may request time on structural unit and bargaining unit agendas.

The following conditions must be met.

1. Request for labels/lists/rosters must be in writing and signed by the candidates. All requests will be honored provided they comply with the MNA information/label request policies.
2. Requests from the candidate for time on structural unit or bargaining unit agendas must be in writing and directed to the appropriate chair. The staff person for the group must also be notified of the request. All candidates for a specific office must be provided with equal access and time.
3. Structural units and bargaining units may invite candidates to speak at a meeting. All requests must be in writing with a cc to staff. All candidates for a specific office must be provided with equal access and time.
4. All costs for labels/space in the Massachusetts Nurse, and mailing shall be the responsibility of the candidates. Labels will be provided at cost. Ad space in the Massachusetts Nurse will be at a specific advertising rate.
5. Records of requests received, the date of the request, as well as distribution of materials shall be kept by the Membership Department.
6. All campaign mailings utilizing MNA membership labels shall be sent through a mailing house designated by the MNA. Mailing utilizing rosters may be done directly by the candidates.
7. The membership list shall be available for review/inspection, by appointment with the Membership Department. Lists or records must remain on the premises.
- B. All candidates must follow acceptable practices in the acceptance of goods, services and contributions. This includes
 1. Employers shall not provide money, supplies, refreshments or publication of and "endorsement" on behalf of a candidate.
 2. Candidates may not use MNA, Region or employer stationary to promote their candidacy.
 3. Candidates may not use postage paid for by MNA, Region or an employer to mail literature to promote their candidacy.
 4. Neither MNA its structural units or bargaining units may use dues money for a function to promote the candidacy of a particular candidate. MNA may sponsor a function at which all candidates for a particular office are invited and no candidate is shown preference over another.
 5. Individual members may make voluntary contributions of money, goods or services to a candidate.
 6. The amount that a candidate may expend in campaigning is not limited by MNA.
 7. MNA elected and appointed officials may endorse candidates. In the event that the endorsement is to appear in the Massachusetts Nurse, then and only then, the endorsements must be verified on the official MNA Campaign Endorsement Form and must accompany ad copy. However, no endorsements may carry identification as to the MNA office held by the endorser (see attachment A).
 8. MNA staff shall not wear promotional materials of any candidate or in any manner promote the candidacy of any individual.
 9. Candidates shall not use the MNA corporate logo on campaign materials.
 10. Campaigning or campaign materials are not allowed on

MNA premises with the following exceptions:

- When invited to a MNA structural unit or bargaining unit meeting.
- Meeting attendees may wear promotional material.

5. Ballot/voting instructions

- A. Ballot will be mailed at least 15 days prior to the date which it must be mailed back (postmarked).
- B. Complete area (as per instructions on form) next to the name of the candidate of your choice. You may vote for any candidate from any Region.
- C. Do not mark the ballot outside of the identified area.
- D. Write-in votes shall not be considered valid and will not be counted.
- E. Enclose the correct and completed voting ballot in an envelope (marked Ballot Return Envelope), which does not identify the voter in anyway, in order to assure secret ballot voting. **ONLY ONE BALLOT MAY BE PLACED IN THE ENVELOPE.** All mailing envelopes will be separated from the inner envelope containing the ballot before the ballots are removed, to assure that a ballot can in no way be identified with an individual voter. (At the discretion of the Nominations & Elections Committee, mailing envelopes containing the voter's name and address may be checked off on a master membership list. This process may be of the total membership list, or randomly selected envelopes.) If the mailing envelope has been misplaced, another envelope can be substituted. This envelope must be addressed to: MNA Secretary, c/o Contracted Election Administrator (address) In the upper left-hand corner of this envelope you must:

- a. Block print your name
- b. Sign your name (Signature required)
- c. Write your address & Zip

If this information is not on the mailing envelope, the secret ballot inside is invalid.

- F. The ballot must be received no later than 5 p.m. on Aug. 22, 2008 in order to be counted.
- G. The ballots must be mailed to MNA Secretary, c/o Contracted Election Administrator, LHS Associates 13 Branch St., Methuen, MA 01844

6. Observation

- A. Each candidate or their designee who is a current MNA and/or Labor Relations Program member is to be permitted to be present on the day(s) of the opening and counting of the ballots. Notification of intent to have an observer present must be received in writing or electronic message from the candidate 5 working days prior to the ballot counting date.
- B. Each observer must contact the MNA staff person assigned to the Nominations & Elections Committee 5 working days prior to the day in question for space allocation purposes only.
- C. The observer must provide current MNA membership identification to election officials and authorization from the candidate.
- D. No observer shall be allowed to touch or handle any ballot or ballot envelope.
- E. During all phases of the election process, the single copy of the voter eligibility list will be present for inspection.
- F. All observers and candidates will keep election results confidential for 72 hours after the ballot procedure is completed and certified.

See **Election**, Next Page

Position descriptions for MNA elected offices

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

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

Board of Directors

The specific responsibilities and functions of the Board of Directors are to:

- 1) Conduct the business of the Association between annual meetings;
- 2) Establish major administrative policies governing the affairs of the MNA and devise and promote the measures for its progress;
- 3) Employ and evaluate the executive director;
- 4) The Board of Directors shall have full authority and responsibility for the Labor Program;
- 5) Adopt and monitor the association's operating budget, financial development plan, and monthly financial statements;
- 6) Assess the needs of the membership;
- 7) Develop financial strategies for achieving goals;
- 8) Monitor and evaluate the achievement of goals and objectives of the total Association;

- 9) Meet its legal responsibilities;
- 10) Protect the assets of the association;
- 11) Form appropriate linkages with other organizations; and
- 12) Interpret the association to nurses and to the public.

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

Center for Nursing Ethics

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

Congress on Health and Safety

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

Congress on Health Policy and Legislation

The Congress on Health Policy and Legislation develops policies for the implementation of a program of governmental affairs appropriate to the MNA's involvement in legislative

and regulatory matters influencing nursing practice, health and safety, and health care in the commonwealth. Meets eight to 10 times per year at MNA or MNA's District 2 office in West Boylston for two to three hours.

Congress on Nursing Practice

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

Bylaws Committee

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

Nominations and Elections Committee

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

... Election policies

7. Candidate notification

- A. Results of the MNA Election will be made available to candidates (or their designee) within 72 hours after completion of the ballot counting. Only the names of those elected will be posted on the MNA website when all candidates have been notified after the ballot procedure is completed and certified. Hard copies of the election results shall be sent to each candidate.
- B. Results of the MNA election will be kept confidential until all candidates are notified. Notification of all candidates will occur within 72 hours of certification of the election.
- C. Results will include the following:
 - Number of total ballots cast for the office in question
 - Number of ballots cast for the candidate.

- The election status of the candidate (elected/not elected)
- D. Any MNA member may access these numbers by written request.
 - E. Election results will be posted at the annual meeting.

8. Storage of election materials

- A. Pre Election: All nomination forms and all correspondence related to nominations shall be stored in a locked cabinet at MNA headquarters. The Nominations & Elections Committee and staff to the committee shall have sole access to the cabinet and its contents.
- B. Post Election: All election materials including ballots (used, unused and challenged), envelopes used to return marked ballots, and voter eligibility lists shall be stored in a locked cabinet at MNA headquarters for one year. The Nominations & Elections Committee Chairperson and staff to the committee

shall have sole access to the cabinet and its contents.

9. Post-election press release

The Department of Public Communications shall check the information on file/CV data for accuracy/currency with the elected candidate prior to issuing a press release.

*Member List—a computer listing of the total MNA membership eligible to vote, including name, address, billing information, etc.

*Membership Labels—computer-generated labels of the total MNA membership eligible to vote, provided in keeping with MNA Label Sales Policies.

*Rosters—computer-generated list of the Board of Directors of MNA and all MNA structural units. List includes names and addresses.

Approved by Board of Directors: 5/16/02, 8/21/03, 3/17/05 ■

MNA incumbent office holders

Board of Directors

President

Beth Piknick (2007–09)

Vice President

Donna Kelly-Williams (2006–08)

Secretary

Rosemary O'Brien (2007–09)

Treasurer

Nora Watts (2006–08)

Directors Labor

Region 1

Vacant (2007–09)

Diane Michael (2006–08)

Region 2

Pat Mayo (2007–09)

Mary Marengo (2006–08)

Region 3

Judy Rose (2007–09)

Stephanie Stevens (2006–08)

Region 4

Fran O'Connell (2007–09)

Vacant (2006–2008)

Region 5

Barbara Norton (2007–09)

Ginny Ryan (2006–08)

Directors (At-Large/Labor)

Karen Coughlin (2007–09)

Patty Healey (2007–09)

Karen Higgins (2007–09)

Richard Lambos (2007–09)

Kathie Logan (2007–09)

Nancy Gilman (2006–08)

Judith Smith-Goguen (2006–08)

Directors (At-Large/General)

Sandy Eaton (2007–09)

Tina Russell (2007–09)

Ellen Farley (2006–08)

Helen Gillam (2006–08)

Sharon McCollum (2006–08)

Vacant (2007–09)

Labor Program Member

(Non-RN, Health Care Professional)

Beth Gray-Nix (2007–09)

Congress on Health Policy and

Legislation

Melissa Croad

Ann Eldridge Malone

Nancy Pitrowski

Kathy Metzger

Julia Rodriguez

Donna Dudik

Sandra Hottin

Chris Folsom

Kathleen Charette

Congress on Health and Safety

Terri Arthur

Mary Bellistri

Maryanne Dillon

Sandra LeBlanc

Gail Lenehan

Lorraine MacDonald

Elizabeth O'Connor

Kate Opanasets

Kathy Sperrazza

Nominations & Elections

Committee

Janet Spicer

Center for Nursing Ethics &

Human Rights

Ellen Farley

Sarah Moroney

Lolita Roland

Kelly Shanley

Congress on Nursing Practice

Mary Amsler

Marianne Chisholm

Ellen Deering

Susan Howe

Susan Lipsett

Marian Nudelman

Linda Winslow

Bylaws Committee

Jane Connelly

Elizabeth Kennedy

Sandra LeBlanc

Susan Mulcahy

Elizabeth Sparks

Kathryn Zalis

Regional Council election

Pursuant to the MNA Bylaws:

Article III, Regional Councils,

Section 5: Governance

a. The governing body within each region will consist of:

(1) A Chairperson, or designee, for each MNA bargaining unit.

(2) One Unit 7 representative on each regional council, to be designated by the Unit 7 President.

(3) Four at-large elected positions. General members, labor members, and labor program members are eligible to run for these at-large positions. At-large members serve a two year term or until their successors are elected.

b. At-large members shall be elected by the Regional Council's membership in MNA's general election. Two at-large members shall be elected in the even years for two-year terms and two at-large members shall be elected in the odd years for two-year terms. *Proviso: This election commences in 2008.* ■

**Consent-to-serve forms,
See Pages 14 & 15**

Join the MNASM Team

Director of Membership. Responsible for carrying out activities of the Membership Division related to recruitment, retention, dues compliance, benefit programs of the Association, oversight of staff administering discount benefit programs, maintenance of computerized information processing needs and accurate membership files of the Association. Keep up-to-date and knowledgeable on state and national trends in health care and nursing. Work with structural units, MNA Division Directors, and members, direct and supervise the Division's support staff.

Qualifications: RN, bachelor's and advanced degree preferred (equivalent career experience considered). Experience with the IBM AS400 database or a computerized membership database system desirable.

The MNA represents more than 23,000 registered nurses & health care professionals. Salaries commensurate with experience. Excellent benefits.

Associate Director, Division of Nursing. Proven educator with extensive current clinical practice in acute care. Requirements for the position include knowledge of clinical practice and the regulatory issues related to nursing practice. Documented experience in planning, presenting, implementing and evaluating nursing education programs. Experience in researching and writing articles for publication related to nursing practice. Collaborative skills in working with nursing and other health related groups. Documented collaborative skills. Experience in working with direct care nurses. Accountable for carrying out activities related to the labor goals of the Association. Master's degree in nursing required.

Send resume to:

Massachusetts Nurses Association
Attn: Shirley Thompson
340 Turnpike St., Canton, MA 02021
Tel: 781-821-4625, x711 • Fax: 781-821-4445
e-mail: Sthompson@mnarn.org

MNA CONTINUING EDUCATION COURSES

Winter/Spring 2008

Nurse Protect Thyself: Tools to Minimize Legal Exposure

Description: This program, which is co-provided by the MNA and the Southern New England Chapter of the American Association of Legal Nurse Consultants, will provide nurses with 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: May 9

Time: 8 a.m. – 4 p.m. (light lunch provided)

Place: MNA Headquarters, Canton

Fee: MNA and AALNC Members, \$95; Others, \$125

Contact Hours: Will be provided.

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, MSN, RN

Date: June 10

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

Place: MNA Headquarters, Canton

Fee: MNA Members, Free*; Others, \$95

***Requires \$25 deposit which will be returned upon attendance.**

Contact Hours: Will be provided.

MNA Contact: Phyllis Kleingardner, 781-830-5794 or 800-882-2056, x794

Wound Care

Description: This program will provide a comprehensive overview of the factors effecting wound care and strategies for managing complex wounds. A thorough review of wound products will enable the attendee to select the optimal dressing based on clinical findings. Newer modalities wound management, such as growth factors, hyperbaric oxygen, electrical stimulation, cultured skin, replacements and vacuum-assisted closure devices will also be discussed.

Speaker: Carol Mallia, MSN, RN

Date: June 24

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

Place: MNA Headquarters, Canton

Fee: MNA Members, Free*; Others, \$95

***Requires \$25 deposit which will be returned upon attendance.**

Contact Hours: Will be provided.

MNA Contact: Phyllis Kleingardner, 781-830-5794 or 800-882-2056, x794

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: Contact hours will be provided as specified in the program description. Continuing nursing education contact hours for all programs are provided by the Massachusetts Nurses Association. 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.

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

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.

Note: All CE programs run entirely by the MNA are free of charge to all MNA members. Pre-registration is required for all programs.

Congress on Nursing Practice seeks additional members

The Congress on Nursing Practice is responsible for identifying issues and practices impacting the nursing community, and it is currently working to develop a mentorship program for members and a position statement specific to the compact legislation filed by the Board of Registration in Nursing.

The Congress meets on the fourth Monday of each month, from 5:30–7:30 p.m., at MNA headquarters in Canton.

If you are interested in joining the Congress on Nursing Practice, please contact Dorothy McCabe, director of the MNA's divisions of nursing and health and safety, at 781-830-5714 or via e-mail at dmccabe@mnarn.org. ■



...Position statement

From Page 13

vided as necessary. *Note:* Massachusetts employers are required by law (MA 105 C.M.R 300.180) to report all cases of suspected or diagnosed occupational asthma which are believed to have been caused or aggravated by factors in the individual's workplace to the MDPH, Occupational Health Surveillance Program. The report form can be obtained by calling 617-624-5632 or by visiting www.massnurses.org/pubs/positions/env_cleaning_chem.htm

- associate the symptoms noted on the MSDS that are related to environmental cleaning chemicals with the symptoms reported by nurses and others when they experience these adverse health effects in the presence of environmental cleaning chemicals.

Summary Statement

Data recently released by the Massachusetts Department of Public Health Sentinel Event Notification for Occupational Risk (SENSOR) program indicate that healthcare was the industry most frequently identified among confirmed cases of work-related asthma (29 percent of all cases, 1993-2006) and nursing was a frequently reported occupation accounting for over 13 percent of all confirmed cases of occupational asthma. Occupations such as health aides and health technicians were also high on the list of those affected. The leading causative agents were

cleaning products and poor indoor air quality.

Health effects, associated with cleaning products include dermatitis, respiratory distress, headaches, dizziness, nausea and increase incidences of occupational asthma. As more and more workers become sensitized, there are also significant increases in lost work days and associated costs in compensation claims and replacement workers. Patients also suffer from exposures to the same chemicals and disruptions in staffing.

For many cleaning products or chemicals used in healthcare there are safer more environmentally friendly and cost-competitive alternatives. It is in the best interests of the organizations, patients and the workers to continually identify and evaluate new products and alternatives to find the "best" product available that meets all of the requirements of the given cleaning regimen or task while still providing a safe and healthy environment.

Healthcare organizations should be leaders in the movement to safer working environments. Each institution should have clear policies and directives that minimize the use of hazardous agents, inform all workers about potential health effects and how to respond if they believe they are suffering symptoms of exposure, and continuously improve their programs and products. ■



Learn how nurses make a difference in developing nations: short-term medical missions trips

**Attend the MNA Informational Program:
Mercy Ships Upcoming Medical Missions Trip
May 13, 2008
6 – 8 p.m. • MNA office, Canton**



Members of the MNA Diversity Committee's Medical Missions team will share their experiences during a recent Mercy Ships trip to Honduras. Learn how this team of nurses and health care professionals provided medical care to impoverished communities.

**This program is free and a light supper will be provided.
Contact Theresa Yannetty, 781-830-5727 or tyannetty@mnarn.org to register.**



**Rosemary Smith RN
Memorial Golf
Tournament**

Save the Date!

Monday • July 21, 2008
to benefit Scholarship Programs
for Nursing & Healthcare Professionals

Visit www.massnurses.org or
call to register at
781-821-4625 x745



It's Time...

- To Utilize Your Experience
- To Make Fulfilling Career Choices
- To Help Children & Adolescents
- To Become a Leader in:



Northeastern University School of Nursing was awarded a HRSA grant to expand the **Masters in Nursing** specializing in child and adolescent mental health nursing, focusing on psychopharmacology and underserved populations. To learn more, visit: www.childpsychiatricnursing.neu.edu or contact us at 617.373.5587 or capnursing@neu.edu

Child & Adolescent Mental Health Nursing



**Northeastern
UNIVERSITY**

BOUVÉ COLLEGE OF
HEALTH SCIENCES

360 Huntington Avenue, Boston, Massachusetts 02115-5000

2008 MNF scholarships available



- Scholarship
- Research
- Education

Massachusetts Nurses Foundation, Inc.

New: Carol Vigeant Memorial Scholarship *(Entry Level)*

Carol Vigeant was an RN at UMass Memorial University for 30 years. Carol had great compassion and devotion to her patients and loved mentoring new nurses. This scholarship was established through memorial donations from her bargaining unit and family. The scholarship will be awarded to a student (entry level) pursuing an associate's degree or bachelor's degree in nursing. Preference will be given to students living in or working in the Worcester area.

Kate Maker Scholarship *(Entry Level)*

This scholarship was established to honor the memory of Kate Maker, RN, a great leader and powerful activist. Kate's primary focus as an activist was with the Massachusetts Nurses Association. Kate was a long-time member of the MNA Board of Directors, and she served two terms as the chairperson of her bargaining unit at UMass Memorial Health Care's University Campus in Worcester. Kate participated in pickets and strikes for nurses at several Worcester area hospitals and was particularly effective when it came to explaining the connections between safe-RN staffing ratios and their immediate impact on patient safety.

The scholarship will be awarded to a student (entry level) pursuing an associate's degree or bachelor's degree in nursing. Preference will be given to students living in or working in the Worcester area first, and then to other areas of MNA Regional Council 2.

Janet Dunphy Scholarship

Funded by a scholarship established by Regional Council 5, scholarships are given annually to an MNA member in good standing in Regional Council 5 and who is pursuing a B.S., M.S. or doctoral degree. Second preference will be given to those seeking advanced degrees in public health policy or labor relations at any level. ***If the applicant is an MNA member in a collective bargaining unit an additional reference is required from your local unit representative/committee member attesting to distinguished service within your local unit. Anyone who is known to have crossed a picket line cannot be considered.**

Regional Council 5 Scholarship *(Child of member in nursing program under the age of 25)*

Funded by Regional Council 5, these scholarships will be awarded to a child of an MNA member in good standing from Regional Council 5 and enrolled in an NLN accredited program in nursing.

Regional Council 5 Scholarship *(Child of member – higher education under the age of 25)*

Funded by Regional Council 5, these scholarships will be awarded to a child of an MNA member in good standing from Regional Council 5 and enrolled in an accredited program in any course of study.

Regional Council 5 Scholarship *(Spouse/domestic partner of member)*

Funded by Regional Council 5, scholarships will be awarded to a spouse/domestic partner of an MNA member in good standing from Regional Council 5 and who is accepted in an accredited nursing program. If applicant is a practicing RN, he/she must be an MNA member. *Second preference will be given to those pursuing degree in public health policy, health care professional tract or labor relations*

Regional Council 4 Scholarship

Funded by Regional Council 4, scholarships are given to active Regional Council 4 MNA members to assist with his/her studies for a B.S.N., M.S.N. or doctoral degree in nursing.

Regional Council 3 Scholarship

Funded by Regional Council 3, scholarships are being offered to an MNA member in good standing and active in Regional Council 3 to assist with his/her studies for B.S.N, M.S.N or doctoral degree.

Regional Council 3 Scholarship *(Child of member in nursing program)*

Funded by Regional Council 3, scholarships are being offered to a child of an MNA member in good standing and active in Regional Council 3 to assist with his/her studies toward a BSN in an accredited nursing program.

Regional Council 2 Scholarship

Funded by Regional Council 2, scholarships will be awarded to an active Regional Council 2 member in good standing to assist with his/her studies in an accredited bachelor's, master's or doctoral program in nursing.

Regional Council 2 Scholarship *(Family/child of member in nursing program)*

Funded by Regional Council 2, scholarships will be awarded to a child of an active Regional Council 2 member in good standing to assist with his/her studies in nursing.

Labor Relations Scholarship

Two \$1,000 scholarships are funded annually by a grant established by the MNA Division of Labor. The scholarships are for an RN or health care professional who is an MNA member in good standing. Applicants must be enrolled in a bachelor's or master's degree program in nursing, labor relations or related field. Additional reference is required from your local unit representative identifying your involvement in labor relation/collective bargaining activities.

Unit 7 Scholarship

Two \$1,000 scholarships are being offered to a member of Unit 7 State Chapter of Health Care Professionals who is pursuing a degree in higher education. One will be awarded to a registered nurse and one will be awarded to a health care professional.

Faulkner Hospital School of Nursing Alumni Association Scholarship

Funded by a sustaining scholarship endowed by the Faulkner Hospital School of Nurses Alumni Association, these awards are given annually to a student attending entry level RN program (priority given to Faulkner Alumni descendants).

For further information or to request an application, visit www.massnurses.org or call the MNF at 781-830-5745.

Applications must be postmarked by June 1, 2008

MNA membership dues deductibility for 2007

The table below shows 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	\$35.55	5.0%

TRAVEL TO EUROPE WITH MNA IN 2008

British Panorama

October 17th - 25th • \$1859

This 8 night tour of England, Scotland and Wales will feature: London, Bath, Cardiff, Wrexham, Stratford-on-Avon, Chester, York Rotherham and Edinburgh.



Grand Tour of Sicily

October 30th - November 7th • \$1769

Tour the highlights of Sicily on this 7 night grand tour. The featured tours will include: Palermo, Segesta, Marsala, Sciacca, Agrigento, Valley of the Temples, Piazza, Armerina, Taormina, Catania, Mount Etna and Siracusa.

Prices include air, transfers, hotel, all tours and most meals. A fabulous value! Space fills fast, reserve early.

* Prices listed are per person, double occupancy based on check purchase. Applicable departure taxes, fuel tax and travel insurance are not included in the listed prices. Credit card purchase price is \$30 higher than listed price. *For more information on these great vacations and to be placed in a database to receive yearly flyers, contact Carol Mallia at cmallia@mnarn.org with your mailing address.*

Sexual Health Matters Conference

WHY DOES SEXUAL HEALTH MATTER AND HOW DOES IT APPLY TO YOUR JOB?

Sexual health relates to complex factors from sexual behavior and attitudes, to cultural and social norms, to sex education in schools, to innate biological risk. Join us to reach beyond band-aid solutions and learn to better help the people you serve.

FRIDAY, SEPTEMBER 26, 2008

The Joseph B. Martin Conference Center at Harvard Medical School
77 Avenue Louis Pasteur, Boston, Ma 02155

LEARN MORE AND REGISTER ONLINE AT

www.SHM.ATLASTRAVEL.COM

Keynote Speaker

Silvia Henriquez, Executive Director
National Latina Institute for Reproductive Health

CEUs provided upon approval of application

*For more information, please contact events@pplm.org
or 617-616-1600 x 1595*

DISCOUNT MORTGAGE PROGRAM

Purchasing or Refinancing a Home? 1-877-662-6623

Take advantage of **low mortgage rates and discounts** on **points and closing costs** provided by the MNA Discount Mortgage Program.

Program Discounts:

- \$275 Discount Off Closing Costs
- 1/8% Discount Off Points Incurred
- 10% Discount On Owner's Title Insurance
- 10% Discount On Homestead Act
- Free Pre-approvals and Credit Analysis
- Free Review of Purchase & Sales Agreement
- Program Available to Direct Family Members

About the MNA Discount Mortgage Program

The Massachusetts Nurses Association has partnered with Reliant Mortgage Company to create a discounted home loan program for MNA members and their direct families. As the only MNA-endorsed mortgage lender, we provide low rates, group discounts, straight-forward advice, and quick results for MNA members and their families.

Programs are available for single-family homes, condos, multi family, second homes, and investment properties.

Before you purchase or refinance a home, please call for a free consultation.



Ask about our:

- No points/No closing cost programs
- No money down purchases
- Second Mortgages and Equity Loans Available!

Low Rates • Discounts • Quick Approvals

Call the MNA Mortgage Line for rates and details.



THE CALL IS FREE.

1-877-662-6623

1-877-MNA-MNA3



MA Lic. MC1775; NH Lic. # 8503-MBB; CT Lic. 10182; RI Lic. #20011277LB; ME Lic. #SLM5764. Not every applicant will qualify for these programs.

2008 MNA ANNUAL AWARDS



You know nurses who have made a difference. You can identify individual contributions that go beyond the ordinary. You recognize excellence in nursing practice, education, research and service.

Now it's your turn to make a difference! You can nominate candidates for a 2008 MNA Annual Award. Help give MNA the opportunity to reward and applaud outstanding individuals. Let them know that you care about their important contributions to the profession of nursing.

To receive nomination papers for any of the MNA Annual Awards, please fill out and mail the enclosed Nomination Paper Request Form.

Deadline for submission of nominees to the MNA Awards Committee is June 13, 2008.

Completed forms and other requested materials must be received by the Awards Committee by the deadline; late or incomplete applications will not be reviewed by the Committee. For additional information or questions regarding the 2008 MNA Annual Awards, please contact Liz Chmielinski, Division of Nursing, at 781-830-5719; or toll free in MA at 1-800-882-2056, x719.

Elaine Cooney Labor Relations Award

Recognizes an MNA Labor Relations Program member who has made a significant contribution to the professional, economic and general welfare of nursing.

Judith Shindul Rothschild Leadership Award

Recognizes a member and nurse leader who speaks with a strong voice for the nursing community at the state or national level.

Kathryn McGinn-Cutler Advocate for Health and Safety Award

Recognizes an individual or group that has performed outstanding service for the betterment of health and safety for the protection of nurses and other health care workers.

MNA Excellence in Nursing Practice Award

Recognizes a member who demonstrates an outstanding performance in nursing practice. This award publically acknowledges the essential contributions that nurses across all practice settings make to the health care of our society.

MNA Human Needs Service Award

Recognizes an individual who has performed outstanding services based on human need, with respect for human dignity, unrestricted by consideration of nationality, race, creed, color, or status.

MNA Advocate for Nursing Award

Recognizes the contributions to nurses and the nursing profession by an individual who is not a nurse.

MNA Image of the Professional Nurse Award

Recognizes a member who has demonstrated outstanding leadership in enhancing the image of the professional nurse in the community.

MNA Nursing Education Award: Professional Nursing Education

Recognizes a member who is a nurse educator and who has made significant contributions to professional nursing education/continuing education and/or staff development.

MNA Nursing Education Award: Continuing Education/Staff Development

Recognizes a member who is a nurse educator and who has made significant contributions to formal nursing education/continuing education or staff development.

MNA Research Award

Recognizes a member or group of members who have effectively conducted or utilized research in their practice.

MNA Bargaining Unit Rookie Of The Year Award

Recognizes a Labor Relations Program member who has been in the bargaining unit for five or less years and has made a significant contribution to the professional, economic and general welfare of a strong and unified bargaining unit.