



LIFELINES

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Nursing Department Vision Has Changed; Have You Heard?

Dear MNA RN,

Budget-centered care will now be the new mantra of the nursing department. This change appears to be immediate because the family-centered model has been bypassed by the budget when it comes to staffing.

Those of us who actually work at the bedside have experienced the fall out from this budget approach to staffing. Over the past several months nurses from around the hospital have been communicating with the MNA committee about the negative approaches being used to staff the hospital.

First and foremost is the unsafe floating that is happening throughout the hospital. Nurses are being floated to floors/units where they are not clinically expert. This is a set-up for disaster for both patient and nurse. When our patients are admitted to the hospital they expect that clinically experienced nurses will be there to care for them. This is not happening. Nurses are being forced into unsafe practice situations just to save money. There can be no other reason administration would place our patients in

danger. The constant scrutiny of assignments every four hours is time consuming for our charge nurses, who also have a full assignment, and it destroys the foundation of patient continuity. For a more in-depth look at this issue and what nurses can do to protect themselves from inappropriate floating, turn to page ____.

At our recent Labor Management meeting the MNA committee brought forward examples of how unhappy nurses are with staffing practices that are eroding the quality of care we pride ourselves on delivering as BWH nurses. Nursing administration responded, "We have to do this to be responsible with the budget. We cannot have extra nurses". How many of you working on the units are being told that there will be more doubles? How many nurses are routinely working extra shifts and OT? While census can be a "tricky" thing, the single most important aspect of providing safe quality care in a hospital, BWH in particular, is that we are prepared for emergencies and "unplanned admissions". Isn't



Barbara Norton

that what a hospital is all about? It appears this concept has been lost in the pursuit of the almighty dollar. The recent administration's "pilot program" to deal with unplanned admissions has been troublesome at best.

BWH is far from being financially strapped and yet to have the appropriate nurses and resources available for our patients when they need it most is treated as "fluff" or described as a "budget-buster".

The time has come for all nurses to stand together and tell administration to.....Staff It!

In unity and strength,
Barbara Norton RN,
MNA Chairperson

New Floating Plan is a Shell Game with Nurses

The new Staffing Program that was rolled out one month ago has actually highlighted the communication breakdown between the directors, managers and Vice President of Patient Care

Services. Management has denied that they knew anything about any problems encountered with the new staffing/floating program. It is the B&W administration's "disconnect" once again;

don't ask, don't tell and hear no evil, speak no evil.

The fact is that we are all aware of the fragility of the patient population especially in the ICUs. In-hospital

Violence, page 3

Vertical Violence at BWH is Unacceptable

Much has been made of the issue of lateral violence at BWH.



However, there is another problem that contributes directly to the problem of staff nurse-on-staff nurse conflict that is not being adequately

addressed, or even mentioned. That problem is vertical violence.

In recent years, there have been a number of studies on the impact of harm done by psychological violence. The study by the International Labor Office is the most in depth one on the subject. It describes vertical violence as when a person in authority is abusive or bullies a subordinate or a peer. Such an individual, through vindictive, cruel, malicious or humiliating behavior, seeks to belittle one or more employees.

The issue of vertical violence, the psychological harassment of staff nurses by nurse managers, is becoming a significant problem at the Brigham. There is a difference between management and harassment, and some of the nurse managers at BWH frequently cross the line - inflicting psychological violence on nurses. This demeaning behavior promotes lateral conflict, where nurses take out their frustrations on each other rather than responding

to the actual source. With no support from co-workers, individual nurses can easily feel victimized by management oppression.

Vertical violence, as a means of manipulating and controlling staff nurses, can also include the covert tactics of playing favorites, denial of requests, detrimental shift and rotation scheduling, etc.

Ask the staff nurses on any floor/unit; they will be able to tell you about vertical violence. Some managers make no attempt to hide their disdain for the nurses they do not like. On a regular basis, they are subjected to intimidation over their appropriate use of sick time. Nurses are belittled and condemned. They are told that their illness will cause hardship on co-workers because the sick nurse will not be replaced, thus increasing the workload on an already busy unit. What these managers fail to realize is that their actions create a lack of morale on the floor and this has a negative impact on patient care. It leads to a loss of trust, a decrease in effective communication and it may also increase staff illness rates.

Nursing administration at BWH is focusing on the issue of lateral violence. At annual competencies, nurses are shown a film where one nurse "rolls her eyes" while receiving report from another nurse. This is used to illustrate disrespect as a form of lateral violence in the workplace. There are presently BWH

nurse managers who not only roll their eyes when speaking to nurses, but they also spread rumors and divulge confidential about staff to other staff members.

Unfortunately, we are not seeing any efforts to investigate or control one of the root causes of lateral violence – the psychological oppression that results from vertical violence. Hospital and Nursing Administration must take a strong stand on this issue in order to increase job satisfaction, promote retention, and improve patient care. They must institute a culture that is free from vertical violence.

Until that happens, what can staff nurses do? First, it must be recognized that any unit with low morale, high sick-time usage, and high staff turnover is probably being managed by a leader who uses oppression and vindictiveness on a regular basis. Staff nurses on these units must make a diligent effort to provide support for each other in order to diffuse the effects of this negative management style. Secondly, nurses should contact their MNA Representative to report all instances of overt and covert vertical violence. The MNA will then present Nursing Administration with regular reports summarizing these detrimental behaviors and identifying the managers most responsible.

If Nursing Administration fails to respond by taking actions against vertical violence, then the MNA will seek other remedies.

Floating Plan, from page 1

crashes or a precipitous change in acuity can throw an otherwise organized, well-

staffed ICU into chaos. This new program ensures that an unplanned trauma med-

flighted to the ED (shouldn't we be prepared for these?) will compromise the staffing at any moment. This style of logic highlights the real lack of connection that exists between the authors of this plan and the reality of bedside nursing care they are supposed to be directing and managing.

The fact that we are running at 95 – 105% census, and higher in the ED and OR, suggests to anyone, including John Q. Public, that we need more nurses, not a shell game where nurses are moved around, regardless of their expertise, regardless of the acuity of the unit or regardless of the impact on the safety of the patients.

Generic nursing went out with the flood and the float pool was created to help out with periodic short staffing not to staff the hospital. And you, the staff nurse, work in your specialty because you are the very best at giving excellent care in your field. You may float to help out on occasion when an unforeseen need arises but you are not hired to staff the whole hospital every day, every shift -- ditto for the Shapiro



Center.

Evaluating the staffing and admissions every 4 hours is creating a shell game with nurses.

Theoretically this ensures that we can be moved from one unit to the other as if we are *one big float pool*.

What is occurring now is that variable nurses are being cancelled so that a float pool nurse can work their assignment or an “extra” nurse on another unit gets floated to the flexed nurse’s unit, leaving his/her unit short. When an emergency happens or the “unplanned admission” arrives, a designated ICU float shows up. Where is the common sense, where is the patient safety? This kind of planning is setting up the nurses for failure and the patients for unsafe budget-centered care.

Extra nurses on 12D, (e.g. running with 5 nurses to 7 patients and covering the Code Beeper), are regularly being sent to fill the “holes” in 3BC, 11C, 8CD, 9CD and 7CD created by the cancellation of the variables and by the deliberate understaffing of the units. And likewise, these units and their patients are subject to the same disorganized, unreliable and unsafe care.

When the ED gets a critically ill patient for the CCU, 12D might get the float pool nurse (if he/she isn't being used somewhere else) to help out with the

admission or to pick up an assignment there, but meanwhile 12D's own staff may have been floated to another unit thus making them short to begin with.

When 7CD, which is now being staffed with one less nurse, cannot take a burn/trauma admission or a critical patient from the OR, where will this patient go if the float nurses are staffing the rest of the ICUs? This is happening if there is one in-hospital crash or twp unplanned admits. What happens when this scenario is repeated just once per ICU, per day? **Got a nurse? Got a shell? Got room in the ED? Just say “Staff it.”**

This situation is dangerous and your union contract includes language to protect nurses from being floated inappropriately. See the box to your right which contains the language from the contract and an explanation of your rights.

Floating – Article XVI, MNA/Contract

Any nurse who finds her/himself in the position of being asked to float to a unit never before oriented to, per the contact language shown below, should first make it known to the NM/supervisor that you are not competent to care for that assignment since you have never received a formal orientation per the contract language. (Page 52, Article XVI). Second, if the hospital continues to insist that you go, you should call/email an MNA rep. and call/email Risk Management. The fact that you have worked on a unit before without formal orientation does not preclude the language in the contract protecting you, your license and the hospital's patients. Effective January 1, 1997, except in emergency circumstances, nurses will not be floated to another unit without their having received the unit-based orientation per the Hospital's floating guidelines. Such orientation shall **include competency orientation in the technical skills required of float nurses in such unit, which shall be provided to the nurse in advance of any floating, and shall also include unit familiarization.**

Health and Safety Update

Staying Safe at Work Requires Prompt Reporting of Concerns

As you know, the MNA supports a safe work environment for nurses. A review of the communication tools currently in use regarding emergency adverse events, work safety and environmental concerns has revealed the need for nurses to remain alert to environmental changes within the hospital. The consistent reporting to the appropriate department will facilitate a healthy and safe work environment to the benefit of all. Poor indoor air quality caused by construction projects, routine building maintenance and climate control problems may cause headaches, nausea, dizziness, eye, nose and throat irritation, coughing, wheezing, allergic reactions and exacerbation of respiratory conditions.

Prompt recognition and reporting of the conditions that can lead to adverse health effects allows for changes in scheduling, product selection and other factors such as adjustments to the ventilation system which will prevent continuing exposures. If you have any of the above concerns inform your nurse manager and call Occupational Health Service (OHS).

Air Quality Beeper 15000 -- call in the event of unusual odors e.g. floor cleaning agents, sewer, oil, diesel, or other construction related odors

OHS - 617-732-8501

M-F 7 a.m. - 4:30 p.m.

OHS On-call NP beeper - 34414 after hours including weekends nights and holidays

MNA committee phone numbers are located on the MNA bulletin boards.

MNA Health and Safety Rep - Mary Anne Dillon RN (3BC) 2-7780

Over the past several months the Health & Safety Division of the MNA has been working closely with bargaining unit and hospital administration on environmental issues affecting the workplace. CWN 7-8-9 are experiencing moisture buildup in bathrooms causing odors, mold and other environmental issues. Because of the involvement of the B&W Health and Safety Committee facilitated by CWN Nurse Manager and Judith Racowsky, RN, CWN MNA, an immediate visit was scheduled for July 26, 2007 by the Vice President of Patient Services and Engineering to correct the most immediate problems.

A recent event on 3BC MICU involving the ad-

ministration of inhalation ribavirin treatment required the assistance of the Health and Safety Committee. The infrequent use of this treatment strained the delivery system which created multiple nursing and system challenges. A meeting is scheduled in August to determine the direction of this treatment in the future.

A few months ago CDIC experienced an air quality issue after the Wednesday morning generator check. Four nurses required an ED visit with one nurse unable to work the remainder of her shift. The engineering department completed air quality measurements for humidity as well as the flow of the system. HEPA filters continued to be maintained and plans for custom shelves will be installed to house the filters. Occupational Health (OH) did a follow up visit to reassess the

safety of the environment and monitored the health of the nurses. Engineering double checked the operation of the system before the department opened the following Monday morning.

Nurses who experience the need to be seen by OH are encouraged to utilize the standard handwritten employee incident reports which are available on your units and *in OH*. OH cannot trend issues if the incident is not reported to anyone. Remember – if it isn't documented it didn't happen or *no data no problem!*

To learn how you can help identify and correct potential safety hazards at work, see the box on this page which explains how you can report problems that need to be addressed.

NICU Night Call for Meeting to Address Staffing Concerns

On July 11, 2007 a large group of NICU nurses, some on their night off, came together for a staff meeting with their manager, Marianne Cummings, and acting CWN director, Detta Quigley-Lavoie. The meeting was called by the night shift nurses. They chose the date and time and asked their manager to be present. The issue - a change in staffing and nurse/patient ratios on the night shift.

In the couple of months leading up to the meeting, many nurses brought concerns to their MNA representative about the detrimental changes in staffing. The census and acuity were at an all time high, and the NICU at one point actually reached 140 percent capacity. The unit was operating only by

having many nurses regularly doing overtime and there was no end in sight. More than one nurse heard the nurse manager say that the as-

signments on the night shift were going to change and she talked about how it is done on other units. Charge nurses shared what they had been told to do and what not to do regarding staffing. They were stuck in the middle. For example, they were not to replace sick calls to make assignments in the step down area appropriate; the intermediate care units would work short. The nurses felt that this was unacceptable and called the meeting to address the current state of the NICU staffing at night. They were also concerned because several staff nurses left their positions and had not been replaced; their jobs had not even been posted.

A statement was prepared which included the information collected from the staff that addressed the issues of staffing and their declining ability to provide quality and safe care to the NICU babies. The nurses then spoke individually and gave management the opportunity to respond. They wanted to know why this was happening, and what plan was being put in place. Unfor-

tunately, they left the meeting without any real explanation. The nurses were dissatisfied with the response but felt the meeting was a success. They brought forth the issues to an Advisory (labor/management) meeting with hospital leadership. In that meeting the nurses received an on-the-record statement from Chief Nursing Officer Mairead Hickey stating that there are no plans to decrease staffing in the NICU or to change the nurse/patient ratios. The nurses will hold administration to their word.

The night shift nurses of the NICU are to be commended for their commitment to quality care and safe practice. They brought forth a concern, chose a way to address it, and got results. Our collective voice is much louder than our individual voices and when we need to, we will use it.

Point of emphasis: you have a right to call for a meeting with your manager