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THE VOICE OF NATIONAL NURSES UNITED

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Provide Safe Patient Care

United We Stand
NEW RN SUPER-UNION SHAKES UP THE HEALTHCARE SCENE

MISSION TO HAITI
RNs’ Dispatches from the Field

HEALTHCARE REFORM
What Went Wrong?

Union RNs
Provide Safe Patient Care
Letter from the Council of Presidents

Welcome to a new era of nursing. As we begin the decade, the power of nurses to advocate for their patients and shape healthcare policy has never been greater. When 150,000 nurses in the California Nurses Association/National Nurses Organizing Committee, Massachusetts Nurses Association and United American Nurses came together to form National Nurses United at the end of last year, we didn’t just build a bigger organization. We found our collective voice as a profession. It is an exciting moment for RNs everywhere, as we finally begin working together nationally to improve working conditions for nurses, bring union representation to all non-union RNs, raise patient care standards and create a just and effective healthcare system. In this premier issue of National Nurse magazine, we take a look inside NNU, and answer your questions about the new RN super-union.

Already, National Nurses United has successfully faced several tests of our determination and solidarity. When a devastating earthquake rocked Haiti in early January, NNU nurses immediately volunteered by the thousands to tend victims of the disaster. You can read about the relief effort inside.

When federal lawmakers failed to pass meaningful health-care reform legislation, we responded with an ambitious campaign to win universal healthcare at the state level, one state at a time. In the News section, NNU legislative advocate Donna Smith and National Nurse acting editor Felicia Mello explain what’s next in the fight for healthcare for all.

In January and February, and July and August, Periodicals postage paid at Oakland, California. POSTMASTER: send address changes to National Nurse™ 2000 Franklin Street, Oakland, CA 94612-2908. To send a media release or announcement, fax (510) 663-0629. National Nurse™ is carried on the NNU website at www.nationalnursesunited.org.

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They can be about practice or management trends you’ve observed, or simply something new you’ve encountered in the profession. They can be about one nurse, unit, or hospital, or about the wider landscape of healthcare policy from an RN’s perspective. They can be humorous, or a matter of life and death. If you’re a writer and would like to contribute an article, please let us know. You can reach us at nationalnurse@nationalnursesunited.org.

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A
n intense year of political effort and legislative work has so far failed to produce the sweeping reform of the broken U.S. healthcare system that many envisioned would happen with the election of an energized, reform-minded Democratic leadership. Congress may either pass President Obama’s newest version of a merged House and Senate reform bill or act on parts of the system’s problems with shorter, less intricate bills. Either way, the result is unlikely to mean dramatic change for the average working American.

The January 19, 2010, election of Republican Sen. Scott Brown from Massachusetts to replace the late Democratic Sen. Ted Kennedy was a blow to the Democratic super-majority in the Senate and the culmination of many disappointments in the overall effort to reform healthcare during President Barack Obama’s first term.

As the final scenes unfold, efforts to find bipartisan middle ground are eroding even modest reform possibilities. Many health reform supporters believe if a bill does not pass that it may take another generation to make its own mark on the issue. And nurses also knew that too much time had passed and the nation’s healthcare system was deeper in crisis, with costs exploding for families and health outcomes losing ground when compared to other nations.

But as the health reform debate began, there was something missing. There was no discussion of extending a single-payer, Medicare for all program to every person, the reform favored by the RNs of NNU. Aside from the internet listing of 90-plus co-sponsors of HR 676, The National Health Care Act—Rep. John Conyers and Rep. Dennis Kucinich’s single-payer bill—it was hard to tell that more than 20 percent of this Congress already professed a legislative preference for a complete overhaul of the system and implementation of single-payer. In fact, we heard much more discussion about the possibilities of a public “option” for an alternative to private insurance.

From winter to spring, various interest groups—from labor organizations like the AFL-CIO to disease-related advocacy groups—met with Congressional members and staff in both houses to dicker about a wide variety of fine detail. But single-payer advocates often found their only way to be heard came in protest or in hearings where their voices were not seen as representative of any majority position.

Three legislators stood out in their support of single-payer. Dennis Kucinich, D-OH, was successful in offering a state single-payer amendment in the House Education and Labor Committee. The Kucinich amendment would have offered a state single-payer bill—HR 676, The National Health Care Act to every person, the reform favored by the RNs of NNU. Aside from the internet listing of 90-plus co-sponsors of HR 676, The National Health Care Act—Rep. John Conyers and Rep. Dennis Kucinich’s single-payer bill—it was hard to tell that more than 20 percent of this Congress already professed a legislative preference for a complete overhaul of the system and implementation of single-payer. In fact, we heard much more discussion about the possibilities of a public “option” for an alternative to private insurance.

As the 111th Congress got underway, with its heavily Democratic majority, passing some modest healthcare reform was dawning, and nurses stood ready to be a part of crafting a healthcare system that did more to help patients and less to enrich for-profit health insurance giants.

As the 111th Congress got underway, with its heavily Democratic majority, passing some meaningful health reform appeared more likely than it had been in the past 15 years. Finally, enough time had elapsed since the Clinton era health reform debacle to allow a new administration and a new Congress to make its own mark on the issue. And nurses also knew that too much time had passed and the nation’s healthcare system was deeper in crisis, with costs exploding for families and health outcomes losing ground when compared to other nations.

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Rep. Anthony Weiner, D-NY, also offered a “substitute” amendment that would have replaced much of the House reform bill with the text of the single-payer HR 676. Weiner was promised a debate and vote on his amendment but ended up withdrawing it when the House leadership hoped to avoid
all amendments (like the Stupak amendment to restrict abortion funding).

On the Senate floor, Sen. Bernie Sanders of Vermont tried to amend the Senate reform bill to include single payer, but in a procedural move, Republicans demanded a full reading of the 726-page amendment and Sanders was forced to withdraw it or have the entire bill be stalled or even defeated.

So by December it seemed that the bills emerging out of both Houses of Congress were not only an awfully long way from Medicare for all but also contained troubling provisions that might make matters worse. Both bills contained an individual mandate that would compel every American to buy health insurance coverage, a windfall for the for-profit private insurance industry.

Where the two Houses were most different in their reform legislation was in financing. The Senate bill sought to tax what were termed “Cadillac” health insurance plans while the House bill taxed the wealthiest Americans and stock and bond transactions as a funding source.

Labor leaders were outraged by the Senate plans as many rank and file union members had helped campaign for Democratic candidates—including the President—who had promised they would never support taxing health insurance benefits. That struggle was still underway when January 19, 2010, rolled around and the election in Massachusetts changed the political landscape on the Potomac. The Senate lost its veto-proof super majority, and the future of any healthcare reform on a national level became much more murky.

But within just a few days, the energy of the single-payer movement shifted to California, with the passage of single-payer legislation in the state Assembly.

Stay tuned. As state budgets are strained to the breaking point by recession and by rising health costs, passage of single-payer legislation will become not only an ethical imperative but also a fiscal necessity.

And because the struggle for a progressively financed, single standard of high quality healthcare for all is also a struggle for basic human rights for every patient, the nurses will lead the way wherever the battle needs to be fought, whether that is in Washington, DC, Sacramento, Harrisburg, or Springfield. —Donna Smith, NNU community organizer/legislative advocate in Washington, D.C.

**Single-Payer Fight Moves to States**

**F**ederal health reform may have stalled, but the struggle for universal healthcare is alive and well in the states. That was the message heard around the country when California legislators passed SB 810, a bill that would create a Medicare for all system in the state, January 28.

“This vote offers California the chance to chart a new course for the nation,” California Nurses Association/National Nurses Organizing Committee Co-president Geri Jenkins, RN, said of the bill’s passage. “People will pay less, and no longer be denied care based on their income, age, location, or pre-existing health conditions.”

California is just one of several states currently considering legislation establishing single-payer healthcare, where care is publicly funded and privately delivered, and everyone is covered. With prospects for meaningful change at the national level ever-slimmer, nurses and other single-payer advocates are shifting their focus to the states, aiming to convert the public’s widespread sympathy for universal coverage into a political movement that can win real gains now.

In Pennsylvania, a broad coalition is lining up behind Medicare for all...including moderate Republicans who see it as the best way to contain costs and improve care. At a recent state senate hearing, several Republicans joined Pennsylvania Association of Staff Nurses and Allied Professionals President Patricia Eakin, RN, in testifying in favor of a single-payer bill.

“A healthcare system dependent on the business community to provide is not sustainable,” said David Steil, a former Republican legislator who owns a small manufacturing company. “We are not always good negotiators in deriving the best and most economical healthcare plan for our employees. The fact that SB 400 relieves business of these responsibilities is a major benefit.”

Dwight Michael, a Republican physician, decried the amount of hours he and other doctors have to spend dealing with insurance industry paperwork. “This bill truly will give us more time to see patients,” he said.

Maine nurses are campaigning to set up a legislative commission to enact Medicare for all—an initiative approved by voters years ago but never implemented.

Single-payer bills are also making their way through state legislatures in Minnesota and Illinois. In Arizona, nurses are fervently opposing an insurance-industry ballot proposition that would make single-payer illegal in the state.

While Medicare for all faces intense opposition from the healthcare industry and its backers in government, it enjoys widespread and consistent public support. Most recent polls show close to two-thirds of Americans think the government should pay for a plan that covers everyone.

Opponents of single-payer initiatives cite the budget crises facing many states. But a Medicare for all system could actually provide new revenue streams for states by reclaiming healthcare dollars that currently go into insurance industry coffers.

“We spend $200 billion annually on healthcare in California,” state Senator Mark Leno, SB 810’s sponsor, said during a floor debate on the bill. “What this bill does is it takes that $200 billion and puts it into a scheme that will make better use of those dollars, removing this administrative waste that we currently have.”

SB 810 now must go before the California Assembly, which has passed similar bills in the past. While Governor Schwarzenegger has threatened to veto the bill, Californians’ broad support for single payer leaves open several options for securing its enactment, including a ballot proposition sponsored by the legislature.

Michael Lighty, director of public policy for National Nurses United, said a key factor in passing Medicare for all will be building coalitions among nurses, other labor unions, and small businesses.

NNU will also focus on consolidating support for single payer among liberal organizations that officially back such a system but failed to advocate aggressively for it during Congressional debates.

“Our message to those groups is, you tried something you thought was politically viable and it failed,” said Lighty. “We have to go back to single payer because nurses know it’s what works, and we have to fight for it.” —Felicia Mello
Minnesota Nurses Gear Up for Major Contract Negotiations

MINNESOTA

Twelve thousand nurses in the Twin Cities and 4,000 more across the state will determine their workplace conditions for the next three years as they sit down to contract talks in the coming months with 32 different hospital systems.

Surveys completed early this year reveal a tightly unified membership eager to defend their nursing practice and advance the safety of patients in their care.

The Twin Cities pension is especially valued by Metro nurses. The Minnesota Nurses Association negotiated this defined-benefit plan in 1962 as the first multi-employer pension agreement for nurses in the nation. Unlike 401(k) plans, a defined-benefit plan pays out the same set amount to retirees regardless of stock market performance.

Employers have sent multiple signals they intend to seek concessions in negotiations, specifically targeting the pension plan. But each announcement only intensifies nurse solidarity.

“People couldn’t find a pen fast enough when we asked them to sign a petition (of support for the pension),” said MNA Pension Negotiations Committee Chair, Kristen Schneider. She went on to point out that the benefit is essential to keep nurses at the bedside in the face of a nurse shortage looming by the end of the decade.

The eve of bargaining for the pension comes on the heels of a Minneapolis Star Tribune report that Minnesota’s hospitals are enjoying substantial profits (on top of impressive reserve balances) and CEOs are still receiving lucrative compensation packages. Twin Cities hospitals earned $327 million in profits in the first three quarters of 2009 alone, while laying off nearly 1750 employees. The CEO of Allina, parent company of the Twin Cities’ largest hospital, Abbott Northwestern, saw his salary increase over 37 percent from 2008 to 2009, to $1.74 million.

“Over the years, we have given up pay and other benefits to get the pension where it is,” said MNA President Linda Hamilton. “The stock market was such that it didn’t cost hospitals much money. Now that the stock market went south, they have to start putting money in and they’re crying foul. The question is, who’s taking the risk, is it us or is it them?”

Besides protecting pensions, ensuring safe staffing is a major goal, Hamilton said. Twin Cities hospitals have been consistently increasing the number of patients assigned to nurses, using staffing grids that don’t take into account how sick patients are, she said. Current contract language allows nurses to close a unit to new patients if they don’t have the staff to safely care for them; hospital management claims the provision imposes an unfair burden on them, while nurses want to strengthen it.

The nurses also want to preserve their health benefits against management demands for cost-sharing, and clearly define which work must be performed by a registered nurse.
“Hospitals want to use a lot more assis-
tive personnel to do nursing work,” said
Hamilton. “The patient ends up with piece-
meal care.”

Contracts for 14 hospitals in the Twin
Cities come due on May 31; seven in north-
east Minnesota (including the Duluth area)
expire on June 30. Additional bargaining
units scattered throughout the state will
have their contracts expire at various times
this year. In all, the year’s contract negotia-
tions will affect 80 percent of the MNA’s
membership.

With hospitals spooked by potential cuts
in state aid and seeking to pass
those costs on
to nurses—and
nurses equally
determined to
defend themselves and their patients—
it’s clear that a major battle is brewing
in the state.

The nurses are preparing for negotiations
by holding citywide all-nurse meetings and
workshops on the pension benefit. MNA is
strengthening ties with community organi-
zations through its campaign against cuts to
state medical benefits that target Minneso-
ta’s poorest residents.

Support from nurses in other parts of the
country will greatly solidify MNA’s position,
said Hamilton. “The employers are negotiat-
ing on a national basis and setting their
agenda, and we need to do that, too.”

The Twin Cities are the site of the
nation’s largest mass nursing strike
in 1984, when 6,000 nurses walked the
picket lines to defend seniority rights.

—Jan Rabbers
Registered nurses at Mountain-View Hospital in Las Vegas, Nevada voted overwhelmingly to join the California Nurses Association/National Nurses Organizing Committee in January. The 61 percent vote marked the first organizing victory since nurses across the country came together to form National Nurses United, the RN super-union, last year.

“I am so excited. It is a victory for patients, patient safety, and for us, the nurses. We have our voice at last,” said Alta Meyer, an intensive care RN at Mountain-View.

CNA/NNOC will represent over 400 RNs at the hospital, which is owned by HCA, the largest private hospital corporation in the world.

“This election should provide tremendous encouragement to HCA and other nurses across our nation who also long for representation to enhance patient care conditions and advance standards for their colleagues, their families and the nursing profession,” said Malinda Markowitz, an HCA nurse and NNU board member.

Nurses from other HCA hospitals, as well as nurses from other Nevada hospitals represented by CNA/NNOC, supported the MountainView nurses in their campaign. With the election victory, nurses at five Nevada hospitals are now NNU members.

The MountainView nurses have formed a bargaining council, are preparing to negotiate their first contract and will elect a bargaining team February 26. Their goals include a secure retirement plan for RNs, a fair grievance procedure, safe patient lift teams, guaranteed meal periods and breaks, and minimum nurse-to-patient staffing ratios to ensure safe patient care.

Organizing new nurses is a top priority for NNU. NNU Co-President Jean Ross, RN welcomed MountainView nurses as new members of NNU, “who will be a vital part of our national campaign to change the face of patient care, and assist the ability of all RNs to promote a better life for themselves and their patients.”

“We are thrilled to be part of the national nurses movement and we’ll be looking forward to helping other nurses come on board,” said Nenita Garcia, a medical-surgical nurse at MountainView. —Staff Report
Massachusetts Nurses Take On Workplace Violence

Jennifer Fitzgerald, RN, was coming out of a supply closet at her job in a Massachusetts psychiatric hospital one day when a patient charged around the corner, grabbed her hair, pulled her under a desk and started kicking her.

“My reaction was just to hold my head. I couldn’t believe she was so strong,” Fitzgerald recounted at a recent hearing of the state legislature on workplace violence against nurses.

“That is how fast someone can turn violent on you—for no reason, I was just in the way.”

The hearing was called to address one of the handful of emergency nurses report experiencing physical violence on the job, including being “spit on,” “hit,” “pushed or shoved,” “scratched,” and “kicked,” with one in four experiencing such violence more than 20 times in the past three years. In Massachusetts, a 2004 survey found that 50 percent of nurses had been punched on the job at least once in the last two years.

“Workplace violence is an issue that is becoming a growing concern among an increasing number of healthcare professionals,” says Christine Pontus, RN, associate director of health and safety for the MNA. “It used to be considered a part of the job. But that is no longer the case.”

The MNA established a special task force on workplace violence ten years ago, after hearing reports from members that they were attacked on the job and received little or no support from their employers.

The task force was charged with assisting nurses injured by violence, researching the extent of the problem, and developing contract language and a position statement for nurses to use when confronting their employers about violence prevention. It developed a comprehensive package of bills designed to address violence prevention in healthcare settings. SB 988 would require health care employers to perform an annual risk assessment and implement violence prevention programs based on those findings. HB 1696/SB 1753 would enhance penalties for patients who assault nurses and healthcare professionals. Finally, HB 1931 would create a “Difficult to Manage” unit for potentially dangerous patients within the Department of Mental Health.

All three bills have been heard by the legislative committee to which they were assigned, and the assault bill has been released by its committee and is awaiting a vote to be scheduled.

“It takes management commitment and follow-up to have good policies and procedures in place and that’s what we hope to achieve through these bills,” said Pontus.

The MNA is holding a Workplace Violence Lobby Day at the Massachusetts State House on March 31, where hundreds of nurses will flood the building and lobby for passage of the measures. The theme: “A nurse is not a punching bag.”

Task force members have also worked with the judicial system to educate court officers and prosecutors that violence is not part of a nurse’s job. Numerous MNA bargaining units have negotiated language requiring employers to work with nurses to prevent workplace violence, and the MNA has generated extensive state, local and national media attention to the issue.

As a result of MNA’s advocacy, Massachusetts Essex County District Attorney Jonathan Blodgett supported an MNA member who had been viciously assaulted on the job and helped put the perpetrator behind bars. Blodgett also testified at the legislative hearing, saying, “I had a mother who was a nurse for 35 years. To be spit at, punched, kicked and treated with that kind of disrespect in a healthcare setting is just not something we should tolerate.”

Kathy Gill, RN, would agree. The emergency room nurse at Boston’s Faulkner Hospital was punched by a patient two years ago. After his blood splashed into her wound, she feared being exposed to HIV or other contagious diseases.

“I go to work, I give 150 percent to all my patients, and I got nothing in return,” Gill testified at the hearing. “I received absolutely no support from hospital administration. Under no circumstances does a patient ever, ever have the right to put a hand on a nurse.”

For more information about MNA’s activities related to workplace violence, visit http://www.massnurses.org/health-and-safety/workplace-violence. —David Schildmeier
They came expecting to hear about nurses and their desire to provide safe patient care. What state legislators got was a bitter dose of reality about what constitutes patient care in Michigan hospitals.

The Michigan Nurses Association is helping hold a series of Town Hall meetings across Michigan this year to put nurses face to face with their legislators and educate lawmakers about MNA-supported legislation that would eliminate mandatory overtime and establish minimum safe staffing levels in hospitals.

At each meeting, Representatives have been visibly taken aback as nurses share horrific stories about what life is like in their workplaces.

Twelve neurological patients: one nurse.
Eight to 10 newborn babies: one nurse.
Three wings of a large nursing home: one nurse.

“The bottom line is more important than the nurses,” Karen Amato, RN, a former nurse at the Detroit Medical Center (DMC) commented at a Detroit meeting with Representative Coleman A. Young II (D-4). “My hospital does minimal recruitment and obviously they do no retention because who wants to stay and work in that?”

“You work 16 hours, seven days a week,” Renae Matthews, a DMC nurse, shared. “How effective are you going to be?”

“We have patients that I’m begging the family members, who are exhausted, to stay so that their family member is safe,” said oncology nurse Theresa Cabras. “I don’t want to do that. But I have to. ”

“How some patients make it through the night—alive—it’s a miracle,” added Chris Sherlock, a medical/surgical nurse.

Elise Lett, RN, a faculty advisor at Everest College, explained that students were routinely counted as part of the nursing staff census in local hospitals. “This is a disservice to the patients and to the students,” she said. “It discourages them to think this is the way they’re going to have to work when they become RNs. We’re never going to keep a supply of nurses unless something is changed.”

“Nurses are becoming like professional athletes,” said Dr. David Green, an officer of the Michigan Universal Health Care Access Network. “They have an effective span of 10 to 20 years, then the physical labor, burnout and stress from minimum nurse staffing takes its toll. You can’t trust hospital administrators to do what’s in the best interest of patients.”

At a recent meeting in Kalamazoo, the issue of minimal staffing hit close to home as the nurses at Borgess Health, represented by MNA, are in the midst of bitter contract negotiations, much of which are focused on appropriate staffing levels.

“I go home crying, many, many, many days,” Kari Kitzmiller, a medical/surgical nurse from Borgess Health, told legislators. “I don’t go home crying because of my 12 hour shift. I don’t go home crying because of the tasks I have to do. I go home crying because I worry that I’m potentially harming somebody for not being adequately able to take care of them. It’s not safe.”

Along with eliminating mandatory overtime, HB 4008, the Safe Patient Care legislation, would require that every hospital have minimum, safe nurse-to-patient ratios for each department. Suggested by Representative Lesia Liss, RN (D-28), the bill has been assigned to the Committee on Health Policy.

At the end of the Detroit meeting, Rep. Young was eager to speak with the Michigan Speaker of the House and urge him to get HB 4008 out of committee and onto the floor. “Ask him if a nurse will be available when he or his loved ones need one!” advised one RN. —Ann Kettering Sincox
WRAP-UP REPORT

Arizona
After a year-and-a-half-long fight, Alison McLeod, RN, has won a settlement from a hospital that terminated her unfairly and has donated a significant amount of the funds to National Nurses United.

“Floating and unsafe staffing were issues I brought up at the Arizona hospital where I worked for eleven years,” McLeod writes.

“Ultimately I was fired after reporting a physician who hit me with a medical device - although the excuse administration used was that I advocated for a patient too sick to speak for herself. By terminating me, my hospital sought to send a message to any other RN who might dare to speak up. Instead, they created a determined nurse activist.”

“I’m donating to NNU because I want to give back to the professional organization which supported me and will work toward making sure that what happened to me does not happen to another nurse.”

Kentucky
Southern United Nurses is working to defend RNs targeted for retaliation by Appalachian Regional Hospital management in the aftermath of a 2007 strike over patient care conditions. Four nurses had disciplinary action taken against them for misconduct following the strike at the rural Kentucky hospital system, three were suspended and one was discharged. SUN has won reinstatement for the nurse who was dismissed, but the hospital is refusing to pay the nurse lost time.

Meanwhile, SUN negotiated the right of return for all nurses that went out on strike and continues to file grievances over favoritism towards the replacement nurses and the nurses that did not honor the picket lines, who were given preference in jobs and shift assignments.

Ohio
In their first action of 2010, Ohio nurses expanded their campaign around nurse-to-patient ratios by issuing a press release criticizing a State Health Department website, Ohio Hospital Compare, which allows consumers to compare Ohio hospitals to each other according to a series of quality indicators. The website provides no information about nurse and hospital worker staffing levels, the nurses pointed out, thereby providing limited and inadequate information to patients and their families concerning the chances of surviving a hospitalization.

Cleveland Metro Committee member Michelle Mahon wrote an Opinion piece which was published on www.MedCityNews.com concerning Ohio Hospital Compare.

As a result, the Health Department invited nurses to provide testimony about

“All the replacement workers are now members of the union. And some of them have discovered how important the union can be when they have received an unfair disciplinary action. SUN is now standing in solidarity with members of the United Steelworkers who are also entering into negotiations with this very anti-union hospital system in one of the poorest areas of the country.

Kentucky RNs formed SUN as an independent union in the wake of the strike, after the Kentucky Nurses Association decided that it would no longer support a collective bargaining division.

California
The California Nurses Association/National Nurses Organizing Committee is supporting several bills in the 2010 state legislative session to advance nursing practice and promote safe patient care.

California RNs and patients won a major victory when the state senate passed SB 810, which would establish a single-payer Medicare for all system in the state, in early February; a similar bill is making its way through the Assembly.

Assemblywoman Nancy Skinner has reintroduced AB 1994, which recognizes that nurses are vulnerable to occupational injuries like MRSA infection and back problems and provides them with the same presumed eligibility for workers’ compensation enjoyed by firefighters and others with dangerous jobs. SB 360 would require

“Smart Rooms” a Dumb Idea, Say California Nurses

The California Nurses Association/National Nurses Organizing Committee has forced the withdrawal of a dangerous bill that would have allowed hospitals to circumvent California’s groundbreaking safe staffing law by housing patients in so-called “smart rooms,” where beds would have different acuity labels depending on which patient was in them. Critically ill patients, for example, would have been scattered throughout different units rather than grouped together in a dedicated ICU. Nurses bombarded legislators with emails explaining that the proposal would undermine nursing practice, put patients in jeopardy and rob nurses of the ability to specialize.

“As nurses go into their respective areas of expertise based on what they are called to do,” said Bonnie Castillo, RN, CNA/NNOC Director of Government Relations. “Besides being unsafe, this bill would have allowed legislators and administrators to tell nurses where and how they are going to practice.”
the website in the state capitol March 12, and informed NNOC that hospitals might be required to report staffing ratios in the future.

**Pennsylvania**

In December, Pennsylvania’s State Senate held a historic first hearing on a bill that would establish a state-based single-payer healthcare system. The hearing was historic in part because it was held by a Republican, Senator Don White, a former insurance broker. As he said at the hearing, “there were those who said I should not have this hearing”, but he believed it was a “positive” hearing and that it should be the beginning of a series.

Pennsylvania Association of Staff Nurses and Allied Professionals union president and ER nurse, Patricia Eakin testified at the hearing about the health problems she sees in the ER in patients who lack insurance as well as the excess spending by the hospital on billing and administration. Others who testified in favor of single payer included two Republicans, one a business owner who said that the cost of health care has made his business uncompetitive and the other a doctor who argued that he spends less time with patients because so much of his time is spent wrangling with 20 different insurance plans with different rules.

Pennsylvania is a key state in the fight for single-payer healthcare as there is a robust grassroots movement in the state. There is also support by both Democrats and Republicans and a Governor who had previously committed to sign onto single-payer legislation. While continuing to support a national single-payer healthcare bill, the nurses of PASNAP will continue to play a role in Pennsylvania’s fight for guaranteed healthcare.

**Texas**

Members of National Nurses Organizing Committee Texas have mobilized to support a nurse who faced criminal charges for blowing the whistle on a doctor who she believed posed a threat to patients at her hospital.

In a surreal case of Wild West justice, Anne Mitchell, RN, was arrested by the sheriff in Kermit, TX (population 5200) last year after making what she thought was a confidential report to the Texas Medical Board. The sheriff, a former patient and friend of the doctor in question, charged Mitchell with misuse of official information, a third-degree felony that could have carried a 10-year prison sentence.

NNOC Texas collected over 100 signatures from Texas RNs on a petition urging the state’s attorney general to intervene in the case. Mitchell was acquitted February 11.

NNOC Texas nurses say the case illustrates the need for the whistle-blower protection law they will introduce in the Texas legislature in 2011, as well as a federal bill sponsored by National Nurses United that would protect nurses nationwide who speak out for patients.

“As nurses we have an obligation to report any type of medical breach or misconduct and that’s what these nurses did,” said Gwen Agbatekwe, RN, an NNOC Texas member who attended Mitchell’s trial. “With whistle-blower protection, this scenario would never have gone any farther than the Texas Medical Board.”

**Veterans Affairs Council**

National Veterans Affairs Council RNs voted by an overwhelming majority in February to endorse the organization’s affiliation with National Nurses United and transfer collective bargaining rights to the new organization.

VA nurses are working to repeal a federal law forbidding them from bargaining with the government over compensation, competency, peer review or professional conduct. Though there are loopholes in the statute, the VA has often used it to avoid negotiating with nurses over matters from accidental needle sticks to medical equipment sterilization. The Veterans Affairs Council along with other unions representing VA workers plans to have a joint meeting with the VA in late February to discuss the issue.
When the ground shook in Haiti in mid-January, the tremors went far beyond that long troubled island nation, with reverberations to the north that remind us of the incredible humanitarian spirit, generosity, and dedication that define what it means to be a registered nurse.

Just hours after we posted notices on our National Nurses United website, offers to help came pouring in from nurses across the nation, and even in other countries. A few dozen, then hundreds, then thousands.

Within two weeks more than 13,500 RNs had volunteered for the relief mission through NNU’s Registered Nurse Relief Network, along with several hundred other medical personnel. More than 1,500 of them joined a national conference call we convened.

They offered to take time off work, without pay, for weeks at a time, despite the repeated reports about appalling conditions on the ground. For a mission that we know will go on for months.

Donations also began arriving, in small and large sums, to help pay for travel costs and medical supplies for the volunteers. The brilliant Emmy-award-winning actor James Gandolfini magnanimously recorded a TV and radio ad for us to help generate contributions. Legislators, students, business people, nurses contacted us—most asking that their contributions be anonymous, saying they just wanted to help.

The need is almost unimaginable. Even prior to the present nightmare, conditions in Haiti were catastrophic—the poorest country in the Western Hemisphere, massive problems with nutrition, infant mortality, HIV infection, tuberculosis, unsafe drinking water. If that weren’t enough, mix in a debilitating history of hurricanes and other natural disasters and political strife.

And now this. A death toll of 150,000 according to the Haitian government, another 700,000 with traumatic injuries, 1 million or more homeless. An infrastructure, including hospitals, clinics, schools, and the government, in tatters. And a worsening health emergency.

A bulletin from Doctors Without Borders spelled out just a few of the concerns: widespread infections, an outbreak of tetanus for which there is no cure, growing alarm over water-borne diseases, a particular threat to children, and an overall “elevated risk of disease outbreaks.” Low vaccination rates also mean diseases like measles can cause “many deaths and much sickness with children under five being most vulnerable.”

Overall, they conclude, “a lot of the infrastructure that keeps infections at bay has been disrupted or destroyed—shelter, water, food. Secondly, the population’s health has been greatly weakened. So not only are you more likely to become ill, but the illness is more likely to be severe.”

It’s within that context that we have witnessed an unparalleled, astounding response by dedicated RNs volunteering to participate in the relief effort—rushing off for the battery of shots and pills they need, pressing their colleagues to sign up, donating funds and getting family members to contribute, and then beating down our doors wanting to get on the planes and ships headed to Haiti.

These are nurses willing to fly into the face of disaster. As Patricia Taylor, a Chicago operating room nurse, said as she prepared to deploy with other RNRN/NNU volunteers aboard the Navy ship USNS Comfort, “I thought it was devastating and how frightened the people must be. I kept thinking about how I would feel if I was there, and praying for them not to lose hope. I was raised to help people that need help. It was nothing heroic, just plain common decency.”

Some nurses, including NNU members, have also gone to Haiti through other, mostly private organizations.

Each nurse volunteer could serve as an emblem for the quiet heroism of what it means to be a nurse. As a quote floating around the internet from Lexie Saige puts it, “A nurse is compassion in scrubs.”

Read the stories of many of these heroic RNs on our special web page, www.RNheroes.org.

With NNU, we have a perfect match for those compassionate women and men in scrubs: a powerful national organization of direct-care RNs, able to rally thousands of nurses to utilize their unique, professional expertise to help people most in need, and mobilize the resources needed to support them.

Rose Ann DeMoro is executive director of National Nurses United.
United We Stand

Only two months old, the largest RN organization in United States history is already changing the face of nursing. By Felicia Mello

It may have taken more than a century for direct-care nurses to form their own national union. But the 150,000-member National Nurses United is wasting no time getting to work on an ambitious patient-advocacy agenda.

NNU “will transform the face of healthcare and nursing, rattle the windows in all those fancy hospital corporate boardrooms, and shake the halls of Congress and our state legislatures,” NNU co-president Deborah Burger, RN, told nurses gathered in Phoenix in December for the organization’s founding convention.

In the months since the convention, National Nurses United—formed by combining the California Nurses Association/National Nurses Organizing Committee, the Massachusetts Nurses Association and United American Nurses—has won its first organizing cam-
paign, coordinated a major international disaster relief effort, and launched a state-by-state campaign to win free, quality healthcare for every American. The successes signal a new era in nursing, in which RNs flex their collective muscle to transform the healthcare system, not just within individual hospital chains or regions, but nationwide.

The strength of that collaboration quickly became clear in January, when a catastrophic earthquake rocked Haiti, killing tens of thousands of that country’s residents and toppling hospitals and nursing schools. NNU put out a nationwide call for help and within hours, thousands of nurses had volunteered for an emergency nursing mission to care for earthquake victims. Members of the public responded to NNU’s ‘Send a Nurse to Haiti’ campaign with over tens of thousands of dollars in donations to pay for nurses’ travel and supplies. As the official voice of registered nurses in Washington, NNU worked with the White House and international governments to arrange transportation for the nurses and ensure their security in the field.

Having the backing of a national organization is proving equally important in negotiating contracts that address nurses’ day-to-day concerns on the job.

As 12,000 nurses in Minnesota’s Twin Cities region gear up for collective bargaining with the area’s hospitals this spring, they know their fight to protect their pension benefits is part of a larger NNU campaign to ensure a secure retirement for all nurses.

The Minnesota nurses will use their NNU ties to research contract language that has proven effective in other areas of the country, and to turn out large numbers of nurses for mass rallies and events, said Minnesota Nurses Association President Linda Hamilton, RN, an NNU vice president. “Our employers will know that they’re not only dealing with nurses in the Twin Cities, that this is on a much larger scale.”

Meanwhile, forming NNU has allowed nurses to speak with a single voice in the most pivotal national conversation since President Obama took office: the debate over how to overhaul the country’s healthcare system. As federal lawmakers haggled over the details of a weak healthcare-reform bill, NNU leaders took to the airwaves. They pointed out how the proposed legislation left the power of the insurance companies intact, and urged Congress to close loopholes that would allow insurers to continue denying coverage to sick patients and charging exorbitant premiums. Media outlets that had rarely interviewed nurses on healthcare reform soon began calling.

NNU is now building on that momentum to pass ‘Medicare-for-All’ laws in every state that will ensure universal health coverage,

Donna Stern, RN, Massachusetts
“We need to have a voice on every level: local, state and national.”

Fong Chuu, RN, California
“I am looking forward to standardizing nursing practice for the whole country so everyone would have the same nurse-to-patient ratios, and we won’t be afraid of speaking up.”

NNU members and their allies march in support of single-payer legislation in California (left). NNU’s newest members at MountainView Hospital in Nevada pose following their unionization victory (top right).
regardless of what happens at the federal level. NNU board members met in late January to coordinate those efforts and share strategies, from phone-banking seniors to holding rallies at state capitols.

“In this country, in order to move real, true healthcare reform, it’s got to be all of us together, and it’s got to start with the nurses, because only nurses know how it needs to be done,” NNU co-president Jean Ross, RN, told nurses at the December convention.

A unified nurse perspective on national health policy “could have a very big effect,” said Sue Hassmiller, senior adviser for nursing at the Robert Wood Johnson Foundation, a healthcare think tank. “Patient care is at stake and when you have people like lawyers and policymakers at the table, not to have the voice of nursing is a real missed opportunity,” she said. “If there are one or two issues that policymakers at the table, not to have the voice of nursing is a real missed opportunity,” she said. “If there are one or two issues that nurses can really put their arms around and say this is what we stand for, that can go a long way.”

At the convention, NNU co-president Karen Higgins, RN of Massachusetts laid out a vision of a progressive nurses movement that can not only advocate on healthcare issues, but “stand shoulder to shoulder with other working people and American families for genuine social progress in our nation, to refuse to accept wide-spread joblessness, or hunger or poverty. As registered nurses we see every day the consequences of the economic crisis, the inequality, the disparities in wealth that are surely as destructive as a global pandemic.”

Many RNs who attended the convention said they’d been waiting their entire career for nurses to work together nationally. For two days, the event—part celebration, part business meeting—was punctuated with tears of joy.

“I’ve been a nurse for 34 years and I’ve represented nurses in contract negotiations and I always felt something was missing,” said RN Kris Michaelson of Michigan. “I needed more to feel I’d really accomplished something. And this is it. This is the legacy we pass on for nurses, for the women in this country. We are finally coming into our own.”

Besides electing Higgins, Burger and Ross as co-presidents, delegates to the convention named an executive director, Rose Ann DeMoro, the current CNA/NNOC executive director and one of the nation’s most prominent voices on labor and healthcare. They heard from Canadian Federation of Nurses Unions president Linda Silas, RN about nurse organizing in Canada, and from retired nurses and nursing students about their experiences and their vision for the future of nursing.

The convention was the culmination of years of struggle by direct-care nurses to take control of their practice, their organizations and their profession. Twenty years ago, most RNs were members of the American Nurses Association, a professional group controlled by nurse managers who weren’t involved in day-to-day patient care and often put hospital profits before the needs of patients. But as hospitals across the country started cutting costs and laying off nurses in the 1980s and 1990s, nurses realized they needed to work aggressively and independently to protect them-

FAQ on NNU

Why do nurses need a national RN super-union? Today’s nurses practice in a healthcare system in crisis. Employers are reducing RN staffing and benefits, affecting nurses’ ability to protect their patients. Meanwhile, an estimated 45,000 Americans die each year because they lack health insurance. With economic changes and new legislation promising to reshape the industry, RNs need a strong, united voice to effectively represent the interests of nurses and patients. National Nurses United will protect and enhance the gains in wages, pension and health benefits, and safe working conditions that nurses have made through collective bargaining, organizing unrepresented nurses to spread those

achievements across the country. We will advocate for a single, excellent standard of healthcare for every American, regardless of ability to pay; win national patient-protection laws such as safe-staffing ratios and an end to mandatory overtime; and take back our profession so that every RN can advocate for patients without fear of retribution.

Where do NNU members work? National Nurses United represents 150,000 nurses across the country, from California to Maine. Most NNU members work in acute-care hospitals, but many also practice in clinics, skilled nursing facilities, schools, and home health—anywhere and everywhere that patients need care. National Nurses United has set up divisions so that RNs who work in similar environments—such as Catholic hospitals and university medical centers—can collaborate on shared concerns and goals.

How is National Nurses United governed? National Nurses United is a democratic organization run by and for direct-care RNs. Every two years, members gather at a national convention and elect a board of directors—all working direct-care nurses—to guide the organization. The board then elects a council of presidents who share responsibility for the day-to-day business of the organization; this year they
selves and their patients. First California nurses, then nurses in Massachusetts and other states, left the American Nurses Association and founded new organizations dedicated to representing nurses in collective bargaining, organizing new nurses and ensuring affordable, high-quality healthcare for all. National Nurses United finally brings together those state-based groups into one union.

“This is a quantum leap for nurses, and to an outside observer it might seem like oh, this just happened,” said Martha Kuhl, RN of California, a longtime nurse activist who was elected NNU Secretary-Treasurer at the convention. “But it took years of conversations and consensus-building and outreach to get here.”

Kuhl said the biggest share of NNU’s funds will go towards organizing, to strengthen the national RN movement. About 20 percent of nurses nationwide are union members. That’s higher than the average for private-sector employees, but still leaves more than three-quarters of RNs with little protection when they speak out for their patients.

“Our numbers here today form the front line of a great movement, one with unlimited potential and opportunity,” Burger said in a convention speech. “Today we represent 150,000 RNs, but there are tens of thousands of other direct-care RNs who can, should, and will one day be with us.”

Another top priority will be passing national legislation that will make hospitals safer for nurses and patients—including setting nurse-to-patient staffing ratios, banning mandatory overtime, and protecting nurses who expose dangerous conditions at their hospitals.

National Nurses United will also set up divisions of nurses who work in similar settings—such as children’s hospitals or universities—so they can share experiences and strategies.

Nurses at HCA’s MountainView Hospital in Nevada, who won an organizing campaign with NNU in January—the first election victory since the formation of the super-union—said they have already experienced the benefits of being part of a national RN union. “We had HCA nurses from around the country standing with us throughout our campaign,” said Nenita Garcia, RN. “Their support, education and solidarity really made a difference.”

Christopher Williams, RN, Texas
“This is a phenomenal feeling, to be right here in the midst of all these nurses who want to change the world.”

Kris Michaelson, RN, Michigan
“I’ve been a nurse for 34 years and I’ve represented nurses in contract negotiations and I always felt something was missing. NNU is it. This is the legacy we pass on for nurses, for the women in this country.”

include Deborah Burger, RN (California), Karen Higgins, RN (Massachusetts) and Jean Ross, RN (Minnesota). The board also appoints an executive director, currently Rose Ann DeMoro.

So, is National Nurses United a professional organization or a union? National Nurses United is both a professional organization and a union. Through education and legislative advocacy, National Nurses United helps nurses improve their practice and have a greater voice in decisions that affect patient safety. And by representing nurses in collective bargaining and organizing new nurses on the job, NNU ensures that all nurses have the staffing standards and benefits they need to provide excellent patient care and attract new RNs to the profession.

My organization hasn’t yet affiliated to National Nurses United, or is debating about joining. What’s going on? When registered nurses around the country decided to take the bold step of forming a new national nurse organization, they faced opposition from forces in the healthcare industry who were afraid of the collective power such a large and united RN organization would wield. Some of that opposition has come from within state nursing organizations, which some believe should continue to be controlled by nurse executives the way they were in the 1980s, rather than by the staff nurses who actually provide care. National Nurses United is committed to organizing direct-care RNs in any state who want to have a voice at work and within their professional organizations. If you have any questions about NNU organizing in your state, please contact your local NNU office.

I just became a National Nurses United member. How can I get more involved? Visit www.NationalNursesUnited.org. You can also follow NNU on Twitter at @NationalNurses. And you can send story ideas to National Nurse at nationalnurse@nationalnursesunited.org.
Meet NNU’s National Officers

Fearless Leaders

The four RNs leading National Nurses United bring to the table decades of experience as nurses and patient advocates in the West, Midwest and East...and a good-sized dose of courage. Elected at NNU’s founding convention in December, each national officer will serve a two-year term. Here’s your chance to get to know them.

Deborah Burger, RN

CO-PRESIDENT

Deborah Burger, RN doesn’t like to talk about herself. The three-term president of the California Nurses Association/National Nurses Organizing Committee prefers to praise others who have helped turn CNA/NNOC into one of the most dynamic labor unions in the country and Burger into a respected nurse leader. She mentions the dedicated members, the experienced RNs who mentored her along the way—and yes, her husband, for holding down the fort at home while Burger was taking on California Gov. Arnold Schwarzenegger and the nation’s healthcare corporations in her quest for safe patient care.

“The heroes in my life are the ones who are out there working to make life better for people, instead of lining their pockets like a lot of politicians are,” Burger says.

Burger’s own commitment to nurse activism began with a tragedy. Leaving work after pulling a double shift one day in 1984, Burger called her first husband to let him know that she was on her way home. At the time he sounded fine, Burger recalls, but when she arrived at their house, she found him unconscious on the living room floor, the victim of a heart attack that would take his life.

“It was one of those experiences that change your world view in terms of what your priorities are and how fast things can happen,” she says now. “You realize that you have to make the best of life, and you stop taking things for granted.”

When Burger’s employer refused to grant her leave time to settle her husband’s estate, she decided to fight. After winning the time off with the help of her labor representative, she was asked by CNA/NNOC leaders to take a seat on the organization’s collective bargaining commission—a role that led to other positions as treasurer, vice-president and finally, president and co-president.

“Deborah is very committed to what she believes in and to the cause of nursing,” said Geri Jenkins, RN, CNA/NNOC co-president and vice president of National Nurses United. “She always puts the interests of nurses first in everything she does, and she has a great institutional memory of who we are, where we’ve come from, and where we’re going.”

Burger saw the need for mandatory RN-to-patient staffing ratios early on and became a leader in that campaign, even though she was working in a clinic at Kaiser Permanente, not an inpatient setting, and wouldn’t be directly impacted. “I understood that in the long run ratios would affect all of us, both as nurses and as patients,” she says.

She credits the democratic leadership structures in CNA/NNOC and NNU (all leaders are working nurses involved in their profession and union activities) with keeping her energized and engaged over the years.

“Just because you have a title doesn’t mean you are aloof and away from the action,” she says. “You’re not just hanging out waiting for things to happen, you’re making things happen.”

Making time for simple pleasures like roasting her own coffee beans and making her own jam helps, too.

Burger’s colleagues on the CNA/NNOC board say she helps keep them on track and focused during a busy time for the national nurses’ movement, with the formation of National Nurses United, contract negotiations on the horizon, and a relief effort in Haiti to coordinate.

During the founding of NNU, Jenkins says, Burger “played a pivotal role because of the relationships she developed over the years with people, the understanding she had of everyone’s issues and what we were going to do to fix the problems in our profession.”

Burger says she was impressed, as she and her nurse colleagues from the California Nurses Association/National Nurses Organizing Committee, Massachusetts Nurses Association and United American Nurses gathered last spring to plan NNU’s founding convention, at how smoothly everyone worked together.

“It’s kind of like when you have a friend that you haven’t seen in 10 years, you think that when you see them again they will have
Karen Higgins, RN

A s a 35-YEaR vEnTER of critical care nursing, Karen Higgins, RN knows intimately the power of nurses’ professional judgment to save lives. She remembers clearly her experience with one particular patient, a young man in his thirties who had been brought to the intensive care unit at Boston Medical Center in Massachusetts with kidney failure and a buildup of fluid around his heart. Doctors were pleased with his progress and ready to discharge him, but Higgins sensed that something was wrong.

“Every time the dialysis nurse attempted to adjust the machine to draw fluid from the patient, his blood pressure would drop,” Higgins recalled. She asked the attending cardiologist to run just one more echocardiogram, which revealed a dramatic deterioration in his condition, and the patient was rushed to surgery. Had he been discharged, Higgins says, he might have died.

Higgins recounted the episode in an essay for a documentary on nursing that aired on National Public Radio in 2007. “Like air traffic controllers, [nurses] watch over our patients making sure they remain safe and don’t crash,” Higgins wrote. “We are the surveillance system for our patients. But as a nurse I not only monitor my patient’s condition—but I am also pilot who delivers complex technological care on a minute by minute basis. As the nurse I am the one person who is responsible for the patient’s survival from the moment he or she comes into my care and making sure that care is continuously tailored to meet the patient’s needs.”

“I love being a nurse and love using my years of experience and skill to care for patients and their families at perhaps the most difficult time of their lives. But the expectations of nurses have become unrealistic. I cannot be in two places at once—and as patients’ medical needs become more complex, I worry that I will not be there at a critical moment to assess a patient in need... I have been my patients’ last line of defense and will continue to be there until I can no longer provide safe care.”

Higgins brings the same sharp instincts and dedication she displays in the ICU to her work as a patient advocate and spokesperson for her profession. During Higgins’ two tenures as Massachusetts Nurses Association president, from 2001-2005, her eloquence and candor made her a favorite of the media, where she has been quoted in dozens of articles about nursing and has been involved in numerous radio and TV talk show debates. Radio and TV talk show producers often called the MNA public relations department frustrated because they were having trouble booking hospital and nursing industry executives who would be willing to go up against her to discuss patient safety issues.

Higgins led the MNA through one of its most successful periods following its disaffiliation from the American Nurses Association in 2001. “MNA has become the organization it is today because of the passionate, unflinching leadership of Karen Higgins,” said current MNA President Donna Kelly-Williams, RN. “And her commitment to MNA’s participation in a national union for frontline nurses has been a driving force in the founding of the NNU.”

Jean Ross, RN

W hen someone confronts Jean Ross, RN with the statement, “We’re not trying to solve world peace, here Jean,” be prepared. You will see the blue eyes flicker and the jaw set. “Yes we are,” she will say. And you will know unequivocally that it’s time to get back to work on thechunk you’re working on, because it all fits into a bigger picture. For Ross, that bigger picture is a better world built on fairness and equity, which she knows will take constant diligence to achieve.

“Some things in life are not fair,” says Ross. “But you can do things to make them fair—and no one can tell me they can’t be changed.”

Ross’s tenacious personality makes her a natural activist—a passion she discovered shortly after beginning her nursing career in the mid-1970s.

“I happen to work in Minnesota, where we are highly unionized through the Minnesota Nurses Association,” she explains. “That
brought me into the labor movement, which instilled in me a core value of social justice.”

An early lesson came when Ross was working as a casual float nurse at Fairview Southdale Hospital in Minnesota’s Twin Cities. A supervisor questioned her about not working weekends, stating that working them was “hospital policy.” Ross pointed out that the nurses’ union contract had no such clause, and that it couldn’t be superseded by hospital policy. The encounter left the supervisor sputtering.

Ross’s bargaining unit chair, Pat Johnson, backed up her claim, and when Jean asked if others knew about this issue, Johnson posed a challenge. “Yes Jean, that’s a problem. How should we let them know?”

“I replied, ‘Well, I’ve just been talking to people, but maybe we should put something into a newsletter,’ and the rest is history,” says Ross. Ross went on to serve as bargaining chair for Fairview for 20 years, was elected to the Minnesota Nurses Association’s Economic and General Welfare Commission and became Treasurer of United American Nurses, among other accomplishments.

As Ross sets her focus on national efforts with National Nurses United, she revels in the fact she gets to act with 150,000 other like-minded people. “We’re moving forward with one agenda that benefits all of us,” says Ross. “This is what unions should be doing, and we are leading the way.”

It is a critical juncture for nurses, one rife with both necessity and opportunity, Ross says. She points to the increasingly concerted efforts of hospital employers to block important initiatives like safe staffing ratios. “They don’t let state lines bother them,” she says. “They’re all putting their resources toward fighting ratios.”

A super-union of nurses is essential to move forward patient-protection measures that can succeed despite this opposition, Ross contends. With National Nurses United, nurses are poised to be a formidable force in setting healthcare policy, she says.

“The profit-based healthcare system is in direct conflict with the needs of our population,” says Ross. “Nurses want to make sure patients are cared for safely and well. I am convinced we will do this together.”

**Profiles**

**Deborah Burger, RN**
- **Facility:** Kaiser Permanente Santa Rosa, California
- **Unit:** Gastroenterology/infusion center
- **Nursing for:** 34 years
- **Astrological sign:** Pisces
- **Nursing pet peeve:** Nurses who know the contract but don’t enforce it and let things slide
- **Favorite work snack:** No longer snacks
- **Recent work accomplishment:** Helping to contact thousands of nurses that volunteered to go to Haiti
- **Color of favorite scrubs:** Royal blue
- **Hobbies:** Gardening, sewing (she recently made a three-foot-high stuffed bear for her niece)
- **Last book read:** _The Great and Secret Show_, by Clive Barker

**Karen Higgins, RN**
- **Facility:** Boston Medical Center, Massachusetts
- **Unit:** Intensive care
- **Nursing for:** 35 years
- **Astrological sign:** Aries
- **Nursing pet peeve:** That the public still does not understand what nurses really do
- **Favorite work snack:** Anything chocolate
- **Recent work accomplishment:** Encouraging fellow nurses to be more involved in union activities
- **Color of favorite scrubs:** Any bright color
- **Hobbies:** Golf
- **Last book read:** _The Killing Game_, by Iris Johansen.
  “Pure enjoyment.”
Martha Kuhl, RN
SECRETARY/TREASURER

If there’s such a thing as a renaissance nurse, Martha Kuhl, RN is it. Ask her what she likes about nursing and she responds with a list of all the intellectual challenges involved in the profession—challenges the insatiably-curious Kuhl has dedicated herself to mastering.

“You’ve got science—medical science, life science, immunology. You’ve got ethics—how you provide care, and who gets it. You can be involved in the greater struggle for social and economic justice as an advocate for your patients. And you can teach and mentor new nurses and help families cope with crises.”

Kuhl’s coworkers at Children’s Hospital in Oakland, California say she excels in all these areas, but where she really shines is in educating others.

“She’s a walking library,” said Violeta Borjas, RN, who works with Kuhl on the hematology/oncology unit. “She knows so much, and her level of confidence is so high. Just by talking to her, you also become confident.”

Kuhl honed that confidence early on in life, as an activist in the feminist and anti-Vietnam War movements. She majored in biology at the University of California at San Diego in the 1970s. But it would be years before she found her way to nursing.

“I kind of resisted being a nurse because it was a woman’s profession, but then I realized I really like doing it,” she says.

When Kuhl joined the California Nurses Association/National Nurses Organizing Committee as a rookie nurse in the 1980s, the organization was led by nurse managers and there were no regular union meetings. Looking for a way to empower herself and other staff nurses, Kuhl brushed up on accounting and got herself elected to the association’s finance committee.

“I thought, we’re paying 97 percent of the dues and they’re complaining about the money,” said Kuhl. “But patient advocacy has become such an important part of nursing that I thought, ‘I need to do something about this.’”

Kuhl describes that confidence early on in life, as an activist in the feminist and anti-Vietnam War movements. She majored in biology at the University of California at San Diego in the 1970s. But it would be years before she found her way to nursing.

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“I thought, we’re paying 97 percent of the dues and they’re controlling the money,” Kuhl recalls. “We can’t implement our policy because we don’t control the funds.”

That experience came in handy when in 1992 staff nurses took over CNA/NNOC, elected Kuhl treasurer, and embarked on an aggressive organizing campaign that would more than quadruple the association’s membership and lead to the passage of the nation’s first-ever law mandating safe staffing in hospitals.

Kuhl is proud that the improvements in patient safety and working conditions that she and other CNA/NNOC nurses achieved have encouraged new nurses to stay in the profession.

“For a while, as an experienced RN you would train new nurses and they would all leave because things were so crazy,” she says. “As staffing has improved, people stay longer and you’re not so overwhelmed yourself, so you can provide more mentoring on the job.”

Kuhl looks forward to her new role as NNU Secretary/Treasurer, where she will ensure that members are well-informed about the organization’s finances, along with keeping records—or, as she says, “documenting history.”

When she isn’t working, gardening, or traveling to Southeast Asia, Kuhl enjoys giving the new-hire talk at her hospital, explaining what it means to be a part of CNA/NNOC, and now National Nurses United.

“I tell them that besides all the economic data that shows workers do better when they’re represented by unions, being in a union means we decide to work together to advance all of our interests as opposed to working as individuals,” she says.

Solidarity might be a difficult concept to get across in a country that prizes individualism. But for Kuhl, the best way to start that discussion is unit by unit, hospital by hospital.

“In American culture, people assume that you just take care of your own—you go to work, you come home, you vote every couple of years and even that is a chore,” she says. “But patient advocacy teaches nurses that they can work in a group to make things better for all patients. And if they can change their workplace, then they can change the world.”

Then she smiles. “I sometimes think I’m a little too grandiose, but whatever.”

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Name: Jean Ross, RN
Facility: Fairview Southdale Hospital, Minnesota
Unit: Acute care
Nursing for: 35 years
Astrological sign: Sagittarius
Nursing pet peeve: Hospitals spending money on consultants instead of listening to the nurses
Favorite work snack: “Who has time to eat at work?”
Recent work accomplishment: Helped plan and implement major mobilization effort to prepare for difficult contract negotiations
Color of favorite scrubs: Midnight blue
Hobbies: Reading, crosswords, walking, biking. She also took second place in the women’s division of a truck rodeo.
Last book read: The Glass Castle, by Jeannette Walls

Name: Martha Kuhl, RN
Facility: Children’s Hospital Oakland, California
Unit: Hematology/Oncology
Nursing for: 28 years
Astrological sign: Pisces
Nursing pet peeve: People who complain a lot and don’t get involved
Favorite work snack: Peanut butter cups
Recent work accomplishment: Getting involved in building a children’s division within NNU
Color of favorite scrubs: Teal
Hobbies: Gardening, reading mysteries, travel
Last book read: Dancing in the Streets, by Barbara Ehrenreich
It was sweltering inside the maternity tent at the improvised hospital in Haiti's earthquake-ravaged capital, and beads of perspiration were collecting on the young mother's forehead. Cecelia Williams, RN, reached out and began to wipe her face with a cloth.

“She looked into my eyes and it was like I was seeing my own daughter lying there,” said Williams, an oncology/medical-surgical nurse from Pennsylvania. It was then that Williams broke down—overwhelmed by round-the-clock shifts tending maggot-infested wounds and the sight of so many mothers giving birth with no privacy, their babies left unwashed.

“The tears were just going down my face. I felt so hopeless,” Williams recalled.

She staggered out of the tent and immediately ran into a two-year-old boy with “the cutest smile.” Missing an arm and a foot, his head and stomach bandaged, the boy nevertheless struck a pose as Williams lifted her camera to take a picture.

Helping Haiti

When Haiti’s earthquake survivors needed medical attention, nurses from across the United States answered the call. BY FELICIA MELLO AND GERARD BROGAN, RN
“He was saying, ‘Look at me, look at how I’m starting my life, and I still have a smile. Go back and do your work,’” Williams said.

And she did.

As Haitians begin to put the pieces of their country back together in the wake of the devastating January 12 earthquake, nurses—both Haitian and foreign—are playing a key role. Some, like Williams, have traveled thousands of miles to a country they’d never seen before, braving lack of food and electricity and scarce medical supplies to tend to those in need. Wilson Bowers, RN, used skills he picked up as a flight nurse in rural Michigan to safely ferry Haitian patients to the United States for treatment. Massachusetts RNs Kathy Reardon and Betty Sparks performed operations and dressed wounds for hundreds of patients a day in makeshift clinics. Others, like Texas RN Mike Brewer, were working in Haiti long before the ground began to shake.

Their experiences testify to the unique combination of courage, skill and compassion that makes nurses essential in times of disaster, and the ability of human beings to adapt and survive in the face of extreme suffering.

Williams traveled to Port au Prince, Haiti’s capital, with the Haitian American Nurses Association. The group arrived January 23 at the city’s main hospital and immediately got to work. Tents had been set up to house patients after part of the hospital building was destroyed in the quake. Just yards away lay the site of a collapsed nursing school, where debris still hid over 100 bodies—deceased nursing students and their professors who could have helped in the disaster.

“The stench was great, but the need of the people was greater,” Williams said.

Born in Guyana, Williams was one of only two non-Haitian nurses in the group and spoke no Creole. But she soon made herself useful.

“We had a young woman with amputated legs and a two-month-old baby, and another nurse asked if I could find something for the baby—milk, anything.” In her search, Williams came across a tent where donated pharmaceutical supplies had been dumped in a pile. “There was no pharmacist, so we had pain medication, bandages, antibiotics, but everything was in a massive confusion. Nurses and doctors were running in, screaming in English, I need this, I need that.”

Within hours, Williams constructed a working pharmacy, alphabetizing the medications and coordinating with Haitian medical staff to distribute them. “We found a way of communicating. I was speaking some kind of French, I don’t even know—it was like glovey glovey, drinkie drinkie.”

In the tents around Williams lay patients with amputated limbs and crushed pelvises. She saw people that were malnourished, and others with pressure ulcers from staying in one position for a long time waiting to be rescued.

“The thing that worries you is the aftercare—how much do they understand the instructions you give them? They’re not getting enough pain medication. You have a 19-year-old with no arm and he’s screaming and what do you tell him?”

Because patients’ families had lost their homes, Williams said, they would move into the hospital. “You have a patient lying on the bed, and their grandma or sister is just there under the bed, because there’s nowhere for them to go,” she said. “You can’t tell them, please leave. That is what hits you hard.”

It was easy for patients to get lost in the sea of tents. If a patient went to another area of the camp for an X-ray, a nurse would affix the number of their tent to their clothing so that staff would know where to send them when they were done.

**Mike Brewer, RN (left) with some of the young people he has rescued from the streets of Port au Prince in a decade of working with homeless youth there.**

Tending to patients under such conditions “was like community nursing, psych nursing, and medical-surgical nursing in one,” said Williams. “It really tests you.”

Williams remembers one patient in particular, an old man who came in with his daughter. The rest of their family had perished in the quake, and the man’s spirit was crushed along with his body. He soon went into a coma and for several days, doctors and nurses labored to keep him alive. When the doctor told his daughter that he had only an hour left, both doctor and daughter burst into tears.

“The daughter started screaming, and they don’t cry in French, they holler just the same way we do,” said Williams. “You don’t even know what happens afterwards because you just go on to the next bed, but these are things you remember for the rest of your life.”
National Nurses United members joined a Navy mission to care for the quake’s most seriously injured.

Operating room nurses from National Nurses United’s Registered Nurse Relief Network have been working round the clock assisting with surgeries on severely wounded patients aboard a floating hospital off the coast of Haiti. At press time, one delegation of RNRN volunteers had recently returned to the United States and another had just arrived on the USNS Comfort, a Navy ship that received transports of patients with urgent conditions from the mainland.

Nurses described a massive volume of cases with dramatic injuries that far outpace what they see in their jobs at high-level trauma centers in the United States.

“I have never seen so many broken bones and such traumatic injuries,” said Lauren Aichele, RN, an operating room nurse at the University of California in San Francisco. Aichele saw paralyzed patients and those suffering from tuberculosis and tetanus, as well as those who had languished for weeks without treatment, often waiting so long for care that their fractures had already started to heal, making them more difficult to fix.

“Some people had to choose between amputation and death because of gangrene,” said Aichele. “Some chose death.”

Despite the tremendous suffering, there were moments of hope for the nurses, who spent up to 30 hours at a time in surgery and bunked in a dorm with dozens of other volunteers.

Aichele remembers clearly a boy of about 10 who was found alone in an orphanage in the days after the quake and had a large tumor on his eye. “He couldn’t walk or talk and someone brought him by motorcycle to a Haitian hospital before he was flown to the ship,” said Aichele. “He wanted to bump fists with everyone he saw and it was touching to see him happy despite what he had been through.”

Volunteers said they were motivated by the opportunity to provide not only medical attention but also psychological support for patients.

“It’s an emotional situation. I feel for those people,” said Lansing, Michigan RN Ashley Forsberg.

A state-of-the-art facility, the Comfort houses 12 operating rooms and over 1000 beds. RNRN volunteers provided much-needed relief for their Navy colleagues, many of whom had been working for weeks with no rest, caring for large numbers of earthquake survivors. The team operated on up to 25 patients a day, many with multiple crush injuries.

The RNs cared for some patients who had lost not only their health but all their material possessions in the quake.

“In the states when you performing emergency surgery you don’t worry about preserving the clothes a person may be wearing,” explained Patricia Taylor, RN, an operating room nurse at Stroger Hospital in Chicago. “Here a woman may come in with literally only a shirt on her back. You have to prep very carefully and make sure that you don’t separate her from her clothing or stain it.”

The deployments are part of an ongoing collaboration between National Nurses United and the United States Navy to assist earthquake victims, funded by NNU’s Send a Nurse campaign.

Nurses returning from service aboard the Comfort described it as a life-changing experience.

“The two weeks went fast, and I didn’t feel ready to leave,” said Aichele. “I wanted to do more.”
Haiti was the poorest country in the Western Hemisphere before the earthquake, with close to 80 percent of the population living on less than $2 per day. In Port au Prince in the weeks following the quake, the smell of death pervaded the streets. Vendors sold corn porridge and plantains amid clouds of flies, steps away from where pigs rooted through open sewers. The price of gas had skyrocketed to $10 per gallon. Foreigners walking the streets were surrounded by Haitians rubbing their stomachs and gesturing towards their mouths, asking in pantomime for food.

On one muggy afternoon, Mike Brewer, RN, bent over the ruins of a concrete-block house in Solino, one of the city’s poorest slums, his face carrying the strain of barely-contained grief. Beside him stood Benjy, the stocky 19-year-old Brewer saved from Port au Prince’s streets years ago, and who built the house with Brewer’s help to shelter other homeless kids. Around them stretched lines of shacks and squat cement dwellings, many reduced to rubble.

A tough, weather-beaten Texan, Brewer spent the last 10 years in Haiti, founding an organization dedicated to getting children off the streets, where they faced beatings at the hands of street gangs and police, and into a network of safe houses around the capital. Now, at least one of his charges—14-year-old Chelo—is dead, crushed when the house he was staying in collapsed. Brewer lost all of his safe houses to the quake, and most of the children he’d sheltered are homeless again, hungry and in need of medical attention.

“All of the kids were really traumatized by the quake,” Brewer said. “We are setting up tarps and tents in parks for them to stay in until I can raise the funds for a home big enough for all of them.”

Brewer’s commitment to Haiti’s children began on a visit to the country in the 1990s, he says, while on leave from his job conducting health assessments for the United States government. Brewer had heard of the plight of Haiti’s *restaveks*—children orphaned, abandoned or sold into slavery by desperate parents. One day while walking near the city docks, he came upon a child lying in a ditch who was barely breathing. Ignoring passers-by who urged him to let the boy die, Brewer revived him.

Moved by the experience, Brewer quit his job, moved to Haiti and started the nonprofit Haitian Street Kids, Inc. He spent his days walking the streets of Port au Prince, conversing with street children—sheltering those he could, while giving others clothes, food, or simple comfort.

“They have very dangerous lives and so they have to put on a mask to survive,” Brewer said. “But the minute you take them in and let them know that somebody is going to care for them and provide them opportunities, they change just like that.”

Since the quake, Brewer had focused his efforts on advocating not just for children but for the entire neighborhood of Solino, which he said has yet to receive its fair share of humanitarian aid.

“**It was like community nursing, psych nursing, and medical-surgical nursing in one.**”

—CECELIA WILLIAMS, RN

Excerpts from

A Nurse’s Journal in Haiti

Massachusetts RN Kathy Reardon was stationed at a hospital in Milot, a small town 70 miles from the capital, where she wrote in her diary every day.

**FRIDAY, JANUARY 29, 2010**

Puddle jumper to Cap Haitien. A little nerve-wracking when they have the instruction manual out! It took 45 minutes to arrive at the “hospital,” over dirt roads with people in the streets, living in shacks on the side of the road. All Pam and I kept saying was “I can’t believe we’re doing this.” I think we’ve been saying this since we got the call to come.

We saw the soccer field where the choppers land, and where all the patients are housed. What a sight—people in every corner of these large rooms. It was a school house. The hospital has taken it over for patients. They all have various injuries—some with one limb missing, some with both legs missing, some paraplegics with huge open sacral wounds like you’ve never seen sleeping on mattresses on the floor.

They try and do three rounds a day for about 60 to 65 patients. Some can be discharged but there’s nowhere for them to go—and the family members stay and sleep there too. Unbelievable. An exhausting, shell-shocking, eye-opening day.

**SATURDAY, JANUARY 30, 2010**

Today was a very long day—we worked from 8:30 a.m. to 12 midnight. We heard choppers overhead all day.
SUNDAY, JANUARY 31, 2010
I’m trying to keep my sense of humor about me. The people are very nice and grateful for whatever you do for them. We supply most of the water. But there’s so many family members and they’re taking it too.

Things were a little more organized today. We were able to do morning rounds and get meds out by noon.

MONDAY, FEBRUARY 1, 2010
Another day in paradise. Tents were set up today outside the hospital. It’s in a field where the people grow bananas and tomatoes. They bulldozed the field and graveled it over. The people were nervous we were moving them out to the tents—but we had to give the school back to the village.

More and more organized as the days go on.

TUESDAY, FEBRUARY 2, 2010
One of the translators, Jacqueson, who has been wonderful, has a little boy with him all the time. While I was giving out night meds I asked him who he was. He said his name was Voltaire. He’s about 10. He lost his family in the earthquake in Port au Prince—and he had no one. I don’t know how he got there, but Jacqueson said he took him into his house because he needed a place to be—for sleep, food, clothing and education. No Department of Social Services here. I cried on the spot. He told me not to cry and that God gives us what we can handle, and will take care of us.

They are very religious people. The church groups come into every room and sing and pray. The singing is really nice and breaks up the monotony. When one person starts to sing, they all start.

WEDNESDAY, FEBRUARY 3, 2010
Much better day today—more nurses, people more organized in tents. The Partners in Health ortho people have been here since Sunday to get people up and change dressings. It makes a world of difference to their psyche, which hasn’t been addressed since the earthquake.

We’ve really gotten to know all these people and they are all very nice. They take care of each other, and help each other. Some patients have no one—they lost their family in the earthquake. So other people in the room help them wash, and fix their beds, and change their linens.

There was a mob of people in the big kitchen where the food is made. They wanted the food but the food was for the patients. I had to call for security to help disperse the crowd. It was very unnerving.

THURSDAY, FEBRUARY 4, 2010
The doctors we’ve been working with have been great. We all gave meds together today and only had a few sick patients. One kid I worked with had renal failure and his left arm was crushed in the earthquake. So he had some nerve damage but is moving his arm better and up walking with a walker, doing well.

We also had a lady in makeshift Buck’s traction which consisted of Kirlex and sand in a bleach bottle!

One of my patients lost his arm above the elbow and they did a skin graft from his leg. One of the days the ortho team missed his dressing—it hadn’t been changed in three day and was seeping green drainage through the stump. We had to really soak it to change it. It was very painful to him. I apologized for causing him pain, but he understood and thanked me for changing his dressing. His son asked me how long his father would have to stay. I told him that in the U.S. we would send patients like him home and have the visiting nurse change his dressings every day. He said they lost everything in the earthquake and had nowhere to go.

SUNDAY, FEBRUARY 7, 2010
Our flight left Cap Haitien at 10 a.m. We all agreed that we did a great job. The team that came in before us had all they could do to manage the mobs of patients the choppers brought in every day. We felt we had a little more breathing room after the first two days to organize and create some structure for groups that would come after us.

If I never hear another rooster crow again it will be too soon—right outside our window this morning. Glad to be going home, though I’m very glad we went. I made some great friends and learned a lot about Haiti, the people and their culture.
“If you have a very sick patient and you can save their life, you share in their gratitude and it’s an emotional experience for everybody. That’s what makes it all worthwhile.”
—WILSON BOWERS, RN

“For some nurses, disasters are a calling. As a member of a United States Disaster Medical Assistance Team, Massachusetts RN Betty Sparks has tended to victims of Hurricanes Katrina, Ivan and Gustav—and even runners in the Boston Marathon.

“I’m usually at the finish line there, and we sometimes call that a disaster—it’s definitely a mass casualty incident,” she said.

When National Nurse caught up with Sparks by telephone, the operating room nurse was on a break from her 12-hour shift tending to surgical patients at a repurposed HIV clinic in Port au Prince. Helicopters flew overhead, and crackling from Sparks’s radio interrupted the conversation.

The only operating room nurse in the camp, Sparks had lost count of how many surgeries she’d performed that day, but thought it was around five—including one man who had been shot in the leg for money.

“We’ve operated on him three times. He has a bullet behind the knee we have not gone after, and we’re trying to get circulation into the leg so we can save it,” said Sparks. “He says, ‘Tell the American doctors, don’t kill me, don’t take my leg.’”

Other patients had wounds that needed to be cut and drained. Doctors attached external fixation devices to fractured limbs—a temporary fix for an injury that in the United States would be treated by opening the limb and inserting plates and screws.

When she wasn’t working, Sparks was on call, and slept outdoors on a cot trimmed with mosquito netting, where she could be easily found when needed. Next to her bed, an oxygen machine hummed all night. She snacked on military meals-ready-to-eat and used headlamps to navigate the darkened camp at night.

“Sometimes I get to take a shower and I take my scrubs off, put them on floor, rinse them out, hang them up and they’re good for the next day,” she said. “That’s laundry.”

Sparks has also chaired the Massachusetts Nurses Association’s emergency preparedness task force. Why does she like working in disaster zones? “I’m a very sick person,” she laughed.

“No, really it’s just exciting doing the unknown and seeing what you can do with the skills you have. It’s amazing how you can improvise. You’re seeing things you haven’t seen before and helping people that so need it.”

“These people had no healthcare whatsoever before,” Sparks continued. “And now they’re getting stuff they’d never get and unfortunately, when we leave, may never get again.”

Because Sparks originally trained as an ER nurse, this was her

“In other neighborhoods they are getting more than they need; there are people selling some of the aid, they’ve got so much,” Brewer said. “They haven’t brought one grain of rice into Solino, because it’s hard to get in there. It’s right in the middle of town but it’s a serious slum and it’s neglected.”

Shortly after the quake, Brewer and a few nurse colleagues from the United States opened an impromptu clinic in Solino. He borrowed a small courtyard from a local preacher and shaded it with a plastic tarp. Several boys Brewer had helped—polite youths ages five to 15, dressed in clean clothes—rounded up benches and, miraculously, soda for the volunteers. Dozens of people lined up for treatment, most for minor injuries exacerbated by chronic conditions like malnutrition. Some were diagnosed and referred to larger hospitals, among them an elderly woman with a fractured back.

Even amidst the suffering throughout Port au Prince, evidence of the Haitian people’s resilience abounded. Women carried on with daily chores, washing clothes by hand in bowls on the side of the road. In camps across the city, the newly homeless marked the setting of the sun by singing, their voices raised not in the wailings of grief, but in hymns of harmony and optimism.

Brewer attributed the lack of overt sadness on the streets to Haitians’ belief in _volunte bondye_, or God’s will. In a country where many hold strong religious convictions—both Catholic and voodoo— _volunte bondye_ is used to explain everything from tragic death to changes in the weather. It’s a way of coming to terms with life’s blows, and persisting in spite of them.

Of course, on many occasions throughout history, Haitians have not waited for God to fix their problems. In the early 1800s, Haitians fought and won perhaps the most famous slave revolt in history, gaining independence from France only to have their economy crushed by a U.S. trade embargo and debt repayment to their former colonial masters. The country was controlled by a brutal United States-backed dictatorship for much of the 20th century, then endured decades of violent regime changes and short-lived governments. In 2004, Haiti’s democratically-elected President Jean-Bertrand Aristide was ousted and the United Nations occupied the country.

Aristide built public parks throughout Port au Prince, evidence of which went largely unused, Brewer said…until now. Today those parks provide homes for tens of thousands of people displaced by the earthquake. Brewer hoped the new situation would provoke sympathy among Haitians for the plight of street children, who have long been a scapegoat for the country’s ills.

“We are all street kids now,” he said.
first overseas deployment to an operating room. The tent was a far cry from the gleaming, high-tech setting of Newton-Wellesley Hospital, where Sparks works. Sparks sterilized her own instruments by soaking them in Cidex solution for 20 minutes, then rinsing them in water.

The daily routine was broken by the occasional treat: embassy workers bearing frozen Gatorade, and visits from former President Bill Clinton and actor Sean Penn. Penn brought an X-ray machine and pediatric ventilator. “He was grubby and dirty and carrying things in here like he was one of the workers,” said Sparks.

Though she’s no stranger to disasters, Sparks knows her experience in Haiti will affect her. “Every time I come back, my friends and coworkers tell me that I’ve changed,” she says. “It definitely humbles you. Being an OR nurse you tend to be kind of anal. You lose a little bit of that here, because you have no choice.”

Bowers joined the survival flight team at the University of Michigan, he never imagined he’d one day be flying an emergency mission to Haiti. Bowers and the doctors and pilots he works with use helicopters and fixed-wing aircraft to transport critically injured patients from Michigan’s remote backwoods to the university’s hospital.

“You go up to northern Michigan and you have chest pains and it might take an hour for an ambulance to get to you,” said Bowers, also a trained paramedic. With no major medical facilities nearby, a helicopter flight is often the fastest route to care. The team also picks up children from around the country who need the university’s expertise in pediatric cardiology.

On day eight after the earthquake, officials with the Federal Emergency Management Agency contacted the university about a Haitian patient whose condition required transport to a U.S. hospital. Though he’d never traveled outside the U.S. and Canada, Bowers, who had the day off, volunteered for the flight.

As the plane descended towards Port au Prince airport, Bowers saw blocks and blocks of “sheer rubble,” interrupted by the occasional concrete block, tin-roofed house that was still standing.

“The TV cameras aren’t able to show you the big picture, so it’s only when you actually get there that you realize how catastrophic it is,” he said.

Dozens of helicopters clustered on the tarmac next to mountains of medical supplies. The quake had taken out the air traffic control tower, and planes were landing under a primitive system of first-come, first-served, Bowers said.

The team met with staff from a local hospital and evaluated the patient there on the runway. They were accustomed to moving quickly in unpredictable circumstances. At home, “one day you might be going to the scene of a car crash to provide care to someone and the next day you’re going to save a sick baby at a hospital,” said Bowers. “You really don’t know what you’re going to get, and you have to be ready to go.”

But here there were a few surprises. “We asked the hospital staff did they get any lab values, and they said no, we don’t have a lab,” Bowers said. “Blood sugar levels, potassium—all those things that you take for granted when you transfer a patient, we didn’t have that.”

Bowers’ team determined that the patient was stable enough to allow them to transport another patient at the same time. As Haitian medical workers rushed back to their hospital to pick up someone else, Bowers and his colleagues rooted through their supplies to see what they could share with their Haitian colleagues. They had already brought antibiotics to donate, along with peanut butter and baby food. But they wanted to give more.

“We had planned for any eventuality, so we were fully stocked with IV solutions, a full pharmacy, splints and trauma supplies,” said Bowers. Everything they didn’t think they would need on the way back, the team turned over before taking off for the seven-hour flight home.

Bowers said the Haitian patients were successfully transported to the university, and he and his team have checked in on them several times since they arrived.

For Bowers, making personal connections with patients and their families in the midst of a crisis is one of the most rewarding parts of his job. “When a hospital says to a family, we don’t have anything more to offer, we’ve called an outside medical crew, we represent the last ray of hope for that family,” he said. “If you have a very sick patient and you can save their life, you share in their gratitude and it’s an emotional experience for everybody. That’s what makes it all worthwhile.”

Of his journey to Haiti, Bowers says: “It’s the type of experience you never forget. If they call us to go again, we’ll be there.”

Gerard Brogan, RN reported from Port au Prince and Felicia Mello from Oakland.
Influenza Pandemics
The Critical Advocacy Role of the Registered Nurse

The H1N1 pandemic is grabbing headlines around the world. Are you prepared? 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 critical advocacy role of the RN in preventing and mitigating the impact of influenza pandemics. Though this course focuses on H1N1, the role of the registered nurse is constant and consistent for all other potential pandemics, such as the avian influenza.

INTRODUCTION

Novel influenza A (H1N1) is a new flu virus of swine origin that was first detected in April 2009. Human influenza is transmitted from person to person via virus-laden large droplets that are generated when infected persons cough or sneeze; these large droplets can then be directly deposited onto the mucosal surfaces of the upper respiratory tract of susceptible persons who are near (i.e., within three feet of) the droplet source. Transmission may also occur through direct and indirect contact with infectious respiratory secretions.

Influenza-like illness can include fever, body aches, runny nose, sore throat, nausea, vomiting or diarrhea. The Center for Disease Control and Prevention (CDC) has posted emergency warning signs for children and adults requiring emergency medical care. See http://www.cdc.gov/flu/swine, or call CDC at 800-CDC-INFO (English and Spanish) or 888-232-6348 (TTY).

As of January 8, 2010 the Center for Disease Control reported that there had been 37,778 hospitalized cases and 1,735 deaths from swine flu in the United States. As of January 2010 the World Health Organization reported 12,799 confirmed deaths from H1N1 worldwide. WHO believes the reported number of novel influenza A (H1N1) virus. A Phase 6 designation indicates that a global pandemic is underway. Dr Margaret Chan, director-general of the WHO, said, “The virus is contagious, spreading easily from one person to another.” WHO emphasized that this does not mean the virus is causing more severe illness or more deaths and cautioned against overreactions to the increased alert level.

WHO’s decision to raise the pandemic alert level to Phase 6 is a reflection of the spread of the virus, not the severity of illness caused by the virus. It is uncertain at this time how serious or severe this novel H1N1 pandemic will be in terms of how many people infected will develop serious complications or die from novel H1N1 infection. Because novel H1N1 is a new virus, many people may have little or no immunity against it, and illness may be more severe and widespread as a result.

IMMUNIZATION

In early July 2009 the Strategic Advisory Group of Experts (SAGE) working with the World Health Organization recommended that healthcare workers worldwide be immunized as a first priority, but acknowledged that ultimately, national authorities will identify priority groups for vaccination based on circumstances within their own countries.

In late July the Advisory Committee on Immunization Practices (ACIP) in the United States recommended five target groups for initial immunization using the criteria of increased risk of H1N1 infection, complications and contact with vulnerable people:

- Pregnant women
- Household contacts of babies under six months of age
- Healthcare and emergency medical services (EMS) workers
- Children and young people aged six months through 24 years
- People between 25 and 64 years who have chronic medical conditions

REGISTERED NURSE ROLE

The centrality of the RN role in preparing for and responding to any disaster is critical in all practice settings. The key functions are:

- to achieve optimal public health through provision of preventative care in order to prevent, mitigate or contain a potential pandemic; and,
- to provide safe, therapeutic, and effective restorative care so patients can achieve optimum health.

RNAs are at the front line of communicable disease prevention and control through outreach screening, case finding, resource coordination and the delivery and evaluation of care of individuals, families and communities. RN skills and expertise are critical in restoring and protecting the health, welfare and safety of communities.
of individuals, families and communities in any disaster. Engaging in social advocacy and social mobilization is incumbent on all RNs, especially since the profession is held in high esteem with respect to the public trust.

Levels of prevention: Primary prevention relies on epidemiological information to identify those behaviors which are protective, or will not contribute to an increase of disease, and those that are associated with an increased risk. Health promotion includes actions taken to foster a safe environment or healthful lifestyle. Specific protections include immunizations to protect against and reduce the incidence of a disease.

Secondary prevention (after pathogenesis) includes screening and physical exams aimed at disease detection and early diagnosis, and interventions that provide early treatment or cure.

Tertiary prevention includes limiting complications and disability, and rehabilitation/restoration to an optimum level of health, function, and well-being.

Preventative Care
The primary focus of preventative care nursing is to engage in health promotion and disease prevention activities for entire population groups. This means the provision of direct care through a process of assessments and evaluation of the needs of individuals in the context of their population group. The goal of preventative care is to improve the health of the community. Public health nurses, school nurses and outpatient/clinic nurses play a key role in the prevention and early detection of the spread of swine influenza, with a strong focus on mitigation or containment to avoid it reaching pandemic proportions. These RNs are the community's primary responders.

RN Role in Preventative Care
Case finding: surveillance, intervention and assessment of health care needs of individuals and populations.

Case management: referral, follow-up, counseling and consultation.

Community-focused intervention, interdisciplinary collaboration, coalition building, community organization and system-focused interventions.

Making recommendations regarding closure of schools and/or public institutions and cancellation of public events to mitigate and contain any outbreak.

The Public, Community and Outpatient RN Role in Preventative Care
In general, only registered nurses and licensed physicians with current demonstrated and validated competency can perform assessments, prescribe/implement treatment, conduct evaluation, and determine the need for follow-up surveillance vs. “quarantine.” RNs must apply the following:

Secure the reporting by non-public health clinics of suspect swine flu patients to the local Public Health Department.

Recognize that emergency departments play a key role in the tracking and reporting of suspected swine flu cases and must remain a key member of the state or county notification network.

Ensure that RNs and MDs control their practice environment and are able to provide care in the exclusive interest of the patient, particularly in a pandemic environment.

Identify individuals who have health problems that put themselves and others in the community at risk, such as those with infectious diseases like the swine flu.

Collaborate with other providers of care to plan, develop, and support systems and programs in the community to prevent problems and provide access to equitable care.

Assess health and health care needs of individuals.

Identify nursing diagnoses, plan interventions to meet identified needs, and implement the plan effectively and equitably.

Evaluate the extent to which the interventions impact the health status of individuals, families and communities.

Advocate in the exclusive interest of the individual and the community.
Provide education about swine flu infection and how and where viral transmission occurs. Disseminate information on the appropriate PPE (Personal Protective Equipment), such as gowns, gloves, eye protection and fit-tested disposable N95 respirator or better. (Note: persons who have certain chronic pulmonary conditions, such as asthma, emphysema, or restrictive airway disease may require alternate respirators.)

Present education to workers on hand washing, appropriate respirator use, gloves and triaging patients who come into the clinic or hospital setting coughing or febrile.

Educate patients and families to: (1) Stay home if symptomatic but seek medical help if very high fever (greater than 101 with Tylenol or other appropriate fever-reducing medications), uncontrollable diarrhea, shortness of breath/difficulty breathing. Also, if parents are unwilling or unable to follow simple directions at home then they should seek medical care. (2) Cover mouth/nose if coughing or sneezing, and (3) Identify their primary care provider, hospital, and health insurance or local public health system.

**Restorative Care - Acute and Long Term Care**

Direct care RNs in acute care and long term care facilities have a pivotal role in the early detection of signs and symptoms of the disease, the implementation of scientific-based intervention, and the evaluation of the patient’s response to the treatment prescribed, including patient advocacy intervention when in the independent professional judgment of the RN the treatment regimen is not in the best interest of the patient. Infection prevention and control play a vital role in our patients’ safety and well being. This is even more crucial in our hospitals where our patients may already be compromised due to illness, injury or disease and are at very high risk of life-threatening infections.

**RN Role in Restorative Care - Acute and Long Term Care**

- Early detection and intervention.
  - Continuous environmental surveillance and monitoring.
  - Minimizes and seeks to eliminate patients’ risk of preventable complications.
  - Reduces susceptibility and exposure to risk factors.
  - Modifies, removes, or treats problems to prevent serious or long term effects.
  - Alleviates the effects of disease and injury by providing competent care that is safe, therapeutic and effective.

**RN Role in Acute Care**

- Insist that your hospital immediately implement—at a minimum—state and federal, OSHA, HHS/Public Health Department and CDC guidelines on disaster preparedness and response, including facility-based policies on disaster preparedness and response.
- Insist that your facility, at a minimum, provide protection for health care personnel by providing personal protective equipment (PPE) in accordance with state and federal OSHA, HHS/Public Health Department and CDC guidelines.
- Enforce acute care hospitals’ requirement to immediately staff up. There shall be no violation of safe-staffing ratios or any state work rules and no retaliation for sick-calls or care of a family member suffering from swine flu.
- Insist that medical facilities monitor and track all caregiver and patient unprotected exposures to H1N1 patients and/or patients with flu-like symptoms and provide treatment and follow-up in accordance with state and federal OSHA guidelines, including timely notice of exposure and access to anti-viral medications, when medically indicated/recommended.
- Assess all patients for signs and symptoms of abrupt onset of fever, myalgia, headache, malaise, nonproductive cough, sore throat, and rhinitis; because the typical incubation period for influenza is one to four days, a patient admitted for an accident or other illness may develop symptoms after hospitalization. Patients and visitors with the above symptoms should immediately be isolated as if they had H1N1 flu until H1N1 can be ruled out.
- RNs caring for adult patients will observe for primary influenza viral pneumonia, exacerbation of underlying medical conditions (e.g., pulmonary or cardiac disease), secondary bacterial pneumonia, sinusitis, and otitis media; and for co-infections with other viral or bacterial pathogens.
- Provide care for each individual patient as needed. All patients and families need teaching and reassurance.

**RN Role in Infection Control for Patients**

- In general, the Center for Disease Control (CDC) recommends that nurses consider the possibility of H1N1 influenza virus infections in patients presenting with febrile respiratory illness. A combination of infection control strategies is recommended to decrease transmission of influenza in healthcare settings. These include:
  - Placing any patient with confirmed H1N1 or flu-like symptoms in a private, negative-air-pressure isolation room when possible and having health care personnel observe contact and droplet isolation precautions, plus eye protection. All healthcare personnel who enter the rooms of patients in isolation with confirmed, suspected, or probable novel H1N1 influenza should wear a fit-tested disposable N95 respirator or better. Respiratory protection should be donned when entering a patient’s room. Personal protective equipment must be disposed of after each use.
  - Applying current knowledge and demonstrating competency in infection prevention and control procedures.
  - Understanding and implementing Primary, Secondary, and Tertiary prevention measures in all practice settings.
  - Performing ongoing assessments and science-based interventions to eliminate the risk of nosocomial infection and the spread of multi-drug-resistant organisms.
  - Observing and monitoring compliance with infection surveillance standards and protocols.
  - Maintaining professional vigilance and self-awareness to promote a safe and therapeutic environment of care.
  - Providing appropriate education to co-workers, visitors, patients, friends, and families regarding hygiene and infection prevention and control measures.
  - Engaging in case finding of possible undiagnosed patients with influenza.
  - Advocating for laboratory confirmation of diagnosis because the symptoms may or may not be influenza, H1N1 or other form.
  - Observe visitors, physicians, and others for respiratory symptoms. These people will be restricted from visiting patients and encouraged to stay at home until recovered.

**RN Role in Clinical Facility-Based Enforcement of Patient Health and Safety Regulations**

Collectively and professionally hold employers accountable.
for following licensing and certification regulations pertaining to the maintenance of a safe care environment when managing an unusually high census or influx of patients due to an unexpected event, such as a disease outbreak or mass casualty incident.

Enforce safe staffing ratios and standards to ensure that staffing is based on the severity of illness, need for specialized equipment and technology, complexity of clinical judgment needed to design, implement, and evaluate the patient’s plan of care, the dependency/ability for self care of the patient, and the licensure of personnel required to provide the care.

Notify supervisory personnel when unsafe working conditions exist.

Carry out the principles of the Nursing Practice Act, Scope of Practice mandates, and applicable institutional licensing and certification regulations of health facility employer.

Assess each patient’s needs, plan the nursing care, and determine the care that can be safely and appropriately assigned to other health care team members.

Change decisions and activities which interfere with or override the direct care RN’s professional judgment in determining the health facility non-compliance with state or federal regulatory standards for patient health and safety and file a report with such agencies.

**RNRRN CALL TO ACTION**

In 2009 CNA/NNOC issued an RNRRN Call to Action notice to encourage a nationwide social advocacy movement of RN patient advocates to fight for achieving the demands identified in the RNRRN Call to Action [www.calnurses.org/rnrrn](http://www.calnurses.org/rnrrn)

The RN Response Network (RNRRN) is a national network of direct care RNs that:

- **Recruits and coordinates** sending volunteer RNs to disaster evacuation sites where and when their help is needed most. When disasters like pandemics, hurricanes, tsunamis, earthquakes, and other emergencies strike, RNs are needed to relieve the human suffering and provide hands-on care and relief for exhausted local RNs.
- **Provides consultation** on how RNs can prepare for disaster response, which include social advocacy for the provision of preventative and restorative patient care in a safe, therapeutic and effective manner, regardless of age, gender, ability to pay, social status, ethnicity, lifestyle, religion, or belief.

**ACTION PLAN**

Every registered nurse regardless of practice setting must immediately engage in the NNU social advocacy action plan in order to mitigate or contain this imminent pandemic.

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**Avian Influenza (H5N1)**

Avian influenza is an infection caused by avian (bird) influenza (flu) viruses. These influenza viruses occur naturally among birds. Wild birds worldwide carry the viruses in their intestines, but usually do not get sick from them. However, avian influenza is very contagious among birds and can make some domesticated birds, including chickens, ducks, and turkeys, very sick and kill them.

Influenza A virus normally seen in one species can sometimes cross over and cause illness in another species. Until H5N1 infected humans in the 1990s, this was the only reason avian flu was considered important. Since then, avian flu viruses have been intensively studied, resulting in changes in what is believed about flu pandemics, changes in poultry farming, changes in flu vaccination research, and changes in flu pandemic planning.

Since 2009 the world community has spent billions of dollars fighting this threat with limited success. H5N1 has evolved into a flu virus strain that infects more species than any previously known flu virus strain, is deadlier than any previously known flu virus strain, and continues to evolve, becoming both more widespread and more deadly.

**Economics**

Address and resolve U.S. relative ineffectiveness of current vaccine technology in producing anti-influenza vaccines.

Redirect funds earmarked for healthcare information technology to:

- Expand the number of laboratories able to effectively analyze the virus.
- Add to the number of personnel employed to gather raw data for analysis.

Government must stop its incentive which diverts resources to private interest drug corporations and commercial enterprise at the expense of public health.

It is more cost-effective to reinvest in public health clinics in each community, creating access to preventive and restorative care provided in a safe, therapeutic and effective manner for the benefit of a broad segment of populations.

Insurance companies must waive all out-of-pocket co-payments, co-insurance, and deductible mandates, so as not to discourage patients from seeking preventative care at early signs of infection.

There must be immediate funding for recruitment and retention of school nurses and public health nurses, including funding for public health clinics.

Insist on a public and private moratorium on closure of any public health clinics.
health facility, including the closure of emergency departments as well as the reduction of bed capacity.

Address the critical need for several thousand ventilators/respirators.

**Clinical/Practice**

**Only Registered Nurses** and licensed physicians with current demonstrated and validated competency can perform assessments, prescribe/Implement treatment, conduct evaluation, and determine the need for follow-up surveillance vs. “quarantine.”

Non-public health clinics must report suspect swine flu patients to the local Public Health Department.

Emergency departments play a key role in the tracking and reporting of suspected swine flu cases and must remain a key member of the state or county notification network.

Ensure that RNs and MDs control their practice environment and are able to provide care in the exclusive interest of the patient, particularly in an imminent pandemic environment.

Acute care hospitals must immediately implement state, HHS and CDC guidelines on disaster preparedness and response including facility-based policies on disaster preparedness and response.

Secure protection for health care personnel by providing personal protective equipment (PPE) including fit-tested disposable N95 respirator or better.

Acute care hospitals must immediately staff up; there shall be no violation of safe staffing ratios or any state work rules and no retaliation for sick calls or care of a family member suffering from swine flu.

Health care providers, first responders, and medically fragile and vulnerable populations must be given timely access to anti-viral medications, such as oseltamivir or zanamivir, when medically indicated/recommended.

**Conclusions**

**In order to reduce** the incidence of Novel H1N1 (swine influenza, the United States needs to implement a nationwide surveillance, prevention and containment policy. It is critical that all facilities follow the same standards consistently; Swine Flu knows no geographic boundaries.

CNA/NNOC recognizes registered nurses’ role as patient advocates who are at the front lines of all serious health care problems and as such must be the leaders in influenza control.

**CNA/NNOC POSITION**

As frontline caregivers at the heart of the health care system, CNA/NNOC strongly recommends that all registered nurses (RNs) are vaccinated against the H1N1 influenza virus.

Any vaccination program for RNs should include extensive education on the risks and benefits of vaccination with an emphasis on patient protection and the need to be prepared for a serious pandemic outbreak.

CNA/NNOC supports an RN’s right to decline vaccination. RNs should be granted presumptive eligibility for workers compensation benefits as a result of contracting the H1N1 influenza virus, and should not be subject to disciplinary action by an employer due to absenteeism or illness resulting from the vaccine.

Hedy Dumpel, RN, JD is National Director of Nursing Practice and Patient Advocacy for CNA/NNOC.

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CDC Key Facts about Swine Influenza: http://www.cdc.gov/h1n1flu/key_facts.htm

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Influenza Pandemics: 
the Critical Advocacy Role of the Registered Nurse

For continuing education credit of 2.0 hours, please complete the following test, including the registration form at the bottom, and return to: CNA/NOC/Nursing Practice, 2000 Franklin St., Oakland, CA 94612. We must receive the complete home study no later than March 31st, 2010 in order for you to receive your continuing education credit.

Test Questions

1. A combination of infection control strategies is necessary to decrease transmission of influenza in all healthcare settings.
   - True
   - False

2. All RNs must advocate for laboratory confirmation of diagnosis because the symptoms may or may not be influenza, H1N1 or other form.
   - True
   - False

3. Because emergency departments are understaffed and busy there is no need for ER MDs and/or RNs to track and report suspected swine flu cases to the state or county notification network. Only intensive care units need to test for and report suspected cases.
   - True
   - False

4. Because novel H1N1 is a new virus, many people have little or no immunity against it, and illness may be more severe and widespread as a result.
   - True
   - False

5. Citizens, including registered nurses, must hold government accountable for reinvesting tax dollars into the public health system.
   - True
   - False

6. During times of high census RNs must hold employers accountable for enforcing safe staffing ratios and standards. RNs must notify supervisory personnel when unsafe working conditions exist.
   - True
   - False

7. H1N1 (Swine) influenza does not transmit easily from one person to another.
   - True
   - False

8. It is not necessary to dispose of Personal Protective Equipment (PPE), such as gowns, gloves, eye protection and fit-tested disposable N95 respirator. This equipment may be donned or re-used.
   - True
   - False

9. It is OK for RNs and other workers to come to work still coughing and sneezing when feeling well enough.
   - True
   - False

10. The typical incubation period for influenza is one to four days so a patient admitted for an accident or other illness could develop symptoms after hospitalization; therefore all patients must be assessed for signs and symptoms of abrupt onset of fever, myalgia, headache, malaise, nonproductive cough, sore throat, and rhinitis and respiratory droplet precautions initiated.
    - True
    - False

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