Chapter 5

Nurse Union Strategies for Improving the Quality of Patient Care

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INTRODUCTION

Unions exist to provide workers with voice in the workplace. Workers use this voice to improve their compensation and benefits and the conditions at their workplace through collective bargaining. They also use it to help ensure that they receive fair treatment and due process by establishing grievance procedures that include arbitration. And, through their unions, workers engage in voice through political action and government lobbying in an effort to influence government in a way that benefits and protect employees. Somewhat less commonly, workers use voice to gain input into decisions regarding the production of the product, or the provision of the service, that the employer produces or provides through labor–management collaboration and partnerships.

Unions of professional workers seek a voice for their members in all of these areas. However, they—more than other types of unions—seek to participate in decisions involving the work process. The fact that professional work is often predominantly intellectual and requires the significant exercise of discretion and judgment is one reason professional workers tend to be more interested than unions in some other sectors in participating in workplace decision making. Professionals are also more invested in the final product or service than nonprofessional employees (Molyneux 2001).

This chapter addresses the efforts of unions representing registered nurses (RNs)—one of the largest groups of professional workers in the nation—to give their members a greater voice in decisions and work practices that directly impact the quality of patient care. In particular, the chapter focuses on three mechanisms nurses unions have employed to impact the quality of care provided in acute care hospitals: contract language established through collective bargaining, union–management collaboration and partnerships, and political and legislative action. The chapter looks at how RN unions have used these mechanisms to address

three important issues: safe staffing levels, mandatory overtime, and the "floating" of nurses to cover understaffed units. The chapter also examines additional ways in which nurses and their unions have used greater voice to improve the quality of patient care.

NURSES, NURSES UNIONS, AND VOICE

Registered nurses (RNs) are the largest group of professionals in the American health care system. In hospital settings they play a vital and unique role as the primary direct care providers. Nurses believe that as individuals and as a profession, they have an obligation to do all that they can to ensure their patients receive the best possible care. For this reason, they have long viewed themselves as the primary patient advocate within the health care system. In fact, the American Nurses Association (ANA) Code of Ethics, as well as most state-level nurse practice codes, list patient advocacy as one of the primary responsibilities of RNs. Most definitions of patient advocacy include a common point: advocates must act to ensure that the patient's welfare is paramount in any medical setting, procedure, or treatment (Tate 2005).

At a time when the American health care system is wrestling with myriad problems, including high cost and underperformance, it needs to use every resource at its disposal to address the challenges it faces. The vast majority of health care facilities and systems in the United States employ a variation of traditional, hierarchical, command and control management. This approach overvalues the contributions of managers and greatly undervalues the potential contributions of RNs and other health care professionals. To make the kind of progress necessary for the U.S. health care system to meet its potential requires hospitals and health care systems to use the knowledge and commitment of their entire workforce—not just administrators and managers.

One of the critical groups of health care workers who are ready and able to contribute to improving patient care are nurses. Many RNs, and most nurses unions, recognize the potential contributions the nursing profession can make and are looking for opportunities to participate to a greater degree in decisions involving the delivery of patient care. This is why many unions representing RNs are beginning to aggressively promote labor–management collaboration and partnerships that will give their members a greater voice in patient care decisions and, they believe, will greatly improve the quality of care and reduce costs.

Given the reluctance of managers to give up sole control of decision making in the health care workplace, unions provide nurses with the collective power needed to win a greater voice in how patient care is delivered. This is one of the key reasons that during a period of generally declining

union membership, RNs have been one of the few occupations that has not seen a significant decline in union density over the past 20 years. In fact, the percentage of registered nurses belonging to unions has remained among the highest of any occupation. In 2002, union density among nurses was 17%. It increased to 20% in 2012 and remained at 18% in 2014 (Hirsch and Macpherson 2016).

Certainly nurses recognize that an increased voice can be used to increase salaries and benefits, and the unions they formed have used their collective bargaining rights to pursue improvements in those areas. However, the importance nurses place on having a greater voice in patient care is reflected in the degree to which RN unions have stressed that issue in their organizing drives. And it is reflected in the fact that nurses unions, over the past 10 to 15 years, have focused their collective voice on patient care issues (Clark and Clark 2006).

Several unions represent RNs in the U.S. health care industry. This appears to be a function of at least two factors. First, a large segment of the health care workforce did not become eligible to organize a union until 1974, after many national and international unions were already well established. Thus, there was less reason for the formation of entirely new health care unions. Second, during that period, many existing unions suffered significant membership losses. Not surprisingly, many of those unions saw the growing health care industry as fertile ground for organizing.

A significant proportion of RNs belong to unions that largely, or exclusively, represent only nurses. Most of these "craft type" unions trace their origins to the ANA, which was founded in 1896 as a professional organization to advance the nursing profession. In the years following its founding, the ANA created state-level affiliates in every state. As a professional association, the ANA focused on promoting standards of nursing practice, providing professional development opportunities, and advocating for health care issues that impact nurses and the public (American Nurses Association 2016a). When the National Labor Relations Act (NLRA) was expanded to include health care workers in nonprofit hospitals and nursing homes in 1974, ANA leaders at the national and state levels wrestled with the issue of whether to take on the role of collective bargaining agent. Because of differing views, some ANA state associations split into two separate organizations—one that continued to function solely as a professional association and the other functioning as an independent union.

This was the case for the California Nurses Association (CNA), which severed ties with the ANA in 1995 to become the largest union of RNs in the nation. In 2009, the CNA joined with the Massachusetts Nurses

Association (MNA), the Minnesota Nurses Association (MINNA), and an amalgamation of state nursing associations called the United American Nurses (UAN) to become the National Nurses Union (NNU). At its founding, the union reported a combined membership of 150,000 RNs (Association for Union Democracy 2010).

Since its founding, the NNU has been both one of the fastest growing unions in the country and the most influential and dynamic union in the burgeoning nurse labor movement. It now claims 185,000 members from all 50 U.S. states and continues to grow rapidly, in part because of its organizing work in union-hostile states such as Texas and Florida and in other states that had previously seen little nurse organizing (National Nurses Union 2016).

The union representing the second largest number of nurses—the Service Employees International Union (SEIU)—differs from CNA/NNU in that it represents a wide range of professional and nonprofessional employees in the health care industry, rather than just one professional group. SEIU's "industrial union" approach means that in any given hospital the union might represent nurse aides, therapists, custodians, maintenance workers, office staff, and even physicians, as well as RNs. Of its 2.1 million members, 1.1 million work in health care. A subdivision of the union, the Nurse Alliance, represents 80,000 RNs across the country (Service Employees International Union 2016a).

The AFT Nurses and Health Professionals union represents 82,000 RNs in a variety of settings, including acute care hospitals, making it the third largest nurses union in the United States. Another union with a significant number of nurse members is the American Federation of State, County, and Municipal Employees (AFSCME), which represents 60,000 nurses, most of whom work in acute and long-term care facilities operated by state or local government. And the American Federation of Government Employees (AFGE) represents 55,000 RNs working mostly in the federal government's Veterans Administration facilities.

Other unions representing small numbers of nurses include the United Food and Commercial Workers (UFCW), the Communications Workers of America (CWA), the Office and Professional Employees International Union (OPEIU), and the International Union of Operating Engineers (IUOE).

NURSES AND THE CHALLENGE TO PROVIDE QUALITY CARE

The 1970s and 1980s saw the introduction of a new approach to the provision of health care in the United States. Managed care is a market-driven approach to the delivery of health care services that focuses heavily on cost containment. As this approach gained momentum, one of the

main ways that administrators sought to cut costs in acute care hospitals was by downsizing the nurse workforce. As the number of RNs was reduced, the remaining nurses were required to take care of more patients. Because managed care's cost-reduction focus called for hospitals to admit only "the sickest patients for the shortest possible stay" (Sochalski and Aiken 1999: 1), nurses were forced to deal with rising patient "acuity" (the measure of how sick a patient is). Thus, in recent decades, nurses have been asked to care for more patients, and those patients are sicker and require greater attention (Sochalski and Aiken 1999).

In a 2001 survey of RNs, approximately 75% of the respondents reported that both their working conditions and the quality of nursing care in their facilities had declined in recent years. Thirty-eight percent of the nurses in the study reported that they felt "exhausted and discouraged" upon leaving work. Thirty-four percent said they were "discouraged and saddened by what they could not provide their patients," and 29% felt they were "powerless to affect change" (Michigan Nurses Association 2001).

Nurses contend that being unable to provide the kind of quality patient care they believe their patients need and deserve leads to anxiety and guilt. This anxiety and guilt reach the point where many RNs voluntarily leave nursing to work in less stressful occupations outside the health care system. And, of course, the inability of the system to stem the exodus of nurses sets a damaging dynamic in motion—as more nurses quit, fewer are available to care for the steady stream of patients that come and go, forcing the remaining nurses to take on a larger number of patients, which inevitably increases their stress and dissatisfaction, causing more nurses to leave, and on and on. Providing adequate, let alone optimal, patient care under these conditions becomes a very challenging task.

From the perspective of nurses, the most detrimental manifestation of managed care's relentless focus on reducing labor costs was three workplace practices related to nursing care: understaffing, mandatory overtime, and floating.

Nurse staffing concerns over the past 20 years led to a significant amount of research on understaffing and its impacts on health care. For example, a study by Rogowski and colleagues (2013) found that understaffing in neonatal intensive care units, relative to national guidelines, was common and widespread and was associated with an increased risk for nosocomial infections in very low birth weight infants. Also, an influential study by Aiken and colleagues (2010) found that nurse understaffing was associated with significantly higher patient mortality levels. Moreover, research by Kane and colleagues (2007) found that increased nurse staffing in hospitals was associated with lower hospital-related mortality, less failure to rescue, and other improved patient outcomes. Greater nurse staffing was

also associated with better outcomes in intensive care units and in surgical patients. Overall, the research on this issue strongly indicates that insufficient nurse staffing significantly reduces the quality of care that RNs are able to provide.

Similarly, research has found that mandatory overtime compelling nurses to work beyond their assigned shifts is associated with significant patient care problems (American Association of Critical-Care Nurses 2016). A study by Trinkoff and colleagues (2011), for example, found that excessively long work hours for hospital nurses over a six-month period were significantly related to patient mortality, after controlling for staffing levels and hospital characteristics. Another study found that the risk of medical errors was three times higher when RNs worked shifts lasting 12.5 hours or more (Rogers et al. 2004). Research has also demonstrated that long work hours have adverse impacts on nurses as well as on patients. The use of excessive overtime has been associated with increases in RNs' needlestick injuries and musculoskeletal problems (Clarke, Rockett, Sloane, and Aiken 2002; Trinkoff, Le, Geiger-Brown, and Lipscomb 2007), as well as other work-related illnesses and injuries (de Castro et al. 2010).

A review of the literature on floating has found that the practice increases stress and dissatisfaction among RNs and can lead to adverse impacts on the quality of patient care generally and on specific problems such as increased bloodstream infections (Dziuba-Ellis 2006; Larson et al. 2012).

As discussed previously in this chapter, many nurses have turned to unionization as a way to gain a greater voice in the workplace. In particular, nurses have used this greater voice to try to address the challenges to patient care posed by understaffing, mandatory overtime, and floating. To do so, most nurses unions have employed some combination of three voice mechanisms—collective bargaining, joint collaboration and partnerships, and lobbying and legislative action. Each of these mechanisms and the manner in which different nurses unions have employed them is examined in the following sections.

Collective Bargaining

As the result of an amendment to the National Labor Relations Act, RNs working in nonprofit or for-profit acute care hospitals have had the right to organize unions, engage in collective bargaining, and strike (after giving ten days' notice) since 1974. To form a union, nurses in a facility must provide evidence to the National Labor Relations Board (NLRB) that at least 30% of eligible RNs would like an election to decide whether to have union representation. If an election is held, a majority of nurses who vote in the election must vote for the union for it to be certified as their official bargaining representative.

Certification means that the management of the facility is obligated to collectively bargain over wages, hours, and other terms and conditions of employment. Patient care issues such as staffing levels, mandatory overtime, and floating are considered "other terms and conditions of employment," and employers must negotiate over those issues if they are brought up by the union. Whether a union can convince management to agree to its proposals concerning staffing levels, mandatory overtime, and floating depends on the strength and skill the union brings to negotiations.

Staffing Levels

In 2015, the New York State Nurses Association (NYSNA) signed what they described as a "historic" contract covering 17,000 RNs working in 12 private sector hospitals in New York City. The central focus of the negotiations leading to the contract was staffing ratios and their enforcement. The new agreement included a commitment on the hospitals' part to hire 1,000 new RNs to meet the need for more nurses created by previously negotiated staffing ratios. To better enforce the agreed-to staffing ratios and other issues, the contract included language creating joint union–management professional practice committees (PPCs) in each hospital. The main purpose of these committees is to monitor and enforce the negotiated nurse-to-patient ratios (New York State Nurses Association 2015).

The NYSNA contract is just one of the latest and most visible efforts by RN unions to win staffing language that enables nurses to provide high-quality care to their patients. Other examples are the contracts the Massachusetts Nurses Association (MNA) negotiated in 2011 with the Tufts Medical Center in Boston and St. Vincent Hospital in Worcester that featured significant improvements in nurse-to-patient ratios. At Tufts, the hospital agreed to limit patient assignments for nurses working on the medical–surgical floors to six patients on the night shift and to no more than two patients in the intensive care units. The hospital also agreed to language in the contract that ensures that the hospital will not move to a six-patient assignment on medical–surgical floors during the day and evening shifts, for the life of the agreement. In addition, the hospital made a commitment to convert a number of temporary travel nurse positions to core staff, which will further improve care on a number of units (Massachusetts Nurses Association 2011).

At St. Vincent's, the new contract reduced medical–surgical nurse-to-patient ratios from up to six patients on days and evenings and up to seven patients on nights to a limit of four to five patients per nurse on days and evenings and no more than five patients on the night shift. The hospital also agreed to improve RN-to-patient ratios in the hospital's maternity

unit to bring them in line with established national standards for maternity care. Another feature of the contract was the addition of a "resource nurse" to supplement core staffing on medical–surgical and telemetry floors on day and evening shifts, coordinate the flow of patients in and out of the units, and support RNs caring for patients with complex needs (Massachusetts Nurses Association 2011).

The NYSNA and MNA contracts are emblematic of collective bargaining involving RN unions in recent years. These settlements build on contracts negotiated across the country over the past 10 to 15 years that have established minimum nurse-to-patient staffing ratios in an effort to improve the quality of care in American hospitals.

Some nurses unions have found that including staffing levels in contracts does not ensure that a hospital's administration will always abide by those standards. Sometimes hospitals will choose not to do so; other times, they are unable to abide by the standards because they do not have an adequate number of RNs. For that reason, nurses unions are now negotiating contract language that requires that staffing disputes be resolved by neutral third parties. For instance, many of the contracts negotiated by the CNA contain provisions requiring the parties to submit any dispute over nurse staffing levels, whether it be contractual or legislatively mandated ratios, to a tripartite arbitration panel made up of one member selected by the union, one member selected by the employer, and a third neutral member jointly chosen by the union and the employer (California Nurses Association 2016a). This provision takes the unilateral right to make decisions about staff out of the hands of management and places it in the hands of a neutral arbitrator—and the fact that the union has the option to take such disputes to arbitration serves as an incentive for management to follow the negotiated staffing guidelines.

Finally, some unions have successfully negotiated provisions that give nurses the final say on appropriate staffing levels. The Minnesota Nurses Association (MINNA) has contract language that gives charge nurses authority to determine whether sufficient staffing resources are available to meet patient care needs and to close the unit to further admissions if staffing is not sufficient (Minnesota Nurses Association 2004). This does not appear to be a widespread practice, at least currently, but it does present model language to which RN unions can aspire.

Mandatory Overtime

When hospitals try to cut costs by operating with the absolute minimum nurse workforce possible, problems arise when a nurse calls in sick or a hospital experiences a higher than normal census. When that happens, administrators turn to mandatory overtime to meet their staffing needs.

Not only is mandatory overtime disruptive to an RNs family life by keeping nurses from meeting family commitments and obligations, it also has negative ramifications for patient care because tired nurses are significantly more prone to making medication errors and suffering lapses in judgment.

One way that RN unions protect their members from the dangers of excessively long hours is by negotiating contractual bans on mandatory overtime. Florida's National Nurses United (NNU) won such protection from mandatory overtime in 2012 for 3,100 RNs at ten Florida hospitals that are part of the Hospital Corporation of America (HCA), the nation's largest for-profit hospital chain (Indest 2012).

The single employer contract covering the largest number of nurses (18,000), between Kaiser Permanente (KP) and the CNA, was one of the first to contain contract language prohibiting the employer from assigning mandatory overtime. Dating back to 2002, CNA contracts have had some of the strongest language on this issue of any nurses union in the country (Business Wire 2002).

Another 17,000 to 18,000 RNs work for KP but are represented by unions other than CNA, including the United Nurses Association of California (UNAC), an AFSCME affiliate; the Oregon Federation of Nurses and Health Professionals (OFNHP), an AFT affiliate; and local unions represented by the UFCW and the OPEIU (Pruitt 2016). These nurses are covered by separate agreements with KP. They were able to get KP to discontinue the use of mandatory overtime in 2003 (the only exception to the ban on mandatory overtime being a government-declared state of emergency) (Kaiser Permanente 2010).

The goal of most nurses unions is a complete ban on mandatory overtime, and an increasing number of contracts contain such language. However, when not able to win a complete ban on overtime, many nurses unions have settled for language that limits mandatory overtime. One such approach is to negotiate contract language that limits its use to emergency situations. SEIU has negotiated such language into their contract with the University of Iowa Hospitals and Clinics. While the language does not eliminate forced overtime, the hospital can no longer force nurses to work overtime instead of hiring more staff to fill vacant positions (Service Employees International Union 2016a).

Another approach to reducing mandatory overtime is to place limits on the amount of overtime employees can be forced to work. The Ohio Nurses Association (ONA) has done this at Northside Medical Center in Youngstown, where management cannot require RNs to work more than 33 hours of mandatory overtime during a calendar year (Cotterman 2015).

Floating

Floating is the practice of moving nurses from their regularly assigned areas to parts of the hospital with a greater need. Many RNs believe this is a problematic practice, particularly when an RN is required to work in an area of the hospital in which he or she has insufficient experience or knowledge to deliver the kind of care required. For example, in many hospitals it is not uncommon to float a nurse who works in a general medical–surgical unit to the intensive care unit or the emergency room, where they are unfamiliar with the procedures, equipment, and medical conditions they will face (Eakin 2016).

Floating is an additional issue that nurses unions are trying to address through collective bargaining. Given that a complete ban on floating is, in most cases, unrealistic, unions have worked to place restrictions on the practice. The most common language negotiated on this issue is a prohibition on moving nurses to areas that are outside their areas of expertise. For example, SEIU's contract with hospitals in New York City includes comprehensive floating policies guaranteeing that nurses cannot be floated to areas where they do not have appropriate qualifications and training and where they have not had an up-to-date orientation (Service Employees International Union 2016b).

Another approach is negotiating contract language requiring that nurses be cross-trained to work in multiple areas and limiting floating to those specially trained nurses. Nurses represented by SEIU Healthcare NW and working at Swedish Medical Center in Seattle have a contract provision that requires that cross-trained nurses be floated before other nurses are (Service Employees International Union 2016c).

Where they can, RN unions bargain "float differentials" requiring hospitals to pay floating nurses a wage premium above and beyond their normal rate. And in some hospitals, contract provisions are included that mandate the creation of special "float pools." This arrangement is a part of an agreement negotiated by SEIU at Swedish Health Services Hospital in Seattle. At that facility, floating is handled by a special group of nurses who receive extensive, wide-ranging training. These nurses also receive a $5 per hour wage differential (Service Employees International Union 2016c).

The CNA has also negotiated language that prohibits "double floating" (the practice of moving nurses a second time in mid-shift) (California Nurses Association 2016a).

Collaboration and Partnerships

A second strategy RN unions have employed to increase nurse voice in decisions involving patient care is the formation of collaboration and partnership mechanisms through which nurses have regular opportunities to

discuss patient care–related issues with management. These committees are often established in bargaining and operate throughout the life of a contract. They take many forms, including nurse staffing committees, professional practice committees, joint nursing practice councils, patient care committees, and staff ratio oversight committees; on a regular basis (e.g., biweekly, monthly, quarterly); and often include equal numbers of representatives from the union and from hospital administration.

The effectiveness of collaborative efforts in bringing about change in patient care practices appears to vary considerably. The formation of such groups does not guarantee that the union and employer representatives involved will be able to shift from an adversarial mode to a cooperative one. Where they are able to do so, however, significant improvements to the delivery of quality care can result.

The largest—and most extensive—partnership in the health care industry is the Kaiser Permanente Labor Management Partnership (KPLMP). It includes over 86,000 employees and more than 25 local union partners from eight international unions. However, CNA/NNU has chosen not to participate in the KPLMP. The 17,000 CNA/NNU nurses working in 70 of the KP facilities in northern and central California represent the largest group of eligible employees not participating in the partnership. CNA/NNU refuses to be a part of KPLMP because it believes an adversarial approach is the only effective means to address the problems its members face (California Nurses Association 2008; Clark and Clark 2008).

However, as mentioned previously, several other unions representing approximately 17,000 to 18,000 RNs at KP do participate in the partnership. Those unions include UNAC and OFNHP, as well as local unions represented by UFCW and OPEIU (Pruitt 2016).

Staffing

Staffing issues are a primary topic of discussion for these committees. In the absence of established staffing ratios, a nurse staffing committee could be given the responsibility to put together a staffing plan for a hospital that might set staffing guidelines or even specific staffing levels (American Nurses Association 2016b). Where such guidelines or ratios are in place, these committees often monitor compliance and resolve disputes over staffing. Where they are not, the committees can serve to gather data and study staffing patterns and problems as a first step toward developing solutions.

Mandatory Overtime and Floating

Where mandatory overtime or floating is restricted or banned by contract language or legislation, joint committees can serve to monitor compliance.

In the absence of such restrictions, committees can gather information about such practices and begin to work on solutions.

Lobbying/Legislative Action

In addition to addressing patient care and nursing practice concerns through bargaining, nurses unions also use lobbying and the legislative process to bring about change. The quality of patient care is a potent political issue. Moreover, nurses have a very positive public image, which makes them a formidable political force and allows them to effectively lobby for legislation they support (Sachs 2014).

Staffing

Legislation that sets minimum staffing levels has a significant advantage over the negotiation of staffing levels in collective bargaining agreements. Staffing laws can cover every hospital under a legislature's jurisdiction. Thus, legislation would do across the board what might take nurses unions years, or even decades, to achieve on an individual contract-by-contract basis.

The passage of federal legislation would clearly be the most effective way for unions to address patient care and nursing practice issues. A coalition of nurses unions has successfully lobbied to have the Nurse Staffing Standards for Patient Safety and Quality Care Act, a bill establishing minimum staffing levels, introduced in Congress in every legislative session since at least 2004. The bill has been strenuously opposed by the American Hospital Association, the industry's employer group, each time it has been introduced and has little chance of being enacted in the near future. State legislatures, at least in some parts of the country, have been more open to such legislation (McDonagh 2014).

The most significant effort to date in this regard has been in California, where a ten-year campaign by nurses unions resulted in the 1999 passage of a law mandating RN-to-patient ratios in California hospitals. Hospitals in the state fought the legislation, arguing that, because of the ongoing nurse shortage, the law's passage would cost them $500 million annually and might force them to shut down some of their facilities if they were unable to find enough nurses (California Healthcare Association 2003). At the hospitals' behest, then–Governor Schwarzenegger raised legal challenges that delayed the implementation of the mandated ratios.

However, in early 2005 the court challenges were dismissed and hospitals in that state were ordered "to implement ratios of no more than one RN for every five patients in general medical units" and to restore safe staffing in emergency rooms (California Nurses Association 2016b). The ratios required by the act are significantly better than those found in most American hospitals (such ratios vary from 1:6 to 1:10 or even more), and

nurses unions expect the law to attract more nurses to California and have a positive impact on patient care (Lafer 2005).

The CNA was a leader in the effort to establish safe staffing through legislatively imposed RN-to-patient ratios. They have since added a second mechanism to ensure that California hospitals fully implement the established ratios. The CNA makes the establishment of professional practice committees (PPCs) a priority in bargaining at each new hospital it organizes. The PPC is an "RN-controlled" committee "with the authority to document unsafe practice issues and the power to make real changes." The committee is composed of elected staff RNs representing each nursing unit. It meets on paid time at the hospital worksite to monitor the implementation of nurse-to-patient ratios established either through legislation or bargaining. The committee also has the authority to address and change any other patient practice issues it deems unsafe (California Nurses Association 2016a). The addition of negotiated PPCs is an example of unions using combinations of strategies, in this case legislation and contract language, to win advances in patient care.

Massachusetts is the only other state to date that has implemented mandatory nurse-to-patient ratios. In contrast to California, its law is limited to intensive care units (ICUs) for which it requires ratios of 1:1 or 1:2 depending on the stability of the patient. The driving force behind the passage of this legislation was the Massachusetts Nurses Association (MNA), which has been lobbying the Massachusetts state legislature to pass a comprehensive staffing bill since at least 2002. The union sees the passage of the ICU staffing law as a stepping stone to more extensive staffing legislation (Massachusetts Nurses Association 2014).

While California's efforts in the area of safe-staffing legislation have not been replicated, seven other states have passed laws requiring hospitals to have staffing committees responsible for plans and staffing policy. Those states are Connecticut, Illinois, Nevada, Ohio, Oregon, Texas, and Washington. As in California and Massachusetts, nurses unions have been among the main advocates for these laws (American Nurses Association 2016b). While unions have worked hard to establish staffing committees via contract language, establishing committees by legislation accomplishes more because all acute care hospitals in a state would be required to create such committees.

Mandatory Overtime

Legislation has also been introduced at the federal level to address the problem of mandatory overtime in health care settings. The Safe Nursing and Patient Care Act "would prohibit the requirement that a nurse work more than 12 hours in a 24 hour period and 80 hours in a consecutive 14 day

period, except under certain circumstances" (American Nurses Association 2016c). The act was strongly supported by nurses unions, but it has not become law (GovTrack.US 2016).

At the state level, however, unions representing nurses have made much more progress in addressing the problem of mandatory overtime. To date, 16 states have passed laws restricting mandatory overtime for RNs: Alaska, Connecticut, Illinois, Maine, Maryland, Massachusetts, Minnesota, New Hampshire, New Jersey, New York, Oregon, Pennsylvania, Rhode Island, Texas, Washington, and West Virginia. And two states—California and Missouri—restrict the use of mandatory overtime by regulation (American Nurses Association 2016d; Wood 2012). Most ban compulsory overtime after a nurse has worked 12 hours, although the New Jersey law prohibits it after eight hours, except in the case of an emergency (American Nurses Association 2016c). Again, in virtually all of those states, nurses unions have been the moving force behind the passage of this legislation.

Floating

Floating is an issue on which nurse unions have made little legislative progress. Their efforts to address this issue have focused largely on the negotiation of collective bargaining provisions restricting the practice.

NURSES UNIONS, VOICE, AND ADDITIONAL PATIENT CARE ISSUES

While this chapter has focused on the three patient care issues that have garnered the most attention from nurses unions, there are a number of other patient care issues on which nurses unions have had an impact by giving nurses greater involvement in patient care decisions. In most of those cases, nurses unions have used a combination of two of the mechanisms discussed in this chapter to provide nurses with the opportunity for greater voice. Those mechanisms are collective bargaining and union–management collaboration/partnership. The following case studies provide more details on these approaches.

The California Nurses Association's Registered Nurses Quality Liaison Program

The CNA used one of these mechanisms, collective bargaining, at the Kaiser Permanente (KP) hospitals in California at which they represent RNs to establish the Registered Nurses Quality Liaison (RNQL) program. Part of the contract settlement of 1998, the RNQL program created 18 new positions "focused solely on identifying and solving systemwide Kaiser nursing practice issues (California Nurses Association 2015: 9)." The program's goals included improving the quality of patient care and outcomes

and increasing "staff RN/NP participation in the quality assurance and/ or performance improvement process within the organization (California Nurses Association 2015: 17)." These new positions were staffed by RNs selected by bargaining unit nurses themselves and resulted in recognition of the fact that nurses, because of their significant experience and knowledge, were qualified to play a more important role in decision making about patient care, safety, and quality (California Nurses Association 2015).

The program caused KP nurses to "really begin to think of themselves as on par with nursing colleagues in administration" and "gave [them] control of their practice and acknowledged that they are the experts in their field of nursing practice" (California Nurses Association 2015: 9). Over the years, the number of RNQL positions has more than doubled, from 18 to 37, and the program has made innumerable contributions to improved care.

The RNQL program is, at its heart, an employee involvement program, but because of CNA's strong opposition to union–management collaboration in general, and the KPLMP in particular, the language of the program downplays any cooperative angle. From CNA's perspective, the program is a union initiative that they bargained for and won to give their members a greater voice in running KP. The RNQLs are elected by their fellow nurses and are independent from the employer, thus distinguishing the program from KPLMP initiatives.

RNs and nurse practitioners (NPs) working as RNQLs represent CNA on quality process/structure committees, KP's acuity staffing system, professional performance committees, the Nurse Practitioner Regional Committee, and home health committees. These opportunities provide RNQLs with much greater information and access to important contacts in the KP system (California Nurses Association 2008).

CNA believes that the RNQL program has been a significant asset to patient care. Examples of initiatives resulting from the program include the creation of protocols at KP's call centers and after-hours clinics for addressing requests for information from pregnant women. Previously, such callers were instructed to either see their primary care provider the next day or to seek care at a nearby emergency room. The new protocols provided increased and immediate access to valuable information and to care opportunities (California Nurses Association 2008).

The RNQL program was also instrumental in developing both a peer review process and a formal mentoring program for NPs. Nurse practitioners who furnish medications are required by California state regulations to participate in peer review processes to ensure that all NPs are aware of standards of patient care. The RNQLs worked with KP to create and implement a peer review program for KP facilities in northern

California that met the legal requirements. CNA also negotiated a contractual agreement to create an NP mentoring program. RNQLs were instrumental in shaping the mentoring program so that it would meet the needs of NPs (California Nurses Association 2008).

The RNQLs also created a Staff Nurse Quality Awareness program. This program was designed to increase awareness and participation among the nurse workforce in KP's various quality structures. For example, RNQLs resolved a problem in the Bariatrics Service Department at KP that involved a confusing insulin order form that had led to medication errors. RNQLs redesigned the form, eliminating the possibility of potentially serious mistakes in administering insulin (California Nurses Association 2008).

SEIU Healthcare Pennsylvania/Allegheny General Hospital Partnership

Another substantial example of nurses and their unions collaborating with management to improve patient care is the partnership SEIU Healthcare Pennsylvania negotiated with Allegheny Health Network (AHN) in Pittsburgh. This initiative has provided RNs at that hospital with opportunities to develop and implement structures that give nurses a greater voice in improving care delivery and actually result in processes to improve patient satisfaction, patient outcomes, and the financial health of the hospital (Zobrist 2016). Lauded by U.S. Secretary of Labor Thomas Perez as a "national model for labor–management partnerships," the initiative centers around teams and training programs that are created to work on specific areas of improvement using methods based on the "lean manufacturing" approach (Labrador 2014).

Established in 2008, the initiative was funded by grants provided by AHN and the Pennsylvania Department of Labor and Industry. In 2013, the union negotiated for additional funding from the hospital's management. In past years, nurses and management at AHN collaborated on a comprehensive, nurse-driven, quality and performance improvement initiative that created and implemented programs to reduce infections, streamline processes, improve reporting accuracy, and cut down on time taken away from care (Zobrist 2016).

In 2014, five registered nurses at AHN's Allegheny General Hospital developed and implemented a work plan to reduce two "hospital-acquired conditions." The team addressed central line–associated bloodstream infections in the surgical intensive care unit and catheter-associated urinary tract infections in the medical intensive care and step-down units at the hospital. The plan resulted in the virtual elimination of those infections in targeted units in the first month of the initiative (Service Employees International Union 2015).

The program has evolved over time. Most recently, the union and the hospital agreed to a structure that includes four newly created positions called quality coaches. These positions are filled by front-line RNs from the bargaining unit who work full time to support the quality improvement projects of unit-based teams, who are the heart of the program. The parties have committed to the creation of 30 quality teams across the AHN. Significant training is provided to all participants in the program. Already these teams have identified a number of problems to focus on. These issues include patient falls, the manner in which patient assignments are distributed, and patient flow in the emergency room (Zobrist 2016). The agreement also provides for the hiring of a quality manager paid for by AHN and a quality coordinator, whose salary is paid partly by the union (65%) and partly by the health network (35%) (Zobrist 2016).

The increased commitment made by the AHN RNs, the union, and the health system's administration is a testament to the positive experience they have had since the partnership began in 2008. The additional investment has the potential to result in significant improvements in patient care in the years ahead.

The Vermont Federation of Nurses and Health Professionals/ University of Vermont Medical Center Model Unit Process

The Vermont Federation of Nurses and Health Professionals (VFNHP) is an affiliate of the American Federation of Teachers. It represents licensed practical nurses (LPNs) and RNs at the University of Vermont Medical Center (UVMC) (formerly Fletcher Allen Healthcare), an academic medical center in Burlington, Vermont. The Model Unit Process (MUP) is a joint problem-solving process designed to improve quality of care and patient safety.

The MUP has its roots in a 2006 dispute between VFNHP and UVMC over the application of contract language about staffing levels. In the process of arbitrating the dispute, the union offered to withdraw its grievance if the hospital would agree to work with the union on developing a collaborative mechanism that, in addition to jointly determining appropriate staffing levels, would work to find solutions to other care-related problems (Lazes, Figueroa, and Katz 2012). The UVMC administration agreed, and the MUP was established in a sidebar agreement. It was not until 2009 that the process formally became a part of the labor agreement.

Like most union–management collaboration programs, the MUP process has changed and adapted as the parties have learned which processes and structures work and which do not. Since 2008, the MUP program has involved four units at a time. MUP teams comprised of managers and bargaining unit members undergo joint training to prepare themselves to

work together on projects over a six-month period. The teams are asked to take on four projects. Two of the projects are required to address the systemwide issues of infection prevention and improved communication. The teams have the opportunity to pick two unit-based issues for their other projects. MUP team responsibilities involve coming up with innovative solutions to problems. Once those solutions are conceived and developed, the implementation of the solutions is usually turned over to that unit's professional practice council (PPC). Unlike MUP teams, which operate for a fixed period of time, PPCs are joint bodies that operate on an ongoing basis (Lazes, Figueroa, and Katz 2012).

The MUP initiative has contributed numerous innovative solutions to significant patient care problems. For instance, the UVMC psychiatric unit MUP tackled an unusual, but critically important, problem that psych units nationwide face. A portion of the inpatients in psychiatric units have a much higher rate of exposure to bedbugs than the population at large. When these patients are admitted, there is a risk that they will introduce this problem into the hospital. This was an ongoing concern in the UVMC psych unit (Lazes, Figueroa, and Katz 2012).

To address this problem, the unit's MUP team developed a more systematic protocol for dealing with the means by which bedbugs can be introduced into the ward. This protocol included making sure that "patients' belongings were bagged and stored on the unit, [that] patients were screened for bedbug exposure, [that] social workers alerted those bringing belongings to bring them in plastic bags and to pack no more than three changes of clothes, and [that] belongings were searched in a designated non-carpeted area" (Lazes, Figueroa, and Katz 2012: 39).

The nurses and nurse managers involved in the UVMC Orthopedic and Urology Surgical Unit's (OUSU) MUP choose the reduction of patient falls as one of its projects. At the time the MUP team took on this project, the OUSU's fall rate was 3.07 per 1,000 patient days, which was above UVMC's target fall rate. The OUSU MUP group set 2.00 falls per 1,000 patient days as its goal and proceeded to develop strategies for meeting this target. These strategies included "the use of bed alarms according to policy for all patients, LNA and RN alternating hourly rounds, charge nurse responsibilities to include the printing of a list of fall risk patients and monitoring bed alarm use of fall risk patients, and posting a list of fall free days in the nurses station to keep staff focused on preventing falls" (Lazes, Figueroa, and Katz 2012: 37).

In the months following the implementation of the corrective strategies recommended by the MUP team, the patient fall rate for the OUSU was 2.00 per 1,000 patient days. As a result, the OUSU PPC took steps to ensure that the strategies would remain in place after the MUP project concluded (Lazes, Figueroa, and Katz 2012).

The UVMC Outpatient Surgery MUP team also came up with an innovative plan to improve patient outcomes in its unit. Citing research that indicated "that patients who are warmer during their surgery spend less time in the hospital as sustained normothermia promotes healing and reduces surgical site infections," the MUP team put in place a plan to keep patients' temperatures at or above 98.6°F (36°C) during their time in the Post Anesthesia Care Unit. After investigating various alternatives, the MUP group decided to use Thermolite hats and warming blankets to keep patients at the proper body temperature to maintain normothermia. After implementing the plan, the team put in place a recordkeeping system that would, after substantial time had gone by, allow the effectiveness of the effort to be evaluated (Lazes, Figueroa, and Katz 2012: 37–38).

Maimonides Strategic Alliance

A last example of a labor–management partnership designed to improve the quality of care in a hospital setting is the Maimonides Strategic Alliance (MSA). The MSA differs from the other partnerships discussed in this chapter because it includes multiple unions representing a range of occupations.

Established in the late 1990s, the MSA is a partnership between Maimonides Health Center in Brooklyn, New York, and three unions: the New York State Nurses Association (NYSNA), representing RNs; the Committee of Interns and Residents (CIR), an SEIU affiliate representing physicians (house staff and residents); and 1199SEIU United Healthcare Workers East (1199), representing the support and technical employees. According to the Strategic Alliance Report 2007, the MSA

> is grounded in the belief that fostering respect among employees and supervisors, promoting rank-and-file leadership, encouraging broad workforce participation in problem-solving and decision-making, and developing a true partnership between unionized workers and management are all essential to the Medical Center's success. (Strategic Alliance 2007: 4)

The MSA is overseen by a hospital-wide Labor Management Council (LMC). Most of the work of the partnership is done by Departmental Labor Management Committees (DLMCs) formed "to work on quality of care and patient satisfaction issues, as well as issues related to employee needs of respect and input into decision-making" (Strategic Alliance 2007: 4). All participants are provided with extensive training on problem solving and teamwork.

Over the years, the nurses participating in the MSA have made many significant contributions to improve the quality of nursing care at the hospital, such as a hospital-wide strategy for reducing patient falls. The

strategy cut the number of falls by almost half. At the same time, the use of patient restraints was significantly reduced. DLMCs involving RNs also have developed strategies to reduce the prevalence of pressure sores among patients at risk for that complication. They also initiated an immunization program for elderly patients in danger of developing pneumonia and other bacterial infections (Strategic Alliance 2007).

In addition to the contributions that nursing-related DLMCs have made to patient care, the fact that the MSA involves nearly all professional and nonprofessional occupations means that similar quality-related initiatives occur in every department and unit in the hospital. For example, the physicians in the Cardiology DLMC helped assess and improve the way that caregivers respond to cardiac monitor alarms (emergency codes), decreasing average response times to less than one minute. Likewise, the manner in which special dietary meals are prepared and delivered have undergone significant changes as a result of a DLMC initiative that included a workflow analysis and retraining program led by the hospital's food and nutrition staff. The goal of the initiative was to increase the percentage of meals delivered on time. That metric did in fact improve over time and is now in the high 90s.

As another example, the Environmental Services Study Action Team conceived and implemented a hospital-wide cleanliness and orderliness project to improve sanitation across the entire hospital. That project was part of a larger effort to prepare the hospital for scrutiny by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) (Strategic Alliance 2007).

An additional, and unusual, aspect of the MSA is that it is the mechanism by which managers and supervisors are hired at Maimonides. This joint hiring process has been in place for years, and while its impact cannot be measured directly, several departments led by managers hired under the MSA approach have seen significant performance improvements. While also hard to quantify, involving employees in hiring their supervisors gives them a stake in their supervisor's success and provides them with an incentive to help the supervisor succeed. It also ensures that the supervisor is going to be supportive of the partnership approach under the MSA (Strategic Alliance 2007).

CONCLUSION

Nurses see each of the issues discussed in this chapter—understaffing, mandatory overtime, and floating—as issues that affect the quality of the patient care they are able to deliver at their workplaces. The strategies nurses unions employ to address those and other issues—collective bargaining, joint consultation, and lobbying/legislative action—provide RNs

with direct and substantial opportunities to have a greater voice in shaping the way care is delivered in hospital settings in the United States.

The case studies discussed in this chapter demonstrate how collaboration and employee engagement in particular can expand the opportunity for nurses to have a voice in a wide range of patient care–related issues.

The opportunity for, and expansion of, RN voice in decisions involving patient care in a hospital setting is a development that benefits all of the stakeholders in the health care system—nurses, nurses unions, patients, administrators, and by extension, other health care workers. Nurses are at the heart of the care delivery system. They are better educated than ever before and have a deep commitment to quality care for their patients. The experience and knowledge they develop over time makes them a valuable and unique source of information and ideas.

No other health care professional spends as much time as RNs in actually delivering hands-on care to patients or has the intimate knowledge of patient needs that RNs do. Physicians and administrators are rarely around at 2 a.m. to see how the facility operates at that time of day. Nor do they regularly use the basic equipment required to take care of acutely ill patients on an hourly or daily basis. The combination of nurses' knowledge and commitment to patient care makes them a tremendous resource for ideas and suggestions about how to deliver care, as well as how to keep costs down. While they have much to contribute, nurses clearly also benefit from having a greater voice in patient care decisions. Helping to improve care increases job satisfaction, and having a greater say in decision making causes nurses to feel valued and appreciated.

Nurses unions benefit from the greater commitment of its members that results from the union providing a greater opportunity for them to have more input in their workplace and, as a result, creating a situation where they are able to provide the quality of care they believe they have a responsibility to provide. As a result, patients receive better care and outcomes, as suggested by the research on staffing levels, mandatory overtime, and floating.

Administrators also benefit from the improved outcomes and associated cost savings that result from enhanced RN participation in the patient-care decision-making process (although some administrators might see greater nurse involvement as diminishing their prerogatives, and hence the value and status of managers).

Finally, other health care workers benefit from improved patient care outcomes, as well as from an openness on the part of administrators to the expansion of voice opportunities for all employees that comes from positive experiences with nurse–administrator collaboration and partnership.

The promise of collaboration and partnership as a model for health care workplaces provides reason for optimism concerning the enormous

challenges facing the American health care system. The biggest single challenge facing that system is rapidly increasing costs. The cost issue threatens the very viability of health care in our society. The potential that collaboration and partnership has, if put in place across our health care system, is that it can, as demonstrated in this chapter, improve the quality of care for patients without increased costs and investment. Reducing infections by changing existing processes and practices can be accomplished without adding additional costs to patient care; in fact, the shorter hospital stays and reduced readmission rates for patients that result can decrease costs and provide an incentive to expand the use of collaboration and partnership. Similar cost savings can result from other improvements in patient safety, including the reduction in falls and faster responses to emergency codes.

While most of the cost savings cited are almost serendipitous (and secondary to) the primary goal, which is improved quality of care, the potential for collaboration and partnership to directly address the issue of cost reduction is great. RNs and other health care workers are very much aware that the continued increase in health care costs threatens their ability to provide care, which ultimately affects their own job security. This awareness provides significant incentives for those health care workers to use collaboration and partnership mechanisms that have proven successful in addressing the problem of health care costs.

Unfortunately, at the moment, successful collaboration and partnership programs involving nurses and other health care workers are the exception and not the rule. As long as there is willingness to do so, there is little reason that health care workers, the unions that represent them, and hospital administrations cannot expand this promising approach to health care workplaces across the United States. And the fact that many hospitals remain non-union does not mean that this approach is unavailable to those workplaces. The desire for, and the efficacy resulting from, increased voice are ubiquitous. While there is a need for greater experience with collaboration and partnership programs in the non-union sector, this approach, in theory, could bring many of the same across-the-board benefits it has created in the unionized health care sector.

The first step in moving in this direction is greater awareness—on the part of all parties—about the improvements that collaboration and partnership approaches can have in health care settings. Until then, nurses unions can continue to use collective bargaining and political/legislative work to try to improve patient care in American hospitals.

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