

the Massachusetts

nurse



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Standing tall for patient care at Morton Hospital

ADVOCATE



Inside: House passes workplace violence prevention bill

April 2010

MNASM

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High level of RN commitment to serious reform

Nurses from California to Maine participate in national labor forum



Representatives from the Labor Campaign for Single Payer at their annual conference.

By Sandy Eaton, RN

At the second annual conference of the Labor Campaign for Single Payer (LCSP) in early March, 15 front-line nurses and six staffers from their unions—17 percent of those registered — played an active role in hammering out labor's health care agenda for the coming year. Nurses from California, Oregon, Minnesota, Illinois, Michigan, Ohio, New York, Massachusetts and Maine also participated.

The NNU was represented by its co-president Jean Ross from Minnesota and by Martha Kuhl from California, its secretary-treasurer. NNU's policy director, Michael Lighty, addressed the plenary on strategy. NNU's political director and its DC lobbyist also played active roles. Donna Smith, whose family was featured in Michael Moore's exposé "SiCKO" and who is now NNU's single-payer organizer, played a strong role as well. NNU organizing staff from Illinois and Ohio also contributed.

"[This] meeting highlighted the serious grassroots organizing that thousands of workers and their unions are doing to change the terms of the debate on health care reform," said Kuhl. "Many unions need to expand member-to-member education so that workers understand that an improved and expanded Medicare for All is the best solution to the health care crisis. We emphasized the need for union activists to

increase their efforts to push some labor leaders to actually lead on this issue."

Other speakers at the conference included national union officers, AFL-CIO Executive Council members, AFL-CIO state federation and central labor council presidents along with many other major union leaders.

Over the course of the weekend meeting, delegates heard presentations on "Lessons from the Past and Prospects for the Future," "Strategies to Move Forward," "Impact of the Health Care Crisis on Collective Bargaining" and "How to Deepen Labor's Support for Medicare for All." Congressman John Conyers, the lead sponsor of HR 676, participated in the entire conference and gave a keynote presentation on "Current Legislative Issues and the Future of HR 676."

Delegates were also treated to a rousing speech from U.S. Rep. Donna Edwards, D-Md.. "Just because a health care reform bill is passed and signed into law this year doesn't mean that our fight is over," she said. "We've got to redouble our efforts for legislation that will provide real health care for all."

Most nurses who attended participated in a nurses' caucus, where they grappled with such questions as how to help rank-and-file nurses realize the relationship between their ability to deliver proper care and the urgency of fundamental health care reform.

Kuhl and Sandy Eaton, chair of the NNU's Legislative Council and secretary of MNA's Congress on Health Policy & Legislation, were re-elected to the campaign's steering committee. Ross was elected to this LCSP working body. ■

On the Cover: MNA members picketing at Morton Hospital in Taunton. From left, Jen Rogers, Aleta Bezanson, Kara Melb, Christina Leone, Marie Breen, Joyce Wilkin and Ann May

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MASSACHUSETTS NURSES ASSOCIATION



Building a bigger lifeboat

By Julie Pinkham

MNA Executive Director

Whenever the opportunity arises, I like to talk to MNA members about the rapidly changing environment in which they work—particularly when it comes to the phenomenon of “back to the future in health care.” I focused on this topic in my February column, but I think it is important to keep talking about what is happening, what might happen and what we need to do with these pieces of information.

First, we need to understand the impact of health care reform and specifically health care expansion as it was implemented here in Massachusetts. While the policy succeeded in getting health insurance to those who did not have it, the plan did not tackle the issue of cost. The more people with access to care, the bigger the total bill. The belief was that with better access to preventive care, costs would go down. This has not happened, mainly because the cost of providing care to those who have entered the system is still greater than the savings. And in crafting the health care bill, the Legislature did not put in place the funding to sustain it ... that problem was to be addressed later.

But “later” has arrived, and it has arrived in the midst of a major financial crisis. As a result, the state cannot provide the funding to adequately underwrite its health reform plan and the problem of cost is not going away.

Employers say the cost of insurance is too high, while insurers say the cost of health care is too high. Meanwhile, hospitals and doctors say they are not paid enough to survive. So while everyone is pointing fingers, the problem of actually reducing health care costs has reached epic proportions.

Recently the attorney general and the Division of Health Care Finance and Policy set out to investigate the costs that drive the state's health care systems. The current reimbursement system (outside of Medicare and Medicaid) is a “private insurer” model where price is dictated by competition. How does that model work? Well, the industry—after deregulation in the 1990s—negotiated with insurers over reimbursement rates through contract arrangements with various insurers. Hospitals quickly came out of the gate to form networks, allowing them more market leverage to negotiate favorable reimbursement rates with the insurers. Not long after, mergers, closures and affiliations affected nearly every hospital in the state. Under this model, some networks have grown strong while many stand-alone hospitals have struggled to survive.

With a recent analysis of hospital pricing, the attorney general found that the negotiated

price of services had no correlation to patient care outcomes; teaching status; proportion of Medicare/Medicaid patients served; or the complexity of patients. There was also no significant difference between charges for the same service between hospitals, other than the advantage of the provider/hospital network to negotiate a good rate.

This information is not sitting well with the hospital industry, and the blame game and finger pointing are in full swing. Stakeholders have attempted to drag nurses into their funding battle by saying nurses' salaries are a reason for rising health care costs.

The MNA conducted a thorough review of this situation and we testified last month that nurses, as a percent of hospital expenses, account for no more than 18 percent of the total hospital budget and it has been that way for the last five years. On the other hand, capital expenses (new technology, infrastructure) represent 30 percent. The bottom line is that the cost is not driven by the industry's investment in nursing, but rather by its investment in bells, whistles, bricks and mortar. Given this priority, it is no surprise the industry wants to cut salaries/benefits and to “speed up” nurses by redesigning the model of patient care delivery.

We saw this 15 years ago in response to managed care funding pressures and it is in vogue once again, except now the research documents this is the wrong approach. In fact the research proves that these tactics will result in increased morbidity and mortality for patients.

So with all this finger pointing, what's happening? Well, the governor is looking to cap insurance premium increases to not greater than the medical inflation rate. There is also talk of re-regulating the provider industry and nurses can expect an onslaught of troubling reactions to the health-reimbursement policy debate.

By way of example: For the Caritas Network the “survive or thrive” reaction has led to its acquisition by Cerberus Capital. Why? Because Cerberus can inject \$830 million into the network to rebuild services, eliminate debt and position it for growth (read, add more hospitals), thus making Caritas a stronger competitor. Tufts Medical Center announced its intent to change their model of patient care delivery (read, cut nursing staff, increase the number of patients assigned to each nurse and



Julie Pinkham

replace nurses with unlicensed personnel). Morton Hospital, Quincy Medical Center and North Adams Regional Hospital are all facing difficult bargaining with employers pushing for concessions and all are looking to be acquired. They are not alone: I cannot name an institution that isn't “shopping” or being “shopped.” Health care is transitioning from small business models to health care corporations.

So what do we do to navigate these troubled waters? Metaphorically speaking, we build a bigger lifeboat. A small lifeboat means only a few people can survive and the focus is on who is tossed out of the boat and who stays in. A bigger boat will help both you and your colleagues survive. What do I mean exactly? When services are cut or consolidated you can look at it as, “I have high seniority, so I have protection; too bad for everyone else.” Or, instead, you can choose to partner with everyone who needs the lifeboat and push to make it bigger. Will the bigger lifeboat be perfect and protect all aspects of every person's job? I doubt it. But it is very likely that you will ALL do better by strategizing collectively.

In the case of MNA bargaining units being merged, this brings up the sensitive subject of seniority. Seniority becomes important when discussing reduction-in-force rights, job bidding rights and time-off access. And when things get tight—like now—all of those items become important and, therefore, potentially giving up a perceived or real security may be a difficult leap of faith. But I can tell you that the alternative is a small lifeboat. What if it is you in the next “consolidation?” Do you want to be thrown out?

We need to stay together and support each other or else management will divide and conquer. We also need to help nurses who are not yet organized to do so because non-union hospitals are already imposing such changes. Those nurses don't have the chance to negotiate.

Nurses are most powerful when they act collectively. Before all of these current changes began to unfold, your bargaining unit was positioned against the decisions of a single facility viewed as your employer. That is not what the future holds. The employer will no longer be the individual hospital. It will be a corporation and decisions will be made at a corporate level. While we do not aspire to the corporatization of health care, we do need to define our power within that structure. Doing so will help us protect both our practice and our patients.

The solution to the health care financing crisis is not the devolution of our working conditions. We need to stand together to ensure that these burgeoning health care corporations do not push any of us out of the lifeboat. ■

Reports from the field: MNA members help to heal those in Haiti

Since January, MNA nurses have volunteered in huge numbers for relief work in Haiti, including delegations, pairs and individuals from the Boston teaching facilities, the Caritas network hospitals, several Worcester-area hospitals, Mercy Medical Center, Lawrence General and many other MNA facilities.

The time, care and skills that each of these nurse volunteers shared with the people of Haiti has been both celebrated and appreciated, and their work and efforts made an immediate difference in those who were in such desperate need of medical care

More than 12,000 nurses have volunteered on the National Nurses United's RNRN Web site, and the MNA and NNU have been working to match volunteers to Haiti's local needs based on skills, experience and availability.

Dispatch from Betty Sparks

Betty Sparks, an MNA member and OR nurse working at Newton-Wellesley Hospital, departed on Feb. 1 for Haiti as an International Medical Surgical Urgent Response Team (IMSURT) volunteer. This team operates under the jurisdiction of the National Disaster Medical System, the Office of Homeland Security and FEMA.

Sparks is the chair of MNA's Emergency Preparedness Task Force and a former MNA Board member. One of her first dispatches to the MNA follows.

Date: Feb. 7 Here for a week so far and seeing many patients with wound infections and fractures who are in need of dressing changes and reassessments of their external fixations devices. We are seeing so many of those.



Things here are unimaginable in terms of where and how we are caring for patients although, at the same time, everyone is doing amazing work that is making a tremendous and

immediate difference. We are putting external fixation devices on fractured distal femurs while swatting flies off the sterile back table.

It has been common to see patients with gastroenteritis and respiratory ailments, and we have done some pregnancy checks as well. We have also treated a few gunshot wounds.

In terms of my surroundings and lodging, I am sleeping on a cot outside under a tin roof covered with mosquito netting. We are eating MREs—meals ready to eat—and drinking warm water. We bathe in outdoor shower tents with cold water, but it feels great as it has been 90 degrees here. We have hit on an ingeniously simple system for doing our laundry: We wash everything while we are in the shower and then we just hang everything out to dry.

We have a bathroom, but if you need to flush, you have to refill the tank with the water runoff from our outdoor sinks where we wash up. No drinking or brushing your teeth with that water though! We use bottled water only, and then we cut the bottles in half and use them as coffee cups.

One of the most entertaining moments though was when, after drinking warm water for more than a week, the U.S. Embassy sent us frozen Gatorade in med containers!

But forget the flies and frozen Gatorade: this experience is truly rewarding.

Dispatch from Mike Savoy

Mike Savoy is an MNA member and nurse at Brigham and Women's Hospital in Boston. He traveled to Haiti with several friends and colleagues as part of NGO, Partners in Health.

As I stepped through the door of the vintage A707 that had ferried us from Miami to Port au Prince, I was struck by a blast of air so hot I was nearly knocked off my feet. I looked out on the tarmac taking in the seeming chaos. The international relief effort evolving over the airport grounds was overwhelming: helicopters and aircraft of every sort and from all nations, trucks, and lines of people, jet engines screaming, and the pungent stink of exhaust and the shouting of commands. In the near distance, vast makeshift tent cities and the ruins of Port au Prince with streams of traffic winding through its streets.

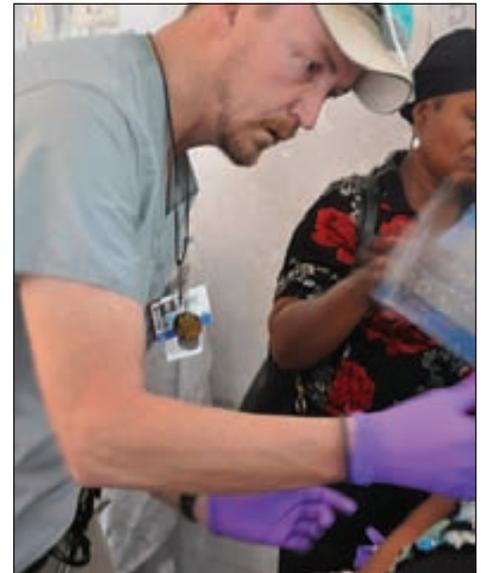
Immediately after the quake that devastated Haiti on Jan. 12, nurses nationwide volunteered to help. I was one of them. By Jan. 28 I was given word that I would be part of a medical team to be dispatched to the now completely overwhelmed 100-bed St. Nicolas Hospital in St Marc, Haiti. The city lies 50 miles north of Port au Prince with a population of roughly 250,000. At its center, the population is roughly 60,000-80,000 people but since the quake, no one knows for sure. On Feb. 3 we were in the

air en-route to a nation of people in need.

Our affiliate NGO, Partners in Health, decided they would rotate in MD and RN teams consisting of trauma, surgical, orthopedic and reconstructive-plastics, to augment operations already in place in St Marc.

Having left a devastated Port au Prince, hundreds of desperate patients seek treatment at St. Nicolas, many rest on stretchers or mattresses on the floor. Doctors and nurses zigzag from one patient to another. The turmoil at St. Nicolas was tempered by the nurses there before us, pathfinders like NPs Annie Lewis and Ed Arndt and OR nurses Cheryl Grove and Deb Pitts. Our teams built on existing Haitian systems that before the quake were seriously deficient and difficult.

When we arrived, the hospital was flooded with all manner of ill and injured. Thankfully, our group overlapped the team that had been in Haiti before us, so much of the difficulty of organizing had been eased.



We quickly prepared the surgical teams, scheduled cases and disbursed nurses throughout the hospital wards to help the Haitian nurses care for their overwhelming patient loads. Dressing changes were scheduled, the more complex to be done in the OR, the rest on the wards. A much needed trauma room was organized in the emergency ward. We gained trust from the staff and, more importantly, from the patients.

The conditions of the facility, the earthquake victims and the poverty in the area are all challenges we faced acutely in St Marc. The nurses and physicians of our team worked tirelessly to help these patients, their families and our Haitian peers. Moving forward, solutions will be needed that are inspired by the Haitian nurses in order to create the kind of hospital they want for their future—solutions that work for them.



Send a Nurse to Haiti...

Donate now at www.SendANurse.org



We arrived home Feb. 14, tired and dusty, but satisfied that we had made a difference. There is so much to tell of Haiti. So much poverty, sadness, maddening bureaucracy, violence, disease and death. Yet there is such love there, deeply rooted religious beliefs, song, hope and potential. The nurses on our team did countless remarkable things, subtle yet profound things, and they touched numerous lives. We did what we could, what we do best. We are, after all, nurses.

Dispatch from Kathy Reardon

Kathy Reardon (below, right) is an MNA member and nurse at Caritas Norwood Hospital. She traveled to Haiti with several friends and colleagues from within the Caritas network. Her employer was one of the area's first to organize and support an independent, internal volunteer program. Her dispatch is based on an interview she participated in at MNA headquarters shortly after she returned from Haiti.

Kathy Reardon knew almost immediately that she wanted to assist the people of Haiti by going there to help the sick and wounded. It just so happened that her employer, Caritas Norwood Hospital, was on the same page.



"This whole process moved fast for us," Reardon explained. "Hospital management got the ball rolling and set up an internal system that allowed us to volunteer our time. We just needed to get our paperwork, medical records and family situations in order; they handled getting our shifts covered."

According to Reardon, the day after she got her passport Caritas pretty much said,

"So are you ready to go?" Her travel-related vaccinations, however, were still outstanding — although that did not take much time to get squared away either. "Two days after we were vaccinated, we were on our way to Haiti."

She traveled with several colleagues but also with one of her closest friends from Norwood, Pam Reilly. Together, they landed in Cap-Haitien. And together they carried their small personal bags and more than five large boxes of donated medical supplies to a small vehicle that was to drive them to the village of Miloto.

"The crowds were overwhelming," Reardon recalls, "and the dirt road that we needed to take to get to the village was barely passable."

Haiti relief nurse volunteers

(as of April 1)

Susan Blouin, Caritas St. Elizabeth's Medical Center

Maura Brennan, UMass Medical Center

Patricia Caruso, St. Vincent Hospital

Tom Curran, Caritas Good Samaritan Medical Center

Amy Desmaris, Mercy Medical Center

Reginna Kennedy, Caritas Carney

Jan Leary, UMass Memorial

Regina Mackenzie, Caritas Carney

Deborah Perry, Lawrence General Hospital

William Pierce, St. Vincent Hospital

David Powers, Mercy Medical Center

Trish Powers, Brigham & Women's

Kathy Reardon, Caritas Norwood

Pam Reilly, Caritas Norwood

Michael Savoy, Brigham & Women's

Betty Sparks, Newton-Wellesley Hospital

Tim Stratton, Caritas St. Elizabeth's Medical Center

Marie Ventimiglia, St. Vincent Hospital

Have you helped in Haiti too?

Let us know: mnainfo@mnarn.org

They were headed to the village's only hospital, Sacre Coeur, which is part of a missionary program that Caritas supports. According to Reardon, the village was not damaged in the earthquake and it was safe, but, like the rest of the island, it had no infrastructure. To make things more difficult, people from all over the island were travelling to Sacre Coeur for medical treatment, shelter, food, safety or to find loved ones who may have been admitted after the quake.

"People were just walking ... walking to any safe village where they thought they might be able to find help," Reardon explained. "And

there were other folks who were so injured that they were brought in via helicopter." To put it differently, the hospital was not just at capacity. It was teeming with the sick, the injured and their families.

"All those people in a hospital that was so small that it could easily fit inside the MNA's second floor open office area," Reardon added. "And each room held between 20 to 25 people, for a total of more than 300 patients. We pretty much just dropped our bags, put on our scrubs and went to work."

Reardon and other volunteers at Sacre Coeur started seeing patients immediately, and they instantly saw common injuries in their patients: amputations, secondary wound infections, open sacral wounds, DVT, and bone injuries that required external fixation devices. "It was hard, exhausting work that was physically, emotionally and mentally draining," said Reardon. "But it was truly rewarding work."

When asked about her best and worst moments, Reardon pauses momentarily and then answers the questions with ease. "I watched one little girl who had suffered a terrible crush injury get up and walk within 24 hours of arriving thanks to the wound care and PT she received," recalled Reardon. "When I saw her last she was sitting outside in the sun ... smiling."

Reardon could also recall her most difficult moment with ease. "We treated an older man whose arm had been amputated, and he also had a skin graft. He was doing well, so his son asked when they would need to leave. He was asking because they had nowhere, absolutely nowhere, to go." She went on to describe her next thought. "I kept thinking, 'He's over the hump in terms of the medical crisis ... but what's really next for him?'"

As she was preparing to return home 10 days later, Reardon was able to be hopeful about the answer to her own question. "The people of Haiti are resilient, and the world is paying attention. I will be optimistic."

Interested in volunteering?

The work in Haiti is ongoing, so contact the MNA at 781-830-5743 or via massnurses.org for details on how to volunteer.

The MNA's Emergency Preparedness Task Force is also continually working to provide any needed emotional support to nurses who are returning from Haiti. If you are interested in joining this task force, contact Mary Crotty at mcrotty@mnarn.org or 781-830-5743. ■



From left, Maria Bairos, Jeanine Viera and Fred Viera.



Morton MNAers holds successful picket; continue fight at the table

As the *Massachusetts Nurse* went to press, the nurses and health professionals of Morton Hospital were engaged in a righteous struggle to win a new union contract to protect their professional practice as well as their defined benefit pension plan. The nurses conducted an enormously successful informational picket on March 10, with more than 300 members and supporters walking in front of the hospital protesting the hospital's refusal to address the nurses' need to negotiate strong limitations on the use of forced overtime, as well as their unreasonable demands to cut the nurses' benefits at a time when the hospital was making healthy profits.

The nurses followed the picket with the filing of unfair labor practice charge against the hospital for failure to engage in a good faith effort to reach a settlement. The nurses were also involved in the initial planning for the potential of a vote to authorize a strike, should that become necessary. In early April, following the nurses' activities, the hospital began to compromise on the issue of mandatory overtime but was holding firm on its plan to cut the nurses pension.

The nurses and health professionals are continuing to negotiate in the hopes that they can avoid a strike, but the issue of preserving their pension is a key issue that needs to be resolved. They continue to engage their community, placing ads in the paper, circulating a community petition, and circulating signs

of support to community members and store owners to display.

The plan to cut the nurses' pension plan, which would result in a 36-50 percent cut to the nurses' retirement benefit, has outraged the nurses, who have been meeting in recent days to consider their options, including a decision to hold a vote to authorize a strike over this and other outstanding issues, including the hospital's refusal to agree to strict limits on the use of mandatory overtime as a staffing mechanism and a proposal to increase nurses' health insurance premiums and co-pays.

The MNA is also considering filing a second charge against the hospital for its failure to present information requested that details specific financial information about the hospital's spending on executives' salaries and benefits, the value of its real estate holdings and the salaries and bonuses for physicians at the hospital. The request was driven by earlier disclosures that the hospital is making healthy profits and has awarded its outgoing CEO an astounding \$3 million retirement bonus at the same time it is looking to strip its staff of their pension. The nurses are also requesting information on what the hospital is paying for its high priced legal counsel, which the nurses' union believes could be as much as \$500 – \$600 per hour.

"We have always been willing to make sacrifices on behalf of the hospital when they have been in real financial trouble," said Joyce

Wilkins, RN, chair of the MNA's local bargaining unit at Morton Hospital. "But this hospital is making millions in profits and is projected to do so for at least the next two years. They are making that money on the backs of nurses and health professionals, who provide 90 percent of the care patients receive. We see no economic justification for the hospital's decisions to cut our pension, or to use forced overtime as an alternative to providing safe staffing conditions for our patients."

The 400 nurses and health professionals, who are represented by the MNA, began negotiations for a new contract in October. To date, 18 sessions have been held, with the last four sessions held with a federal mediator. The nurses' existing contract expired on March 8. On March 10, union members delivered to management petitions in support of their call for an end to mandatory overtime and protection of their pension, which was signed by more than 85 percent of the professional staff. On March 17, more than 300 union members participated in an informational picket outside the hospital, drawing overwhelming support from the public.

Little movement on key issues

Talks held on March 22 failed to yield a settlement on the key issues in dispute. While the nurses' union compromised on its proposal regarding mandatory overtime, the hospital made only token moves on the issue, which

will allow them to continue to force nurses to work forced overtime without restriction. Contrary to management claims that mandatory overtime is rarely used, the nurses have recorded nearly 100 instances in the last few months where nurses were forced against their will to work extra shifts, a practice that medical experts say is extremely dangerous for patients.

The nurses are seeking to limit the number of hours a nurse can be forced to work to 12, which is the standard recommended by medical experts. They want to limit the number of times a nurse could be mandated to work overtime to two times per calendar quarter. And most important of all, the nurses want to require the hospital to provide full staffing so mandatory overtime isn't necessary.

"Forced overtime only happens because a hospital does not have the proper number of staff on hand to cover the shifts needed to care for patients," Wilkins explained. "Our management is regularly posting four-week schedules with dozens of holes in the schedule, holes that can only be filled by nurses working overtime.

If the occurrence of mandatory overtime is as rare as they claim, then they should have no problem accepting our proposal, which would still provide them with hundreds of shifts per quarter to fill unexpected holes in the schedule. The only reason they won't agree to our proposal is because they want to use mandatory overtime as a staffing tool. "

The parties are set to meet again on March 30, the day prior to the hospital's threatened deadline to unilaterally freeze the nurses' pension.

The nurses union has held open meetings and is meeting individually with its membership to provide information about strikes and to answer member's questions about a potential strike vote, as it continues to evaluate all options to reach a settlement.

"None of us want a strike. We want a good faith negotiation for a fair settlement," said Wilkins. "But we are committed to using our legal rights, including a strike, if our members determine that is what is necessary to protect our patients' best interests as well as the interests of the caregivers." ■



An enthusiastically Irish Rep. Jim Fagan (D-Taunton), left, joins Morton Hospital nurses Erika Koch and Kara Melb on the picket line.



Show of support: State Sen. Marc Pacheco (right) joins Louise Nunley, bargaining unit secretary, and Joyce Wilkins, bargaining unit chair, at the Morton picket.



Ginger Derewiany, left, and Joan McRae.

MORTON HOSPITAL NURSES

The nurses from the bargaining unit at **Baystate Franklin Medical Center** in Greenfield, MA support your right to **STOP** the unsafe use of **mandatory overtime** and to keep your **pension benefit!**

An ad that ran in the local Taunton paper.

MNA bill to punish perpetrators of workplace violence passes House

Successful MNA "Lobby Day" simultaneously held in State House

The Massachusetts House of Representatives cast a unanimous vote on March 31 to pass legislation that will stiffen the penalties faced by those who assault nurses and other health care workers providing care. This bill is one of a series of measures the MNA has proposed to address the growing problem of workplace violence in health care settings.

"We are thrilled with the vote and the message it sends, that being assaulted is not acceptable, and health care workers need to be protected as they do their jobs," said Donna Kelly-Williams, MNA president. "This is an important first step in our effort to make health care settings safer for nurses and for patients and we thank the House for its support."

The vote came on the same day when more than 250 nurses, health care professionals and nursing students from across the commonwealth, many of whom are the victims of workplace violence, converged at the State House for a press conference and lobby day. Their mission was to push for the passage of a package of bills filed by the MNA that are designed to address what has become a growing crisis in the health care sector.

"Patients, family members and others must get the message that violence against health care workers will be treated seriously. Several years ago, the legislature increased the penalties for assaulting an emergency medical technician while providing treatment. S.1753, sponsored by Sen. Michael Moore (D- Millbury), and H. 1696, sponsored by Rep. Michael



MNA President Donna Kelly-Williams (left) and MNA member Donna Stern listen intently during the lobby day press conference before Stern spoke about her experiences with hospital violence.



▲ Linda Condon, a nurse at Morton Hospital, spoke about her experiences with violence in the workplace.

◀ Ellen MacInnis, a nurse from St. Elizabeth's Medical Center, spoke to the crowd.

Rodrigues (D-Westport), provides the same increased penalties for those who assault a nurse or health care professional providing treatment,” said Karen Coughlin, MNA vice president, who has been a victim of a number of assaults during her years working at one of the state’s mental health facilities.

The day drew extensive media coverage throughout the state, with MNA members telling their stories of being assaulted, putting a human face on the problem. The next day’s Boston Herald opened its story with the following characterization of the MNA’s victory. It read: “They care, they converged, they conquered”—a nice summary of the day.

Donna L. Stern, of Northampton, a registered nurse in a mental health unit at the Baystate Franklin Medical Center in Greenfield, told a packed hearing room how she has been punched, kicked, almost strangled and spit on during her five years as a nurse.

Linda Condon, an emergency department nurse who works at a number of hospitals, told of “being sucker punched in the face” by one patient and, on another occasion, “I was head butted in the face by a patient who I was attempting to hold back as she attempted to kick another colleague who she had thrown to the ground.”

Ellen MacInnis, a nurse at St. Elizabeth’s Medical Center in Brighton, described an incident when she tried to put an IV into a HIV-infected patient. The patient took a swing at MacInnis, dislodging the IV and spraying blood in her face, mouth and eyes. “The hospital is the one place where, when you show up there, we have to take you in. The behavior that we see, in any other place ... people would be thrown out,” she said.

Throughout the day, MNA members and nursing students dressed in their scrubs and lab coats made visits to their legislators to seek their support for the assault bill and two other measures, S.988, which will require health care employers to develop and implement programs to prevent workplace violence, and H.1931, which will create a difficult-to-manage unit in the Department of Mental Health to treat repeat perpetrators of violence. The assault bill now moves to the Senate, while the other measures are making their way through the legislative process. ■



- ▶ Students from the Mass. College of Pharmacy and Health Sciences were among 100 nursing students who attended the lobby day.
- ▶ MNA members (from left) Kathie Logan, Lynne Starbard, Bill Lahey, Mary Colby (seated), and Vaughn Garabedian (in doorway) meet with Sen. Steve Brewer to talk about the MNA’s violence prevention legislation.

When Chicken Soup Isn't Enough

Suzanne Gordon, a longtime friend of the MNA and a tireless advocate for nurses, recently published a new book *When Chicken Soup Isn't Enough: Stories of Nurses Standing Up for Themselves, Their Patients and Their Profession*. The book is a collection of 73 stories of nurses from all over the world — nurses who know what real advocacy means and who are both an example to and reflection of nurses everywhere.

Gordon is an award-winning journalist and author. She has written for the *New York Times*, the *Los Angeles Times*, the *Washington Post*, the *Atlantic Monthly*, the *American Prospect*, the *Globe and Mail*, the *Toronto Star* and others. She has also been a health care commentator in the U.S. for CBS Radio News and Public Radio International's "Marketplace" business program, and a popular lecturer.

David Schildmeier, the MNA's director of public communications, recently spoke with Gordon about her latest book.

Why did you decide to write this book?

Ever since I first checked out the *Chicken Soup for the Nurses Soul* books, I was concerned about their underlying message to RNs. While I understand that these books are intended to celebrate nurses, I was concerned that they were celebrating some of the wrong things and ignoring some of the right things. Over and over again, I would think, what about a book called, *When Chicken Soup Isn't Enough*. But I kept the idea on the very, very back burner until a couple of years ago. I was having lunch with a group of nurses—academics, workforce researchers, union reps, and staff nurses—who were lamenting the fact that nurses were so easily silenced and silent. I mentioned the *Chicken Soup for the Soul* books and suggested that they inadvertently reinforce nurses' silence. "I'd like to write a book called *When Chicken Soup Isn't Enough*," I said. To which everyone at the table replied, "what a great idea. Do it!" So I did.

So what is the book about? Who are the authors?

The theme of this book is genuine patient advocacy. Not patient advocacy defined as "I hope things go well for patients," but patient advocacy as these authors describe it — doing something to assure that patients are safe and well cared for. I am the editor of the book, its catalyst and facilitator. And I do have to admit that I did a heck of a lot of work getting the essays together. But this book only exists because 73 nurses from around the world took the time to either write an essay or allow me to interview them and then help them write that essay. Most of the nurses are from the U.S., six from Massachusetts, but the book has stories of nurses from Iceland, Sweden, South Africa, Canada, Australia and many other countries. Their

stories describe what happens when nurses assert themselves either as individuals or collectively. They are stories not only of empowerment but of the hidden—and sometimes not so hidden—power of nurses and nursing.

There are three MNA members in featured in the book. Who are they and what do their chapters focus on?

Penny Connolly, Karen Higgins and Charlene Richardson have written stories for the book. Penny's focuses on the role nurses played in the successful fight to save the Carney Hospital. Karen's describes her evolution as an advocate in the fight for safe staffing. Charlene describes being attacked by a patient at work and what happened

when she got no support from her hospital following the assault. She thus began to advocate for legislation to protect hospital workers from such assaults.

Can you describe what you think these nurses have in common?

One of the things all these nurses share is a simple fact of life. Which is that no matter what you have achieved it's usually because, in small ways or large, you fought for it. And no matter what you have won, you have to continue to stand up if you are to maintain your gains. When I say fight, I don't mean going to the barricades or getting into verbal fisticuffs. Sometimes nurses have had to pull out all the stops. But many times, simple persistence is the battle. Sometimes nurses fight by stealth. That's why the title has the words "standing up" in it.

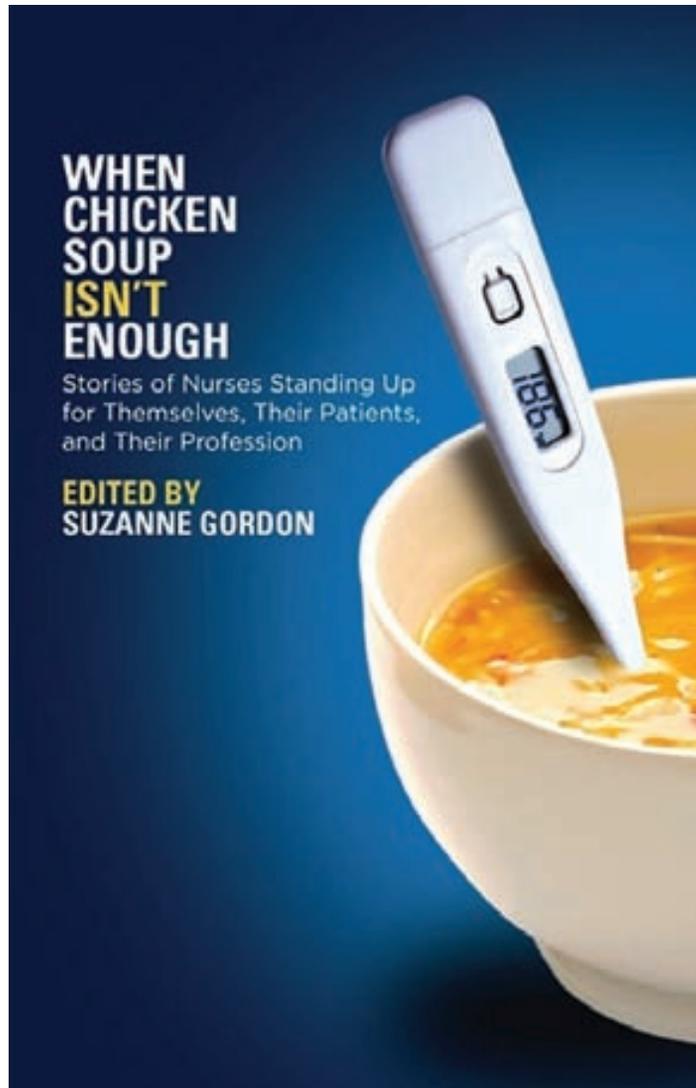
The title argues that nurses have to stand up for themselves.

Absolutely, and that choice of words was very deliberate. Nurses are always told they have to stand up/advocate for their patients. But they are often told that they should sacrifice themselves in the process. I believe nursing involves a certain dose of self-sacrifice. But you can

overdose on sacrifice and, in the process, harm not only yourself but patients as well. Exhausted, stressed out, injured, irritated and frustrated nurses cannot function at their peak. So nurses need to tell us not only what patients need but what they need to fulfill their mandate as patient advocate.

What do you hope nurses will do with this book?

I hope they will use it as a tool and make it a kind of mantra. Chicken soup is not enough. I'm Jewish, so when I have a cold, it's great—particularly when it's got lots of garlic in it. But comfort food is not always the Rx. The very act of standing up, even if you don't win, can sometimes make you feel even better. Plus, it gets real results. ■



Medication and medical errors: how BORN is handling complaints

By Mary Crotty
Associate Director

Disciplinary actions brought against nurses are discussed at BORN's monthly meetings, along with other BORN business. Over the past two years, MNA staff have noticed a change — for the better — in the attitude toward resolution of complaints against nurses by BORN board members, primarily in resolving complaints related to single med errors. There are a few board members who are out of touch clinically, or out of touch with current patient safety research and literature, who are still punitive in their approaches but increasingly they are outvoted.

Some, but not all, new BORN appointees are clearly much more knowledgeable about the current drive to improve patient safety and reduce errors by adopting “just culture” approaches toward med errors.

It is important for bedside nurses to be aware

of this change at BORN. Despite an apparent increase in harassment recently from nurse managers (i.e., threats to report nurses to BORN for incidents of minor infractions or errors) the reality is that BORN has pretty much been dismissing complaints of single med errors for the last two years.

This enlightened approach has arrived slowly but it is being demonstrated fairly consistently in BORN disciplinary decisions. The change for the better is being driven by extensive research by patient safety and patient advocacy organizations and by research done by BORN staff. The most significant findings that are used by BORN and others to support a less punitive approach toward resolving complaints which often stem from system problems are outlined in the resource list included below.

For nurses who feel harassed or threatened with “BORN,” the information below might be useful to share with their managers. Web site

links with further information are also listed below.

Despite the less punitive atmosphere, be *sure* to renew or obtain your own liability insurance (NSO is the MNA's preferred provider). NSO will provide nursing license protection—that is, they will pay an attorney to represent you before the board, no matter the reason. If you are caught in a situation where you must respond to the BORN, having your own liability insurance will be invaluable.

Note: MNA staff and board members attend monthly meetings of the BORN as observers. BORN meetings are held the second Wednesday of every month. Visitors are welcome. Contact Mary Crotty for more information at 781-830-5743 or via e-mail at mcrotty@mnarn.org if you would like to attend or if you have questions related to this topic. Nurses who drop in on BORN meetings find they can be quite enlightening. ■

Resource List

Mass. Board of Registration in Pharmacy

■ www.mass.gov/Eeohhs2

The Massachusetts Board of Pharmacy has developed “Best Practices Recommendations to Reduce Medication Errors.” Its top recommendation: “Promote a non-punitive atmosphere for reporting medication errors.”

Massachusetts Coalition for the Prevention of Medical Errors

■ www.macoalition.org

The Mass. Coalition for the Prevention of Medical Errors is nationally known for its exploration of the causes of medical errors. The coalition recommends two basic principles that make up the foundation of their best practice recommendations:

Adopting a systems-oriented approach to medication error reduction. Recent studies have indicated that errors, while made by individuals, are often the result of error-prone systems, processes and tasks.

Promoting a non-punitive atmosphere for reporting errors which values the *sharing of information about the causes of errors and strategies for prevention.* Other industries, such as aviation, have moved away from an atmosphere of blame and punishment to one of system redesign. The best approach to prevention is one that encourages learning from mistakes. To do this, people must be able to talk about errors in a safe environment. Health care leaders must continue to hold care givers accountable for professional judgment while

at the same time work to make processes for delivering care as error proof as possible.

Institute for Healthcare Improvement

■ www.ihl.org

The Institute for Healthcare Improvement is an independent non-profit organization based in Cambridge with nationally recognized principals (Lucian Leape, Don Berwick and Jim Conway) who work as specialists in health care improvement throughout the world. Founded in 1991 the IHI works to accelerate improvement by building the will for change, cultivating promising concepts for improving patient care, and helping health care systems put those ideas into action. One of its primary focuses is building a “culture of safety.” A leading strategy of IHI is to promote a non-punitive approach to medication errors.

Institute for Safe Medication Practices

■ www.ismp.org

ISMP is a federally certified patient safety organization that promotes and awards recognition to providers who work to develop safe patient practice environments. It advocates for the creation of non-punitive environments where error reporting is encouraged in order to best address what it has determined is largely a problem driven by system or environmental practices.

The Joint Commission

■ www.jointcommission.org

The Joint Commission calls for the creation of a “culture of safety.” It stresses that

organizations should have a “transparent and equitable disciplinary process that takes into account personal responsibility and accountability.”

It notes two major actions that erode leadership credibility and undermine organizational safety culture:

Terminating or failing to support an employee who committed a blameless act during the course of an adverse event.

Exempting influential individuals from complying with organizational quality and safety policies, such as policies on intimidating and disruptive behaviors.

TJC states, “The inconsistent application of such policies are noticed by staff and are correctly interpreted as only paying lip service to safety.”

Massachusetts Nurse Practice Act

The Massachusetts Nurse Practice Act's Standards of Conduct provides the basis for holding *nurse managers* liable for practicing in accordance with “accepted standards of practice.”

The in-state standard pertaining to BORN's duty to discipline nurse managers reads:

A nurse licensed by the Board and employed in a nursing management role shall adhere to accepted standards of practice for that role. The responsibilities of the nurse employed in a nursing management role are to develop and implement the necessary measures to promote and manage the delivery of safe nursing care in accordance with accepted standards of nursing practice.

Protect. Advocate. Unite. Organize!

Have you been wondering how to form a union in your facility? Are you interested in obtaining a legally protected voice to address nursing and workplace issues? Are you ready to join 23,000 nurses and health care professionals in the most powerful nurses union in Massachusetts? Take the first step! Read the questions and answers below and then give us a call.

Q. What is the first step in getting a union in my facility?

A. The first step in this process is to gauge the interest in forming a union at your facility and to set up a meeting with at least two like-minded co-workers. This is just an informational meeting. We can tell you about the Massachusetts Nurses Association and you can let us know about your facility. We meet at a place and time that is convenient for you and your co-workers, in groups as small as two or as large as necessary.

Q. What does it mean to have a union at work?

A. When a group of employees in a facility come together to form a union they gain a legally protected voice at work. Organizing a union is a right that is protected under both state and federal laws. Once unionized, your employer can no longer change existing practices without bargaining with you. Members create a democratic workplace that promotes union members to participate in negotiations, labor/management meetings, unit union activity and protected collective actions. Through collective bargaining, members can define the scope of nursing practice, promote high standards of nursing care, aggressively advocate for patients and work with management as equal partners to help ensure quality care for their patients.

Q. What federal law protects the right to form a union?

A. The National Labor Relations Act (NLRA), passed by Congress in 1935, protects the rights of employees to form, join or assist labor organizations, to bargain collectively through representatives of their

own choosing and to engage in activities for the purpose of collective bargaining or associated mutual aid or protection. In 1974 the NLRA was amended to cover employees of nonprofit health care institutions.

Q. What are my legal rights when forming a union at work?

A. You have the legal right to organize under the NLRA as described above. This law protects your right to talk to co-workers about forming a union before and after work; during breaks and meal periods; and in situations at work where patients are not present.

Q. Can I be fired for joining a union?

A. Federal law explicitly forbids employers from firing you for talking about, supporting or joining a union. Furthermore, you cannot be demoted, reprimanded or otherwise disciplined. Also, your employer cannot threaten the loss of benefits should you unionize.

Q. What are the advantages of forming a union at work?

A. The advantages of forming a union have long been identified. These include the ability to advocate on behalf of your patients and your nursing license, better pension and healthcare benefits, contractual job safety protections, increased employment security and safeguards against arbitrary actions by employers. Union members have a legally protected voice in their workplace.

If you are interested in taking the first steps to form a union at your facility call 1-800-882-2056, x777 or email ENorton@mnarn.org. For more information about the MNA visit massnurses.org. ■



History Repeats Itself!

And it's not good news for nurses and patients

During the 1990s many nurses in Massachusetts unionized with the Massachusetts Nurses Association (MNA) to protect their profession and their patients from a number of bad decisions that were designed to cut costs at the expense of nurses' clinical practice and their financial security.

Is history repeating itself?
Have you experienced any of the following?

- Asked to care for more patients with less support
- Layoffs, forced release time, mandatory overtime
- Replacing registered nurses with unlicensed personnel
- Merging or proposed sale of your facility
- Outsourcing or moving services
- Hiring consultants to redesign your work (beware of time studies)
- Unfilled vacancies or no vacancies when staffing is unsafe
- Increased floating, mandatory call
- Loss of benefits, pensions and earned time
- Job insecurity

Is this happening to you? Hospitals are dusting off the covers of their 1990s playbooks and making the same bad decisions. These practices led to a nationwide patient safety crisis that resulted in patient injuries, patient deaths, and a massive exodus of nurses from our nation's hospitals.

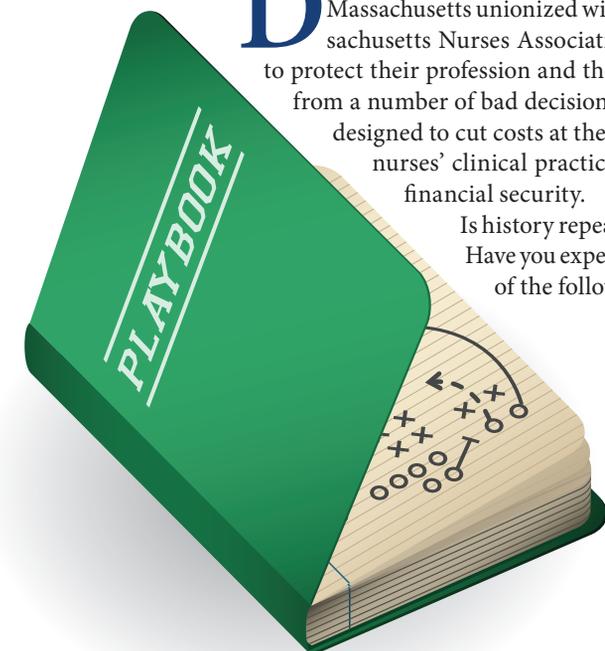
You can break the cycle. Join with over 23,000 MNA registered nurses and health care professionals who are uniting to protect our profession and to advocate for our patients.

Call the MNA today!

Eileen Norton, RN, Director of Organizing

Phone: 781-830-5777

Email: enorton@mnarn.org



Down the rabbit hole

By Deb Rigiero, organizer

I imagine that many of today's nurses often feel like Alice in Wonderland following the White Rabbit down the rabbit hole—chaotically falling into a very strange and surreal world while they are working what should be a regular shift at a typical hospital.



Deb Rigiero

Just imagine “Nurse Alice” sipping the potion labeled “drink me,” only instead of making her large the concoction makes her older. After years of nursing, her back and shoulders are sore, her knees are stiff, her hands ache and she needs glasses to read the computer screen.

Yet, Nurse Alice still loves her profession. She is able to mentor new nurses, provide support to her colleagues, and care for her patients using all her experience, education and skill.

But lurking in the corners of Hospital Wonderland is the Cheshire Cat, grinning and disappearing. It appears to be taunting Nurse Alice. What does that cat want?

Nurse Alice follows the grinning cat down an Oak Corridor into a part of Hospital Wonderland she has never visited before. There, she sees a Red Queen in front of a computer screen. What is the Queen looking at?

Off with their heads!

It is a list of employees and their dates of birth. “What does she need this for?” Alice wonders. Next, she sees the Red Queen strike a line through a name as she yells “Off with their head!” She continues to strike different employees’ names off the list.

Alice recognizes one of the names of a nurse who is just a few years older than her being “red-lined.” She notices that many of the red-lined nurses are the older, more experienced nurses. Why would the Red Queen do this?

Nurse Alice runs into the “Duchess” and tells her what she sees. The Duchess says to Alice, “Everything has a moral, if only you can find it.”

Nurse Alice thinks about this and realizes she is truly in a very strange and surreal world. A world of insidious age discrimination where experienced nurses are targeted for discipline, reported to the Board of Registration of Nursing, or threatened with lay-offs because of their age. Of course in Nurse Alice’s world, her hospital is not unionized so there is no protection.

Is there a moral to the story?

One has to wonder who benefits by “red-lining” experienced nurses. If a greedy employer looks at this as pure financial gain, then this is a good program. It makes financial sense to lay-off, discipline or force out the more experienced nurses who typically are paid more per hour, are at higher risk of using sick time and health care benefits, and who receive more benefit time than nurses who have not been there long.

Who is hurt by this insidious age discrimination? Experienced nurses who now have to worry about job security; patients who depend on nurses for their care; and less experienced nurses who need experience and mentoring. The ideal floor or unit should have new nurses, older nurses and nurses in between who can bring different experiences,



knowledge and support to the patients they care for.

So, what is the moral of Alice’s story? Unionize, unionize, unionize! Prevent this insidious age discrimination by having seniority rights, the grievance process and the unity of your colleagues who know that an injury to one is an injury to all. If you are already in a union, be vigilant in monitoring disciplines and watch for patterns that would indicate age discrimination.

Now, let us all peer “through the looking glass” and see a workplace that values experience and provides mentoring for new nurses. Together, we can make our hospitals places where nurses can nurse and patients get the care they need and deserve.

The End

Concessions: What are they good for? Absolutely nothing!

By Joe Twarog

Associate Director of Labor Education

The U.S. economy is in the midst of recovering from one of the worst recessions since the Great Depression. Many are still unemployed or underemployed, with the official unemployment figure for January 2010 at 9.7 percent. With this as a backdrop, many employers are using the down economy as an opportunity (excuse) to demand that workers open labor contracts and to force concessions. This is always framed as a way to “save jobs” and prevent the business from collapsing.

We have seen this occur recently in a number of the hospitals where the MNA has contracts. At Cooley Dickinson Hospital (CDH), last fall the employer asked the union to open the contract right in the midst of a three-year contract (the current collective bargaining agreement expires in January 2011). The hospital was unabashed in its attempt to have the nurses open their contract for the sole purpose of cutting benefits and wages — concessions! One has to ask, “When is a contract a legally binding contract?”

The union researched the hospital’s finances and found that it was having a banner year of “excess” (read, “profit”) of \$8.9 million for the last fiscal year. Therefore, there was a real question about why the employer was asking for concessions and threatening layoffs.

When confronted with this annoying fact of being comfortably in the black, hospital CEO Craig Melin did not deny it but only feebly offered that it was a “rainy day fund” and then defended the surplus as necessary for the hospital’s financial stability. The nurses subsequently conducted a large informational picket outside of the hospital and management did not continue to push the union to open the contract.

The bargaining unit chair at CDH, Sally Surgen, summarized it best, “If the reverse were true and the hospital had a \$30 million surplus, and we came back asking for more money they’d laugh at us.”

When it comes to concessions and the need to open contracts, things only seem to work one way: from the top down.

This case is not an isolated one by any means. Hospitals often approach the union, hat in hand, looking for givebacks. The story is usually the same. The hospital is in financial trouble; the contract is too rich; the union needs to show some good faith to help the hospital; everyone has to share the pain; cuts are needed to avoid layoffs ... and on and on.

Yet historically, a review of many unions over the years who have granted concessions



Joe Twarog

in benefits and wages in hard-fought contracts show that the promise of saving jobs almost never occurs. Concessions simply do not work and do not produce the intended results. Most often, they are simply an attempt to take advantage of the workers by slash-

ing their pay, benefits, time off, etc. This often occurs while the top officers (CEOs, CNOs, COOs, CFOs, etc.) do not “share the pain” in the least. While the U.S. economy tanked, the very same people that caused the crash rewarded themselves with obscene bonuses with taxpayer bail-out money!

This brings to mind the famous quote of the last great Republican president, Abraham Lincoln: “You may fool all the people some of the time, you can even fool some of the people all of the time, but you cannot fool all of the people all of the time.” Perhaps the new mantra of the hospital CEOs is, “You can fool enough of the people enough of the time to get away with whatever you want.”

A seminal study of concession bargaining written in the 1980s, (*Concessions and How to Beat Them*, by Jane Slaughter) makes the case that when workers engage in concession bargaining they often are simply financing their own future job loss. Slaughter lists numerous companies that closed despite huge concessions from the workers, including Braniff Airlines, Youngstown Steelworks, Motor Freight Express, Akron General Tire and Dubuque Plant. Some of these companies closed despite promises from management to stay in business once they became profitable again—which they did. The workers lost their pay and benefits and then lost their jobs in the end anyway.

Kim Moody, author of “Concessions: From a Bailout to a Tidal Wave,” wrote about the famous government bailout of Chrysler in 1979 that resulted in the near canonization of Chrysler CEO Lee Iacocca. Moody makes the point that the “concession agreement was more of a political act than an economic act” in which the union agreed to freeze wages six months, surrender six paid holidays and defer pension increases. After all that, management demanded additional concessions worth \$673 million a year later.

Few believed that these concessions would “save” the respective businesses.

But Chrysler’s approach undermined the

United Auto Workers’ history of successful pattern-bargaining among the auto manufacturers and it led to a rapid spread of concession bargaining across industries including not only Ford and GM, but also the steel, airline, meat-packing, trucking, grocery, rubber and public employment industries.

Moody observes that in a survey conducted at the time by *Business Week* of 400 corporate executives, fully 19 percent of them said “although we don’t need concessions, we are taking advantage of the bargaining climate to ask for them.”



While this may seem like decades old history, we are seeing the same pattern emerge as hospitals take advantage of the poor economy to force concessions. These may also take subtler forms that normally are not identified as “concessions.” These include cash bonuses instead of across-the-board increases; multi-tiered systems for pay and benefits; work-rule concessions; short staffing; redesigned work; furloughs; and the ever-popular labor/management team concept (Magnet).

Often these are designed to further control the workforce and overshadow the services nurses provide, namely quality patient care. The Boston Medical Center and Tufts Medical Center nurses conducted informational pickets on the same day in February to protest the hospitals’ plans to short-staff as a cost savings mechanism. This, while Tufts CEO Ellen Zane received a \$1.9 million salary and the outgoing BMC CEO received a \$3.5 million bonus. Abe Lincoln comes to mind again!

The current concession trend has also led to attempts to break long-standing master contract agreements in various industries (Delphi workers in Michigan, Indiana and New York for example). In the midst of all of this, nurses are looking to create such master agreements to maximize unity and strength.

This is a threat to the health care industry and we can expect employers to react in-kind: with threats of layoffs or concessions. ■

Summary of unsafe staffing reports at Tufts Medical Center since new staffing plan introduced

Under new model, patients placed in jeopardy 74 percent of the days studied

This is the first in a series of reports the MNA negotiating committee at Tufts Medical Center will provide as we continue our campaign to reverse the misguided and dangerous staffing practices being forced upon nurses by our management team. While the new model of care went into effect officially on Jan. 25, on a number of units, the changes to the staffing grids occurred in September, which explains why we have chosen this time frame for our first report. The findings from these reports are shocking, and include a number of harrowing incidents that have resulted in serious harm to our patients. This data and anecdotes we are gathering will soon be shared with our Board of Trustees, and if need be, the public, as these practices are tantamount to nursing malpractice perpetrated by our nursing leadership.

Key findings

Review of all unsafe staffing reports filed from Sept. 11, 2009 to March 9, 2010 reveals a total of 132 reports over 179 days. This averages out to 74 percent of days in this time frame reported to be unsafe by nursing staff.

Of the 132 reports only 31 of them (or 23 percent) proved to be “at” minimum staffing quotas as set by administration. The other 99 reports (or 76 percent) showed the unit to be running “below” minimum staffing quotas at the time of the unsafe event.

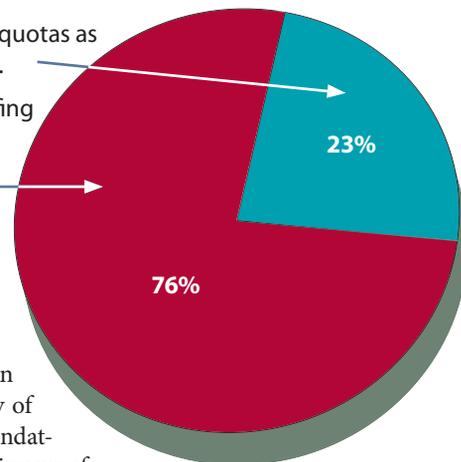
In these reports acuity is recorded as well as staffing levels. 57 percent of the reports showed acuity on the floor at the time was higher than average for the floor (minimum staffing grids do not allow increases in staffing numbers for acuity).

Of the 132 reports, 69 (55 percent) detailed an existing hole in the schedule as an underlying cause.

Staffing levels

At minimum staffing quotas as set by administration.

Below minimum staffing quotas



Only nine reports (7 percent) showed that ill calls contributed to the staffing problem.

The most common theme throughout many of these reports was the mandating of admissions or flexing up of beds, where nurses are forced to accept additional patients beyond what they are staffed for because of increased census. Flexing up was noted in 34 reports (26 percent) of the unsafe events recorded. 33 percent of the reports cited mandatory overtime, where nurses were forced to work double shifts.

We want to thank all those who have taken the time to fill out unsafe staffing reports, and encourage all nurses to fill out a form anytime they feel conditions prevent them from delivering the care their patients need to be safe. Documenting the reality of this crisis is essential to our effort to address it. ■

**MNA REGIONAL COUNCIL 5
ENCOURAGES MEMBERS
TO VOLUNTEER
JULY 23–25, 2010 ♦ BOSTON**



Get Ready for Greatness ♀ Join the Team

Contact Region 5 for more info
781-821-8255/region5@mnarn.org



MNA Diversity Committee

The MNA's Diversity Committee has set its goals for 2010, and it is looking forward to a successful year that includes the support of members from throughout the organization.

Priorities this year include:

- Mentoring new and prospective nursing students
- Identifying disparities in health care
- Conducting community outreach
- Networking with other state nursing groups (with a focus on groups dedicated to meeting needs and understanding the issues of minority nurses)

To get involved or for more information contact Charlene Richardson at crichardson@mnarn.org

Division of Legislation strengthened with arrival of new associate director

This past December Lainey Titus joined the MNA's division of legislation and governmental affairs as an associate director and grassroots organizer for Region 4, which is the Merrimack Valley/North Shore area of Massachusetts.

Formerly the chief of staff for Rep. Steven Walsh (D-Nahant), Titus was employed at the State House for more than six years. She swiftly worked her way up the ladder during her tenure — starting as Walsh's aide during his first term in office in 2003 and ultimately moving into positions that included vast and detailed supervisory responsibilities.

"Having the opportunity to work with Rep. Walsh from day one was invaluable," said Titus. "It gave me a chance to see how everything worked, the entire legislative process. And it all took place in an environment that let me brain-

storm, troubleshoot, build connections and support constituents while working directly with elected officials."

While working for Walsh, the list of Titus' job responsibilities was impressive: to manage all of the chairman's staffers; to act as his primary liaison with committee members, legislative leaders and local, state and federal officials; to manage press events; to write speeches and remarks; to prepare testimony; and to draft budget amendments.

"Lainey arrived at the MNA knowing the



commonwealth's legislative system inside and out," said Andi Mullin, the division's director and the person responsible for hiring Titus. "She had the expertise, experience and in-the-building relationships that made her a perfect match for the MNA. In addition, both her mother and sister are nurses."

In her new role, Titus will be supporting the MNA's legislative initiatives by working closely with Region 4 members with the goal of building a community of nurses and labor activists who can influence change at the State House.

Titus is a graduate of Rivier College in Nashua, N.H. and of UMass Boston, where she earned a master's degree in public affairs from the McCormack Graduate School of Public Policy. She is a lifelong resident of Nahant. ■

Absentee voting information

This past January, the people of Massachusetts voted for a U. S. senator, a seat that Sen. Edward M. Kennedy held for more than 47 years.

Massachusetts residents had not voted for an open seat in the U. S. Senate for over 25 years.

Did YOU vote in that election?

This fall, there will be elections all over the commonwealth for statewide offices. Furthermore, there will be special elections this spring in two state Senate districts and one House district.

Your vote matters in every election, even if you can not vote in person at your local polling place on Election Day.

How is that possible? Through the absentee voting process.

Are you eligible for absentee voting?

You may vote with an absentee ballot if:

- You will be absent from your city or town on Election Day. For example, if you work in Boston but live in suburban Burlington

and are scheduled to work a 12-hour shift from 7 a.m. to 7 p.m. on Election Day, you will likely be unable to vote in your town.

- You have a physical disability preventing you from voting at your polling place.
- Your religious beliefs prevent you from voting on Election Day.

Ways to apply for an absentee ballot

- Go to your local election office in your city or town hall. You do not need an appointment, just show up during business hours and explain that you need to vote absentee. You can fill out the application and vote at the same time; there is no need to make two visits. Ballots are generally available approximately three weeks before an election. You can vote absentee up until noon on Monday, the day before the election.
- Go online: Application forms are available on the Massachusetts secretary of state's Web page at www.sec.state.ma.us/ele/eiefv/howabs.htm.
- Apply in writing to your city or town clerk

or election commission and include your:

Name; address as registered; ward and precinct (if you know them); address where you wish the absentee ballot be sent; In a primary, the party ballot, Democrat or Republican, you want; your signature

The deadline for applying for an absentee ballot is noon on the day before an election. If you are both applying and voting in person, you may apply for an absentee ballot and vote in the same visit.

If you will be sending your ballot through the mail, allow enough time for your application to get to your city or town clerk so that the ballot will arrive at your home in time for you to complete and return it by Election Day. The clerk's office must receive ballots before the close of the polls on Election Day.

You must be a registered voter in order to vote absentee. A few exceptions exist, such as for members of the armed forces or merchant marine.

Voting is fundamental to our democratic society. Don't miss out! ■

Nursing News Briefs

Update from BORN for all APRNs

The Board of Registration in Nursing has recently received a significant number of phone calls and inquiries regarding advanced practice registered nurses receiving two "licenses" upon renewal.

In May 2009, the BORN implemented a new verification and renewal system that improved the manner in which it collects data and allowed licensed nurses the option of renewing online. As part of the upgrade, APRNs now receive two wallet-sized documents. When the board authorizes nurses to practice as an APRN, they receive, in addition to a wallet-sized RN license, a second wallet-sized document indicating their designation as an advance practice nurse in the category for which they are authorized.

For more information contact the BORN at 800-414-0168.

NSO increases license protection limits

The NSO recently announced increases to license protection limits and to hourly rates paid to attorneys for disciplinary defense of claims.

NSO and its carrier partner, CNA, are announcing the following:

- An increase in license protection limits from \$10,000 per occurrence/\$25,000 aggregate to a single aggregate limit of \$25,000 for covered claims.
- An increase in the hourly rate paid to attorneys from \$150 per hour to \$200 per hour.
- These changes affect new NSO policies with an effective date of Nov. 16, 2009 and renewal policies with an effective date of Feb. 1, 2010.

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

Senate Watch



On Feb. 9, the U.S. Senate, in a procedural vote, defeated the nominations of respected labor law attorneys Craig Becker and Mark Pearce to the National Labor Relations Board. The NLRB is a critically important federal agency that rules on labor disputes and it has essentially been unable to function for over two years because only two of the five seats on the board have been filled. Former President Bush left seats vacant for months. President Obama offered the nominations of Becker and Pearce in the summer of 2009, but Senate Republicans did everything they could to stall an up-or-down vote on the nominations because they considered the nominees to be too “worker friendly.” Finally, in February, Republicans voted in lock step to sustain a filibuster, thereby preventing any vote on the merits of the nominations. The vote to end the filibuster was 52 in favor, 33 opposed. While the vote to end debate received a majority, it needed 60 votes to be successful.

This vote was a disgrace. For workers to have their disputes with employers resolved expeditiously, we must have a fully functioning NLRB. The refusal of Republicans to allow an up-or-down vote on these nominations is a slap in the face to working people. Republicans did not have the votes to defeat the nominations on the merits, so instead they used a procedural maneuver to prevent these two highly qualified attorneys from serving on the NLRB. A “No” vote on this matter is a direct affront to union and non-union nurses alike.

How did the Massachusetts U.S. Senators vote?

Sen. John Kerry voted Yes

Sen. Scott Brown voted No

Source: Senate Roll Call Vote #22, 2/9/10

Postscript

On March 26 President Obama used his power to make recess appointments to appoint Becker and Pearce to the NLRB. We praise the president's courage in making these appointments, allowing the NLRB to begin functioning again at least until the end of 2011. ■

MNA membership dues deductibility for 2009

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	\$39.00	5.0%

MNF
Rosemary Smith RN
Memorial Golf Tournament

Save the Date!
Monday • July 19, 2010
to benefit *Scholarship Programs*
for *Nursing & Healthcare Professionals*
Visit www.massnurses.org or
call to register at
781-821-4625 x745

Consent to Serve for the MNA 2010 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, Labor*, (3 for 2 years)
<input type="checkbox"/> Director At-Large, General*, (4 for 2 years)
<input type="checkbox"/> Nominations Committee, (5 for 2 years) [1 per region] | <input type="checkbox"/> Bylaws Committee (5 for 2 years)
<input type="checkbox"/> Congress on Nursing Practice (4 for 2 years)
<input type="checkbox"/> Congress on Health Policy (4 for 2 years)
<input type="checkbox"/> Congress on Health & Safety (4 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, 2010
 Final Ballot: June 1, 2010

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

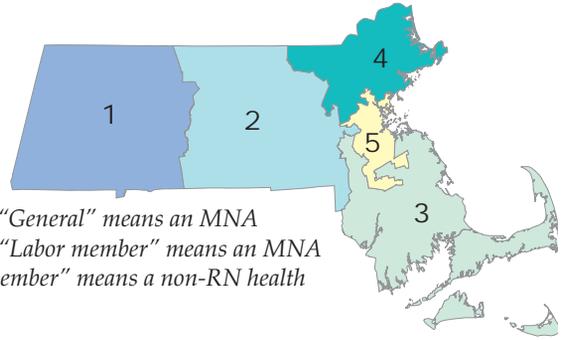
2010 Consent to Serve for the MNA Regional Council

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, 2010
Final Ballot: June 1, 2010

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

MNASM

LABOR SCHOOL

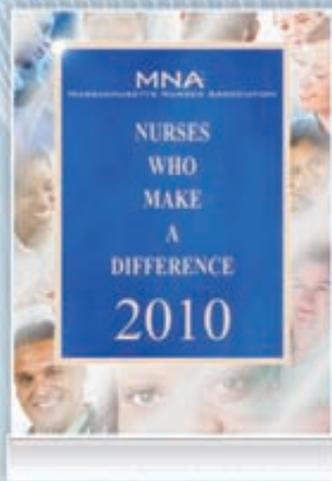


Track 1: MNA Overview and Structure					
Region	1	2	3	4	5
Week 1: Overview of the MNA Divisions By-laws How policies, decisions are made One member, one vote	2/10	C O M P	C O M P	1/14	C O M P
Week 2: Legislative and Governmental Affairs Division: Political Activity	2/24	L E	L E	1/28	L E
Week 3: Nursing Division/Health and Safety	3/3	T	T	2/25	T
Week 4: Public Communications	3/17	E	E	2/11	E
Week 5: Organizing Division	3/31	D	D	3/18	D
Track 2: Role of the Floor Rep., Grievances and Arbitration					
Region	1	2	3	4	5
Week 1: Role of the MNA rep Identifying grievances What is grievable Grievances vs. complaints—how to tell the difference, how to work with the member	C	3/16 3/16	C	C	3/23 3/23
Week 2: Components of the grievance procedure Time lines and steps When/how to settle grievances Discipline vs. contract interpretation grievances Burden of proof, just cause, due process, seven tests of just cause Past practice • Definition • Difficulty in proving a practice • Burden in proving a practice	O M P L	3/30 3/30	O M P L	O M P L	4/6 4/6
Week 3: How to file grievances How to write a grievance Investigation/identifying sources of information Right to information Information requests Constructing the case	E T	4/13 4/15	E T	E T	4/20 4/20
Week 4: Presenting the grievance Dealing with management Settling the grievance	E D	4/27 4/29	E D	E D	5/4 5/4
Week 5: Arbitration Why it's good for the members Why it's bad for the members Unfair labor practices Weingarten rights Organizing around grievances	D	TBA TBA	D	D	5/18

Track 3: Collective Bargaining		
Region	1	2
Week 1: Negotiations and the Legal Basis Process overview Bargaining ground rules	C	C
Week 2: Preparing for Bargaining Importance of internal organizing Contract action team Contract calendar, planning events Surveys, meetings, other methods of gathering proposals from members Setting priorities Developing a campaign	O M	O M
Week 3: Committee Decision Making Conduct at the table Dates, location, etc Open bargaining. Pros & cons Opening statements Proposal exchange	P L	P L
Week 4: Table Tactics/Reading Signals Implementing the contract campaign The contract action team Writing contract language	E	E
Week 5: Costing the Contract Bargaining video Picketing and strikes Bargaining unit job actions Impasse/contract extensions	T E	T E
Week 6: Use of the Media Reaching agreement, writing final language Committee recommendation Ratification process Midterm bargaining	D	D

Track 4: Computer Training		
Region	1	2
Week 1: Excel 1	4/7	1/13
Week 2: Excel 2	4/14	1/25
Week 3: Excel 3 graphs & application	4/28	2/22
Week 4: Word 1	5/5	3/8
Week 5: Word 2	5/19	3/15
Week 6: Publisher 1	5/26	—

2010 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 2010 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.

Deadline for submission of nominees to the MNA Awards Committee is May 12, 2010.

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.

To receive nomination papers for any of the MNA Annual Awards or for additional information or questions regarding the 2010 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 or via email at EChmielinski@mnarn.org. You may also visit: <http://www.massnurses.org/about-mna/awards>

Doris Gagne Addictions Nursing Award: Recognizes a nurse or other healthcare provider who demonstrates outstanding leadership in the field of addictions.

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 and 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.

MNA Nursing Education Award: Continuing Education/Staff Development: Recognizes a member who is a nurse educator and who has made significant contributions to 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.

2010 MNF scholarships available



► Scholarship

► Research

► Education

Massachusetts Nurses Foundation, Inc.

- **Rosemary Smith Memorial Scholarship** for MNA members seeking advanced degree in nursing, labor studies or public health policy (\$1,500)
- **School Nurse Scholarships** for MNA members enrolled in an accredited program related to school health issues (\$1,500)
- **Unit 7 Scholarship** for RN pursuing higher education (\$1,000)
- **Unit 7 Scholarship** for health care professional pursuing higher education (\$1,000)
- **Regional Council 5 Scholarship** for child of an MNA member pursuing higher education (other than nursing) (5 available) (\$2,000)
- **Regional Council 5 Scholarship** for child of an MNA member pursuing a nursing degree (5 available) (\$2,000)
- **Regional Council 5 Scholarship** to an MNA member's spouse/significant other pursuing nursing degree (\$1,000)
- **Regional Council 4 Scholarship** for MNA member pursuing nursing degree/higher education (5 available) (\$1,500)
- **Regional Council 3 Scholarship** for MNA member pursuing BSN (3 available) \$1,500
- **Regional Council 3 Scholarship** for MNA member pursuing MSN/PhD (3 available) (\$1,500)
- **Regional Council 3 Scholarship** for MNA member's child pursuing BSN (4 available) (\$1,000)
- **Regional Council 2 Scholarship** for MNA member pursuing nursing degree/higher education (3 available) (\$1,000)
- **Regional Council 2 Scholarship** for MNA member's children pursuing nursing degree (5 available) (\$1,000)
- **Carol Vigeant Scholarship** for entry level nursing student in Worcester area (\$2,000)
- **Kate Maker Scholarship** for entry level nursing student in Worcester area (\$2,500)
- **Janet Dunphy – MNA Regional Council 5 Scholarship** for member pursuing baccalaureate degree (5 available) (\$2,000)
- **Janet Dunphy – MNA Regional Council 5 Scholarship** for member pursuing master's degree (3 available) (\$2,000)
- **Janet Dunphy – MNA Regional Council 5 Scholarship** for member pursuing doctoral degree (2 available) (\$2,000)
- **Regional Council 1 Scholarship** for MNA member's children pursuing nursing degree (\$1,000)
- **Annual Faulkner Hospital School of Nursing Alumnae Scholarship** (2 available) (\$1,000)
 1. An entry level scholarship for students pursuing an AD or BS. Preference for this scholarship will be given to applicants who are lineal descendants of alumnae of FHSON; second preference will be given to all others.
 2. The Connie Moore Award is for RNs pursuing a BSN or MSN. First priority will be given to FHSON alumnae, then to lineal descendants, then to all other RNs.

Printable applications with instructions and eligibility requirements are available at www.massnurses.org. To have an application mailed, call the MNF voice mail at 781-830-5745.

• Application Deadline: June 1, 2010 •

MNA Member Discounts **Save You Money**

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

Personal & Financial Services

PROFESSIONAL LIABILITY INSURANCE

NURSES SERVICE ORGANIZATION..... 800-247-1500
Leading provider of professional liability insurance for nursing professionals. www.nso.com.

TERM LIFE INSURANCE

LEAD BROKERAGE GROUP..... 800-842-0804
Term life insurance offered at special cost discounts.

LONG TERM CARE INSURANCE

WILLIAM CLIFFORD 800-878-9921, x110
Flexible and comprehensive long-term care insurance at discount rates.

SHORT TERM DISABILITY INSURANCE

INSURANCE SPECIALIST LLC 888-474-1959
Six-month disability protection program for non-occupational illnesses & accidents.

LONG TERM DISABILITY INSURANCE

LEAD BROKERAGE GROUP..... 800-842-0804
Provides income when you are unable to work due to an illness or injury.

RETIREMENT PROGRAM

AMERICAN GENERAL FINANCIAL GROUP/VALIC 800-448-2542
Specializing in providing retirement programs including 403(b), 401(k), IRA, NQDA, Mutual Funds, etc.

HOME MORTGAGE DISCOUNTS

RELIANT MORTGAGE COMPANY..... 877-662-6623
Save on your next home loan/mortgage with discounts available to MNA members and families. Receive free mortgage pre-approvals.

LIFE & ESTATE PLANNING

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

BLUE CROSS BLUE SHIELD

For details on health insurance plans, call 800-422-3545, ext. 65414

Products & Services

AUTO/HOMEOWNERS INSURANCE

COLONIAL INSURANCE SERVICES, INC..... 800-571-7773
MNA discount available for all household members. No service changes with convenient EFT payment.

CELLULAR TELEPHONE SERVICE

AT&T WIRELESS 800-882-2056, EXT. 726
MNA members can now go to any AT&T Wireless company store for all transactions. 24% discounts on rate plans.

T-MOBILE..... 866-464-8662
Get a free phone, free nationwide long distance and roaming and free nights and weekends (on specific plans). No activation fee for members.

DISCOUNT DENTAL & EYEWEAR PROGRAM

CREATIVE SOLUTIONS GROUP 800-308-0374
Best benefits—a health care savings plan that cuts the cost of health care expenses. Discounts on dental, eyecare and chiropractic expenses.

ASSOCIATED EDGE (FORMERLY MEMBER ADVANTAGE)

ASSOCIATED EDGE..... 781-828-4555 OR 800-232-0872
Discount prices on a broad range of products. Log into myMNA.

OIL NETWORK DISCOUNT

COMFORT CRAFTED OIL BUYING NETWORK 800-660-4328
Lower home oil heating costs by 10–25 cents/gallon or \$150 per year.

WRENTHAM VILLAGE PREMIUM OUTLETS

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

CAMBRIDGE EYE DOCTORS

Obtain your Sight Care ID card to receive discounts on eye exams, eyeglasses & contact lenses at Cambridge Eye Doctors or Vision World.

HEALTH CARE APPAREL

WORK ‘N GEAR DISCOUNT..... 800-WORKNGEAR
Receive 15% discount off all regularly priced merchandise. Visit www.massnurses.org for a printable coupon to present at time of purchase.

BROOKS BROTHERS DISCOUNT

15% discount at Brooks Brothers, Adrienne Vittadini and Carolee. <http://membership.brooksbrothers.com>.

Travel & Leisure

CAR RENTAL

AVIS CAR RENTAL..... 1-800-331-1212
Discounts can be used for both personal and business travel.

HERTZ CAR RENTAL..... 800-654-2200
MNA members discounts range from 5 – 20%. (For MNA discount CDP, call 781-830-5726.)

EXCLUSIVE TRAVEL DEALS

MNA VACATION CENTER WWW.MNAVACATIONS.COM
Powered by TNT and Goahead tours. Get exclusive access to travel specials at prices not available to the public.

DISCOUNT MOVIE PASSES..... 781-830-5726
Showcase Cinemas/National Amusements, \$7.75. AMC Theatres, \$6. Regal Cinemas (not valid first 12 days of new release), \$6.

DISNEY DISCOUNT

Discounted tickets to Walt Disney World and Disneyland along with other Florida attractions.

ANHEUSER-BUSCH ADVENTURE PARKS DISCOUNT

Obtain Adventure Card to receive discounts to Busch Gardens, Sea World, Sesame Place, Water Country USA & Adventure Island in Tampa, Fla.

UNIVERSAL STUDIOS FAN CLUB 888-777-2131

Log onto the MNA Web site at www.massnurses.org and click on the Universal Studios Link to obtain special discount prices.

WORKING ADVANTAGE

Discounts for movies, theme parks, ski tickets, Broadway shows. www.workingadvantage.com.

SIX FLAGS NEW ENGLAND

Seasonal. Contact MNA’s Division of Membership at 800-882-2056, x726.