The popularity of the Magnet Recognition Program continues to increase among hospital administrators and decrease among nurses who work in hospitals that are pursuing the designation. As more facilities prepare for the “Magnet journey,” nurses are seeing precious resources diverted from patient care and quality initiatives to funding the elaborate and expensive application process (UNA Action, Winter 2005). And now new concerns are being raised about the program’s lack of commitment to the work environment of nurses.

RNs Working Together (the AFL-CIO RN-Industry Coordinating Committee) has been hearing reports from affiliate nurse unions that unfair labor practices, anti-union campaigns and even strikes have not slowed down the Magnet journey nor removed the affected facilities from consideration for Magnet status.

In November 2006, six nurses from Resurrection Health Care in Chicago met with Elaine Scherer, national director of the Magnet Recognition Program, to talk about those exact issues. In spite of significant quality problems and management’s hostility to AFSCME Council 31’s organizing campaign (UNA Action, Winter 2005), several of the system’s hospitals are being reviewed for Magnet designation. Scherer assured the nurses that Magnet staff would look into their allegations. Unfortunately, there has not been any indication that the meeting had an effect on the application process.

As a follow up to this meeting — and the growing criticism of the program from other nurses, a Nurse Advisory Committee was welcomed six new members to its ranks, including a new LPN co-chair who replaces Bonnie Marpoe, who has retired. The new committee members are:

- Barbara Weaver, LPN, co-chair, Local 2245, Pennsylvania
- Judith Arroyo, RN, Local 436, New York
- Rhonda Cox, LPN, 1199J, New Jersey
- Patricia Flowers, LPN, Local 2209, New Jersey
- Rosemarie Kukys, RN, CSEA/Local 1000, New York

(continued on Page 2)
Labor Board Decision Blocks Nurse Union

There has been much speculation and dread surrounding the recent National Labor Relations Board (NLRB) decisions known collectively as “Kentucky River” (UNA Action, Winter 2006, Summer 2006, Winter 2005). And now nurses in Utah, who voted to join United American Nurses (UAN), AFL-CIO, are bearing the full brunt of the ruling.

The Kentucky River decision redefined “supervisor” to include anyone who exercises the authority to assign and/or responsibility to direct the work of other employees on a regular and substantial basis. The board defined “substantial” to mean at least 10-15 percent of the employee’s time. For nurses, that means that working charge as little as one shift a week could be grounds for exclusion from a bargaining unit.

Over four years ago, nurses at Salt Lake City Medical Center voted to join UAN. The employer appealed the election and the ballots were impounded, pending a decision by the NLRB on Kentucky River; several months after the board’s ruling in October, its regional director applied that decision to the nurses at Salt Lake City Medical Center. He ruled that charge nurses assign RNs, using independent judgment to match the skills of the nurses and the acuity of the patients. The regional director then found that since the vast majority of the nurses employed at the time of the 2002 election acted in a charge capacity more than 10 percent of the time, they meet the definition of supervisor.

With the stroke of a pen, virtually all the RNs at the medical center were designated as supervisors. According to UAN, “The decision stands for the proposition that RNs cannot organize in acute care hospitals where charge duties rotate among virtually all the nurses. They are all supervisors of each other on alternate days... and therefore cannot ever achieve union representation.”

Advisory Committee (continued from Page 1)

- David Miller, NP, Local 3728, Indiana

The committee is made up of registered and licensed vocational/practical nurses from around the country. Members are appointed by Pres. Gerald W. McEntee for two-year terms, and their duties include advising the president and International staff on issues relevant to nurses — often sounding the first alarm about emerging trends we need to address.

The 21-member committee is responsible for planning the biennial National Nurses Congress and staffing the Wellness Booth at the AFSCME International Conventions. A full roster of committee members is at right.

Kathy Sackman, RN
AFSCME International Vice President, Co-Chair
UNAC/UHCP/NUHHCE Pomona, Calif.

Barbara Weaver, LPN
Co-Chair
Local 2245
Shippensburg, Pa.

Judith Arroyo, RN
Local 436
New York, N.Y.

David Bailey, LPN
OCSEA/Local 11
Mount Vernon, Ohio

Jeanne Beers, RN
HGEA/Local 152
Hilo, Hawaii

Sue Conrad, RN
Local 2484
La Crosse, Wis.

Tom Connelly, RN
Local 2026
Niles, Ohio

Rhonda Cox, LPN
NUHHCE/AFSCME District 1199J
East Orange, N.J.

Maxine Davis, LPN
MLPNA/Local 105
Mankato, Minn.

Carole Deneault, LPN
Local 137

Patricia Flowers, LPN
Local 2209
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Terri Jacobs, RN
SNEA/Local 4041
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The AFSCME Nurse Advisory Committee (NAC) provides expertise and recommendations to the union on issues and activities of importance to AFSCME nurses. The committee is composed of registered and licensed practical/vocational nurses from acute care hospitals, nursing homes, public health, corrections and other practice settings. Based on recommendations from International vice presidents, members are appointed to two-year terms by President McEntee.

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Can Aviation Lessons Apply to Hospitals?

Some hospitals are adopting procedures that the airline industry is using to reduce errors and make flying safer. It is believed that some of these aviation safety principles can help hospitals reduce medical errors and save lives.

A primary culprit in both medical errors and airline accidents is human error, most notably failures in communication. In the late 1970s black-box recordings after aviation accidents revealed that people in the cockpits were not speaking up when they suspected a problem. This was due, in large part, to the hierarchy in the air — where pilots are the top of the pecking order and co-pilots and flight attendants were reluctant to challenge their authority. Doctors have similar status in the medical industry — nurses and other health care personnel tend to defer to them.

Instituting new safety procedures and giving all staff “permission” to speak up requires a systemic culture change. The model of “crew resource management” eliminates the hierarchy and sets standards for cross-checking the work of communication protocols, checklists and crew briefings to improve patient care. Communication becomes more organized, regimented and collaborative.

One such safety system, LifeWings, was developed by a team of physicians, former astronauts and pilots. After implementing LifeWings, one hospital reduced its incidence of retained objects from surgery by 75 percent.

According to The New York Times: the British medical journal BMJ, the Journal of the American Medical Association and the Journal of Critical Care have all published research suggesting hospitals that adopt these measures experience fewer malpractice suits and postsurgical infections. Also, patient recovery times tend to be lower, and employee satisfaction is higher.

California Nurses Association to Join the AFL-CIO

The AFL-CIO voted in March to grant a charter to the California Nurses Association and its national arm, the National Nurses Organizing Committee, bringing the number of registered nurses in the federation to 325,000. CNA/NNOC represents 75,000 RNs across the country.

Rose Ann DeMoro, executive director of CNA/NNOC, says: “We look forward to being a part of a federation that has distinguished itself as the national voice of working people in the U.S., and is the leading national champion for all Americans on a broad range of critical issues, including jobs, retirement security, economic opportunity, workplace safety, civil rights, civil liberties and public safety.”

CNA was formed in 1903, and was part of the American Nurses Association until 1995 when it split from the national association.

CNA/NNOC, DeMoro notes, “is especially pleased to be a part of the 325,000 RNs now represented by the AFL-CIO who will have such a prominent voice” in the effort to reform the nation’s health care system.
OSHA Denies AFSCME’s Call to Protect Workers From Pandemic Influenza

After 14 months, the Occupational Safety and Health Administration finally acted on Feb. 26, 2007, denying AFSCME’s petition for an Emergency Temporary Standard for Pandemic Influenza Preparedness. In December 2005, AFSCME — joined by the AFL-CIO and four other unions — called on OSHA to require employers to implement influenza preparedness measures to protect nurses and other health care workers, emergency responders and other essential personnel. AFSCME asked OSHA for regulations because relying on voluntary actions has not worked, leaving potentially millions of frontline workers, who would be called upon in the event of an outbreak, at serious risk.

This nation remains dangerously unprepared for an outbreak of a new strain of flu that has the potential to kill millions of people in this country and the rest of the world. The White House’s National Strategy for Pandemic Influenza, and guidance issued by the Centers for Disease Control and Prevention (CDC), as well as OSHA, are inadequate to protect workers. As a result, AFSCME petitioned OSHA for a standard that would require employers to develop exposure control plans before there is an outbreak — to use isolation rooms, and to provide training and effective respiratory protection, and other measures to protect workers.

In addition to an emergency standard for pandemic influenza preparedness, AFSCME also urged OSHA to begin rulemaking for a permanent standard to prevent occupational exposure to communicable and infectious diseases.

In rejecting the petition, OSHA explained that an emergency standard is not warranted because there currently is no pandemic influenza outbreak. Hurricanes Katrina and Rita showed the country and the world all too vividly what happens when adequate planning and preparedness measures are not in place in advance of a large-scale emergency. The purpose of an OSHA standard would be to compel action now, before there is a crisis.

CMS Issues New Rules for Hospitals

On Nov. 27, 2006, the Centers for Medicaid and Medicare Services (CMS) released new “Hospital Conditions of Participation” (CoPs), five of which will impact the role of nurses in the evaluation of patients and their communication with other health care providers. Hospitals accepting Medicare and Medicaid patients must follow these parameters in order to be reimbursed by the federal government for services they provide.

The five changes affecting nurses are:

• The timeframe for the completion of patient history and physical examinations (H&P) has been expanded to 30 days before or 24 hours after admission to the hospital. Importantly, CMS eliminated the requirement that the H&P be performed by providers with medical staff privileges. The new CoP allows other qualified providers to conduct the H&P “to the extent consistent with state law.”

• CMS has amended the rule governing the authentication of verbal orders by now requiring that verbal orders must be authenticated as mandated by federal or state law, or within 48 hours if state law is silent on the required timeframe. The previous rule was “as soon as possible.”

• The CoP governing distribution and control of pharmaceuticals has been tightened. The new rule requires that all drugs and biologicals be kept in a secure area and locked “when appropriate,” which is not defined. The practice will likely vary from one hospital to the next.

• Post-anesthesia evaluation may now be completed by any individual qualified to administer anesthesia. The old rule required the evaluation be completed by the practitioner who administered the anesthesia.

• The training requirements for health care workers who use physical restraints and seclusion have been revamped to ensure that patients’ rights are protected and that the restraint or seclusion is appropriate. The list of practitioners who can conduct the required face-to-face evaluation when restraints are used has been expanded. It now includes RNs and physician assistants, but they must consult with a physician or other licensed independent practitioner (LIP) “as soon as possible.” Prior to this rule, only a physician or other LIP could conduct the evaluation.
UNAC/UHCP Victories in California

In two back-to-back victories, the United Nurses Associations of California/Union of Health Care Professionals (UNAC/UHCP) has proven that there is power in numbers and that nurses know being in a union gives them the strongest voice possible.

Nearly 800 nurses, including certified nurse midwives, case managers, nurse educators and others from all of Kaiser Permanente’s Southern California facilities joined UNAC/UHCP by majority sign-up. The nurses signed union authorization cards that were then checked by a neutral third party.

Card check recognition is a major provision of the Employee Free Choice Act, one of organized labor’s top priorities. EFCA passed the U.S. House of Representatives in March. The bill now awaits a vote in the Senate.

Kathy Sackman, RN, UNAC/UHCP president and AFSCME International vice president acknowledged Kaiser Permanente’s neutral stance: “Kaiser Permanente proves that respecting workers’ desire to have a voice on the job, rather than fighting the unions, is not only the right thing to do, it also makes good business sense.”

In a second win for the union, more than 1,400 UNAC/UHCP members at four Tenet facilities ratified a new master agreement by an overwhelming majority. In addition to other economic improvements, the three-year contract includes a wage increase of 5.25 percent the first year, 5 percent in the second and 5 percent in the third. Significantly, the contract contains protective Kentucky River language, prohibiting Tenet from using the NLRB’s recent decision to strip nurses of their collective bargaining rights. This contract language is similar to wording UNAC/UHCP won, statewide, from Kaiser Permanente last fall (UNA Action, Winter 2006).

Nurses Entering Workforce Later in Life

The number of people in their mid-20s who are becoming nurses is at its lowest point in 40 years. But a recent study reported in the journal Health Affairs (January/February 2007) concludes that the predicted nurse shortage will be smaller than previously forecast because large numbers of people are entering the profession in their late 20s and early 30s. The authors believe that declining interest in the nursing profession might have been a “temporary lull” and confined primarily to younger people choosing their first career.

The researchers found that those born in the 1970s are entering the nursing workforce at nearly the same levels as did the baby boomers in the 1950s. Among those born in the mid-1950s, by age 23, about 1.2 percent (1,200 per 100,000 U.S. residents) were RNs. As this group aged into their 30s and 40s, participation in the nursing profession grew, leveling off at about 2,000 full-time equivalent (FTE) employees per 100,000 by age 50.

In contrast, among those born 10 years later, participation was about 20 percent lower at every age. But when the authors examined the contingent born in the mid-1970s, they found that though fewer (than their predecessors born in the 1960s) had become RNs by their early 20s, by age 29 there were nearly as many RN FTEs among this portion as there were among those born from 1953 through 1955, which, the authors say “produced the largest number of RNs in the U.S. workforce ever.”

This analysis does not mean that the nurse shortage is nearing an end. The vacancy rate for nurses would still be significant — about 340,000 by 2020, instead of a previously projected shortfall of 760,000. Plus those nurses will be older. Since more people are starting their nursing careers at a later age, the authors project that by 2012 the average nurse age will creep up to 44.9 years. The current average is 43.4 years.

Magnet Programs (continued from Page 1)

unions — Steve Francy, executive director of RNs Working Together, sent a letter in January 2007 to the director of the Magnet Recognition Program calling for rule changes.

The letter demands that facilities with administrators who are actively hostile to unions and union organizing campaigns be disqualified from achieving Magnet status. Francy’s communiqué also questioned the integrity of the program if it continues to reward hospitals that “quell nurses’ concerns and paper over serious quality problems.”

The letter was signed by AFSCME and the other nine unions of RNs Working Together.

If you have a Magnet story, we’d be interested to hear about it. You can e-mail us at kcox@afscme.org.
What is UNA-AFSCME?

The United Nurses of America-AFSCME is more than 60,000 nurses working in unity to advance quality and accountability in the health care setting through organizing, political action and nursing practice. Across the country, we are reaching out to other nurses who want to join UNA-AFSCME. As our numbers grow, so does our power to improve our jobs, the care we deliver and the quality of our lives.

Yes! I’d like to get a free subscription to the UNA Action newsletter.

Please return to: AFSCME Department of Research and Collective Bargaining Services
1625 L St., N.W., Washington, D.C. 20036-5687.

To learn more about United Nurses of America, visit the AFSCME website at www.afscme.org/una or contact the AFSCME Department of Research and Collective Bargaining Services at (202) 429-1215 or by e-mail at una@afscme.org.