Twin Cities Tussle

Minnesota nurses are ready to defend their patients and their practice... whatever it takes.
Letter from the Council of Presidents

As this issue of National Nurse went to press, nurses from around the country were preparing for National Nurses United’s annual staff nurse conference in Washington, DC. The theme? ‘RN Heroes’—a tribute to the bravery and compassion of registered nurses who are making a difference in their workplaces, their communities, and the world.

And now, are they an inspiring bunch...starting with the courageous nurses involved in contract negotiations all over the country who are refusing to give in to management demands to make patients pay for the country’s economic crisis. Our cover story this month highlights our Minnesota colleagues who are standing strong in the face of one of the toughest battles the state has seen, between RNs who have fought hard over the years to win protections for themselves and their patients, and the hospitals who want to take those gains away.

In Pennsylvania this month, RNs at Temple University Hospital displayed incredible heroism on the picket line, standing strong during a 28-day strike in which hospital management tried to force them to give up their right to publicly advocate for patients. Faced with unity among nurses and other professional employees at the hospital, as well as support that poured in from labor unions across the country, the hospital caved and RNs were able to settle on a fair contract.

“Our union is stronger than ever,” Pennsylvania Association of Staff Nurses and Allied Professionals President Patricia Eakin, RN, wrote us after nurses ratified the contract. “I watched all kinds of nurses and allied professionals take leadership roles...Temple’s arrogance helped us create a stronger membership.”

You can read all about the Pennsylvania victory in the news section.

In our features section, you’ll find stories about two RN heroes who are committed to standing up for nurses’ and patients’ rights, under very different circumstances. Orsburn Stone, RN, drew on his experience facing persecution as a teenager in segregated South Carolina to help lead and win an organizing campaign at MountainView hospital in Nevada. Clelie St. Vil, RN, also went back to her roots this year, when she traveled to Haiti with NNU’s Registered Nurse Response Network...the first time she’d seen her homeland since immigrating to the United States at age 11.

Being an RN hero sometimes means taking patient advocacy outside the hospital walls and into the political arena. This month, we offer a couple of takes on this year’s governor’s race in California—a matchup that will affect RNs and patients across the country, not just in the Golden State. As you’ll see inside, RNs are having some fun educating the public about the infusion of corporate money into the campaign. We’re confident that our members will continue to speak out around this important issue, so that we can protect the gains in patient care we’ve made in California and take one step closer to our goal of a single standard of quality healthcare for all.

RN heroes, we salute you! It’s a tough job, but someone has to do it.

Deborah Burger, RN | Karen Higgins, RN | Jean Ross, RN
National Nurses United Council of Presidents
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### The Long Road Home

A Haitian-American nurse returns to the country she left behind. By Erin Fitzgerald

### Rock Solid

Even the toughest of obstacles couldn’t keep Orsburn Stone, RN from standing up for nurses’ rights at his Nevada hospital. He’d seen much worse. By Felicia Mello

### Hospital Magnet Status: Impact on RN Autonomy and Patient Advocacy

What exactly are magnet hospitals, and how does magnet hospital status affect RNs and patients? Submitted by the Joint Nursing Practice Commission and Hedy Dumpel, RN, JD

*ON THE COVER:* Hundreds of nurses rally in Minnesota in support of contract negotiations affecting 12,000 RNs. Photo by Ben Garvin
As employers continue to stonewall in contract negotiations affecting over 12,000 nurses in Minnesota's Twin Cities, RNs are stepping up their campaign for a fair contract that would ensure patient safety and a secure retirement. Hundreds of Minnesota Nurses Association members have piled into negotiation sessions to show support for their bargaining team. Nurses’ anger is mounting as several sessions have failed to produce any progress on the contract, which is scheduled for a vote May 19.

Nearly 1,000 Contract Action Team members have volunteered to spread the facts to members about negotiations. At a rally held March 27 in Minnetonka, close to 1,000 noisy nurses rocked the house, demanding contracts that ensure optimum staffing levels.

“We showed them we stand up for our patients in 1984 and in 2001,” said National Nurses United Co-president Jean Ross, RN, who walked the line during both of those historic strikes. “I guess we have to prove it to them again.”

The negotiations, which are taking place at seven separate tables, affect nurses at Allina Hospitals and Clinics, Fairview Health Systems, HealthEast Care Systems, Children’s Hospitals and Clinics, Methodist Hospital, and North Memorial Medical Center, in addition to the pension plan for the entire metropolitan area. No sessions have been scheduled after May 13 and Twin Cities nurses have never worked
beyond a contract’s expiration date.

Thousands of lawn signs reading “Minnesota Nurses—We Care For You,” were immediately snapped up and distributed within days of printing, and the demand spurred a reprint of the popular item. MNA has also blitzed the roads and highways of the Metro area with billboards bearing the same message. Many of the boards are strategically placed where employers see them every day driving to and from work.

Nurses are sporting stickers and signing petitions in support of their bargaining teams, while social media forums are buzzing with nurses and friends discussing the negotiations. In less than an hour after MNA posted a message on Facebook, more than 160 people pledged support on an online petition. Nurses continue to speak out on Twitter, Facebook, the MNA Blog and other outlets about their determination to advance innovative staffing proposals that will keep patients safe.

The strongest message has been delivered in person, however, by MNA members representing every bargaining unit who crowd behind their negotiating teams in bargaining sessions.

The April 6 meeting with Allina Health Care Systems included 500 nurses, spouses and children, dressed in a sea of red t-shirts. Nurses brought their toddlers to demonstrate to employers the impact of the negotiations on children’s futures.

“They are trying to take away our benefits. When that happens, everyone loses, especially patients,” said Lorna Eikelberg, a registered nurse at United Hospital in St. Paul. Eikelberg held up a document for hospital negotiators to see that calculated the financial effect of their proposal to raise the number of days the hospital could send nurses home due to low patient census. The lost wages from such a change, Eikelberg said, would amount to six mortgage payments for her family.

United Hospital Bargaining Unit Chair Glenda Cartney, RN announced at the table she was representing “all 6,000 RNs of Allina,” and said she had no plans to move backward. “I’ve lived the ‘80s,” she said. “There’s no need to return.”

The union will conduct informational picketing at several of the hospitals on May 6 and 12 to shine a light on the employers’ refusal to discuss staffing issues. —Jan Rabbers

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**StarTribune**

**A Message to the Public: We’re Fighting for Your Care**

_by Brenda Gieser, RN, United Hospital_

A version of the following commentary appeared in the Minneapolis Star Tribune April 15.

More than 12,000 Minnesota nurses are in the midst of negotiating a new labor contract with six Twin Cities area hospital systems. While the hospitals continue to be about their bottom lines, the bottom line for RNs is quite different. Read on:

My name is Brenda, and I will be your registered nurse today.

I will be administering medications prescribed to you. I will make sure you do not have allergies to these medications, and if you do have an adverse reaction to the medication, I will take action. I will be watching for signs the medication is working for you.

I will deliver your baby, or grandchild, in case the physician does not arrive on time. I will assist you with breastfeeding, watch for hemorrhage and make sure your bladder is functioning after the trauma of childbirth, and I will intervene as needed within my scope of practice.

I will assess and address your pain needs before, or when, you ask for pain medications. I will help to re-intubate your preemie neonate in the middle of the night when he extubates himself. In other words, if your new baby stops breathing, I will save his life and help him start breathing again. I will make sure your IV is running.

I will initiate CPR if your heart stops or take action if your heart has irregular rhythms. I will check your new surgical incision for bleeding, and reinforce the dressing and call the physician as needed.

I will apply a new bag to your colostomy, in a respectful manner. I will discuss self-catheterization, in a respectful manner. I will lift the heavy CPM machine, making sure you get your therapy as ordered, pre-medicating you with pain meds. I will educate you about your new joint, pain management, importance of routine stretches and exercise. I will remind you of limitations with your new joint.

I will suction you if you are a patient with HIV/AIDS, and I will attempt to be assigned to you for continuity of care, not because you are an easy patient to care for, but because studies show continuity of care is best for the patient.

I will also care for you if you have MRSA, VRE, H1N1 or other communicable diseases.

I will put myself in harm’s way when an out-of-control psychotic teen threatens himself, his peers on the unit, my colleagues or me.

I will care for an elderly patient with dementia who needs to be fed, bathed and lifted out of bed. I will crush her pills and ask peers if she prefers applesauce or ice cream, so when I feed her the meds prescribed she might take them.

I will assess for skin integrity each shift.

I will hold your hand when you are dying.

I will call a physician in the middle of the night to advocate for my patients, even though I know this particular doctor might be perturbed.

I will conduct myself in a manner becoming of a professional RN, on- and off-duty. I will attend seminars and read research articles and study while off-duty to keep myself professionally astute.

I may go eight hours without taking a sip of any beverage or using the restroom, or work overtime during a snowstorm or a weekend or a holiday, not because of overtime pay, but because otherwise patients may not have adequate staffing and my colleagues will end up having an awful shift.

We are called to this profession. This is not just our job.

Nurses deserve a fair labor contract.

Nothing more, nothing less.
Four hundred and sixty-eight. That’s how many more general surgery patients might be alive today if New Jersey and Pennsylvania had the same nurse-to-patient ratio law as California from 2004 to 2006.

It’s just one of the findings of a major study on California’s safe staffing law released this month by researchers from the University of Pennsylvania. The most far-reaching examination of the law to date, the study found that staffing ratios have improved nurses’ ability to provide quality care, reduced patient mortality, and increased nurse job satisfaction.

“Thousands of deaths could be prevented if we improved nurse-to-patient staffing,” said lead researcher Linda Aiken, RN, PhD, director of the Center for Health Outcomes and Policy Research at the University of Pennsylvania. “In every single outcome we looked at for both patients and nurses, mandated ratios led to better results.”

The study, published in the journal *Health Services Research*, compared nurse staffing and patient mortality rates at hospitals in New Jersey and Pennsylvania—two states without safe staffing laws—to those in California. Researchers surveyed more than 22,000 nurses in 2006, asking them questions about workload, job satisfaction and burnout.

What they found wouldn’t surprise any nurse on a hospital floor.

California RNs were able to spend more time at the bedside, detect changes in condition sooner and send patients home with a better ability to manage their care than their counterparts in the other states, according to the survey results.

The study found that New Jersey hospitals would experience 14 percent fewer patient deaths in surgical units and Pennsylvania 11 percent fewer if they applied the same safe staffing ratios as California. That remained true even after researchers controlled for 130 confounding factors, including the severity of patient illness.

“We knew when the study was done it would show what we’ve been saying all along,” said Malinda Markowitz, RN, Co-president of the California Nurses Association. “Finally, hospitals can’t dispute it and other state nursing associations can’t dispute it.”

Sponsored by CNA, the first-in-the-nation safe staffing law was passed in 1999 and implemented in 2004. Nurses beat back several attempts by the hospital industry and Governor Arnold Schwarzenegger to weaken or repeal it. It set minimum nurse-to-patient ratios by hospital unit—from 1:2 in intensive care to 1:5 for surgical patients—that must be adjusted upward based on how sick patients are.

The study comes as National Nurses United is working to pass similar laws in several states, including Pennsylvania, Florida and Illinois. NNU is also lobbying for S. 1031/H.R. 2273, the National Nursing Shortage Reform and Patient Advocacy Act, which would mandate safe staffing ratios at the national level.

Hospital industry executives have argued that there was no real science to back up the effectiveness of ratios, and some previous research found only a weak relationship.

But this study, led by one of the most prominent researchers in the field and published in a journal with a reputation for stringent peer review, puts the burden on the industry to justify their opposition, said Jack Needleman, a professor of public health at the University of California, Los Angeles who studies nurse workloads.

“The weight of evidence is that the association between nurse staffing and patient care quality is real and causal,” he said.

“Those that make the counter argument need to put data on the table and not just offer theoreticals now.” —Heather Boerner

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Eighty-eight percent of the medical-surgical nurses in California cared for five patients or less on their last shift.

The same was true of only 19 and 33 percent of medical-surgical nurses in New Jersey and Pennsylvania, respectively.
Temple Strike Leads to Victory

HEALTHCARE WORKERS at Temple University Hospital in Philadelphia ratified a new contract April 28 after an energetic 28-day strike that beat back the medical center’s attempts to break their union.

The new agreement for nurses and other health professionals provides wage increases that will keep pay competitive with other area hospitals and partially restores a popular tuition reimbursement benefit that the hospital had tried to unilaterally eliminate. Temple also withdrew its proposal to prevent employees from speaking out publicly about patient care problems at the hospital and compromised on changes to health benefits.

"Temple underestimated the strength of our membership," said Maureen May, RN, president of the nurses’ union. "Their plan to weaken us did not work. Instead, we became more united in this strike, and we will return to work with a great amount of pride in what we achieved.”

The 1000 RNs and 500 other health professionals, represented by the Pennsylvania Association of Staff Nurses and Allied Professionals, struck March 31 after working without a contract for six months.

Workers kept the pressure on management all month long with rallies and solidarity campaigns that forced the hospital back to the negotiating table.

Spirited, raucous picket lines in front of the hospital each day inspired passers-by to honk their horns, community supporters to bring water and pretzels, and other labor unions to pledge their solidarity. Hundreds of strikers and supporters protested in front of the luxury condo of University President Ann Weaver Hart April 3, chanting “Ann Hart, you can’t hide, we can see your greedy side!”

Administration, meanwhile, engaged 850 replacement workers at rates of up to $10,000 per week plus meals and accommodations—spending as much in the first two weeks of the strike as it would have cost to meet PASNAP’s demands, the union estimates.

With Temple demanding to eliminate contract language making the hospital a union shop, reserve the right to make further changes to health benefits without bargaining, and separate contract expiration dates for RNs and technical staff—which are represented by different locals—the strike became a referendum on the union’s very existence, PASNAP leaders say.

The hospital drew negative media attention early in negotiations for its proposed non-disparagement clause, which would have imposed fines and discipline on the union, its staff and members who said anything negative about Temple in any public forum. During negotiations about the clause, Bob Birnbrauer, Vice President of Human Resources, told hospital workers, “If you want your constitutional rights, you need to go somewhere else.”

Union members said they refused to be silenced. “We are patient advocates, first, foremost, and always,” Carol Heyward, RN, a Temple graduate and 23-year employee, said from the picket line during the strike’s third week.

The final contract, overwhelmingly ratified April 28 after an energetic 28-day strike that beat back the medical center’s attempts to break their union, is a great amount of pride in what we achieved.”

The organized and active picket line was crucial in keeping everyone connected, and the solidarity we got from NNU and other unions helped keep people’s morale up until the end. Our victory shows that you can win if you stick together.” —Marty Harrison, RN

Pennsylvania Association of Staff Nurses and Allied Professionals President Patricia Eakin, RN addresses a rally of striking Temple University Hospital workers.

PASNAP members also worked to educate local and state elected officials about their fight. Strikers filled the weekly city council meeting to capacity on the second week of the strike, and councilmembers ultimately passed a resolution calling on both sides to negotiate in good faith.

“We were able to win because our members were well-informed of the issues all along the way,” said PASNAP President Patricia Eakin, RN. “The organized and active picket line was crucial in keeping everyone connected, and the solidarity we got from NNU and other unions helped keep people’s morale up until the end. Our victory shows that you can win if you stick together.” —Marty Harrison, RN
Massachusetts Passes Bill Punishing Perpetrators of Workplace Violence

Massachusetts legislators have passed a bill that will stiffen penalties for those who assault nurses and other healthcare workers, one of a series of measures the Massachusetts Nurses Association is proposing to address the growing problem of workplace violence in healthcare settings. “Violence against nurses is occurring at alarming rate. This is an important first step in our effort to make healthcare settings safer for nurses and for patients,” said Donna Kelly-Williams, RN, president of the MNA.

The bill passed the Senate this month after clearing the House March 31—the same day more than 250 nurses from across the Commonwealth, many victims of workplace violence, converged at the State House for a press conference and lobby day, where they pushed for passage of a package of safety-related bills sponsored by the MNA. MNA members shared with legislators their stories of being assaulted, putting a human face on the problem.

At a press conference before the House vote, Donna L. Stern, a registered nurse in a mental health unit at 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.

Emergency department nurse Linda Condon described an encounter with an out-of-control patient: “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.”

A 2008 study showed that workers in the healthcare sector are 16 times more likely to be confronted with violence on the job than any other service profession. The problem is rampant in Massachusetts: A 2004 survey of nurses in the state found that half had been punched at least once in the previous two years, and a quarter were regularly pinched, scratched, spit on or had their hand twisted.

Besides the trauma of the assault, nurses who are attacked sometimes face additional health risks. Ellen MacInnis, a nurse at St. Elizabeth’s Medical Center in Brighton, once was trying to put an IV into an HIV-infected patient when the patient took a swing at her, she said, 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,” MacInnis said at the press conference. “The behavior that we see, in any other place ... people would be thrown out.”

The event drew extensive media coverage through the state. The next day’s Boston Herald opened its story with the following characterization of the MNA’s victory: “They care. They converged. They conquered.”

Massachusetts law already treats any assault on an emergency medical technician while the technician is providing care as a separate crime with its own set of penalties. The bill the legislature passed extends those same protections to nurses.

MNA is working to resolve slight differences between the House and Senate versions of the bill, and hopes to get it to the governor’s desk within the next few months.

Throughout the lobby day, nurses 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.B. 988, which will require healthcare employers to develop and implement programs to prevent workplace violence, and H.B. 1931, which will create a special “difficult to manage” unit in the Department of Mental Health to treat repeat perpetrators of violence. The other two measures are currently making their way through the legislative process.

MNA Vice President Karen Coughlin, RN, said she has been a victim of a number of assaults during her years working at one of the state’s mental health facilities. “Patients, family members and others must get the message that violence against healthcare workers will be treated seriously,” Coughlin said. —David Schildmeier
Imagine that you are at the negotiating table ready to start the bargaining process for your union contract. This isn’t the first contract you’ve negotiated with this hospital. In fact, you’ve been represented by the Michigan Nurses Association since 1974. Over the years, you’ve fought hard to gain protections in the areas that affect your ability to provide safe patient care, such as floating and staffing. Now, management puts a proposal on the table that essentially strips away all of those hard-won patient and employee protections, turning them into policies that can change at management’s whim. And then refuses to budge on its proposal. At all.

That was the situation this spring for registered nurses at Borgess Medical Center in Kalamazoo, Michigan. So when a busload of Borgess RNs arrived at the Lansing Center for the 2010 Michigan Nurses MARCH! on March 24, they were ready to rally for safe patient care. Fresh from a recent Town Hall meeting with state Rep. Robert Jones, they had heard each other’s stories about what short staffing was doing to their units. For them, the Michigan Nurses MARCH!, a day of political advocacy at the state capital, was a chance to recharge and receive the support offered by nurses and nursing students around them.

“Many of you know that we’re going through a difficult time right now with our contract negotiations at Borgess,” said Shawn Shuler, RN, president of the union, as he addressed over 1,000 nurses and nursing students. “We are standing together to protect our contract so that our patients are safe and nurses have a voice at Borgess. We need your support.” The crowd burst into applause.

Dressed in teal t-shirts stating “RNs United for Safe Patient Care,” the Borgess RNs joined other RNs at the gathering in gaining knowledge regarding current legislative issues in Michigan and at the national level. Topics included a look at how nurse-to-patient ratios would save Michigan hospitals money, what the Michigan Department of Community Health is trying to do in the face of severe financial cuts, and an overview of National Nurses United.

Keynote speaker and leading author on nursing issues Suzanne Gordon fired nurses up with her comments on the importance of winning safe staffing. When it comes to staffing, she said, hospitals “get away with whatever they can.”

“There is no special hospital sleep fairy to deal with weekends and evening staffing,” she told the applauding nurses.

The event culminated in a rally on the steps of the Michigan State Capitol. Chanting, dancing to music, and waving signs, the crowd roared its approval as speakers including NNU Co-president Jean Ross, RN, challenged nurses to fight for safe patient care. The Borgess nurses returned to Kalamazoo encouraged and inspired.

Within weeks of the MARCH!, the Borgess RNs were holding their own rally for safe patient care outside Borgess Medical Center. With still no movement from management and now an expired contract, the nurses wanted to make sure that both the Kalamazoo community and the administration knew the issue of safe patient care was not disappearing. On April 10, over 400 nurses and supporters gathered in front of Borgess Medical Center. Signs waved and people cheered after speakers ranging from nurses to a city commissioner to labor leaders expressed their support for the nurses’ issues. Cheers of “We are union! Let’s stay union! MNA!” rang across the front of the hospital.

The fact that Borgess Medical Center is now owned by St. Louis-based Ascension Health has dramatically influenced the current negotiations. For years, MNA has been able to bargain contracts with Borgess management that met the needs of both patients and nurses. But now, nurses say, corporate profits have taken priority over the needs of workers and patients.

“I was born at Borgess,” said Pat Meave, RN, a member of the negotiating team, at the April 10 rally. “My kids were born at Borgess. I’ve been a nurse at Borgess my entire career. I love Borgess. But that,” she said, pointing at the hospital, “is no longer Borgess.” —Ann Kettering Sincox

Patient Care Rally Hits Home for Borgess Medical Center RNs

NATIONAL NURSE
As a registered nurse in North Dakota, Barb Warren-Bloms never paid much attention to the union organizing drives that periodically happened at her hospital. “I never went to any meetings, but word would spread about how bad the union was,” she said.

Then Warren-Bloms started working at a hospital in Minnesota, where RNs were represented by the Minnesota Nurses Association, part of National Nurses United. There, she discovered, pay was based on a nurse’s experience, instead of “random” like it was in North Dakota, and working conditions were better. The difference, she concluded, was union representation.

“Once you learn what power you can have, it’s hard not to do more,” she said. “My goal used to be to be in management. Now I realize I want to be a leader among my fellow nurses.”

Warren-Bloms was one of over 75 nurses and staff organizers who gathered in Berkeley, California over three days in March to discuss how to organize nurses around the country and strengthen RN unity in healthcare facilities that are already unionized. At the first-ever National Nurses United Organizing Institute, RNs shared their experiences in organizing campaigns, got fired up to take on new challenges, and learned concrete skills that they could bring back to their own hospitals.

The conference kicked off with presentations about the state of the labor movement and the dire need for organizing. Only 19 percent of RNs nationally are organized, compared with 51 percent of teachers and 65 percent of firefighters, National Nurses United organizing director David Johnson told the group.

“Imagine what the world would look like if we had 65 percent of nurses under union contract,” he said. “We would have a different political climate.”

The nurses then broke up into small groups for role-playing, followed by panels where newly-organized nurses talked about how they gained union representation at their workplaces.

On one panel, Kansas City RN Sandy Baldrie explained how she and her colleagues at Menorah Medical Center, a hospital owned by HCA, recently organized with the help of other HCA nurses from around the country. The show of solidarity helped overcome some of the resignation and cynicism of nurses at her facility, she said.

“The nurses said ‘Oh yeah, like we’ll ever get relief nurses so I don’t have to bring my cell phone to lunch.’ We showed them, yes, we can, we can put it in our contract. I felt invigorated,” she said.

Role-playing exercises helped RNs understand the first rule of organizing: listening. In one small group, nurses sat with former California Nurses Association/National Nurses Organizing Committee president Kay McVay, RN, who played the part of a shy, quiet nurse colleague. Through careful probing, group members discovered that McVay’s character was worried about new technologies that were interfering with her ability to connect with patients, and the group engaged in a discussion about how to solve the problem.

A key theme at the conference was the need to engage newer nurses, who often don’t understand that the benefits they enjoy at their facilities have come as a result of years of struggle. One of those younger nurses was Rosie Holland, RN, a former political science major who said she had learned more at the institute than she had in years of studying for her degree.

“I didn’t realize everything the union has done to affect my work environment and patient safety,” she said. “I’m going to share more of those stories and ask newer nurses to be more involved, even if it’s something as simple as passing out a leaflet.”

Katie Oppenheim, RN, said the conference had inspired her to do more walkthroughs at the University of Michigan, where she leads the local bargaining unit, to organize members around issues like swine flu and the erosion of benefits at the hospital. Massachusetts RN Betsy Prescott, a cardiac case manager at a Catholic hospital, said she had realized that some of the problems she and her colleagues were contending with, such as management demands that nurses use inflexible scripts while talking to patients, were trends around the country.

“We’re all fighting the same battles, and we’ve got to fight them as one,” she said. “My goal is that every nurse in my hospital system become a member of NNU.” —Staff Report
Veterans Affairs Nurses Seek New Policy to Protect Needle Stick Victims

Suzanne Seta, RN, says she’s always been a careful nurse. But that didn’t stop her from being stuck with a needle contaminated with the blood of one of her patients at a Veterans Affairs hospital.

It was 1999 and Seta was working on a research project, drawing the blood of a patient she knew well, an older man who had Hepatitis C and had recently had unprotected sex. There was no sharps container in the exam room, so Seta went to recap the needle until she could dispose of it properly—and stabbed her finger instead.

“Oh my gosh,” she remembers thinking. “It was one of those moments where you just want to stand there and cry.”

The patient agreed to be tested for HIV. But because test results weren’t available quickly at the time, Seta had to make a split-second decision about whether to start taking antiretroviral drugs that could prevent her from becoming infected—without knowing whether the patient had actually tested positive. Seta chose to take the medicine—a decision she now says left her with crippling side effects from the powerful drugs that she still suffers to this day.

Today, testing for HIV and other blood-borne diseases has improved dramatically. But some registered nurses who may have been exposed to such diseases still face an agonizing decision about whether to start taking antiretroviral drugs that could prevent her from becoming infected—without knowing whether the patient had actually tested positive. Seta chose to take the medicine—a decision she now says left her with crippling side effects from the powerful drugs that she still suffers to this day.

Veterans Affairs policy requires that patients provide separate, verbal or written consent before being tested for infectious diseases, including in needle-stick cases. The National Veterans Affairs Council says it’s a dilemma nurses shouldn’t have to contend with, and is lobbying the Department of Veterans Affairs to change its position on the issue.

“We want the VA to recognize that healthcare workers have a right to know the patient’s infectious disease status if there is an exposure,” said council president Alice Staggs, RN. “Chemotherapy as prophylaxis is quite effective for HIV if you start taking it within a couple of hours of being exposed. If we have one more piece of information, if we know the person is positive, that can help in making an informed decision.”

Veterans Affairs policy requires that patients provide separate, verbal or written consent before being tested for infectious diseases, including in needle-stick cases.

Antiretroviral drugs can save the life of a nurse exposed to HIV, but the side effects can be severe. Becky Johnson, RN, was stuck twice with a needle while working with patients in an HIV clinic in the VA system. The drugs she took the first time raised her liver enzymes to dangerous levels and frequently made her vomit, she said. “I think my husband thought I was going to die,” she said. The second time around, Johnson said, she opted against the medicine and “just prayed to God.”

But the consequences of not taking preventive medicine can be just as serious, nurse advocates said. Ken O’Leary, RN, president of the nurses’ union at a VA facility in North Carolina, said he once represented a nurse who contracted hepatitis from a patient. The office of employee health at the hospital obtained test results for the patients but didn’t show them to the nurse, only reassuring her that everything was fine, he said. It was only months later, when the RN started turning yellow from liver failure, that she discovered she was infected.

VA Council leaders emphasize that they recognize patients’ privacy concerns, but want a policy that balances those concerns with healthcare workers’ rights.

Some private hospitals, for example, have patients sign a blanket consent form when they begin treatment granting the hospital the right to test their blood for infectious diseases in the event that a healthcare worker is exposed to it. Several states, including Ohio, Florida and Georgia, have laws granting healthcare workers exposed to a patient’s blood the right to know whether the patient tests positive for HIV.

State laws don’t apply to the VA system, however.

“It doesn’t make sense that we’re treating disease, yet we don’t have the right to know what we’re exposed to,” said O’Leary.

Nurse leaders are preparing to meet with VA officials to discuss the issue.

Seta, meanwhile, has undergone treatment for liver disease and had two knees replaced due to rheumatoid arthritis. Though she cannot prove her ailments are a result of the cocktail of antiretroviral drugs she took, both are known side effects of the medicines.

The patient whose blood she was exposed to, it turns out, was HIV-negative. —Felicia Mello
As the nation’s most populous state prepares for a June 8 primary election, nurses are mobilizing around a hotly contested governor’s race and ballot propositions that will help determine the future of democracy in the state. This year’s balloting is awash with corporate money, with two multi-millionaire gubernatorial candidates vying for the Republican nomination and companies using paid signature-gatherers to qualify ballot initiatives tailor-made to boost their profits.

Nurses are pushing back, supporting current Attorney General and long-time advocate for working people Jerry Brown in the governor’s race, candidates for other state offices that will advocate for patients and nurses, and a ballot proposition that will provide public campaign financing to level the playing field in future elections.

“There’s only one thing that can overcome money, and that’s people,” Rose Ann DeMoro, Executive Director of the California Nurses Association and National Nurses United said at a recent staff-nurse conference on the elections. “And who is the best in the state of California at talking to people about politics? Nurses.”

The Governor’s Race
Think a billionaire former CEO should be able to buy her way into the governor’s office with a $150-million campaign treasury? Neither does CNA. When former eBay head Meg Whitman announced she was running for governor on a platform of firing workers, cutting benefits and repealing workplace regulations, CNA responded with a satirical campaign to show just how out of touch Whitman is with the reality of ordinary Californians.

“Queen Meg,” Whitman’s imperious alter ego, has showed up at Whitman campaign fundraisers across the state, asking Californians to crown her governor because, well, she’s rich. “California can’t afford a democracy, but I can afford California,” Queen Meg told the press outside a Beverly Hills event, after arriving in a horse-drawn carriage. Her platform: Healthcare for the Nobility, Education for the Few, and Prisons for All.

The light-hearted campaign has a serious message, said CNA Co-president Malinda Markowitz, RN. “Nobody should be able to bid on California, whether it’s a pretend queen or a billionaire CEO,” Markowitz said.

CNA’s Board of Directors has endorsed Democratic candidate Brown, who in his previous terms as Governor in the 1970s and early 1980s signed into law nurse-to-patient staffing ratios for intensive care units, collective-bargaining rights for University of California employees, and a host of other workplace-safety and environmental measures. (For more on Brown’s record of support for nurses and patients, see p. 15.)

The Propositions
CNA is supporting Proposition 15, the California Fair Elections Act, which would create a pilot program of public financing
for the election for Secretary of State in 2014 and 2018. The program would give candidates who can show public support, by collecting a certain amount of $5 contributions from registered voters, up to about $2 million to spend on their campaign. Candidates would be banned from spending more than that amount. The program would be paid for by a tax on lobbyists, and could serve as a model for future elections.

Similar programs already exist in Arizona and Maine. The spending limits clearly represent a shift from business-as-usual: candidates and elected officials in California have directly raised over $1 billion since 2001, according to the state’s Fair Political Practices Commission.

CNA strongly opposes Proposition 17, funded by Mercury Insurance Group, which would roll back state regulations on auto insurance, allowing insurers to discriminate against drivers who weren’t previously insured. CNA also opposes Proposition 16, a deceptive measure sponsored by Pacific Gas and Electric Company that would make it harder for voters to grant cities and counties the authority to directly provide electricity to residents.

The Ratios
What do these elections have to do with California’s first-in-the-nation safe staffing law? Everything. For one thing, gubernatorial candidate Brown supports the ratio law; his likely opponent, Whitman, would probably try to repeal it if elected.

These elections also mark a turning point for United States Senator Barbara Boxer (D-CA), who is sponsoring legislation to extend California’s staffing ratios to the rest of the country. While Boxer looks to be safe in the primary, Republicans have targeted her for defeat in November.

“Barbara Boxer has been there for us and we need to be there for her,” said Deborah Burger, RN, Co-president of CNA and National Nurses United. “Our very nursing practice is going to be at stake.”

With patient care standards hanging in the balance, every nurse in the country has a stake in these elections—not just those in the Golden State. (For more on staffing ratios and nurses’ stake in this year’s elections, see p. 16.)—Staff Report
Florida

Nurses continue to actively support the Florida Hospital Patient Protection Act of 2010, state legislation that would mandate minimum RN-to-patient staffing ratios in hospitals. Florida has a relatively short legislative session, so nurses are writing letters to their legislators as well as making weekly trips to Tallahassee to speak to them about the urgent need for safe staffing and improvements in RN rights to advocate for patients.

There has been ongoing phone banking with nurses talking to other nurses about why the bill is important and asking them to join the campaign. More and more nurses are filling out the NNOC-Florida/NNU Nurse Report Form to keep track of what is really happening in the hospitals and sharing those stories with legislators.

Nurses are clarifying the differences between the NNOC-endorsed bill that calls for mandated ratios based on the individual acuity of the patient and set through a uniform Patient Classification System, and the bill endorsed by the Florida Nurses Association that leaves the final decision to the hospitals. Nurses would also be able to check the website for their own hospitals’ ratio reporting and take action if the hospitals are not reporting truthfully.

On another front, Heather Ives, RN organized a healthcare forum attended by 120 people in Lorain County March 24, which resulted in the formation of a new Lorain County chapter of the Single Payer Action Network of Ohio.

Massachusetts

Registered nurses and health professionals at Morton Hospital in Taunton reached agreement on a new contract with the hospital in late April, averting a strike vote scheduled for April 28. The pact includes strong language to limit mandatory overtime, protection of the defined benefit pension plan, a salary increase and parity for Morton’s home care nurses. "We are thrilled to have achieved this settlement, which is a victory for all of us—nurses, health professionals, management, and most important of all, our patients, who will benefit from this agreement on a new contract with the hospital.

"We stand together to make a better workplace for our patients and for ourselves," said Erica Ramhatal, an RN at the hospital. "We are so proud to be part of National Nurses United."

Ohio

On March 12, ten nurses from across the state attended a meeting convened by the Ohio Department of Health to discuss which hospital quality measures should be reported to the public on a new website, Ohio Hospital Compare. Dayton NNOC member Janet Michaelis, RN argued that RN-to-patient staffing ratio information is an important aspect of patient care that can be easily reported to the website.

The next step for NNOC will be participating in a subcommittee composed of hospital industry, nursing union, and consumer representatives. NNOC’s goal is for the public to be able to compare hospitals’ actual, existing staffing ratios on the site. Nurses would also be able to conduct informational picketing outside the hospital.

Texas

Nurses at Cypress-Fairbanks Hospital in Houston voted this month to remain members of National Nurses Organizing Committee-Texas, defeating an attempt to remove the union at the hospital, the first private-sector medical facility in the state to unionize.

NNOC-Texas represents about 300 registered nurses at Cypress-Fairbanks, who first voted to join the organization in 2008. The nurses hope they will now be able to negotiate a first contract with management.

"We stand together to make a better workplace for our patients and for ourselves," said Erica Ramhatal, an RN at the hospital. "We are so proud to be part of National Nurses United."
Jerry Brown
The Nurses’ Choice for California Governor

The California Nurses Association/National Nurses Organizing Committee executive board unanimously endorsed Democrat Jerry Brown for governor of California at its March 20 meeting.

“Jerry Brown is the only candidate for governor who will fight for ordinary people, and who understands the nursing profession,” said Zenei Cortez, RN, Co-president of CNA/NNOC.

If the past is prologue, nurses and patients would fare very well if Brown, a former governor and current attorney general of the state, is elected governor in November.

In his first tenure as California governor from 1975 to 1983, Brown substantially improved patient care standards as well as the workplace rights for millions of Californians. He implemented the nation’s first nurse-to-patient ratios, in intensive care units, and enacted collective bargaining rights for employees of the University of California, including thousands of nurses.

A consistent ally of the labor movement, Brown signed the first agricultural labor relations law in the country, and created an innovative job training program for low-income Californians, the California Worksite Education and Training Act.

He also made California a national model in environmental and energy regulations and created the California Conservation Corps to provide the state’s young people with employment in environmental stewardship and disaster response. Consumer protections enacted under Brown’s leadership include the right to purchase generic drugs, and the nation’s first affordable “lifetime” utility rates for seniors.

In his current role as California’s Attorney General, Brown oversees corporations and charities, including hospitals, and has blocked the sale of community hospitals to for-profit chains. His office is conducting an investigation into the denial of claims by insurance companies, sparked by a CNA/NNOC study showing denial rates as high as 39 percent.

“As Attorney General, Jerry Brown is working to crack down on the unconscionable practices of insurance industries denying healthcare and access to care,” Cortez said at the organization’s board meeting, before offering the motion to endorse Brown.

At the meeting, Brown decried corporate healthcare’s emphasis on cost-cutting and skill-degrading technology at the expense of patients. “We’re in the midst of an effort to replace people with formulas, with protocols, with computer software,” he said. “That really is inhuman. I see it in healthcare. We have to put the patient, the caregiver right in the forefront. A sense of morality, social justice, and a true spirit of democracy has to be the spirit going forward.”

Brown’s effective enforcement of workplace protections includes suing unscrupulous employers for denying workers wages and benefits required by state law, shutting down companies that have jeopardized worker safety, and prosecuting businesses that have bilked California’s workers’ compensation system or otherwise circumvented state tax and employment laws.

It’s an unmatched record on behalf of working families. And it’s a critical time for California.

Having failed to solve the budget crisis for over two years—a crisis largely created by current governor Arnold Schwarzenegger’s givebacks to the richest Californians and excessive borrowing prior to the financial collapse—the state faces another $20 billion deficit this year. Unemployment is at a modern record of 12.5 percent. We’re just now seeing an increase in consumer spending but no significant uptick in hiring.

Brown’s public service experience will bring Californians together to solve these problems. A Brown victory in the nation’s most populated state would also pave the way to enact nurse- and patient-friendly legislation that could serve as a model for the rest of the country.

As California heads towards a June 8 primary election, the two multi-millionaires vying to become Brown’s Republican challenger boast that they will run the state “like a business.” Arnold Schwarzenegger’s administration has shown what corporate-style rule by a rich autocrat does for California nurses, patients and workers. Continuing with this approach is contraindicated.

Fortunately, California has an effective alternative: experienced leadership with a proven record on behalf of the state’s working families.
A Life-Saving Law, Under Threat

Nurses fought for and won California’s staffing ratios. Now we must defend them from corporate politicians.

"More nurses, less death." The succinct headline in the Philadelphia Inquirer April 20 about the first major study on California’s historic law summed up what nurses and patients have known for a long time. Minimum, specific, numeric RN-to-patient ratios, augmented by a genuine patient acuity system, are the single most effective safeguard for hospital patients.

It’s why California’s ratio law has become the national model for safer nursing care, a critical part of addressing the unfinished business of national healthcare reform, which includes establishing a single standard of quality care for all in hospitals.

It’s also why nurses and patients from coast to coast have a lot at stake in the critical California governor’s race this fall.

Lower mortality rates, understandably, are the calling-card achievement of the ratio law. But ratios, the study proves, also mean more time for educating them and their families to promote better post-discharge care. And, by assuring nurses the ability to safely practice their profession, they reduce nurse burnout, keep nurses at the bedside, and promote recruitment of new RNs.

The documentary evidence, provided in compelling detail by the eminent nurse researcher Linda Aiken and her University of Pennsylvania research team, dismantled reams of anti-ratio rhetoric from the hospital industry and its acolytes in academia and the American Nurses Association. Case closed—the law works. As we always said it would.

There was only one major element missing in the study: agency. California’s life-saving ratios would never have become law, and survived wave after wave of healthcare industry assaults, without the California Nurses Association.

It was CNA, with all the power, focus, creativity, and unity of our direct-care nurse leadership and staff, that wrote the law, mobilized thousands of nurses and patients to fight to enact it, produced unprecedented research to assure strong, specific ratios were adopted, defeated a hospital industry lawsuit and regulatory attacks, and stopped the most famous governor in the world when he tried to roll back the law.

Further, it’s CNA and other National Nurses United and National Nurses Organizing Committee affiliates who have led efforts to pass similar legislation in more than a dozen other states styled on the successful California experience. And it is the coming together of NNU that inspired the creation of a national ratios bill, S 1031, the most comprehensive legislation for nurses and patient advocacy in U.S. history.

But all our efforts to pass and defend the law, and to build a powerful national model, should also serve as a sober reminder. Nurses and patients have powerful adversaries in the multi-billion-dollar hospital industry, with all its economic and political clout, and only the continued vigilance of our leaders and members, and support from the public, will protect the law and its life-saving benefits.

It’s a lifetime that can be very tenuous, as we were reminded when California Gov. Arnold Schwarzenegger issued his infamous emergency regulation in November 2004 at the bidding of the hospital industry as a first step to overturn the law.

It took the most herculean effort CNA has ever mounted to save the law. For those who may not recall, Schwarzenegger issued his fiat two days after a Presidential election in which he was widely credited with helping re-elect George W. Bush and was at the apex of his popularity. Many of the supposed experts counseled us to accommodate and conciliate, not fight.

But RNs knew how much was at stake and refused to be silent. We decided to target his fundraisers, drawing the links between his corporate contributors and his corporate, anti-patient, anti-nurse, anti-worker agenda. As we held protest after protest, others began to join us. Soon it was no longer just RNs, it was a mass movement.

Schwarzenegger lost in court, he lost in the arena of public opinion, and then he lost at the polls with all four of his anti-union special election initiatives crashing to humiliating defeat.

If we had not acted, the Terminator would have won—a prelude to eroding other patient-care and workplace protections.

Today, we face a similar challenge. Billionaire CEO Meg Whitman, who some have characterized as “Arnold on steroids,” threatens to buy the governor’s office in California and ram through an even more amped-up corporate agenda.

Whitman’s avowed program includes “streamlining” regulations to create a more “business-friendly climate” in California, such as eliminating workplace standards that might interfere with accumulation of profits.

So it should come as no surprise that Whitman says she wants to roll back University of California staffing to 2004 levels. That happens to be the very year when the ratios went into effect, and Schwarzenegger, in collusion with the California Hospital Association, sought to overturn them.

We will need every ounce of that same people power and street heat again to protect California’s law. Now that the evidence is in, we know that silence truly does mean death for hospital patients.

From Arizona to Massachusetts, the hospital industry and its allies have contributed to the attacks on the California law which they, too, know serves every day as a living, effective model solution to the patient care crisis for nurses, patients, and legislators in other states and Washington as well.

We will have to summon all the creativity, energy, and dedication of our national nurses movement to re-secure the law in California, and to extend its life-saving benefits to the rest of the nation.

Rose Ann DeMoro is executive director of National Nurses United.
MY MOTHER TAUGHT ME to be on time, to send thank you cards for gifts, and to always help those less fortunate than I am. Most importantly, she taught me about kindness, and the importance of human connection. My career in nursing has allowed me a perfect playing field to nurture these qualities. Throughout my 21 years of nursing, nothing has been more meaningful to me than the times I have been able to step outside of the flurry of tasks, data, and time constraints and enter into a space of quiet intimacy with my patients, simply by bringing my attention to our shared moment without distraction and without agenda. While so many other parts of my job as a hospice nurse are demanding, draining, and stressful, this type of connection is the nectar that sustains me as a nurse. But as nursing gets more regulated, even hospice is being forced to move to a more corporate model for care. Enter the laptop.

What were we thinking? For many of us, it sounded like a good idea at the time. More ease and efficiency, access to patient information at our fingertips, a quick click of the mouse rather than all that writing. The days of suffering from numb hands and stiff necks as we sat charting in our cars, limbs twisted in ergonomically nightmarish positions, would be over. The ease of not having to return to the office every day to drop off charts, or not having to spend hours in the office searching for paper charts only to find that a nurse had taken them home and forgotten to bring them back. All of this sounded pretty good, even to me, a kind of minimal-techno type. However, now four years into it, I can honestly say I don’t think any of us really understood what real-time use of computers in home care would look like.

The use of laptops in hospice has presented many unexpected challenges. Security and confidentiality of private health information is a top one. Suddenly, the “Oh cool, I’ve got all my patients’ information right here in my laptop!” became “Uh-oh, I’ve got all my patients’ information here on my laptop!” No one, not even the managers, was prepared for this. Who knew that it would be a federal issue when a laptop was stolen or lost? Field staff have been scolded, disciplined, and even terminated for lapses in judgment which might allow for private health information, or PHI, to be, well, not so P. Should you find yourself in the unfortunate position of being held at gunpoint with someone demanding “Your computer or your life,” you’d best give up your life so you can hang onto your job. And there’d better be signs of a struggle!

Apart from all the security issues surrounding the use of laptops in hospice, my biggest objection to it is this: While I see the immense benefit from having my patients’ records literally at my fingertips (and I imagine would fight like heck if they ever tried to take our computers away from us for that reason alone), I cannot reconcile the use of laptop computers in patients’ homes, especially in hospice, for one reason alone—it interferes with the capacity to connect fully with our patients. Call me a holdover from the past, but I still believe in the kind of nursing where we hold someone’s hand when they are frightened, versus documenting “anxiety” on a scale from 1-10. Or listening deeply as a dying person searches our eyes for connection, which, by the way, they can’t find if our eyes are glued to a monitor.

Most of all, I value the practice of deep listening and full presence, which requires a minimum of two people and no electronic devices. When my 16-year-old daughter tells me “I’m listening!” while her iPod is blaring in her ears and her fingers are manipulating buttons to find the perfect song, well, call me overly sensitive, but I don’t feel like I’m being heard. Likewise, when I am sitting in my patient’s home plunking in information on my computer, my attention is not fully with my patient. It’s true, I can look up every minute or so and give a reassuring nod to let them know I’m really listening, but we all know the quality of attention is different when a third, electronic party is present.

There are nurses who will defend their ability to handle both patient and computer in the home setting, claiming that they can maintain connection with their patients despite their fingers and their brain doing two separate things at the same time. There are other nurses, and we all know them, who have literally left the profession scratching their heads wondering what happened. Me, I’m somewhere in the middle. I value the use of computers at home or in the office, but I struggle with laptop use in patients’ homes and am outraged at the haphazard PHI protocols and the fear that the PHI gods have implanted in home care nurses. Mostly, though, I am saddened by what looks like the replacement of heart-based listening and attention for those who are physically vulnerable by speed and efficiency which, ultimately, don’t heal a damn thing.

I know one thing for sure, though. My mother was right when she told me years ago, “It’s nice to listen, when you’re being talked to.”

Are You Listening?

By Helen Greenspan, RN
On the plane to Haiti, Clelie St. Vil, RN, is quiet. In a bouncing truck ride across rutted roads on the way to Sacre Coeur Hospital outside Milot, she is the only nurse not laughing about being tossed around the back seat on what another nurse calls, “Mr. Toad’s Wild Ride.” Instead, she looks out the dusty windows, studying everything she sees.

St. Vil is in Haiti with National Nurses United’s RN Response Network experiencing “déjà vu.”

“It’s like I’ve done this same trip before in another lifetime, and I’m seeing it all over again. It’s like I’ve been here before,” she says.

St. Vil has been in Haiti before. She was born here, but swears she can’t remember anything about her life before age 11. That’s when her mother brought her to the United States. But when her mother became too sick to care for her, St. Vil was taken away from her, leaving St. Vil to a life in and out of foster care homes.

After difficult years bouncing from family to family, St. Vil became pregnant at 16 and lived in a group home during her pregnancy.

Some would have called her future bleak, but St. Vil was unstoppable. While she was pregnant she took a high school nursing education class, and later, she worked as a nurses’ aide. She quickly discovered her passion for nursing. At 17, she got her own apartment with her young daughter Abigail and her little sister and began working toward her degree, starting with an associate degree in psychology and completing a B.A. in nursing.

In the United States she works at University of Massachusetts Medical Center at Lowell in cardiac med-surg and is proud of what she has achieved. Her daughter Abigail is now 14 years old and dances professionally. Her second daughter, Savannah, is two.

The desire to adopt a third child orphaned by Haiti’s earthquake was just one of the things that drew St. Vil to notice RN Response Network literature in the National Nurses United brochure given to her by her union, the Massachusetts Nurses Association.

“I’ve always wanted to do disaster relief,” she says. Because she was orphaned herself, St. Vil says she is more empathetic towards patients. The ten-day trip to Haiti seemed like a good fit. So she volunteered.

Since being in Haiti, her happiness is palpable. St. Vil’s journey back to herself began before she ever volunteered. Long a member of a predominately white church, she joined a Haitian church several months before the trip, and immersed herself in Haitian culture.

Before her departure, she fretted that Haitians wouldn’t understand her mix-and-match Creole dialect—part Haitian Creole, part U.S. Creole, and everything in between.

But once in Haiti, it soon becomes clear to St. Vil where she belongs. After her first shift at Sacre Coeur Hospital, talking to and caring for patients in the intensive care unit, the worry on her mouth breaks into a broad smile. “It works!” she says, beaming.

“They understand me!”

“I love it here,” she says.

A few days later she is in Sacre Coeur’s ICU helping pull surgical staples out of a girl’s infected leg. She holds the girl’s hand, and knows everything about her. “She was orphaned as a girl. She works as a vendor,” she says. Her mothering instincts have sprung to life. During the operation she comforted patient Enise and held her hand tightly, calling her “Cherie,” or “Dear.” Later, she will advocate for Enise with the fierceness of a lion, saying she must stay in the ICU and continue care.

One orphan protecting another.

Erin Fitzgerald is a videographer and writer for National Nurses United.
Clelie St. Vil, RN (right) arrives in Haiti for the first time since leaving the country at age 11. Opposite, St. Vil comforts a patient at Haiti’s Sacre Coeur Hospital.
It was a summer evening in 1965 when 13-year-old Orsburn Stone saw the men in the familiar white sheets gather on the front lawn of his family’s home in South Carolina. As the Ku Klux Klan members lit and burned a cross, Stone, furious, grabbed a shotgun and ran towards the front door. He wanted to do something, anything, to stop them.

“My mother and grandmother grabbed me around the legs and said please, don’t go out there,” Stone, now 58 and a registered nurse, calmly recalls. “They probably saved my life that night.” Instead, Stone went to the back door and fired a few shots in the air. The men left, he says… and never came back.

The trials of the segregation-era South may seem like a long way from the corridors of MountainView Hospital in Las Vegas, Nevada, where Stone works as a critical-care nurse. But Stone says experiences like that night prepared him to withstand the pressure of a contentious, year-and-a-half-long organizing campaign that led to the first unionization victory for the newly-formed National Nurses United in January. And Stone’s colleagues say his quiet determination, coupled with kindness and respect for those around him—even when he disagreed with them—helped give nurses the moral high ground in the campaign.

“Stone was relentless; he didn’t let anything get in the way of what he knew was right,” says Julia Gomez, a pre-operative nurse at MountainView, where Stone is known by his last name. “When he believes in something, he puts everything in.”

Tall and immaculately dressed, Stone is a familiar figure in the hospital, where he currently serves on the team negotiating MountainView RNs’ first contract. He has worn many hats throughout his life, from military officer to Catholic deacon. Through it all, he says, he has been guided by the simple lessons his mother and grandmother passed down to him: “There’s no one greater than you and no one worse than you. We’re all human beings. And, make sure you get yourself an education, because once you do, no one can take that away from you.”

That sense of dignity got the teenage Stone in trouble that summer of 1965. He had worked odd jobs for a local white man by the name of Peebles, who always treated him fairly. But then Mr. Peebles referred Stone to a friend of his who ran the county fair and the local general store, and wasn’t as good-natured.

“He rode me like a workhorse and degraded me,” with racial slurs, Stone says. “By the end of the first day, I had had enough. I said ‘Mr. Nash, I apologize because I know Mr. Peebles went to great lengths to get me this job. But I am quitting effective immediately. Whatever money you have set aside to pay me for today, you can keep it.’”

It was that night that Stone’s family received their visit from the men in white. Soon after, while still in junior high school, Stone marched in a civil rights protest called by Martin Luther King, Jr.

He later joined the United States Air Force, working his way up to captain and attending nursing school in his off-duty time. He earned both a bachelor’s of science in nursing and a master’s degree in management, then left military service for nursing in 1991.

At MountainView, he quickly became known as a source of support for his stressed-out coworkers. “We all have big workloads but yet he’ll listen to somebody’s problem with their patient and make a suggestion, when he’s just as busy as we all are,” says Jacque Weise, RN, who works with Stone in the hospital’s float pool. Recently, one of Weise’s patients, a large man, was having trouble breathing and kept trying to get out of bed. Stone came into the room and “just his presence seemed to help,” she says.

Even the toughest of obstacles couldn’t keep Orsburn Stone, RN from standing up for nurses’ rights at his Nevada hospital.

He’d seen much worse.

By Felicia Mello
In 2008, MountainView nurses determined to improve staffing and patient care and win a greater voice in hospital decisions began discussing with the California Nurses Association/National Nurses Organizing Committee about joining the union. Stone was one of the first to sign up. A float nurse, he had developed relationships with nurses in many different units at the hospital. He quit his part-time job teaching nursing at two local colleges and was soon spending his days off at MountainView, talking to RNs about the benefits of being part of a professional organization like CNA/NNOC.

“I was doing it mainly for the benefit of the nurses coming behind me, and the patients they will be serving,” says Stone, who plans to retire within a few years.

“Stone is not the kind of person who says, ‘I’m going to take the lead, you guys need to stand behind me and do what I tell you,’” says Gomez. “If anything, he has a way of empowering people to speak up for themselves, by asking very poignant questions that inspire self-reflection.”

From the beginning, a small minority of anti-union nurses tried to derail the campaign, MountainView RNs say, harassing and even physically assaulting union supporters.

Because he had been outspoken, Stone became known as a nurse leader among both his coworkers and the hospital administration. On one occasion while he was campaigning at the hospital during non-work hours, the police arrived and asked him to leave. Stone explained that he had a legal right to be there, politely complied with their request...then returned another day. The event became legend at the hospital.

“Some people thought I was the heart of the whole operation,” Stone says now, “but in reality there were a lot of people who made this happen, both within CNA/NNOC and at MountainView.”

When in January the MountainView nurses finally voted overwhelmingly to join CNA/NNOC, “it was one of the most joyful times in my life,” says Stone, laughing with glee at the memory. “It was extremely exhilarating. But I recognized that the true work had just begun.”

Stone, who is studying to become a Catholic priest, had put his education on hold during the campaign, but is now on track to become ordained within a year. Like many of the clergy involved in the civil rights movement and other movements for social change, he sees his organizing work as intimately connected with his faith; building National Nurses United, he says, is part of his calling.

“My faith as a Catholic calls me to bind the other’s wound and care for my brethren, and that’s what this organization does,” he says. “I’m supposed to help those that are helpless, and there are a lot of helpless people in healthcare.”

Saying mass at the 300-member St. Thomas’s Catholic Church in Las Vegas—deacons like Stone are allowed to fill in for priests in a pinch—keeps him in touch with the struggles of low-income people in Nevada, where the recession has hit hard. A few weeks ago, one of the congregation members approached him asking for assistance. The man explained shyly that he had a job, but hadn’t eaten in three days. Could Stone do something to help?

“I look out over the congregation and say, how many people are in the same situation but don’t have the courage to come forward?” says Stone, who connected the man with a parish program that helps the needy. Nurses can be part of the solution to these larger injustices, he says.

“I honestly believe that as nurses united, we can change the course of this country and the world,” Stone told a group of RNs at a recent organizing school sponsored by NNU. Shortly afterward, he was on a plane to Texas to help organize another hospital owned by HCA, MountainView’s parent corporation. Though he only spent four days in Texas, he speaks of “the brothers and sisters in El Paso,” with the same affection and sense of solidarity with which he talks about his colleagues at MountainView, or the members of his church.

“Just like I did here, I’ll do whatever it takes to make sure they end up with proper representation,” he says.

Felicia Mello is acting editor of National Nurse.
Hospital Magnet Status Impact on RN Autonomy and Patient Advocacy

Hospitals are increasingly looking to the American Nurses Association’s magnet hospital program as a way to boost their reputations. But what exactly are magnet hospitals, and how does magnet hospital status affect RNs and patients? To find out, take this home-study course and submit the attached quiz by mail for 2 continuing education credits.

DESCRIPTION: This home study examines the impact of hospital magnet designation on the independent professional judgment of direct-care registered nurses and their right and duty to advocate for their patients.

Background

In 1990 the American Nurses Association (ANA) approved a proposal that recognized excellence in nursing services. This was based on an earlier research done by the American Academy of Nursing on practice in U.S. hospitals. The variables used in the study were called “Forces of Magnetism” and the facilities were called “Magnets” because they allegedly attracted and retained registered nurses.

The Magnet Recognition Program was developed by the American Nurses Credentialing Center (an ANA subsidiary) to recognize “health care organizations that provide nursing excellence.” The program also provides a vehicle for “successful” nursing practices and strategies.

The Magnet program is based on quality indicators and standards as defined in the ANA Scope and Standards for Nurse Administrators (2004). The Magnet designation process includes 14 qualitative factors in nursing also known as the 14 “Forces of Magnetism” and the facilities were called “Magnets” because they allegedly attracted and retained registered nurses.

The Magnet Recognition Program was developed by the American Nurses Credentialing Center (an ANA subsidiary) to recognize “health care organizations that provide nursing excellence.” The program also provides a vehicle for “successful” nursing practices and strategies.

In 1983 (See Appendix A). The stated intent is to provide “consumers with the ultimate benchmark to measure the quality of care that they can expect to receive.”

In an updated (2009) edition called Nursing Administration: Scope and Standards of Practice, nurse administrators are required to embrace the concepts reflected in the Five Model Components associated with the Magnet Recognition Program. They include: Transformational Leadership; Structural Empowerment; Exemplary Professional Practice; New Knowledge, Innovation, and Improvements; and Empirical Quality Results. The Five Model Components incorporate the 14 qualitative factors in nursing.

HISTORY OF MAGNET HOSPITAL RECOGNITION

The Beginning—“Forces of Magnetism”

The Magnet program began in the early 1980s when health care provider services were funded by fee-for-service and indemnity insurance methods. Hospital and medical group revenue and profit were generated by providing services to meet patient needs as determined necessary by physicians and other professional caregivers, including direct-care registered nurses. Fee-for-service financing of hospital care delivery generally aligned the interests of physician and hospital providers with patients in ways that promoted trust, continuity, and financial incentives to provide necessary care for patients.

In this economic scheme, the original magnet hospitals were recognized on the basis of superior RN staffing ratios and significant administrative support for direct-care RNs. The staffing ratios and administrative support provided the necessary foundation for effective, RN-friendly scheduling policies and a nurse-patient relationship which allowed competent practice under professional standards of care. As described by the American Academy of Nursing in 1983:

In magnet hospitals there is a low patient-to-registered nurse ratio, with adequate staff to provide total nursing care to all patients.

Furthermore, the quality and complexity of patient care needs are taken into consideration when the staffing is planned; this is important in minimizing stress. The nurse does not feel overworked and has an opportunity to meet all of the patient’s needs — psychological, interpersonal, and physical. There is also time for interaction among nurses so that continuity of care is insured and nurse-to-nurse consultation is encouraged. The nurses express great satisfaction in their opportunity to provide good care and in administration’s support for it.

The 1983 Study by the AAN interviewed nurses working for hospitals that were part of the original magnet selection process who summarized their experiences by identifying the most important factors in promoting recruitment and retention of staff. The key factor and driving force for all factors was “a nurse–patient ratio which assures quality patient care,” followed by “flexible staffing to support patient care needs,” “flexible scheduling,” and the practice of “primary nursing.” Staffing ratios were the absolute and mandatory condition of magnet hospital nursing service that enabled nurses to care for their patients in a manner consistent with their professional practice obligations, ethical norms, and personal career mission as registered nurses. The AAN summarized
the essential finding of its study in unequivocal terms: “The nurses speak of being able to deliver safe, adequate care as a result of these staffing patterns.”

Sharing similar operational interests driven by fee-for-service economic incentives, nursing and hospital management at the original magnet hospitals broadly agreed with nurses regarding the central factors that had an impact on recruitment and retention, citing: “adequate staffing and flexible scheduling,” “good salaries and benefits,” “participative management with active involvement of staff in planning and decision making,” “primary nursing,” and “a predominantly RN staff that is fully supported by nursing administration.” Nursing executives emphasized the importance of RNs being able to carry out skilled nursing tasks themselves, without delegation to less trained individuals. And, the original magnet hospitals were founded on a commitment to maintaining a sufficient complement of direct-care RN staff to meet patient needs at all times, with virtually no use of agency personnel.

This was the meaning and workplace reality of the “forces of magnetism” identified by the American Academy of Nursing twenty-five years ago, at a time when institutional providers and physician groups were generally thriving in a dominant “fee-for-service” market characterized by a close alignment of provider, direct-care nurse and patient interests and institutional economic incentives to ensure safe, therapeutic, effective and competent nursing care. The financial imperatives require massive cutbacks in nursing budgets and concomitant reduction in the direct-care RN staff and administrative support that were the fundamental prerequisites for magnet hospital recognition as it was originally conceived.

Managed care economics motivated a significant restructuring and downsizing of hospital nursing services and decimated the ranks of direct-care registered nurses in hospitals. At the same time, managed care imposed barriers to hospital access, producing an inpatient population that is far sicker and more medically fragile than ever before, and requires more intense, experienced and specialized nursing care. Managed care strategies to increase revenue generation by downsizing the direct-care registered nurse workforce become the dominant means for funding hospital and physician services. HMOs/insurers provide a share of the monthly premium dollar for a negotiated split between medical and hospital provider organizations, transferring to physicians and hospitals the risk of incurring costs for providing patient care services in excess of premium revenue, and the corresponding opportunity to gain surplus revenue by limiting services to ensure premium revenue exceeds costs. This radical change in hospital economics imposes operational mandates which determine the nature and methods of delivery of hospital patient care. The revenue generation priority of capitation-financed hospital service creates an inherently adversarial relationship between patients and institutional providers operating under financial incentives to limit hospital access, ignore individual patient needs, deny necessary services, and disregard minimum standards of safe, therapeutic, effective and competent nursing care. The financial imperatives require massive cutbacks in nursing budgets and concomitant reduction in the direct-care RN staff and administrative support that were the fundamental prerequisites for magnet hospital recognition as it was originally conceived.
and restructuring patient care methods also set in motion a continuing deterioration of working and practice conditions which accelerated registered nurse flight from direct-patient-care positions in hospitals and discouraged new registered nurse interest in such positions. Hospital nursing practice today is severely burdened by excessive patient loads, mandatory extended work hours, unsafe patient handling practices, and routine exposure to risks of professional license discipline and/or malpractice liability inherent in working and practice conditions created and maintained in derogation of prevailing community standards.

The new Magnet recognition program is bound by the economic imperatives and operational incentives of a method of health care service financing which transfers to health care providers the insurance risk of incurring costs for providing patient care in excess of premium revenue from participating groups. The essential hospital market conditions which were prerequisite for achieving a nursing premium revenue from participating groups. The essential hospital market conditions which were prerequisite for achieving a nursing environment eligible for magnet recognition no longer exist and cannot be replicated on an institutional basis.

Shared Governance—Compromising RN Duty of Loyalty to Patient Interests

The new ANCC Core Criteria for magnet hospital accreditation reflect a significant emphasis on staff nurse decision making and influence over the delivery of patient care.

While labels differ, the evidence is conclusive that a shared governance model is a key component in structuring professional nursing practice to achieve magnet recognition. Virtually all the hospitals that achieve “magnet status” use a “shared governance” structural model for sustaining professional nursing practice.

The ANCC magnet accreditation process begins with a potential applicant’s “Organization Self-Assessment for Magnet Readiness” according to a detailed set of standards and inquiries. A threshold condition to demonstrate “readiness” for magnet status consideration is: there must be “congruence between the mission, vision, values, philosophy, and strategic plan of the nursing department and those aspects of the organization.” (ANCC, Organization Self-Assessment for Magnet Readiness.)

The ANCC magnet accreditation process begins with a potential applicant’s “Organization Self-Assessment for Magnet Readiness” according to a detailed set of standards and inquiries. A threshold condition to demonstrate “readiness” for magnet status consideration is: there must be “congruence between the mission, vision, values, philosophy, and strategic plan of the nursing department and those aspects of the organization.” (ANCC, Organization Self-Assessment for Magnet Readiness.)

The shared governance imperative of “congruent interests” requires staff nurse loyalty to the operational priorities of commercial health care institutions. RN professional licensure responsibilities and ethical duties require exclusive loyalty to patient interests. Magnet/shared governance “enterprise loyalty” is antithetical to the direct-care RN’s fiduciary duty to provide care in the exclusive interests of patients.

The structural imperatives of magnet hospital governance over nursing services cannot be harmonized with nor incorporated into collective bargaining representation. Nursing shared governance is a managerial innovation that legitimizes nurses’ control over practice, while extending their influence into administrative areas previously controlled only by managers. Proponents of magnet recognition view union representation of nurses as a barrier to successful shared governance because “union restrictions may prohibit management from implementing shared governance model.” More importantly, participation in magnet-acceptable shared governance procedures and committees requires staff nurses to assume expressly stated managerial and supervisory responsibilities and authority. Such participation provides presumptive evidence of exclusion from labor law rights to organize for collective bargaining.

Today’s Magnet Hospital Imperatives are in Fundamental and Irreconcilable Conflict With the RN Duty of Loyalty to Patients.

The economic incentives of institutional providers and the commercial mandates of the healthcare industry conflict with the interests, health and safety of patients and the professional and ethical responsibilities of direct-care RNs.

Today’s ANCC Magnet Status Recognition certification program and its various components, including Shared Governance, are the direct and exclusive creation of the commercial priorities and economic incentives of corporate health care.

The stated “goals and objectives” are deceptive and are mere smokescreens for the fundamental commercial priorities of the program. Neither these priorities nor the economic interests of the health care industry as presently constituted can be reconciled with the interests of patients or the rights and obligations of direct-care registered nurses.

Moreover, any concession to Magnet Status Recognition/Shared Governance and similar schemes provides continuing cover for an ill-conceived healthcare system and significant obstruction to winning single-payer healthcare reform.

Consistent with the essential purposes of the California Nurses Association/National Nurses Organizing Committee as a voice for direct care RNs and the Code of Professional RN Practice adopted in the CNA/NNOC Bylaws, the position of CNA/NNOC must be unqualified opposition to Magnet Status Recognition and similar programs, including categorical rejection of any form of participation or support for such programs and their deceptive entrapments like Shared Governance. The responsibility of patient advocacy and affirmative obligations of collective patient advocacy offer no opportunity for such concession.

Standards for Evaluating Whether ANCC “Magnet Hospital” Designation Is in the Interests of Direct Care RNs and Their Patients

CNA/NNOC Code of RN Professional Responsibility

The CNA/NNOC Bylaws Code of RN Practice include the following standards:

1. The nurse assumes responsibility and accountability for competent and appropriate performance of the RN Duty of Patient Advocacy, acting in the exclusive interests of the patient, as the patient’s advocate, by initiating action to improve health care or to change decisions or activities which are against the interests or wishes of the patient, as circumstances may require, and by disclosing information and providing patient education as necessary for informed patient decisions about health care before care is provided to the patient.

2. The nurse recognizes the importance of collective patient advocacy to the public health and the integrity of professional nursing standards of care, and participates in necessary and appropriate actions and exercises of collective patient advocacy to protect the public health and safe patient care standards against erosion, restructuring, degradation, deregulation, and abolition by the large health care corporations, hospital chains, HMOs, insurance companies, pharmaceutical corporations, and other powerful economic institutions and interests which today seek to control the availability, access, and quality of health care services for purposes of profit and surplus revenue
generation against the interest of patients and health care consumers.

**Independent Professional Responsibility to Act in the Exclusive Interests of Patients – Direct-Care RN Fiduciary Duty to Patients**

State nursing practice acts and Registered Nursing Board regulations, practice standards, and professional license guidelines generally impose a “fiduciary responsibility” on registered nurses who accept assignment to a direct-care RN-to-patient relationship in which nursing care is provided. The fiduciary obligation is to provide care in the exclusive interests of the patient without compromise or surrender to other interests, including the commercial, operational, revenue generation, or budgetary interests of health facility employers, physician practice groups, healthcare systems, managed care organizations, or health insurers/HMOs.

The fiduciary relationship and related professional fiduciary duties of direct-care registered nurses to assigned patients are fundamental public health and safety regulations created to protect patient safety.

**Necessary Conditions for Safe, Therapeutic, Effective and Competent Registered Nursing Practice in the Interests of Patients**

Protection of working and practice conditions for direct-care RNs that are essential for safe, therapeutic, effective and competent nursing care:

1. an RN-to-patient relationship which allows for competent performance of all aspects of the nursing process, enforced by objective minimum standards for safe patient care (i.e., numeric, unit-based RN-to-patient staffing ratios);
2. the right and practical ability to exercise independent professional responsibility and judgment to determine and implement nursing care in the exclusive interests of patients, uncompromised by and without interference arising from the conflicting commercial and revenue-generation interests and demands of the healthcare industry.

**Magnet Recognition and Replacement Technology**

To achieve and maintain “magnet” status, hospitals are required to demonstrate they have a mechanism in place which collects and analyzes patient outcome data with input from the nursing staff while incorporating clinical decision-making technologies.

Hospitals seeking such designation have deployed these clinical technologies, which incorporate Computerized Physician Order Entry (CPOE) systems, computerized charting programs—including computerized medication charting—and decision-support technology, which is based on rigid standardization of the decision-making process of the direct care RN.

RNs have a unique patient advocacy role in the health care delivery system and technology can only be used to augment this unique role. In analyzing the safe, therapeutic and effective values of any technology, RNs must be able to explore the potential of technology replacing human interaction in the delivery of patient care and the supplanting of critical thinking and independent clinical judgment with rigid clinical pathways or RN displacement and/or override technologies.

Technology-driven care depersonalizes the RN relationship with her/his patients. Unfettered use of technology will have a chilling effect on the RN’s ability to advocate in the exclusive interest of her/his patient. Undue reliance on technology can jeopardize the accuracy of diagnosis and treatment of patients.

Such reliance will also create erosion of skills for the next generation of RNs who (unless stopped) will be trained in tasks instead of educated in skills. It has the potential of destroying the art and science of professional registered nursing.

Human cognition is still superior to so-called “machine intelligence.” One fact is certain: Computers and machines are only good for storing information; they cannot think critically as registered nurses do, nor are they capable of making split-second judgments in crisis intervention situations. Computers and machines are capable of quantifying data, but it will take a qualified RN to synthesize and interpret the data, otherwise it is meaningless.

In order to be competitive in a market-driven healthcare system, “Magnet” recognition schemes have endorsed technologies that degrade skills, replace RNs, obliterate individual advocacy and avoid unions.

**The 14 “Forces of Magnetism”**

| FORCE 1: | Quality of Nursing Leadership |
| FORCE 2: | Organizational Structure |
| FORCE 3: | Management Style |
| FORCE 4: | Personnel Policies and Programs |
| FORCE 5: | Professional Models of Care |
| FORCE 6: | Quality of Care |
| FORCE 7: | Quality Improvement |
| FORCE 8: | Consultation and Resources |
| FORCE 9: | Autonomy |
| FORCE 10: | Community and the Healthcare Organization |
| FORCE 11: | Nurses as Teachers |
| FORCE 12: | Image of Nursing |
| FORCE 13: | Interdisciplinary Relationships |
| FORCE 14: | Professional Development |

**The Healthcare Reality and Context of Magnet Hospital Recognition**

In response to the imperatives of capitation financing and consolidation of the hospital and health insurance industries over the past two decades, aided significantly by federal policies supporting economic concentration in HMO and provider markets, the hospital industry abandoned safe, therapeutic, effective and competent nursing care as an operational priority and restructured hospital nursing services to accommodate predominantly revenue-generation purposes.

Key elements of this restructuring of hospital nursing care are a substantial cause of the current shortage of hospital direct-care registered nurses, including the following:

(a) mass layoffs and permanent reductions in force of hospital direct-care registered nurses beginning in the early 1990’s;
(b) work “redesign” measures to fragment and deskill hospital registered nursing practice in order to transfer registered nurse functions to unlicensed personnel and other non-RN caregivers;

(c) elimination of the direct-care registered nurse assessment-controlled, transparent and verifiable patient acuity system methodologies for determining registered nurse staffing levels based on individual patient needs;

(d) implementation of new, “proprietary” patient classification systems for determining nurse staffing levels and “skill mix” which purport to rely on registered nurse assessment of patient needs, but conceal methodologies and determinative functions from staff nurses and government licensing authorities, are incapable of scientific verification and validation, and routinely produce outcomes forecasting nurse staffing levels which objectively serve revenue generation targets and bear no relation to registered nurse patient assessments; and

(e) introduction of new technologies which override the independent professional clinical judgment of direct-care registered nurses.

**Essential Elements of the Magnet Recognition Program**

- Strategic avoidance of hospital direct-care nursing regulation;
- Application of “evidence-based” deceptions to hospital nursing service patient care/practice standards;
- Rip-off of high public trust in nurses (to provide care in exclusive interests of patients) to cover commercially-motivated, deceptive redesign of direct-care practice standards intended to restrain independent judgment and action by direct-care RNs, obstruct patient advocacy, and subvert direct-care nursing process with mandate to serve commercial interests over patient interests;
- Marketing gimmick to promote false appearance of superior hospital nursing practices and quality patient outcomes (the “gold standard”);
- Strategy to gain market advantage for public and private reimbursement for hospital nursing services; and
- Most importantly, a strategy to compromise the direct-care RN duty of exclusive loyalty to patients by making commercial enterprise loyalty to hospital employers a condition of RN employment for the purpose of eliminating a significant barrier to unchecked profiteering on individual and family health care risk presented by an independent direct care RN voice, professional responsibility, and patient advocacy.

**Conclusion**

The conflicts between commercial and revenue generation interests and patient interests cannot be reconciled by marketing gimmicks and workplace deceptions—Direct-care RN participation in schemes to conceal this reality and enable industry priorities is a fundamental conflict of interest and repudiation of professional ethics.

**CNA/NNOC Position**

Oppose any and all accreditation or recognition (including “Magnet” designation) schemes that:

- Directly or indirectly interfere with or compromise direct-care RN professional responsibilities to provide care in the exclusive interests of patients and take all necessary and appropriate actions to ensure patient safety even if such actions conflict with employer interests, policies, or orders.
- Establish or permit sanction or recognition of different standards of nursing service or patient care performance which allow for substandard or different classes of competent care in derogation of the universal health principle of one standard of care.

Purport to replace or in effect operate to replace governmental regulation of hospital services for the public health and safety.

Directly or indirectly coerce, intimidate, induce, or encourage front line caregivers to accept assignments, duties, or responsibilities which require enterprise loyalty and/or apparent assumption of managerial or supervisory authority that would disqualify them from collective bargaining representation.

Apply Total Quality Management/Shared Governance schemes for the strategic purpose and effect of individual and collective patient advocacy suppression and union avoidance.

Deploy technologies that override the independent professional judgment of the RN and restrict the RN duty and right to advocate; degrade skills; or are purposely developed to maintain a healthcare industry driven by private interest rather than the individual healthcare needs of the patient.

Fail to establish and promote safe staffing standards based on individual patient acuity of which objective, unit-specific hospital RN-to-patient staffing ratios are the minimum.

Fail to establish or allow for an objective, transparent process for determining and establishing direct-care RN control over working conditions to ensure patient safety even if such actions conflict with employer interests, policies, or orders.

Deploy and confuse direct-care RNs with Total Quality Management/Shared Governance schemes, including pay for performance incentives to engage support for and suppress direct-care RN resistance to benchmarking schemes that redefine disease, treatment and outcomes, cutbacks in safe, therapeutic, effective and competent direct-care nursing service, reductions in staff and nursing service budgets, prioritization of surplus revenue generation and other anti-patient practices under the cover of “gold standard” redesign of patient care standards.

—CNA/NNOC position on hospital magnet status

August 2, 2007

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www.nsnaleadershipu.org/nnalu/Implementing Shared Governance: Creating a Professional Organization, Tim Porter-O’Grady
Hospital Magnet Status
Impact on RN Autonomy and Patient Advocacy

For continuing education credit of 2.0 hours, please complete the following test, including the registration form at the bottom, and mail to CNA/NNOC, Attention: NP/Home Study CE, 2000 Franklin Street, Oakland, CA 94612 postmarked no later than July 1, 2010.

1. CNA/NNOC opposes any and all accreditation or recognition (including “Magnet” designation) schemes that deceive and confuse direct-care RNs with Shared Governance schemes, including pay for performance incentives, as well as cutbacks in safe, therapeutic, effective and competent direct-care nursing service.
   ❑ True ❑ False

2. In analyzing the safe, therapeutic, and effective values of any technology registered nurses must explore the potential of technology to replace human interaction in the delivery of healthcare.
   ❑ True ❑ False

3. Magnet designation is an excellent alternative to local, state, and federal governmental regulation of hospital services for the public health and safety.
   ❑ True ❑ False

4. Magnet hospitals improve patient care by collecting and analyzing patient outcome data with input from the nursing staff while incorporating clinical decision-making technologies.
   ❑ True ❑ False

5. Magnet hospitals improve wages, pensions, and other economic benefits for recruitment and retention of RNs.
   ❑ True ❑ False

6. Registered nurses must take all necessary and appropriate actions to ensure patient safety even if such actions conflict with employer interests, policies, or orders.

7. The CNA/NNOC position opposes any and all accreditation (including “Magnet” designation) that purports to replace or in effect operates to replace governmental regulation of hospital services for public health and safety.
   ❑ True ❑ False

8. The economic interests of the health care industry as presently constituted, the interests of patients, and the rights and obligations of direct-care registered nurses are the same. “Magnet” status is the “gold standard” of these interests.
   ❑ True ❑ False

9. The Magnet Recognition Program promotes superior hospital nursing practices and quality patient outcomes. Shared Governance empowers nurses to achieve this goal.
   ❑ True ❑ False

10. Undue reliance on technology can jeopardize the accuracy of diagnosis and treatment of patients. Such reliance will also create erosion of skills for the next generation of RNs who (unless stopped) will be trained in tasks instead of educated in skills. It has the potential of destroying the art and science of professional registered nursing.
    ❑ True ❑ False

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