Wish you were here

Thousands of Florida RNs Win Stunning Unionizing Victories

Sunshine State

Greetings from Florida
Letter from the Council of Presidents

Someone pinch us already! We’ve never seen anything like it: Thousands of Florida registered nurses working at HCA hospitals unionized in the span of just a couple of months. It’s a testament to the strength of our organization, National Nurses United, the power of the RN movement to improve patient care that we are building, and the courage of RNs in the Sunshine State.

In November and December, NNU’s affiliate, National Nurses Organizing Committee-Florida, conducted elections at six Hospital Corporation of America facilities and nurses overwhelmingly voted in favor of the union at each one. As of press time, we have an upcoming election at one more hospital. A big congratulations and welcome to these Florida nurses. We look forward to working with them to win ratios for Florida and helping them negotiate solid contracts. Read all about it in the news section.

Unfortunately, there’s some bad news as well. This issue of the magazine also discusses two different threats to RNs: The first is workplace violence, and the second is a push by players in Washington, D.C. to gut Social Security and Medicare in the name of “deficit reduction.”

It seems that violence at our workplaces has dramatically worsened over the last five years, in all likelihood a reflection of patients’ stress levels and dire straits during this awful recession. A number of our members have been assaulted at work, and it is with heavy heart that we learned one California RN member, Cynthia Barraca Palomata, died in October after she was attacked on the job. National Nurses United members around the country are pursuing various strategies to prevent such violence, from legislation to contract negotiations to education. Take a moment to read this important story.

On the subject of decimating Social Security and Medicare, all three of us have stories to tell about those critical social safety net programs. Our parents rely on it, we plan to rely on it when we retire, and our kids and grandkids should be able to rely on it when they reach the end of their working lives. Yet the very same Washington insiders who support tax breaks for corporations and billionaires who make more money per day than most Americans will ever see in their lifetimes want to slash away at Social Security’s fairly modest benefits. The article in this issue will explain how Social Security doesn’t really have anything to do with the national deficit and how the current push to restructure the programs is actually the first step toward eliminating social safety net programs entirely.

Check out the news section for much more on NNU’s activities around the country. Maine nurses held a successful, first-ever strike. Massachusetts RNs negotiated a landmark contract with an unprecedented pension fund.

It is grim out there, but it would be even worse if we NNU nurses were not on the front lines, fighting for ourselves and our patients.

Deborah Burger, RN | Karen Higgins, RN | Jean Ross, RN
National Nurses United Council of Presidents
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In a remarkable display of how eager the country’s registered nurses are to join a real movement for patient safety, a voice at work, and fair treatment, a total of more than 2,100 RNs at six HCA-owned hospitals in Florida voted in November and December by overwhelming margins to unionize with the National Nurses Organizing Committee—Florida, an affiliate of National Nurses United.

The wave of organizing victories, some spaced just days apart from one another, is a stunning achievement for Florida nurses who, in just a matter of months, have managed to create a strong base of unionized nurses who can now fight for patient care improvements and better working conditions, wages, and benefits. A common theme among all the RNs is a wish to secure safe RN-to-patient staffing laws in the Sunshine State.

“What a monumental day for nurses and patients in Florida,” said Malinda Markowitz, RN, a national vice president of NNU and chair of NNU’s HCA RN Council. “HCA RNs are uniting across the country to win dramatic gains for patients and nurses. We could not be more proud of our Florida pioneers.”

The registered nurses at Osceola Regional Medical Center in Kissimmee, near Orlando, led the way on Nov. 15 by voting 354–30 to join. “We are very excited. Everybody’s excited,” said Vernon Ligad, an operating room RN who has worked at Osceola for 21 years. “Sometimes it feels like I’m dreaming, I can hardly believe it.” Ligad, who had worked at unionized hospitals in New York, said that he has always supported unionization because when nurses have more of a say at their workplace, patients get better care. The union will represent some 550 RNs at Osceola.

Osceola was followed by Central Florida Regional Hospital in Sanford on Nov 22. Karyn Hayduk, a medical-surgical RN there, said that chronic short staffing on the floors at her hospital is burning out her colleagues. “We decided we are all better off having the union,” said Hayduk. “It’s exciting—We’re very excited here in Florida. After we won, it was just tears of joy and relief.” About 300 RNs will be represented at Central Florida Regional.

The next day, RNs at Community Hospital in New Port Richey also voted to join. “This is a great victory for nurses and patients at Community Hospital,” said Lydia Music, RN. “This brings us a step closer to realizing our vision of safe staffing ratios.” About 325 RNs will be represented.

On Dec. 1, RNs at Fawcett Memorial Hospital in Port Charlotte voted by 62 percent in favor of that facility’s 250 nurses to unionize. And the next day, nurses at Largo Medical Center in Largo voted by 69 percent to have the 400 RNs there join NNOC-Florida/NNU. On Dec. 9, RNs at Oak Hill Hospital in Brooksville also voted to join their Florida colleagues. About 300 RNs will be represented there.

All of the Florida RNs are now electing representatives and leaders at their facilities, and will soon form bargaining councils to start contract negotiations. This string of victories brings the number of RNs newly organized by National Nurses United to almost 8,000 in places as varied as Texas, Missouri, Illinois, and Washington, D.C. —Staff report
S teven akerley, a registered nurse at Eastern Maine Medical Center in Bangor, knew understaffing was getting intolerable on the floors when the professional practice committee, of which he is secretary, started receiving assignment despite objection forms with notes from colleagues reading, “I cannot physically and mentally carry on like this anymore. I’m tired.”

Staffing at the second-largest hospital in Maine, with more than 900 registered nurses, had become so bare bones over the last year that one call-in from a sick nurse would spell disaster for the entire unit and even necessitate charge nurses taking on up to six patient assignments.

“Now it’s just about the bottom line,” said Akerley, who has worked at EMMC for more than 30 years and currently practices in the pre- and post-anesthesia care unit. “It’s out of control. They want more for less and they don’t care where they put you. They say, ‘Suck it up or get out.’”

But EMMC registered nurses refused to back down, instead making safe staffing a centerpiece of their contract negotiations this year. The RNs wanted to include the hospital’s staffing plan in their contract language, but management would not entertain this proposal. So nurses voted by overwhelming numbers to stage a one-day strike on Nov. 22 – the first time ever that Maine nurses have walked off the job.

EMMC locked the RNs out for two days prior to the strike, spending what RNs estimate is about $1 million on replacement RNs and security, but the hospital’s actions just galvanized the nurses.

“The decision by EMMC to lock us out is completely consistent with their behavior throughout this process,” said Judy Brown, an RN leader at EMMC. “Our concerns over the safe staffing of nurses to patients remain ignored.”

Hundreds of nurses turned out to walk the strike lines from 7 a.m. to 10 p.m., braving snow, sleet, and rain. Nurses from other hospitals, Bangor residents, and members of other unions, such as firefighters and steelworkers, showed up laden with hot coffee, handwarmers, and home-baked goodies to lend support. The strike was a major success.

When RNs reported for work on Tuesday morning, they assembled in the cafeteria and returned unit by unit. As each unit was called, the nurses spontaneously broke out in cheers and applause. “For me, that was the most exciting moment,” said Akerley. “It showed management, ‘You did not beat us down. You did not kick the spirit out of us.’”

He added that though the strike took a lot of effort and courage, it was a growing experience for himself and his coworkers. “I can follow through with my convictions,” he said. —Staff report
After months of solid teamwork, the 2,100 nurses and healthcare professionals at Sparrow Hospital (PECSH) in Lansing, Mich., represented by the Michigan Nurses Association, won in November a new contract that features landmark staffing language to greatly improve safe patient care.

The nurses and healthcare professionals entered negotiations with the goal of increasing staffing at the hospital after reports that staffing had fallen to dangerously low levels. To bolster their efforts, MNA released a report identifying multiple concerns with safe staffing practices in the hospital. The report, “Misplaced Priorities: The Deteriorating Condition of Safe Patient Care at Sparrow Hospital,” documented 1,400 instances of unsafe patient care based on Documentation of Staffing Concern forms that were filed by nurses and other healthcare professionals at Sparrow from 2009 and 2010. The report was submitted to the Michigan Department of Community Health with a request to investigate the staffing at Sparrow Hospital because management had ignored both the staffing guidelines in the current contract and the short staffing forms.

Preparations for the fight for safe patient care included an aggressive internal organizing campaign and educating the Bargaining Action Teams in their role as the communications and mobilization link to members. PECSH members began to turn up the heat on Sparrow, with a “wear red” campaign inside the hospital, leafleting at a home Michigan State University football game and Sparrow tailgate party, and preparation for a rally at the hospital’s major fundraising gala.

Alerting the community became a top priority. A strategic campaign using television and newspaper ads shared MNAs commitment to safe patient care with the community. Elected officials and other community leaders were educated on the issues at Sparrow. The message of safe patient care appeared on a sign pulled by an airplane at a Michigan State University football game and attendees that day at Sparrow’s tailgate party were given leaflets explaining patient safety concerns at Sparrow. Media outlets in Lansing were provided with on-camera interviews and press releases at every turn, and leaders were provided with media training.

Sparrow’s final offer was soundly rejected by the nurses and healthcare professionals. With 92 percent of the vote in favor of rejecting the offer and authorizing a strike, nurses and healthcare professionals began making plans to walk by creating signs and signing up for shifts on the picket line. Members kept careful track of managers who tried to coerce or threaten them, and gathered enough evidence for an unfair labor practice charge to be filed with the National Labor Relations Board. The ULP was filed in early November to protect the rights of members and stop the hospital’s desperate attempt to intimidate and coerce members who proudly stood up against the boss.

A tentative agreement with unparalleled staffing language was put to vote on Monday and Tuesday, Nov. 29 and 30. The agreement includes nurse-to-patient ratios and tech-to-patient ratios, and a penalty of $200 for every four hours a shift is short staffed.

“I am proud of the solidarity our members demonstrated at Sparrow,” said John Karebian, MNA’s executive director. “This employer witnessed firsthand that our members won’t idly sit by and watch the hospital lower standards in their contracts. Their unity led to improvements in the employer’s proposal on pension, health insurance, and staffing that ultimately sealed a deal.”

Rose Ann DeMoro, executive director of National Nurses United, hailed the agreement in The Washington Post as an “enormous victory for patients.”

—Ann Kettering Sincox
Caritas RNs Reach Landmark Master Agreement, Pension Benefit

The Massachusetts Nurses Association and Caritas Christi Health Care, the state’s second-largest healthcare network, in October ratified a landmark master agreement covering nearly 1,700 registered nurses working at four Caritas facilities: Carney Hospital in Dorchester, Good Samaritan Medical Center in Brockton, Norwood Hospital in Norwood, and St. Elizabeth’s Medical Center in Brighton.

The centerpiece of the agreement is the creation of a Taft-Hartley, multiemployer defined-benefit pension fund for the nurses, the first of its kind for RNs in Massachusetts, which will provide lifetime retirement security for nurses at a time when other employers are cutting, freezing, or attempting to eliminate pension benefits.

“We are pleased that Caritas has made a concerted effort to recognize and reward the nurses at their facilities for the contributions they make now and into the future,” said Julie Pinkham, RN, executive director of MNA. “The creation of a multiemployer defined-benefit pension fund has been a long standing goal of the MNA. I credit the senior leadership of Caritas who have the vision and leadership to address the pension issue for nurses, providing them an opportunity to retire with dignity after a career of caring for their patients, bucking the trend of many employers who are seeking concessions simply because they feel the climate will allow for it.”

The five-year agreement also includes a market-leading expansion of the nurses’ paid time off benefits, a generous early retirement package, and a commitment by MNA and Caritas to form a strategic alliance to address issues of quality care, with the proviso that both parties will soon work out a “neutrality” agreement to allow other nurses working at non-union Caritas facilities the opportunity to organize a union with the MNA if they so choose.

As a result of the paid time off benefit, nurses will be awarded between two and five extra days off per year, depending on their years of service, and will be able to cash out up to 80 hours of paid time off per year. The parties also negotiated hospital-specific contracts for each of the four MNA bargaining units, which address a number of nursing practice concerns that will improve patient care.

In addition to the pension benefit, each of the facilities were able to negotiate wage increases, with ratification bonuses of 2 percent and across-the-board pay increases of 2 percent at all four hospitals, additional 2 percent increases per year at most of the hospitals, and a salary reopener for all four hospitals in 2014. In addition to the bonuses and across-the-board increases, the nurses will maintain their stepped salary scales, which award nurses an additional 3.5 - 5 percent annual raise for each year of clinical experience at their respective facility.

The pension, dubbed the “The Nurses Pension Fund,” will augment the hospital’s existing 403b defined contribution plan, which Caritas had frozen last year, causing great concern for the nurses. As a Taft-Hartley pension fund, the new plan will be jointly administered by representatives of the MNA and the participating Caritas facilities. Caritas has agreed to establish the fund in 2012 by investing 4 percent of each nurses’ annual earnings into the plan, and will raise that contribution to 5 percent per year beginning in 2013. Under the plan, when nurses retire they will be guaranteed a defined benefit, a set monthly payment for the rest of their lives. Nurses have no obligation to contribute to the defined benefit plan, but if they choose, they can participate in a 401k plan to further bolster their retirement savings.

The creation of the new multiemployer plan is significant because now MNA and Caritas can work on expanding the plan to include other MNA local bargaining units outside of the Caritas system to negotiate agreements with other employers to join the fund.

“We are not only solidifying the retirements of the nurses at Caritas with this agreement,” Pinkham explained, “but laying the groundwork for the development of a real pension benefit that we hope to make available to thousands of nurses across the state.”

Finally, the nurses were able to address a number of other nursing and patient care issues in their respective agreements, which improve the quality and safety of care patients receive. At St. Elizabeth’s Medical Center, the nurses negotiated staffing language that creates a committee of nurses and management who will review and address staffing needs on all units in the hospital, while limiting the assignments of charge nurses, who are responsible for assuring the appropriate flow of patients through the system. The Carney Hospital nurses were also able to negotiate improvements in their staffing procedures, including protections for inappropriate “floating” of nurses, which is the practice of moving nurses between units to cover for staffing shortages. The Norwood Hospital nurses also formed a staffing committee to help ensure safe patient care, and have created a group to focus on preventing incidents of workplace violence at the hospital, a significant problem in healthcare today, as nurses are assaulted on the job as much as police officers and prison guards.

“We have made history with this agreement,” said Betsy Prescott, RN, chair of the MNA local bargaining unit at St. Elizabeth’s Medical Center. “We have achieved language that supports safer staffing levels on our units, and the creation of a multiemployer pension will not only provide retirement security of our nurses but will also open the door for other nurses throughout the state to eventually become part of this fund. The nurses at St. Elizabeth’s are thrilled with this settlement.”

—David Schildmeier
Despite disappointing losses in the recent midterm elections by candidates who would have better represented the interests of registered nurses and other working people, there were a number of hard-fought but significant victories around the country by NNU-backed candidates that tempered the rightward shift in political power.

In the Golden State, the California Nurses Association played a key role, arguably the key role, in defeating billionaire corporate darling Meg Whitman and carrying Jerry Brown, a longtime labor and consumer advocate, into the governor's office.

California is facing a $25 billion deficit and Whitman's proposals for balancing the budget would have all come at the expense of working, middle-income people: massive layoffs of public employees, the gutting of pensions earned after a lifetime of work.

Farewell, and Thanks

In these last midterm elections, more than 50 members of the U.S. House of Representatives lost their reelection bids and six Senate seats changed hands. Many of those who lost had been around a long time and had political careers that were notable. Members of National Nurses United around the country and all working Americans will have cause to miss those listed below.

Sen. Russ Feingold. For 18 years he has been a pro-labor senator and supportive of single-payer healthcare reform. He signed on to our Senate resolution protecting Social Security. He often took positions that were politically unpopular but principled, such as being the only vote against the Patriot Act. In 2007 and 2008 he pushed to cut off funding for the Iraq war and to set timetables for troop withdrawals. He was the main sponsor of reform of the campaign finance system, which he called “legalized bribery and influence peddling.” We will be hard pressed to find another Senator as willing to take on the political power of the rich and large corporations.

Rep. Jim Oberstar, Chairman of the House Transportation and Infrastructure Committee. A labor stalwart in the House, he devised the plan to help airlines after 9/11. He was a cosponsor of our Safe Patient Handling and Veterans Administration collective bargaining bills. The St. Paul Pioneer Press described him “as part scholar and part Iron Range street fighter, part pothole-filling ward healer and part working-class family man.” As chair of his committee, he continually worked to repair the infrastructure of the nation and put people back to work.

Rep. Joe Sestak. Considered by PASNAP to be a close ally in the House, he was defeated in his effort to be elected to the Senate from Pennsylvania. He had pledged to cosponsor with Sen. Barbara Boxer's NNU's national ratio bill in the next Congress and publicly opposed cuts to Social Security.

Rep. Dina Titus. She was close to NNU members in Nevada and a cosponsor of our VA collective bargaining and Safe Patient Handling bills. Nurses in Southern Nevada will miss her often public support for their efforts.

Rep. Phil Hare. He was a union worker and leader, having worked 13 years in a clothing factory. He was a supporter of single-payer health reform and outspoken critic of international free trade agreements. A cosponsor of our Safe Patient Handling and VA collective bargaining bills, he could always be called upon for help by the labor movement. We will miss his “working class” voice in the halls of Congress. —Joe Jurczak
States Stepping Toward Single-Payer

It’s time to work of registered nurses and other single-payer advocates across the nation, the untold story of the midterm 2010 elections is the encouraging news for single-payer. Prospects for single-payer healthcare reform efforts on a state-by-state basis brightened even as other progressive issues faced uncertainty following November’s elections.

In Vermont, Democrat Peter Shumlin, a strong supporter of single-payer, was elected governor. Before the election, Vermont’s Legislature passed a bill commissioning Dr. William Hsiao of Harvard University (and chief architect of Taiwan’s single-payer system) to prepare three design and implementation plans for a statewide healthcare system, and the Legislature designated that one of those design plans must be a single-payer. Hsiao’s plans will likely be presented in January 2011, and Governor-elect Shumlin has already been lobbying President Barack Obama to secure the federal waiver Vermont needs to pursue a single-payer system. With Shumlin’s election, chances are good that a single-payer plan in Vermont would survive legislative scrutiny and be signed by the governor into law. The state-by-state movement to enact single-payer may gain its first toehold in Vermont.

In Hawaii, former Rep. Neil Abercrombie, who had cosponsored the federal single-payer bill HR 676, was elected as governor and brings hope for single-payer in that state. In Massachusetts, where nurses have worked steadfastly to improve care for patients under the strain of their state’s insurance mandates, also known as Chapter 58 or “Romney-care” after their former governor Mitt Romney, voters in 14 districts overwhelmingly passed non-binding resolutions supporting single-payer reform, the largest number to date of districts to simultaneously pass these resolutions. Sandy Eaton, a Massachusetts RN who sits on the steering committee of the Labor Campaign for Single-Payer Healthcare, said that activists targeted districts represented by key legislative leaders and those with vacancies. The resolutions were direct and simple: The ballot question simply asked voters whether or not to instruct their local representative to “support legislation establishing healthcare as a human right regardless of age, state of health, or employment status, by creating a single-payer health insurance system like Medicare that is comprehensive, cost effective, and publicly provided to all residents of Massachusetts.”

“People already have concerns that the Massachusetts plan we have is not the way to go,” said Karen Higgins, a Massachusetts RN and NNU copresident. “We see costs being passed from employers to employees or companies just changing to cheaper plans. I think this is the people saying, ‘This is not working. We need to push and say that single-payer is the answer.’

And while no one in California would see Jerry Brown’s election as a slam dunk for single-payer in a state that has twice passed the measure only to have it vetoed twice by Gov. Arnold Schwarzenegger, the state now has the opportunity to look for a strategic single-payer solution that would never have seen the light of day had Meg Whitman been elected. California, with the world’s eighth-largest economy and 37 million people, provides an excellent environment for establishing a progressively financed, single standard of high-quality care through single-payer reform.

“Nurses know insurance companies don’t provide any value in the delivery of medicine,” said Malinda Markowitz, RN and NNU copresident. “We see costs going, ‘said Karen Higgins, a Massachusetts RN and NNU copresident. “We see costs being passed from employers to employees or companies just changing to cheaper plans. I think this is the people saying, ‘This is not working. We need to push and say that single-payer is the answer.’

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Texas

Metro Committee members throughout the state have been busy meeting with state legislators and community allies to make their case for supporting the Texas Hospital Patient Protection Act of 2011, the safe staffing ratio bill that state nurses plan to introduce this next legislative session. Besides state representatives, the RNs have set out to garner local city and county government support for the bill.

Austin metro RNs have meetings set with Texas Watch, Texas Forward, Grey Panthers, and the Coalition of Texans with Disabilities. At a recent AFL-CIO breakfast, San Antonio metro RNs used the opportunity to gather signatures in support of ratio legislation, and Houston RNs submitted a formal request to meet with the mayor’s office on a ratio resolution. Nurses also attended a legislative discussion hosted by Houston Congressman Gene Green.

While the landscape of Texas politics may have shifted some at the state level recently, the role of Texas nurses continues to be to engage more colleagues in the social movement for change, to improve the lives of their patients and the nursing profession.

Veterans Administration

Interim Chair NNU-VA Irma Westmoreland visited three Chicago VA facilities in October to discuss NNU-VAs focus on staffing and working conditions for staff RNs. She visited with nurses at the North Chicago VA, Hines VA, and West Chicago VA (Jesse Brown). RNs had lots of questions about NNU and were excited to see that NNU had a presence in their facilities.

NNU-VA will be working over the next few months to accomplish training in all the local units on the assignment despite objection (ADO) process and how registered nurses can make a concerted effort to address issues like safe staffing, mandatory overtime, and VA’s Staffing Methodology plans.

—Staff report

Healthcare Stat of the Month

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<td>47.6</td>
<td>Percentage of elderly living below the poverty line before receiving Social Security</td>
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<td>11.9</td>
<td>Percentage of elderly living above the poverty line after receiving Social Security</td>
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<td>19</td>
<td>Percentage of recipients who rely on Social Security as their sole source of income</td>
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<td>56</td>
<td>Percentage of seniors who had hospital insurance before Medicare</td>
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<td>47</td>
<td>Percentage of individuals receiving Medicare with incomes below $21,660</td>
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Source: Social Security Administration; Center on Budget and Policy Priorities; Kaiser Family Foundation; Commonwealth Fund
A chill wind is blowing from Washington.

The message that some inside the Beltway are embracing is that they have a mandate to escalate the transfer of resources from nurses and other working people to those who least need it, the Wall Street speculators, corporate titans, and the most wealthy among us.

A first shot came from the report of the president’s National Commission on Fiscal Responsibility and Reform which, fortunately, failed in early December to secure the votes it needed to move to Congress.

But with Wall Street still salivating at the prospect of full or partial privatization of pension plans, and the misguided deficit hawks in Washington still eyeing cuts in Social Security, the threat remains very real, and we must continue to speak out.

Proponents of the commission plan, Republicans and Democrats alike, called for raising the retirement age to 69 to qualify for benefits you’ve earned your entire working life, severely slashing retirement benefits by up to 35 percent for younger, middle-income workers, and reducing annual cost-of-living increases, along with other unwarranted cuts.

No wonder some called it the “catfood commission” to memorialize the conditions they wanted to force upon far too many retirees.

For RNs, predominantly non-union nurses, many who have labored with no or minimal employer-sponsored pension plans much of their adult lives, and many of whom now face escalating demands by management for reductions in their retirement programs, these recommendations are ominous indeed.

Take Marie Barrentine, an operating room RN in Kansas City. Marie has concluded that she needs at least $3,000 a month in order to retire, but can only account for $2,000 a month. That’s why Marie is still working full time as a staff nurse in the OR at age 69.

NNU Co-President Karen Higgins of Massachusetts, an RN who works in critical care, said she “cannot even fathom nurses at 69 still being required to work. You need to have the highest mental and physical alertness to be able to provide safe care. The idea that nurses would be able to do that at 69 is dangerous to patients, but forcing us to be in a position that we would have to is disgraceful.”

Social Security, says retired Sacramento RN Elizabeth Pataki, “is vital. Many RNs retired early with back injuries and a long work history that involved great stresses on backs and joints, and simply have to retire early because they can no longer keep up with the pace of work that every year becomes physically more demanding.”

As a result, more nurses than ever, “cannot work to the usual age of retirement,” says Pataki, with the effect that “pensions and savings are both lessened.” The margin of economic protection is eroded, and “they may fall lower and lower in living standards and be struggling just to get by. Yet to require nurses to work longer can harm a nurse for the rest of her life.”

There are many RNs like Marie and Elizabeth across the country, nurses who have good reason for concern about the security and dignity they can look forward to upon retirement after a lifetime of caring for others.

They wonder why those in the insular world of Washington politics would be playing games with their future and seeking to “fix” a system that is not even broken.

Speculators on Wall Street who hope to cash in on privatization of Social Security, along with those in the media and Congress who say cuts in Social Security are needed to reduce the budget deficit, have sadly misled the public.

Social Security is not part of the federal budget; it was consciously set up by the Roosevelt administration during the New Deal to be funded through payroll deductions. It would be hard to find a program that has been more successful, or popular.

The year after Social Security was enacted, finally securing a degree of economic security and hope for millions in the midst of one of the deepest moments of despair in our nation’s history, the president who promoted and signed the law, Franklin Roosevelt, was reelected in perhaps the biggest landslide in U.S. history. For 75 years, its opponents have had to resort to deception and distortions when seeking to erode this legacy.

Even today, Social Security has a $2.6 trillion surplus, a figure expected to rise to $4.3 trillion within the next decade, and will remain in the black for at least the next 27 years.

Whatever problems Social Security may face in the future, progressive economist Robert Kuttner recently wrote on Huffington Post, derive from “the fact that all the income gains have gone to the top ... If you want to get Social Security well into the black for the indefinite future, the easiest way is to restore wage growth.”

The priority in Washington ought to be creating good-paying jobs at living wages, such as expanding Medicare to cover everyone which, as NNU has documented, by itself would create at least 2.6 million new jobs, plus guarantee healthcare for everyone while curbing the still-escalating costs of healthcare.

The fight to defend and protect Social Security is a battle for the security of all nurses and all working Americans – and the best message we can send to the incoming Congress and continuing administration in the White House for solutions is to expand the social safety net, not enrich those who need it the least.
Not in
Workplace violence for registered nurses is rising steeply, and RNs are rightly refusing to accept it as part of the job. How they’re fighting back.

A STAFF REPORT

PHOTO BY JACLYN HIGGS
AS ANY REGISTERED NURSE CAN TELL YOU, VIOLENCE AT WORK CAN TAKE MANY DIFFERENT, UNEXPECTED FORMS.

It can be the belligerent, drunken 20-something who needs stitches in the ER, or the disoriented, elderly lady in post-op who scratches and tries to bite you every time you change her dressing. Maybe it’s not physical, but a verbal threat to hurt you after work. Sometimes it’s not even the patient, but the patient’s family members who abuse the medical staff.

But workplace violence in medical settings does have one thing in common: it’s prevalent, and rising quickly. The Joint Commission, the federal body that accredits hospitals, in June warned that since 2004, the database it keeps of sentinel events on hospital grounds had significant increases in reports of assault, rape, and homicide, with the greatest number of reports from 2007 to 2009. The healthcare industry has the highest rates of workplace violence among all sectors, constituting 45 percent of the two million incidents that occurred annually in the United States between 1993 and 1999, according to the U.S. Bureau of Labor Statistics.

A survey released in July 2009 by the Emergency Nurses Association reported that more than half of all emergency room nurses had been physically assaulted at work, which includes being spit upon, hit, kicked, pushed or shoved, and scratched.

Anecdotally, RNs are reporting that conditions have worsened in the past five years because patients are more prone to lose control. Due to the Great Recession and massive layoffs which have resulted in even more patients losing health insurance coverage and mental healthcare, people are stressed out, desperate, and more agitated when they enter the hospital or seek help from the emergency room.

Several severe attacks on medical providers have captured headlines recently. In late October, a patient inmate at a jail in Martinez, Calif. faked a seizure and smashed a lamp into the head of responding RN Cynthia Barnca Palomata, killing her. In June, Joan Meissler, an emergency room RN at Temple University Hospital in Philadelphia, was badly beaten by patients. A psychiatric technician at Napa State Hospital in California was strangled by a patient in October. And in September, the son of a patient shot a Johns Hopkins Hospital doctor before turning the gun on his mother and himself.

“It’s all part of inadequate healthcare for people and especially the lack of mental health,” said Patricia Eakin grimly. Eakin is an emergency room registered nurse who works with Meissler at Temple University Hospital and is president of the Pennsylvania Association of Staff Nurses and Allied Professionals. “People don’t have a family doctor or social safety net, so they come to the ER, and the wait times are huge.”

In response to workplace violence, many National Nurses United affiliate groups are working to help prevent the incidents from happening in the first place through better staffing, and to ensure that incidents that do happen are prosecuted or handled seriously. Some RNs who are currently bargaining contracts are seeking to include model workplace violence language into their agreements. Another route for groups is to pursue legislation in their respective states.

Following Palomata’s death, the California Nurses Association worked with California Assemblymember Mary Hayashi to introduce a bill, AB 30, that would assure RNs have adequate staffing and safety measures at work. Staffing, say RNs, is critical to minimizing violence because not only is the physical presence of more nurses a deterrent to someone who might cause trouble, but more nurses also ensures that patients and their families receive quality care and attention, keeping frustration levels down.

In Massachusetts, the law already treats any assault on an emergency medical technician while the technician is providing care as a separate crime with its own set of penalties. The Massachusetts Nurses Association in spring helped pass a law that extends those same protections to nurses. MNA is also still working on additional pieces of workplace violence legislation.

Pennsylvania RNs are also considering introducing legislation. Meanwhile, they are tackling the problem through education. Eakin said that RNs at Temple have been complaining to management for years about inadequate security and problem patients, but that the hospital never took their concerns seriously. For example, after one impatient man repeatedly confronted an ER triage nurse about getting examined and then threatened to “blow [her] f****** head off with a shot gun” when she got off work, the security guards simply told the man that he “shouldn’t be rude to the nurses.”

Eakin ultimately filed a class action grievance against Temple around the time Meissler was attacked. Once she started doing research into workplace violence for nurses, she learned it was a major issue for RNs all over the state.

So on Nov. 10, PASNAP decided to hold its first statewide workplace violence conference for unionized as well as nonunion RNs, an event so well attended there was standing room only. The Massachusetts Nurses Association presented its continuing education course on workplace violence, the RNs shared stories, and district
attorneys from two major counties spoke about prosecution of violence against nurses. Though many attendees knew violence at work was a serious problem, even they were surprised to learn the vast extent of the violence: bites, punches, kicks, knives being thrown, guns being pulled, faked seizures, out-of-control patients, pulled hair, insufficient security. Everyone had a similar story.

Eakin said that some of the main lessons nurses took away from the conference was that, first, being attacked at work is not part of the RN job description. No other profession would tolerate such behavior at work. It’s management’s responsibility to ensure that violent acts do not happen or to respond quickly and appropriately if they do.

Second, nurses who are assaulted need to understand that they are victims of a crime. Before the conference, many nurses and healthcare professionals were led to believe that being attacked at work was “just part of the job” or that “the patient didn’t know any better.” There was a general misbelief that as caregivers, they had no right to stand up for their own safety.

PASNAP is forming a workplace violence task force that will work toward crafting legislation and educating RNs on the topic. Meanwhile, Eakin reports that Temple University Hospital has not only changed security companies for the emergency department, but beefed up the number of guards from three to five.

“Nobody should ever accept violence and assaults at the workplace,” said Eakin. “It doesn’t matter whether the patient is on drugs, psychotic, or out of control. Management should have methods and a plan in place. Let’s prevent violence in the first place.”

Emily Randle contributed to this report.

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Cynthia Barraca Palomata, RN died Oct. 28 from injuries she sustained when an inmate at the California jail where she worked allegedly faked a seizure and hit her on the head with a lamp when she tried to help him. Palomata was 55.

Born Nov. 28 in Nabas, Aklan in the Philippines, Palomata immigrated to the United States in 1983 after nursing school and worked at a variety of Bay Area hospitals, including San Francisco General Hospital and Children’s Hospital of Oakland, for more than 20 years before she started at the Martinez Detention Facility in 2005.

Her relatives and coworker friends remember Palomata as a caring, humble, gentle person who understood that the important things in life were love of family and to be content with what you had. “She was a very sweet, loving, happy person,” said her younger sister, Cecille Schutzmann-Barraca. “For me, I will miss her companionship, especially when she spends time with just me and our mom – just us three girls talking and laughing.”

Greg Montes, an RN who often worked alongside Palomata on their busy 3 p.m. to 11:30 p.m. shifts, described her as an excellent, empathetic nurse whom her coworkers greatly admired. He remembers she was always willing to lend an extra hand if she had the time, and that she had a quiet strength about her.

“I looked up to her,” said Montes. “Cynthia was very calm. You know, people come upset into the jail. But Cynthia will not react to it or let it affect her doing her job. She was able to deflect their anger and understand that they were angry not at her, but their situation. Usually by the time she was done with their medical screening, they’d be a lot calmer because they knew she wasn’t trying to do anything to them but help them.”

A registered nurse through and through, Palomata believed that her patients deserved quality healthcare just like anyone else, and never hesitated to advocate for them in her reserved, behind-the-scenes manner. In turn, the inmates deeply respected her. Montes said that many inmates always took the time to greet “Nurse Cynthia” and her sister said that Palomata had mentioned that she was some of the inmates’ favorite nurse. Palomata was so well liked by her patients that Montes said, after her death, the inmates in one wing of the jail presented the nursing staff with a pencil drawing one of them had done in her honor. The sketch depicted the river and tree of life and they had all signed it.

Palomata would have appreciated the artwork. Besides nursing, she also liked to draw, mostly flowers and nature scenes. She also played the piano and the guitar, and gardened, sometimes bringing her orchids into work. She enjoyed going out, shopping, spending time with her family, and practicing her faith, which her family said sustained her during hard times.

Palomata is survived by her husband, Gedelfo; her adult son, Earl; her mother, Perla Barraca; her siblings; and other family members. A trust account has been set up for Palomata’s family in her name: Cynthia B. Palomata Trust Fund, Redwood Credit Union, San Rafael Branch, Routing #321177586, Account #356859.

—Lucia Hwang
Brewing Storm

How the recent push to slash Social Security and Medicare in the name of deficit reduction is really a revocation of the social pacts these programs represent. **BY CARL BLOICE**
Registered nurse Deborah Burger’s father died at 38, leaving her mother to care for three girls. Because of that and her life’s trajectory since then, Burger has a special vantage point from which to view the current political battle over the future of Social Security and Medicare.

“If it hadn’t been for Social Security, our lives would have been much different,” she said. “We were very, very lucky the programs existed. I learned this very early on, especially because I was able to stay in college until I was able to earn a living on my own.”

Because of Social Security and veterans benefits, Burger’s mother today enjoys some financial security. Together they make it possible for her to pay the rent (though there’s not much left over) and Medicare makes it possible for her to get the care she needs and pay for her medications.

And as an RN, Burger, a co-president of National Nurses United, said she views Social Security and Medicare almost as preventive health programs. “They are patient lifesavers because they keep people out of the hospital as much as possible, free of grinding poverty and thriving in their retirement,” said Burger.

Another NNU RN co-president, Karen Higgins of Massachusetts, said she too views the issue both professionally and personally. Her father, a construction worker, died in his forties. Higgins’ mother raised six children and today receives only a very small benefit check each month. Higgins said her family members are fortunately in a position to help her mother but not everyone is as lucky. “More women are living below the poverty level and must depend on Social Security,” she said. “They are frequently paid less than men and are also likely to move in and out of the workforce as they raise families and therefore the benefits they receive are less. I think it is disgusting that we should even consider cutting back on Social Security benefits or reducing Medicare provision,” said Higgins.

Both programs are critically important for women, particularly registered nurses, and plans to cut back benefits and raise the eligibility age could hit RNs particularly hard. “Nurses have worked for years with substandard retirement systems and now there is an effort to reduce them even further,” said Jean Ross, RN and the third NNU co-president from Minnesota. “Almost every time we go into negotiation these days management proposes to erode our retirement plans. In fact, defined benefit pensions are disappearing all over the place. Any cutbacks in Social Security will only increase our insecurity and that of others, like our younger nurses, as well.”

The three NNU leaders reflected on these watershed programs just a few days after the co-chairs of the National Commission on Fiscal Responsibility and Reform, former Sen. Alan Simpson and former White House Chief of Staff Erskine Bowles, publicly released a statement Nov. 10 calling for drastic scale backs of Social Security and Medicare without the support of or discussion with the larger commission. The final report, which recommended raising the retirement age to 69 among a host of other changes, was issued in early December. “I cannot even fathom nurses at 69 still being required to work,” said Higgins. “You need to have the highest mental and physical alertness to be able to provide safe care. The idea that nurses would be able to do that at 69 is dangerous to patients, but forcing us to be in a position that we would have to is disgraceful.”

Critics of the effort to sharply reduce or eliminate the two programs have taken to calling the body the “Catfood Commission,” referring to the danger of indigent seniors being compelled to consume pet food, as has been known to happen. They also point out that blaming Social Security for our national deficit is a red herring since the program is funded through payroll taxes and does not contribute to our debts.

As the Congressional holiday recess neared, the fact that the commission had scarcely deliberated, not voted on the report, and that more than 130 members of the House of Representatives had already promised to vote against severe Social Security cutbacks almost guaranteed that no action would be taken by the outgoing Congress.

But efforts to permanently undermine Social Security and Medicare are very real and well funded. The stage has now been set for the attacks on Social Security and Medicare to be a major factor in the spring when Congress takes up the federal budget to be submitted by the Obama administration.

The release of the Simpson-Bowles recommendations coincided with the launching of a new media campaign by the Peter G. Peterson Foundation, a group established in 2008 with an endowment of $1 billion by investment banker Peter G. Peterson, a co-founder of the Blackstone Group. The $6 million campaign is titled “OweNo” and employs television advertisements to warn the public about what the foundation characterizes as the danger of the current federal deficit.

The two commission heads acknowledged in their statement that the aim of their proposals on Social Security are not intended as steps to reduce the deficit, thereby acknowledging that the program does not contribute to the federal budget shortfall. It underscores what critics of the commission have maintained all along: that what motivates Peterson, Simpson, and Bowles to go after Social Security and Medicare is nothing but ideological—a determination to whittle away whatever remains of the New Deal and Great Society social programs.

There was no reason the commission needed to deal with Social Security at all. Dean Baker, co-director of the Center for Economic and Policy Research (CEPR), said it is “striking that they felt the need to address Social Security’s solvency even though it was not part of their mandate. The commission’s mandate was to deal with the country’s fiscal problems. Since Social Security is legally prohibited from ever spending more than it has collected in taxes, it cannot under the law contribute to the deficit.”
RN Jean Ross pointed out that Simpson and Bowles could have suggested any other number of possible real solutions to our deficit. “These commissions are proposing nothing to close tax loopholes and create jobs,” said Ross. “A good place to start would be to expand Medicare to include everyone. That alone would create about 2.6 million jobs. They also say nothing about the wars that are draining the economy.”

Critics say that despite all the commissioners’ talk of defending the poor, the victims of their plan would be working people and the effect will be to exacerbate economic inequality. Social Security benefits now go to nearly 54 million retirees, disabled workers, surviving spouses, and children. Payments for retired workers average $1,020 a month; disability benefits average $929 a month.

Contrary to what some media reports have maintained, the proposed change in the cost-of-living calculation would begin in 2011 and affect all beneficiaries, not just future retirees.

Part of the flimflam around the commission co-chairs’ proposal is the oft-stated notion that these changes would help the poor and lower benefits for the rich. In fact, those hardest hit would be average workers. “The vast majority of near-retirees will rely on Social Security for most of their income in retirement,” said Baker. “All of these proposals will result in significant cuts in income for low- and middle-income families.”

Within a few years, people now making about $40,000 a year could expect that if they retired in 2040, their monthly benefits would be 12 percent lower than under present law. A worker retiring in 2080 would get $900 a month, 28 percent less than she or he would receive currently. Someone earning an average of about $100,000 over a 35-year working life would receive close to 50 percent less.

Much is being made of the commission’s proposal to switch to “progressive price-indexing,” which means tying initial benefit levels to changes in prices rather than average wages. However, critics charge that the change would significantly cut security benefits for many recipients. In a report issued by the Center on Budget and Policy Priorities, researchers Kathy A. Ruffing and Paul N. Van de Water maintain that, among other things, this approach is “misguided” for several reasons.

First, it would significantly cut future benefits for very large numbers of workers — including those with relatively modest incomes — compared to currently scheduled benefit levels and “under the most common progressive price indexing proposal, benefits would be reduced by nearly 30 percent for those who earned medium wages (about $43,000 in 2010 dollars) and by as much as 50 percent for higher earners.”

Second, future retirees would over time fall further and further behind their previous standard of living — and behind the rest of society “because price indexing would steadily reduce the fraction of workers’ past earnings that Social Security benefits replace.”

Third, progressive price indexing “would weaken — and eventually, for many workers, eliminate — the link between their earnings and the benefits they receive upon retirement” which “would represent a sharp change in the program’s philosophy and would risk undercutting its broad base of support.”

On the question of eligibility, Simpson and Bowles propose to increase the age a person would qualify for Social Security by one month every two years past the current eligibility age of 67. The normal retirement age would rise to 68 in about 2050 and 69 in about 2075. But by raising the retirement age, their plan discriminates against lower-wage workers. As the Strengthen Social Security
Social Security is not in any trouble that cannot be overcome with a little common sense. Lower-income women have experienced declines in longevity. Yet, the higher retirement age applies to rich and poor, healthy and sick, alike. In effect, the proposal says to lower-wage workers that they must work longer because the rich are living longer.

According to a recent report from the Government Accountability Office, any raising of the retirement age for Social Security can be expected to disproportionately hurt low-income workers and minorities, and increase disability claims by seniors no longer able to work.

On Medicare, the commission co-chairs’ recommendations and much of the media commentary overlook the fact that it is not the escalating cost of Medicare that is causing the program to suffer but rather the constantly soaring costs of healthcare that is pushing Medicare costs steadily upward. Although the recently passed healthcare reform measure is said to make some inroads in lowering healthcare cost, halting its upward trajectory is a task yet to be undertaken.

“In reality, healthcare cost inflation and insufficient tax revenues are by far our biggest long-term budget challenges,” concluded researchers Harry Ballantyne, Lawrence Mishel, and Monique Morrissey in a study published by the Economic Policy Institute.

“More than half of our healthcare is paid for by the government, so this projected growth rate of healthcare costs would eventually lead to serious budget problems in addition to leading to enormous problems for the private sector,” said Baker, the economist. “However, the underlying problem is the broken healthcare system, not public-sector healthcare programs. This subtlety also seems to have escaped Simpson and Bowles.”

Simpson and Bowles are not the only ones attacking Social Security and Medicare. On Nov. 17, former Clinton budget director Alice Rivlin and former Republican Senator Pete V. Domenici of New Mexico released a report from a separate deficit reduction commission they headed. Their Social Security plan would simultaneously increase revenue by gradually raising the amount of wages subject to payroll taxes and cutting benefits for certain groups of beneficiaries, among other things.

On Medicare, the Rivlin-Domenici plan would turn it into a “premium support” program that would limit the rate of increase of federal spending per beneficiary. The plan envisions saving $123 billion by increasing Medicare premium costs. The proposal also calls for slowly raising the eligibility age for Medicare to 67. Huffington Post Senior Washington Correspondent Dan Froomkin wrote that under the Rivlin-Domenici plan, “after 2018, Medicare beneficiaries would either be forced to pay out of pocket for any and all cost increases more than 1 percent greater than the growth rate of the economy – or they would be invited to leave the government program entirely and find private insurance instead. That would no longer be Medicare as we know it—or as future retirees expect it.”

Just who are these characters purporting to “reform” these landmark programs? The backgrounds of the principals involved in targeting Social Security gave good indication where this was all headed. Bowles, a Democrat, is president of the University of North Carolina and sits on the board of Morgan Stanley and General Motors. His wife, Crandall Bowles, is on the board of JPMorgan Chase, which prompted Matthew Skomarovsky, co-director of the Public Accountability Initiative, to refer to the couple as “two of the biggest beneficiaries of the government’s financial welfare over the past two years.”

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CE Home Study Course

Scripting and Rounding
Impact of the Corporate Care Model on RN Autonomy and Patient Advocacy

This home study CE is part two of a two-part series. The first installment appeared in the October 2010 issue of National Nurse and is required reading for successful completion of this home study course.

Description

This home study course examines the impact of scripting and rounding on the autonomous practice of registered nurses that interferes with their critical role as patient advocates. Scripting and rounding schemes are being aggressively marketed, incentivized, and implemented in a variety of acute-care and outpatient settings using deceptively reassuring terms on embracing change, transforming care at the bedside, and increasing customer satisfaction designed to create and influence the public’s “perception” of quality.

It describes a new restructuring model for nursing, which is aimed at deskilling and automating RN interactions with patients. Under these new schemes, patient outcomes are secondary to patient satisfaction scores based on customer service and hospitality as practiced by companies such as Disney and five-star hotels. These schemes are being mandated by hospital policy over the objections of direct-care RNs despite the fact that there is a dearth of evidence linking patient satisfaction to positive clinical healthcare outcomes.

Objectives

Upon completion of this home study RNs will be able to:

Articulate their major advocacy role in the delivery of safe, therapeutic, and effective patient care where the patients’ individual
healthcare needs, interests, and wishes are respected and protected. Explain the potential of protocols and patient interaction scripts for replacing individualized human interaction in the delivery of healthcare. Describe how rounding, scripts, and rigid protocols can supplant critical thinking and override the independent professional clinical judgment of registered nurses.

State why safe staffing with specific, numerical RN-to-patient ratios, and the requirement that hospitals staff up from the minimum based on individual patient acuity, is an evidence-based practice that improves patient outcomes, results in cost-savings, and increases both patient and nurse satisfaction that allows direct-care RNs to be in control of the nursing process.

What’s It All About, All “P’s”?
The essentials of rounding and scripting (The 3 P’s) are as follows:

3. **Position:** The RN is to ask if the patient wants repositioning help.
(Notes: Some scripting schemes add a 4th ‘P’)
4. **Possessions:** The RN is to ask if the patient’s possessions are within reach.

Another common rounding scheme refers to “the Four Rs”
1. **Rx:** Provide any needed medication.
2. **Reach:** Are the patient’s belongings within easy reach?
3. **Respond to questions:** Ask if there is anything else the patient needs.
4. **Reassure:** Express care and concern. Let the patient know at what time the next rounding visit will occur.

Some hospitals are using acronyms to help the RNs remember their scripts. One example is A.I.D.E.T.* (*Studer Group). The tool is marketed as reinforcing “important key words” and is also known as the “Five Fundamentals of Service” to help build customer loyalty. Managers are instructed to coach their staff using A.I.D.E.T” as a “communication framework” to improve patients’ perceptions of care provided by the staff.

A stands for **Acknowledge** the patient. “Hello, Mrs. Jones.”
I stands for **Introduce** yourself. And state your certifications/experience
D stands for **Duration;** “Your test results won’t be back until tomorrow.”
E stands for **Explaination;** “This is part of the excellent care we provide here.”
T stands for **Thank You;** “Thank you for choosing our hospital, Mrs. Jones.”

Many RNs who have been introduced to these schemes are aghast at the patronizing assumptions behind the introduction of these schemes, i.e. that RNs do not already acknowledge and introduce themselves to the patient or explain procedures to the patient.

On the face of it, these seem like very obvious interventions for an RN to perform. Where the danger lies in this scheme is that the RN becomes over-scripted and is pressured to adhere to a script and so ceases using critical thinking skills and focusing on the individual needs of each patient.

The usual initial question asked of this scheme by RNs is, “Why is this necessary?” After all, RNs are educated and experienced in meeting all of their patients’ needs as well as providing first-class patient care using the nursing process. One answer to that question is a familiar one in the corporate model of healthcare: money!

Patient satisfaction scores rather than patient outcomes have become a major driver of the corporate healthcare agenda. The Centers for Medicare and Medicaid Services (CMS) is now using patient satisfaction scores as a measure of quality care and reimbursing hospitals accordingly. Press Ganey, an independent for-profit company, has marketed itself to the hospital industry as the “go-to consultant” on how hospitals can improve their patient satisfaction scores to meet the requirements of the new CMS criteria. In its marketing messages to the hospital industry, Press Ganey makes the following
statement: “...those institutions that react quickly and comprehensively can turn higher patient satisfaction into a clear competitive advantage in the marketplace.”

The new CMS criteria along with aggressive marketing from companies such as the Studer group and Press Ganey have resulted in hospitals experiencing “market anxiety,” leading to a clamoring for new ways of improving patient satisfaction. This “market anxiety” leads to less-than-critical thinking on the part of the hospital administrators and so-called nurse leaders, whereby they become easy prey for outside consulting groups to come into their facilities to “train” their staff on these new schemes. Since their pay and personnel evaluations are often conditional on successful implementation of these schemes, management has a vested, personal self-interest in promoting adoption and could be biased toward reporting positive outcomes, which makes the data and its interpretation highly suspect and unreliable.

Of course these rounding schemes are endorsed and promoted by the same corporations and hospitals that stubbornly fight against improving nurse-to-patient ratios or attempt to replace RNs with lesser-skilled healthcare workers. According to Dr. Christopher Guadagnino, in a December 2003 article he wrote for Physician’s Digest News, “variation in measurement tools is an obstacle to making patient satisfaction a reliable part of the quality equation. Even if redundancy and variation of patient satisfaction measurement can be minimized to permit meaningful comparison across providers, questions remain...whether it is even appropriate to consider patient satisfaction as a valid clinical quality indicator.”

A recent Institute of Medicine report outlined six characteristics of quality healthcare: safe, equitable, evidence-based, timely, efficient, and patient centered. Lack of comparability of patient satisfaction data remains an obstacle to its expanded use. Measured by different entities, for different purposes, using different instruments, patient satisfaction data is far from uniform. In a December 2003 interview also reported in Physician’s News Digest, Carey Vinson, medical quality director for Blue Cross-Blue Shield, said, “Patient perception data about clinical processes and outcomes may lack validity, and not many tools currently exist to measure what is going on inside a hospital or a physician’s office.”

According to Dr. Marshall Webster, MD, president of the University of Pittsburgh Medical Center’s Physician Services Division, and president of UPMC’s physician services, “measurements (surveys) are best kept to the quality of service side rather than become integrated with the quality of care issues. I don’t think the Press Ganey survey is the kind of instrument that is helpful for us in looking at very objective measurements of quality of care. We want specific, objective, measurable things that attest to the quality of care that we are providing—for example, one year survival after liver transplants.”

One obvious method of improving patient satisfaction as well as patient outcomes would be to improve nurse-to-patient ratios. According to a study published in the New England Journal of Medicine, American patients generally express a higher satisfaction with their hospital stays when cared for and treated in facilities with a higher ratio of nurses to patients. They rated their experience with their hospital stays more positively than patients admitted to hospitals with poor staffing and higher nurse workloads.

A recently published study in Health Services Research (2010) titled “Implications of the California Nurse Staffing Mandate for Other States,” (Aiken, L.H., Sloane, D.M., Cimiotti, J.P., Clarke, S.P., Flynn, L., Seago, J.A., Spetz, J., & Smith, H.L.), reveals that improving nurse-to-patient ratios has demonstrated significant positive outcomes:

- New Jersey hospitals would have 14 percent fewer patient deaths and Pennsylvania 11 percent fewer deaths if they matched California’s 1:5 ratios in surgical units.
- California RNs have far more time to spend with patients, and more of their hospitals have enough RNs on staff to provide quality patient care.
- Fewer California RNs miss changes in patient conditions because of their workload than New Jersey or Pennsylvania RNs.
- In California hospitals with better compliance with the ratios, RNs cite fewer complaints from patients and families and the nurses have more confidence that patients can manage their own care after discharge.
- California RNs are far more likely to stay at the bedside, and less likely to report burnout than nurses in North Carolina or Pennsylvania.

There is a direct correlation between nurse satisfaction and patient satisfaction reported in the scientific, peer-reviewed literature, a study titled, “Nurse Burnout and Patient Satisfaction”, Vahey, D.C., Aiken, L.H., Sloane, D.M., Clarke, S.P., & Vargas, D. (2004), published in the journal, Medical Care. The authors reported the following:

**Results of the survey showed:** Patients cared for on units that nurses characterized as having adequate staff, good administrative support for nursing care, and good relations between doctors and nurses were more than twice likely as other patients to report high satisfaction with their care, and their nurses reported significantly lower burnout. The overall level of nurse burnout on hospital units also affected patient satisfaction.

**Conclusions of the survey were:** Improvements in nurses’ work environments in hospitals have the potential to simultaneously reduce nurses’ high levels of job burnout and risk of turnover and increase patients’ satisfaction with their care.

More recently, in a 2008 article published in the New England Journal of Medicine titled, "Patients’ Perception of Hospital Care in the United States,” authors Jha, Orav, Zhou, and Epstein reported the following:

**Results:** As compared with hospitals in the bottom quartile of the ratio of nurses to patient-days, those in the top-quartile had a somewhat better performance on the HCAHPS survey (e.g., 65 percent versus 70.2 percent of patients responded that they “would definitely recommend” the hospital; P<0.001). For example, those in the top quartile of HCAHPS rating performed better than those in the bottom quartile with respect to the care that patients received for acute myocardial infarction (actions taken to provide appropriate care as a proportion of all opportunities for providing such actions) and for pneumonia in unadjusted analysis.

**Conclusions:** This portrait of patients’ experiences in U.S. hospitals offers insights into areas that need improvement, suggests that the same characteristics of hospitals that lead to high nurse-staffing levels may be associated with better experiences for patients, and offers evidence that hospitals can provide both a high quality of clinical care and a good experience for the patient.

Investigators have linked the HCAHPS data to the American
Hospital Association's annual survey which provided information about nurse staffing levels, profit status, number of beds, teaching status, and rural or urban location. According to their study the biggest satisfaction differences between hospitals with higher versus lower nurse-to-patient ratios showed up in the specific areas related to nursing services: discharge instructions, communication with nurses, and communication about medications.

Of interest, researchers also found that patients in nonprofit hospitals ranked their satisfaction higher than patients in proprietary hospitals; something the authors suspected might be related to patient expectations. There was no difference in satisfaction between teaching and non-teaching hospitals. Patient satisfaction was associated with quality of clinical care on indicators for the conditions assessed: acute myocardial infarction, congestive heart failure, pneumonia, and surgery.

Rounding and other similar patient satisfaction schemes do nothing to improve actual therapeutic patient outcomes. They are short sighted and are aimed at manipulating the perception among patients and visitors that staffing is adequate. These “creative” management schemes depersonalize the relationship between RNs and patients. Ultimately they interfere with the Nursing Process, the RN's professional judgment and control of their ability to prioritize, assess, plan, individualize, implement, and evaluate the care they provide. Such interference leads to nurse dissatisfaction and burnout, poor patient outcomes, and lower patient satisfaction.

Rounding schemes are not required by CMS for the purpose of obtaining increased reimbursement incentives. These schemes never discuss the ratio of RNs to patients even though the CMS guideline states:

“The nursing service must ensure that patient needs are met by ongoing assessments of patients' needs and provides nursing staff to meet those needs. There must be sufficient numbers, types and qualifications of supervisory and staff nursing personnel to respond to the appropriate nursing needs and care of the patient population of each department or nursing unit.

There must be a RN physically present on the premises and on duty at all times. Every inpatient unit/department/location within the hospital-wide nursing service must have adequate numbers of RNs physically present at each location to ensure the immediate availability of a RN for the bedside care of any patient.”

By tying reimbursement to patient satisfaction using rounding schemes, CMS would be in violation of its own guidelines. Rounding schemes appear to come from the same philosophical place as computerized charting, charting by exception, overuse of technologies, speed up and fragmentation – all driven by the depersonalization of healthcare. Rather than stress individual care, the new paradigm is population-based care, i.e. fitting patients into a statistical mean. This also corresponds with attempts to deskill the health professions to both save on labor costs and eliminate the voice of professional advocacy.

Experienced bedside RNs are reacting to the introduction of these scripts in their facilities. Here are just a few of the comments made about such scripts:

“Most nurses are ‘people persons,’ and we know instinctively that we can save ourselves a lot of time and give the best care by anticipating our patients’ needs. It’s so much easier to invest a few minutes of time at the beginning of the shift to learn who your patients are and what they need, and assure them that you will do your best to meet those needs. No one has to tell us how to do this; it comes naturally.”

“It’s the idea of the ‘script’ that sticks in my craw. Nurses are professionals; it’s insulting to all concerned to demand that we utter a canned, pat phrase like ‘Is there anything else I can do for you I have the time.’ It sounds insincere and forced, and most patients know it.”

“If hourly rounding and scripting is supposed to be so fundamental in a customer service focus, but if everyone is doing this latest management craze then I don’t see how it will help these institutions stand out. And now the big trend for managers is being taught the lean, mean ‘Toyota Way’ or the ‘Disney Way’; and they have another new thing called a ‘Power Minute’ where a manager comes along and tells you something new, then you have to sign and say you agree with it or you learned it. In about to go ballistic! Who are these people and why should we listen to them? It’s like, they’re not even nurses.”

“Our hourly rounding logs hanging on the patient doors say at the bottom, ‘Always remember to ask: Is there anything else I can do for you, I have time?’ Sure, I have time as my hospital-issued cell phone is ringing off the hook, and the pager connected to my patient’s monitor is beeping. Instead of calling in more staff to answer the call lights, they want us to fill out another form and they write us up if we have to stay overtime to finish our charting.”

“We have the same exact script at our hospital. In critical care you almost never leave the patient’s room anyway, but to be told what to say and to have to initial and check a piece of paper to show I was in the room is insulting. If the patients in a coma they want us to have the family bring in a picture and dialogue with the patient about their picture.”

“Why don’t they just look at my charting and read it if they want to know what I’ve done for my patients? The initial rounding log isn’t part of the patient record anyway; it’s for our boss. If you don’t fill it out you get counseled and if you get more than three counselings, you are suspended and they threaten to terminate you. I didn’t know that R.N. stood for Robot Nurse.”

“At my hospital we formed an informational picket to alert the public about our employer’s failure to correct several safety issues brought forward by the staff nurses. We developed our own acronyms and a rather colorful chant about the phony ‘AIDET’ scripts our boss was pushing: A is for Asinine, Abhorrent, and Abominable; I is for Insulting, Intrusive, and Idiotic; D is for Demoralizing, Deskilling, and Dumb; E is for Egregious, Erroneous, and Excrement; T is for Thoughtless, Terrifying, and Trespassing on our rights as nurses.”

**Compare and Contrast: Nursing Practice and Patient Advocacy Standards vs. Commercial Interests and Corporate Profits**

The CNA/SNOC/NNU professional practice and patient advocacy model definition of “quality” in nursing practice is as follows:

Competent, safe, therapeutic, and effective care provided in the exclusive interest of the patient.

This model ensures that the RN always acts in the patient’s best interests. This is not only the moral obligation of the nurse, inherent within the social contract between the public and the profession of nursing, but it is also a duty and a right. As direct-care nurses, we have a vested interest, on behalf of our patients and our profession,
to be accountable for the provision of care according to the true art and science of nursing as described by Florence Nightingale.

Evidence-based practice can be defined as the conscientious integration of best research evidence with clinical expertise and patient values and needs in the delivery of healthcare. The best research evidence is produced by the conduct and synthesis of numerous, high-quality studies. Improved staffing has a significant and positive correlation with improved patient outcomes; research has shown quality of care is improved when staffing is adequate (Tourangeau, Cranley, and Jeffs, 2006).

There is a dearth of valid and reliable empirical studies which demonstrate a correlation between scripting and rounding schemes, patient satisfaction surveys, and improved health outcomes. Scripting and rounding schemes, when taken together with the mandated implementation and coercive enforcement of them in lieu of or as a substitute for, increasing nurse-to-patient ratios creates a hostile work environment for RNs and an unsafe care environment for patients. In the field of patient safety, management tactics of fear, intimidation, and threat of retaliation have long been recognized as detrimental to safe practice.

Scripting and rounding schemes are a creation of for-profit commercial interests whose priority is to reap the economic incentives of corporate healthcare. Such schemes provide continuing cover for the commodification of healthcare and the failed health policies that continue to pose a significant barrier to the RNs’ ability to control the practice of nursing and RNs’ efforts to winning a single-payer

References


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healthcare system with a single standard of excellent care for all based on medical need.

**Evidence-Based Nursing Practice Points**

**With the Prospect of Increased Reimbursements to Healthcare Providers and Organizations Being Linked with Higher Patient Satisfaction Scores, Administrators and Managers Might Well Consider the Findings of a Study of Nurse Staffing Models, Nursing Hours, and Patient Safety Outcomes Conducted by McGillis, Hall, Doran, and Pink (2004). The Authors Demonstrated that Increased RN-to-Patient Ratios Were Positively Correlated with Increased Patient Satisfaction with the Care They Received.**

Decisions about nurse staffing levels should be based on sound evidence and health policy science to reduce the risk of preventable complications and ensure optimum patient outcomes. The strength of the empirical, peer-reviewed research findings of Dr. Linda Aiken and her colleagues’ 2010 study supports the immediate implementation of California’s landmark RN-to-patient ratio law as a benchmark on a national scale in order to protect the public and reverse the nursing shortage. The evidence is clear and convincing that minimum RN-to-patient ratios, with staffing up based on the patient’s acuity and severity of illness, is the most important and cost-effective safety measure for ensuring therapeutic and effective patient outcomes.

**Conclusions**

**Because Direct-Care RNS Take a Dim View of Expensive and Insulting Scripting and Rounding Schemes, Frequently Reporting that They Are in the Interests of Direct-Care Registered Nurses to Staff Stability, Which Leads to Improved Clinical and Financial Outcomes.**

Rather than increasing the number of RNs, hospitals should increase the ratios of RNs to patients, because RNs’ higher level of knowledge and experience has been shown to reduce patient mortality and reduce the overall costs of care (Aiken et al., 2002; Eastabrooks, Midodzi, and Cummings, et al., 2005; Needleman, 2006; Dall, Chen, and Seifert, et al., 2009). From a hospital and business perspective, improved RN-to-patient ratios have a synergistic and demonstrated economic value for hospitals in terms of lower liability and improved reputation by reducing adverse outcomes such as decreased blood-borne infection rates, patient falls, decubitus ulcers, ventilator-acquired pneumonia, and medication errors. In instances where there is not a clear business case for increased nurse-to-patient ratios, there is a compelling social case that can be made due to reduced adverse outcomes and avoided additional hospital days.

From a patient and social advocacy perspective, improved RN-to-patient ratios have economic and non-economic benefits for patients and their families in terms of decreased pain and suffering from preventable complications, decreased length of stay, lost days from work, and increased patient satisfaction. Increasing nurse staffing is associated with fewer in-hospital deaths under all options. Needleman (2006) and his colleagues concluded that 70,000 deaths could be avoided by raising the hospital nurse staffing threshold to the 75th percentile overall.

Rather than weakening or lowering safe staffing standards, a more appropriate strategy would be for government and other payers to increase reimbursement rates to hospitals that comply with the standards, instead of tying reimbursement to unproven customer satisfaction surveys. Under current reimbursement systems, the incentive and financial reality for hospitals is for them to staff at levels below where the benefit to society equals the cost to employ the additional nurses (Dall, 2009).

A strong reason for employers to change nursing care delivery models and practices is to encourage the development of behaviors and skills that reflect business strategy and organizational design. Salary and pay-for-performance schemes are designed to communicate these messages of strategy and control to generate compliance with organizational policies. Rounding and patient satisfaction schemes are methods by which healthcare organizations can substitute industry-aligned, performance-based competencies as a substitute for professional clinical nurses’ skill, expertise, and practice-based competencies.

Nurse administrators are responsible for allocating nursing staff to meet professional quality-of-care standards and unfortunately, many have aligned themselves with the business interests of their employers. The CNA/NNOC/NNU definition of quality is safe, therapeutic, and effective care, competently delivered, that allows the patient to achieve his or her optimum level of health and well-being. Direct-care registered nurses are responsible for ensuring that the care they provide is in the exclusive interests of the patient they care for, even when the provision of patient care is in conflict with the financial interests, policies, or orders of the employer.

**Recommendations and Social Advocacy Action Plan for RNs**

The evidence evaluated here suggests that patient satisfaction, nurse satisfaction, and optimal patient outcomes are influenced by ensuring that there are an effective number of direct-care registered nurses to meet the needs of patients who require nursing care. Effective RN-to-patient ratios, not creative and illusory rounding and scripting schemes, are required for prevention, care planning, initial and ongoing assessment and evaluation of the treatment plan, patient education, and restoration to the optimal level of health and well-being attainable in the exclusive interests of the patient.

The social good and public benefit of increasing RN-to-patient ratios compels nurses and other social advocates to demand healthy social policy and financial accountability when it comes to solving our current crisis in healthcare. This is congruent with our vision of advocacy for a single-payer national health program, with a single standard of excellent care for all.

**Standards for Evaluating Whether Scripting and Rounding Schemes Are in the Interests of Direct-Care RNS and Their Patients**

State nursing practice acts and registered nursing board implementing regulations, practice standards, and professional license guidelines generally impose a “fiduciary responsibility” on registered nurses to care for patients in the manner that the nurse believes is in the patient’s best interests. This fiduciary responsibility may be expanded to include the social and financial interests of the patient and the public if the nurse is performing a social, community, or public health role (Aiken et al., 2002; Eastabrooks, Midodzi, and Cummings, et al., 2005; Needleman, 2006; Dall, Chen, and Seifert, et al., 2009).

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nurses who accept assignment of a direct-care RN-to-patient relationship in which nursing care is provided. The fiduciary obligation inures a duty of loyalty to the patient to provide care in the exclusive interests of the patient without compromise or surrender to interests of health facility employers, physician practice groups, health-care systems, managed care organizations, or health insurers/HMOs.

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

The CNA/NNOC/NNU Code of RN Professional Responsibility

The Code of RN Practice includes the following standards:

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

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

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

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

1. An RN-to-patient relationship which allows for competent performance of all aspects of the nursing process, enforced by objective minimum standards for safe patient care (i.e., specific, numeric unit-based RN-to-patient staffing ratios, with additional staffing up based upon the severity of illness/acute of the patient).

2. The right and practical ability to exercise independent professional responsibility and judgment to determine and implement nursing care in the exclusive interests of patients, uncompromised by and without interference arising from the conflicting commercial and revenue-generating interests and demands of healthcare industry restructuring schemes.

Hospital direct-care registered nursing practice today is severely burdened by excessive patient assignment loads, mandatory extend-
Scripting and Rounding

For continuing education credit of 2.0 hours, please complete the following test, including the registration form at the bottom, and return to: CNA/Nursing Practice, 2000 Franklin St., Oakland, CA 94612. We must receive the completed home study no later than February 28, 2011 in order for you to receive your continuing education credit.

1. Because hospitals can always be trusted to provide excellent care, patient satisfaction is the most important issue for nurses and management alike.
   ❑ True ❑ False

2. In analyzing the safe, therapeutic, and effective values of any new protocol or script, RNs must explore the potential of protocols and patient interaction scripts replacing individualized human interaction in the delivery of healthcare and explore the potential of protocols and patient interaction scripts causing the supplanting of critical thinking and independent clinical judgment with rigid protocols and/or scripts.
   ❑ True ❑ False

3. One obvious method of improving patient satisfaction as well as patient outcomes would be to improve nurse-to-patient ratios. Patient satisfaction with their hospital stays are more positive at hospitals with fewer patients per RN than patients admitted to hospitals with poor staffing and higher nurse workloads.
   ❑ True ❑ False

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

5. Rounding and scripting depersonalize the relationship between RNs and patients. Ultimately they interfere with the Nursing Process, RNs’ professional judgment, and control of their ability to prioritize, assess, plan, individualize, implement, and evaluate the care they provide.
   ❑ True ❑ False

6. The CNA/NNOC/NNU Professional Practice & Patient Advocacy Model is to provide safe, effective, therapeutic, competent care in the exclusive interest of the patient. The RN has the duty and must exercise the right to advocate in the interest of each individual patient.
   ❑ True ❑ False

7. The economic interests of the healthcare industry as presently constituted, the interests of patients, and the rights and obligations of direct-care registered nurses are the same.
   ❑ True ❑ False

8. The responsibility of the nurse is to represent the hospital. Scripts help the nurse better communicate with patients.
   ❑ True ❑ False

9. The three “P’s” and four “R’s” are not so bad. There just isn’t enough staff to care for patients without this streamlining.
   ❑ True ❑ False

10. There is no need for ongoing patient assessments so long as the RN asks if the patient is in pain, ensures the patient is positioned comfortably, and asks whether he or she needs to go potty.
    ❑ True ❑ False
You don’t need the holiday season as a reason to shop National Nurses United’s new online store. But it certainly helps!

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